CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Sam Cain (a pseudonym)
Hearing dates:	**11 May 2021**
Date of findings:	**11 June 2021**
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate J Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death – Adequacy of medical care and treatment as an involuntary patient
File number:	2019/00040033
Representation:	**Counsel Assisting the Coroner** Ms Donna Ward instructed by Ms Clara Potocki, Senior Solicitor of the NSW Crown Solicitor's Office **Northern Sydney Local Health District** Mr Patrick Rooney instructed by Ms Violet Stojkova of Hicksons Lawyers
Non publication order:	**Pursuant to section 75 of the Coroners Act 2009 I direct that there be no publication of any material including any photograph or pictorial representation that identifies the deceased person (anonymised as Sam Cain) and the deceased persons' relatives as that term is defined in s. 75(3)).**
Findings:	I find that Sam Cain died on 5 February 2019 at the Royal North Shore Hospital, located in St Leonards NSW. The cause of his death was hanging and the manner of his death was from a self-inflicted injury caused with the intention of taking his own life.

IN THE CORONERS COURT

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NEW SOUTH WALES

Section 81 *Coroners Act 2009*

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of Mr Sam Cain who died whilst he was an involuntary patient at the High Dependency Unit at the Royal North Shore Hospital (RNSH).

2. Mr Cain was 23 years of age when he died at the RNSH on 5 February 2019.

3. In NSW, the *Coroners Act 2009*, invests coroners with special jurisdiction to investigate the cause and manner of death of a patient in a psychiatric hospital. All such deaths are required to be reported to the coroner.

4. It has long been accepted that the "rationale for singling out the deaths of psychiatrically unwell people who die while involuntary patients is that they constitute an especially vulnerable group within the community who are deprived of many of their rights through no fault of their own, but because of their symptoms."[1]

5. It is intended that a coronial investigation into the death of such patients ensures transparency and accountability; including the consideration of any care and treatment issues associated with the hospital and medical staff.

6. The role of a Coroner is found within section 81 of the *Coroners Act 2009* ("the Act"). A Coroner is required to make findings as to:

    a. The identity of the deceased;

    b. The date and place of the person's death;

    c. The physical or medical cause of death; and

    d. The manner of death, that is, the circumstances surrounding the person's death.

[1] Death Investigation and the Coroner's Inquest, Freckelton. I and Ranson D, Oxford University Press, 2006, page 17.

7. The issues in this case as to identity, date, place and manner of death are uncontroversial.

8. The principal issue in this case has become the consideration as to whether anything could have been done to have prevented Mr Cain's death.

9. In these proceedings, Mr Cain's family requested that a non-publication order be made. The Court previously made an interim non-publication order and proposes to make a final order preventing the publication of any material that identifies Mr Cain or his family. In these proceedings, Mr Cain has been referred to as Sam, to reflect the personal and less formal manner that his family and friends remember him. It is not intended as any disrespect to him or his memory.

Background

10. Sam was and is, the son of Mr Harold Cain and Mrs Susan Cain (both pseudonyms). In January 1988, Mr Harold Cain moved to Australia and reunited with Mrs Susan Cain who had moved to Australia in October 1987. Sam's parents were married in Australia in 1989. He is the younger brother of his sister, Meredith (a pseudonym). His sister was born in 1992. Sam was born at the Mater Hospital at North Sydney in 1995. There were no reported complications associated with his birth and he was described as a happy and healthy child.

11. Sam attended Cammeray Public School from Kindergarten until Year 6. He attended Killarney High School from Year 7 – 9. He then attended St Andrew's Cathedral School from Year 10 – 12. He enjoyed playing sport, including soccer, baseball, surfing and rugby. He was known to be a talented musician with a keen sense of humour. He was described as a personable and sociable person, with many friends.

12. Sam's family noticed a change in his behaviour when he was about 15 years of age. He was spending less time at home and more time with his friends. His family were concerned that he was possibly consuming alcohol and cigarettes when he was socialising with his peers; however his family perceived that his behaviour was typical of teenage experimentation.

13. In April 2014, Sam's father returned to live in Japan. His sister, Meredith, also returned to Japan in 2014. Sam's mother remained in Australia, residing in Sydney.

14. In 2014, Sam commenced studying at Wollongong University, and was residing on campus. He had enrolled in a mining engineering course. He continued with his studies for just over one year, until he withdrew from his course. At the time, he told his mother that he was bored with his studies, was sleeping a lot and missing classes as a result. During the time that he was studying in Wollongong, he was working on a part time basis at restaurant in Chatswood and would visit his mother on a regular basis when he was in Sydney.

15. After withdrawing from his studies, Sam moved to a share house off campus in Wollongong and commenced working at a restaurant in Wollongong for the next six months.

16. In May 2015, Sam asked to borrow his mother's car to go shopping at Chatswood. Sam drove the car to Wollongong as he believed that he was going to start a cleaning business with his flatmates. Sam was then encouraged by these flatmates to sell the car without his mother's permission and to give them the proceeds of the sale of the car. Sam insisted that he received no financial benefit from the sale of the car. Sam's mother was of the view that Sam may have become involved in some sort of drug related scam.

17. In August 2015, Sam spoke with his mother, stating that "I'm in trouble, please help me. I want to go back to Japan with you."[2] Sam's mother stated that he then explained what had occurred with her car and that she then reported the incident to the police.

18. On 13 August 2015, Sam returned to live with his parents in Japan, (although Sam's father stated that this occurred in August 2014). Both parents noticed that Sam appeared to withdraw socially, rarely leaving their home, not studying or working. His sister indicated that he spent most of his time on his computer.

19. In May 2017, Sam's mother stated that he said to her "Please call an ambulance I want to go to hospital because I feel I want to die".[3] Sam was admitted to Obu Hospital, where he remained for three months. During that time, Sam was placed on medication and was diagnosed with schizophrenia. (Note: Sam's father recalled that this occurred in either 2015 or 2016).

20. After three months, Sam was transferred to another hospital, Yagoto Hospital which was described as a newer facility with better resources. His new treating doctor did not agree with the diagnosis of schizophrenia, and perceived that Sam was more likely to be suffering from ADHD or Asperger's Syndrome. His medication was changed, and he appeared to respond positively to the change in his medication. After Sam was discharged from hospital, he attended for regular assessments of his mental health and his medication. At that time, he was prescribed Aripiprazole, an anti-psychotic. Sam found employment and appeared to be stable in the community.

21. Whilst it now appears that Sam may have experienced symptoms consistent with an emerging mental illness prior to his return to Japan, it was only after his return to Japan that he received any type of medical intervention.

22. Sam returned to Australia in January 2018. He commenced studying a Computer Science Degree at the University of Technology (UTS). He moved into onsite accommodation at the UTS campus and was residing alone. He withdrew from his studies after one semester, and as a result, vacated his university accommodation. Sam moved in with family friends, Ms Towns (a

[2] Statement of Susan Cain, dated 10 February 2019, page 2, Tab 10, Exhibit 1.
[3] Statement of Susan Cain, dated 10 February 2019, page 2, Tab 10, Exhibit 1.

pseudonym), her daughter Sarah (a pseudonym) and Mr Taylor (a pseudonym), for around 6 months until December 2018. Both families had been close friends during the time Sam and Sarah were growing up in Roseville, and Sarah related to Sam as a brother. Sam commenced working in a restaurant and appeared to be happy and well.

23. Mr Thomas (a pseudonym), a former school friend remained in regular contact with Sam, both in Australia and in Japan. Mr Thomas commented that upon his return to Australia in 2018, Sam appeared to "be happy and was making heaps of friends."[4] Mr Thomas noted that after leaving the Towns' home in December 2018, Sam began living in shared accommodation in Chatswood. Mr Thomas indicated that Sam would not tell him where he was living and believed that he was living in the garage area of the shared premises. Mr Thomas commented that Sam's mental state was always going up and down during this time.

24. Mr Thomas stated that he would try and catch up with Sam every two weeks and that Sam always appeared to have financial problems. Mr Thomas would pay for groceries and meals but would not give Sam cash as he had concerns.

25. In December 2018, Mr Thomas received word that Sam's grandfather had died in Japan. Mr Thomas understood that Sam was not able to travel to Japan for the funeral owing to his financial difficulties. He knew that Sam was close to his grandfather and that he began receiving messages from Sam which caused him to believe that Sam was in "a bad state".

26. On 6 January 2019, Mr Thomas saw on Sam's Instagram account that he had purchased a car and believed that he would have experienced difficulties making repayments. Mr Thomas believed that Sam had purchased the car to assist with attending baseball matches which he had recently resumed playing.

27. On 24 January 2019, Mr Thomas saw Sam at his workplace. It was at this time that Sam stated that he was taking cocaine and that he owed money.

Re-emergence of symptoms in 2018 – 2019

28. During 2018, Sam reported feeling stressed and depressed and was worried that he was failing at his university course. With the support of the Towns' family, Sam sought help from the UTS Student Counselling Service.

29. His UTS counsellor referred Sam to the Acute Care Service of the Camperdown Community Mental Health Service, (Camperdown CMHS).

30. The Camperdown CMHS recorded that Sam had reported hearing:

> "multiple voices, derogatory or command in nature, denies being overtly distressed by these and displayed moderate insight in that he is able to recognize they are not real at times, also describes phenomena where he is able to know what people are thinking by their facial expressions,

[4] Statement of Mr Thomas dated 13 February 2019, page 2, Tab 12, Exhibit 1.

somewhat ego dystonic when describing these thoughts and other ideas/feelings he would experience, Sam unable to identify any particular precipitant that may have contributed to decline in mental state. Reports ongoing THC use (approx. 8-10 cones most days) and social ETOH use. Reports has been smoking THC for many years and consistently at this level since commencement of uni this year. Denied other illicit drug use".[5]

31. The discharge referral letter prepared by the Camperdown CMHS, dated 12 September 2018, stated:

> "Despite psychoeducation about psychosis and relapse Sam continued to decline restarting his medication and said he would be moving in October to Chatswood, closer to his workplace where he was working as a chef. Although there was concern that he was experiencing signs of relapse, there was still no immediate acute risk of harm to self or others warranting treatment under the Mental Health Act. He declined to have further appointments with the Camperdown service as he continued to believe he did not need it. He was discharged though referral was to be made to community mental health service covering Chatswood given possibility of relapse into psychosis. On discharge he was still residing at a family friend's home (the Towns' family home on the North Shore). Given there have been chronic symptoms despite some period of abstinence from cannabis, this is likely more than a purely cannabinoid induced psychosis, though substance use made by (sic) exacerbating it."[6]

32. Sam indicated to Camperdown CMHS that he had been charged with an affray resulting from an argument at his workplace that involved pushing and punching between himself and a co-worker who he stated had initiated the fight. Sam indicated that he had been convicted and fined for his involvement in the fight. The treatment notes stated that "he did not give details confirming any definitive psychotic reasoning or motive behind the fight at his workplace." [7]

Lower North Shore Community Mental Health

33. On 14 September 2018, Sam was assessed at the RNSH, mental health triage. The Hospital notes record:

> "Counselling after presenting with psychotic symptoms, experiencing auditory and olfactory hallucinations and paranoid about his computer being hacked, self reported has trouble with thoughts and not functioning normally. Some reluctance of concern over "bad smells". Believed he smelled "spit" on his moustache and on other people, had difficulty describing the smell. Nil other risk factors or concerns voiced at this time".[8]

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5 Lower North Shore Community Health records, pages 21-22, Tab 29, Exhibit 1.
6 Lower North Shore Community Health records, pages 24-25, Tab 29, Exhibit 1.
7 Lower North Shore Community Health records, page 24, Tab 29, Exhibit 1.
8 Lower North Shore Community Health records, page 7, Tab 29, Exhibit 1.

34. Sam was then referred to the Lower Northshore Community Mental Health (LNS CMH) service where he was assessed by Dr Blenkin (Registrar) on 20 September 2018. The medical records note the following:

> "On cross sectional review Sam is a chronically raised risk of harm to self and others due to long term [suicidal ideation] and previous aggression, however he is not an acute risk to self or others today, nor does he fulfill [Mental Health Act] criteria for involuntary treatment."[9]

35. On 25 September 2018, Sam did not attend the scheduled medical review. Mr Daniel Kimber, Clinical Psychologist and Case Manager with the RNSH Community Mental Health Intervention Service, attempted to contact him by mobile phone, however, he received no response.

36. On 26 September 2018, Mr Kimber again attempted to contact Sam by phone and text message. After receiving no response he went to the home of Ms Towns, in an effort to speak with Sam. Sam was not at home and was believed to be at work at the Japanese restaurant where he was working on a part-time basis. Mr Kimber asked Sarah to encourage Sam to contact the service. Later that day, Sam sent an SMS saying that he no longer needed treatment and that his symptoms had gone. He did confirm that he would attend the scheduled appointment on 28 September 2018.

37. On 28 September 2018, Sam cancelled his appointment. Dr Prachi Brahmbhatt, Staff Specialist Psychiatrist, discussed Sam's case with Dr Blenkin and Mr Kimber. Dr Brahmbhatt considered the previous assessments noting Sam's psychotic symptoms in the preceding three months, his admitted non-compliance with medications and refusing treatment. Dr Brahmbhatt formed the view that Sam was likely to be a significant risk of harm to himself and others if not treated. Dr Brahmbhatt considered the least restrictive option would be his treatment in the community and applied for a Community Treatment Order (CTO).

38. On 2 October 2018, Sam attended for his medical review. He described a range of ongoing psychotic symptoms. He denied any "suicidal ideations and described his mood as being 'good'"[10] . After the medical review, Sam was commenced on a long-acting anti-psychotic medication (aripiprazole) which was delivered as an intramuscular injection. The treatment plan included weekly case manager meetings, fortnightly medical reviews and a CTO being recommended. The progress notes record Sam as stating the following:

> "…- feels like he only hears the voices when he's down on himself
> -voices are only critical
> -voices tell him that he's "poor and cheap"…
> -states when it gets really bad "he's in a state of dying"
> -states he uses AO2 (type of Wi Fi) to talk to people, felt better when he could talk to 4G and television,

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9 Lower North Shore Community Health records, page 82, Tab 29, Exhibit 1.

10 Statement of Daniel Kimber, dated 21 August 2019, [12], Tab 23, Exhibit 1.

-states his thoughts are broadcast through the news…"[11]

39. On 9 October 2018, Sam attended the LNS CMH for his medical review. During his review he described ongoing psychotic symptoms. He was prescribed additional oral anti-psychotic medication (paliperidone). A brain MRI and an EEG were also recommended. Sam was given the relevant paperwork for his forthcoming CTO hearing.

40. On 16 October 2018, Sam cancelled his appointment with Mr Kimber, citing poor health. Sam and Mr Kimber spoke on the phone and Sam confirmed that he was feeling happy, however was still experiencing ongoing psychotic symptoms. The treatment notes comment that Sam also described experiencing:

> "gustatory hallucinations, suggesting that he had been tasting things like vegetables and foie gras, in the absence of having these things in his mouth. He described the experiences as pleasant and not distressing nor impairing and said he also experiences 'telegustory', which he described as telepathically communicating his taste sensations to other chefs."[12]

Sam confirmed that he had not filled his script for the paliperidone due to lack of funds. Sam consented to Mr Kimber contacting his family friends and sharing information. This was a very important development in the therapeutic relationship between Sam and Mr Kimber.

41. On 24 October 2018, Sam attended the LNS CMH for his CTO hearing. Sam appeared before the Mental Health Review Tribunal members and consented to the CTOs being made. The Orders included his attendance at weekly case management sessions, to undertake regular reviews with a CMH psychiatrist and to take his prescribed medications as directed. The orders were anticipated to remain in force until May 2019.

42. Later that day, Sam and Mr Kimber discussed the likely diagnosis of schizophrenia. Sam expressed some reluctance in accepting this diagnosis, however, also accepted that he had been experiencing the symptoms for years and no longer remembered what life was like without persistent psychotic symptoms. Sam confirmed that he was now taking all medications as prescribed. Mr Kimber perceived that overall, Sam presented:

> "…as low risk with regard to his harm to self or others. I believed there was a medium risk of exacerbation of his psychotic symptoms due to his history of disengagement with services and non-compliance with medications, however, I felt those risks were managed by way of the CTO, anti-psychotic medication and Sam's engagement with care."[13]

43. Mr Kimber also conferred with Dr Brahmbhatt and the psychiatry registrar, Dr Blenkin to discuss the CTO and the ongoing treatment plans. It was agreed

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[11] Lower North Shore Community Health records, pages 71-72, Tab 29, Exhibit 1.
[12] Lower North Shore Community Health records, page 67, Tab 29, Exhibit 1.
[13] Statement of Daniel Kimber, dated 21 August 2019, [17], Tab 2, Exhibit 1.

that Sam's medications should be transitioned to treatment with paliperidone only, in a long-acting, injectable form.

44. Mr Kimber then spoke with Sam's family friend, Sarah and discussed the developments with his ongoing care, including the conditions of the CTO. Sarah and her family were invited to attend the family information nights organised by the service.

45. On 30 October 2018, Sam attended the LNS CMH for his scheduled review. He described his mood as "good" and denied any suicidal ideation, however, reported ongoing psychotic symptoms. After the review, he was administered his first dose of the long-acting medication, paliperidone by way of an intramuscular injection (IMI).

46. After his medical review, Sam and Mr Kimber discussed the possibility of Sam involving his family members more in his treatment. Sam indicated that he would consider the option, however, indicated that at this time he would speak with his parents and that Mr Kimber was not to contact them directly, unless he was present.

47. On 6 November 2018, Sam attended his appointment with Mr Kimber. He reported a reduction in the intensity and frequency of his psychotic symptoms, which had led to an improvement in his mood and his ability to focus on meaningful activities. He also confirmed that he had enrolled in a hospitality course, in addition to continuing to work at the Japanese restaurant.

48. On 13 November 2018, Sam attended for his medical review. He reported that his symptoms had reduced but were ongoing. He raised the issue of his weight gain since starting on the new medication and he was offered exercise support through the service. He stated that he had purchased a secondhand motor vehicle which was unregistered.

49. On 14 November 2018, Mr Kimber had a telephone conversation with Sarah. She raised the concerns held by herself and Sam's family about his ongoing impulsivity, for example the recent purchase of the motor vehicle.

50. On 20 November 2018, Sam rang Mr Kimber seeking to re-schedule his appointment for that day to the following week. Sam discussed:

> "..having passive suicidal thoughts and ongoing psychotic symptoms, but reported being able to manage these and denied suicidal plans and intent. He also described experiencing difficulties with attention and concentration during university lectures. I reinforced the importance of attending appointments in line with his CTO and agreed to see him the following week."[14]

51. On 27 November 2018, Sam attended the LNS CMH for his scheduled appointment. His review was conducted by Dr Brahmbhatt, together with

[14] Statement of Daniel Kimber, dated 21 August 2019, [25], Tab 23, Exhibit 1.

Dr Blenkin. Sam described reduced but ongoing psychotic symptoms. He also described having used both cannabis and cocaine recently. Dr Brahmbhatt considered that Sam appeared to be:

> "…showing a good response to long acting antipsychotic medication (Paliperidone palmitate 150mg intramuscular monthly) and overall I considered, at that time, that he had made reasonable progress."[15]

52. On 4 December 2018, Sam attended for his appointment with Mr Kimber. Mr Kimber formed the view that Sam appeared to present with an improved mood and stated that he had not experienced psychotic symptoms for around two weeks. He stated that he had been receiving positive feedback from work colleagues relating to his improved mood and performance at work. He had submitted his first study assignment. He also reported to have moved into shared accommodation, stating that his 'room' was the garage area.

53. On 11 December 2018, Sam did not attend a scheduled medical review. He did not respond to telephone calls made by Mr Kimber.

54. On 12 December 2018, Mr Kimber received a phone call from Sam. He explained that he had not responded to phone inquiries the previous day as his phone had run out of credit. He confirmed that he had not been experiencing psychotic symptoms, however, had been smoking around 2 grams of cannabis per night. There was discussion as to the risks associated with illicit substance use and the possibility of a relapse with his mental health. Sam agreed to attend a medical review the following day.

55. Sam attended the scheduled medical review on 13 December 2018, with Dr Blenkin. He initially denied experiencing psychotic symptoms, however, conceded that he was experiencing symptoms. He also admitted to consuming cannabis regularly; as well as MDMA intermittently. Drug and alcohol counselling at the LNS CMH service was recommended.

56. Sam again attended a case review with Mr Kimber on 18 December 2018. Mr Kimber thought that Sam displayed an improved mood and reduced, but ongoing psychotic symptoms. Sam stated that he had reduced his ingestion of cannabis. They discussed some of the causes and contributors to his psychotic symptoms.

57. Sam attended his next scheduled medical review with Dr Blenkin and Mr Kimber on 8 January 2019. The medical staff noted that:

> "…Sam exhibited and described an exacerbation in positive psychotic symptoms, as well as low mood, suicidal ideation and thought of harming others. Sam was offered a voluntary hospital admission but declined."[16]

58. The review notes also contain references to Sam stating that:

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[15] Statement of Dr Prachi Brahmbhatt, dated 25 July 2019, [10], Tab 13, Exhibit 1.
[16] Statement of Daniel Kimber, dated 21 August 2019, [32], Tab 23, Exhibit 1.

> "…he was experiencing auditory hallucinations (people talk to him in his head), persecutory delusions (fears that a man had made threats to kill him) and referential delusions (receiving messages on his computer)."[17]

59. Mr Kimber in his statement records that Dr Blenkin formed the view that:

> "…Sam was experiencing an acute relapse of psychosis due to various stressors, including his living situation, (the) recent death of his grandfather and (a) limited supported network…"[18]

60. Dr Blenkin perceived that Sam was at a high risk of harming himself and others and that he satisfied the criteria for an involuntary admission. Sam was then admitted to the Mental Health Unit.

61. Sam remained in hospital from 8 January 2019 until his discharge from hospital on 21 January 2019. His medication was varied, changing from paliperidone (IMI) to olanzapine (oral) and then transitioning to olanzapine (IMI). He was reported to no longer have thoughts of suicide or homicide at the time of his discharge. He had experienced a reduction in the intensity of his auditory hallucinations, although they remained present.

62. On 23 January 2019, Dr Blenkin prescribed oral olanzapine to account for an anticipated delay in having his injections. He was also prescribed metformin in response to his reported weight gain on olanzapine.

63. Mr Kimber also had a consultation with Sam on 23 January 2019. During that conversation Sam described ongoing experiences of auditory hallucinations and grandiose delusions related to "hacking for the attainment of significant wealth."[19] He confirmed that he had consumed a small amount of cocaine the day before (22 January 2019).

64. On 30 January 2019, Sam reported a significant reduction in the intensity and frequency of his psychotic symptoms. He denied using any illicit substances during the past week. He also reported that he had returned to work and was hoping to increase his hours at work. Mr Kimber noted:

> "Sam told me that his intention was to prioritise his health and wellbeing and move towards a functioning life. He described the transition to olanzapine as positive, and identified the impact it had on reducing his psychotic symptoms. My impression on that day was that Sam showed significant improvement in insight and his overall mental state, with no risk of harm to self or others indicated."[20]

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[17] Statement of Dr Prachi Brahmbhatt, dated 25 July 2019, [11], Tab 13, Exhibit 1.
[18] Statement of Daniel Kimber, dated 21 August 2019, [33], Tab 23, Exhibit 1.
[19] Statement of Daniel Kimber, dated 21 August 2019, [38], Tab 23, Exhibit 1.
[20] Statement of Daniel Kimber, dated 21 August 2019, [40], Tab 23, Exhibit 1.

Events on 4 February 2019

65. Sam's mother stated that:

> "On February 4th, 2019, two of Sam's work friends attended Sam's house where they found him lying on the floor. Sam said, "I want to go to hospital." The friends took him to Royal North Shore Hospital.""[21]

66. On the evening of 4 February 2019, Sam attended at the RNSH CMH service in the company of a friend. He presented with a packed suitcase and requested that he be admitted as a voluntary inpatient to the mental health unit. Sam was admitted to the Psychiatric Emergency Care Centre (PECC) as a voluntary patient under the care of the on-call psychiatrist.

67. The Hospital progress notes contained detail from Sam that he had been experiencing suicidal ideation for the past two days. He denied that he had attempted to follow through with these thoughts. He stated that he had been feeling highly stressed and that this stress related to financial and work issues, and that he felt that he cannot see a way out. He indicated that he was feeling highly anxious, that he had to lay in a foetal position, and felt that he could not stand. He also stated that he felt panicked but denied that it was a panic attack.

68. He continued to indicate that he was feeling very angry, however he was unable to identify the trigger for these feelings and confirmed that it was not directed at anyone. He reported that his auditory hallucinations were at the baseline and are just occasional voices. He confirmed that he didn't have any homicidal thoughts, and that the only person he feels like harming was himself. He reported that he felt frightened and overwhelmed.

69. On the morning of 5 February 2019, the Hospital progress notes record as follows:

> "Pt appeared very anxious, trembling. Reports that he is not feeling ok, admitted to just trying to hang himself with his pants and it "didn't work". Same unwitnessed. Admits to feeling very anxious, and would like PRN. Also still feeling suicidal, "Life, I can't do it anymore" verbal reassurance given."[22]

Events on 5 February 2019

70. Prior to conducting the ward rounds and at hand-over, Dr Brahmbhatt was advised by Registered Nurse (RN) Ms Grace Nagory that Sam had indicated that he had attempted self-harm with his pyjama pants. She indicated that this was unwitnessed.

[21] Statement of Susan Cain, dated 10 February 2019, [25], Tab 10, Exhibit 1.
[22] Northern Sydney Local Health District Records, page 84, Tab 28 Exhibit 1.

71. At approximately 09.30 hours on 5 February 2019, Dr Brahmbhatt, conducted and documented a detailed mental state examination. Dr Brahmbhatt stated that:

> "…I also assessed whether Sam met criteria for being placed under the Mental Health Act. Sam reported suicidal ideation and a deterioration of his mental state over the preceding two days. He told me that while he had experienced suicidal thoughts before, these had never been as intense. He also admitted to thoughts of jumping off a building. He was unable to identify why his mental state had deteriorated though he did admit to financial stress.
>
> My opinion was that he was very distressed. I was very concerned about his risk of harm to himself and potentially to others, and I thus planned for him to be transferred to the High Dependency Unit (HDU) of the inpatient unit. I also placed him under the Mental Health Act as a mentally ill person. I also determined that he needed closer observation, and I hence increased his level of acuity to Care Group Level 2 (15 minute observations). Whilst waiting for transfer to the HDU, I ensured he remained in the common area of the PECC so that he could be monitored at all times by staff. He was administered Lorazepam and Olanzapine for agitation, and he slept for an hour on the PECC whilst awaiting transfer."[23]

72. Dr Brahmbhatt completed the certificate of assessment required to schedule an individual and stated that he:

> "presents as acutely psychotic with AH's (auditory hallucinations) and persecutory delusions. Also voicing SI (suicidal ideations) with plan and intent as well as thoughts of HTD/O???? Admitted to NS (nursing staff) that he tried to hang himself with pants in his room this morning."[24]

73. Ms Rebecca Riva, the Clinical Nurse Consultant (CNC) for the Emergency Department confirmed her attendance at the morning handover. Ms Riva also confirmed that Dr Brahmbhatt, RN Nagory and herself went to assess, and ensure that Sam had not sustained any injuries from the possible act of self-harm involving his pyjama pants. RN Riva recalls discussing her shared concerns with RNs Nagory and Zantos.

74. Sam was transferred to the HDU at around 12.15 hours on 5 February 2019. He was not seen by a doctor at that time; however, he was assessed by the nursing staff and received a visit from his case manager, Mr Kimber.

75. Between 12.30 – 13.00 hours, the Nurse Unit Manager (NUM) (3), Mr Andrew Nicholls, recalls receiving a call from the MHU HDU, requesting a safety blanket for a patient. Mr Nicholls recalls contacting the NUM (1), Ms Lauren Ashe to discuss the circumstances relating to the request. Mr Nicholls recalls being told by Ms Ashe that the safety blanket was being requested for Sam, after the report

[23] Statement of Dr Prachi Brahmbhatt, dated 25 July 2019, [19]–[20], Tab 13, Exhibit 1.
[24] RNSH Medical Records, page 69, Tab 27, Exhibit 1.

of an attempted self-harm incident the evening before, being an attempt to hang himself with his pyjamas.[25]

76. Mr Nicholls recalls discussing with Ms Ashe at that time, whether an Individual Placement Support (IPS) was required. An IPS, sometimes referred to as a "special", is where the patient is:

> "…under constant supervision, whereby, at all times, the patient must remain under visual observation, and at arms-length of a nurse. It was reported to me that Sam had been reviewed by a consultant, before transfer, and Level 2 acuity was assessed to be appropriate. Level 2 acuity, requires that a nurse must observe a patient every 15 minutes. It is also a requirement that the nurse must engage regularly, and randomly observe the patient, at least every 15 minutes."[26]

77. The Hospital Progress notes do not clarify whether the earlier attempt at self-harm occurred the previous evening (4 February 2019) or the morning of 5 February 2019. What does appear clear, is that the medical staff at both the PECC and the HDU, were sufficiently concerned about Sam's presentation, that none of the medical staff doubted the veracity of his assertions.

78. Given those abovementioned concerns, Sam was placed in a room on the HDU ward close to a nursing station to ensure close visual monitoring. Sam appears to have also been encouraged by the medical staff to approach them if he was feeling more unwell. His belongings were removed, and he was not given access to any hospital linens, in an attempt to minimise any associated risk.

79. Mr Kimber is recorded as meeting with Sam in the courtyard area of the unit at 16.05 hours. He remained with Sam until 16.50 hours.

80. Mr Kimber recalls the following:

> "…He reported feeling low, overwhelmed and hopeless, with frequent thoughts of suicide. He also described having attempted suicide while in PECC. We discussed the stressors associated with Sam's request for an admission as well as psychological skills and a safety plan for managing distress and risk. We also discussed reasons for living and treatment options, to engender hope and future orientation.
>
> At the time, my impression was that Sam's risk of suicide was high, particularly given his description of a recent suicide attempt and his reports of ongoing suicidal ideation. I suspected that Sam's recent increase in insight my have contributed to heightened distress, despair and risk of suicide. I believed that Sam's risk of suicide was managed via his inpatient unit admission and his transfer to HDU, with 15 minute checks from staff."[27]

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[25] Statement of Andrew Nicholls, dated 20 May 2019, [7]-[8], Tab 22, Exhibit 1.
[26] Statement of Andrew Nicholls, dated 20 May 2019, [8], Tab 22, Exhibit 1.
[27] Statement of Daniel Kimber, dated 21 August 2019, [43]-[44], Tab 23, Exhibit 1.

81. At the conclusion of their meeting, Mr Kimber stated that he then approached the Nurse's station in HDU and spoke with Ms Kerry Foley, RN. He stated that he relayed some physical health concerns that Sam had mentioned to him; as well as the need to explore the issue of administering anti-depression medication at future medical reviews. In Ms Foley's statement, she does not refer to this conversation.

82. In Ms Foley's statement, she describes her earlier interactions on 5 February 2019 with Sam, as:

> "…difficult to enage [sic] with as he responded with one word answers, having a low mood, appeared withdrawn, had poor eye contact and a 'blunt affect'"...[28]

83. Ms Foley later comments that after Sam had spoken with Mr Kimber, Sam appeared to be:

> "…more reactive, his mood seemed brighter, eye contact was improved and Sam was less isolative, spending time in common areas and interacting appropriately with staff when approached."[29]

84. After the meeting with Mr Kimber, Sam returned to his room and shut the door. Mr Anthony Gunter, RN, recalls speaking to Sam and asking him why he had closed his door. Mr Gunter indicated that Sam had told him he had closed the door to his room as it was "noisy". Mr Gunter stated that he had asked Sam if he had any suicidal thoughts and Sam told him that he didn't. Mr Gunter told Sam that he needed to keep his door open. Mr Gunter stated that he noticed the door shut again. In addition, he stated that he heard other nursing staff speaking with Sam and indicating to him that it was important that he left his door open. Mr Gunter stated that he last saw Sam at 17.45 hours, sitting in the dining room area.

85. Mr Gunter recalls seeing Sam's door shut again at 18.00 hours. He stated that he was aware that his 15 minute observation was due and went to see him. He saw that his door was closed and that he was hanging from the door. Mr Gunter attempted to force the door open, however, was unable to open the door. Mr Taylor Clancy, an Enrolled Nurse (EN) appeared and forcefully kicked the door open and Sam fell to the ground. The noose, fashioned from his pyjama pants, fell away from his neck. Mr Gunter, Mr Clancy and Ms Foley immediately commenced CPR, using compressions and a defibrillator.

86. A "Code Blue" alarm was called and the Code Blue Team arrived within minutes. CPR continued with additional assistance; however, Sam could not be saved. His time of death was recorded at 19.12 hours.

87. Police were contacted and attended the Hospital shortly after receiving the notification at 20.30 hours. The officer in charge of the investigation, Leading

[28] Statement of Kerry Foley, dated 26 June 2019, [10], Tab 20, Exhibit 1.
[29] Statement of Kerry Foley, dated 26 June 2019, [14], Tab 20, Exhibit 1.

Senior Constable Stephen Smith (LSC Smith) became aware after Sam's death, that his body had been moved from his room to another room and that a number of items had been cleaned away. LSC Smith was advised that this had been done to reduce the distress to other patients. Police were able to confirm that the second room had been secured and locked by Hospital security guards prior to the arrival of police, but only after Sam had been moved.

Autopsy

88. A non-invasive, external examination, together with a CT scan and the collection of specimens for a toxicological examination was conducted by an experienced pathologist, Dr Dianne Little.

89. Dr Little perused Sam's medical records, including his current medication regime.

90. Dr Little was provided with the circumstances relating to Sam's admission to the RNSH and the circumstances relating to his time at the hospital on 4-5 February 2019. In particular, Dr Little was provided with the pyjama pants. Dr Little examined the pyjama pants and confirmed that the ligature mark (was) consistent with pyjama pants that she had subsequently received.[30]

91. Dr Little confirmed that she performed a CT scan, and the scan did not disclose any suspicious injury.

92. Dr Little undertook a toxicological analysis of the samples taken during her autopsy which confirmed that Sam had traces of antipsychotic and anti-anxiety medication in his system at a level within the therapeutic range of the medication, and clearly did not contribute to his death. Dr Little concluded that:

> "Toxicological analysis of samples taken at autopsy detected approximately therapeutic blood levels of the antipsychotic drug aripiprazole and the anti-anxiety drug lorazepam".[31]

93. It is noted that Sam's family understandably were concerned as to whether the pyjama pants could have been the ligature used by Sam. Dr Little concluded that the:

> "External examination revealed the presence of a ligature mark across the front and sides of the neck rising to an apparent suspension point at the back of the neck. CT scans showed no injuries to the bones in the neck. However, as an internal examination was not performed, any injuries to the soft tissues of the neck cannot be excluded. The changes however are consistent with those seen in hanging."[32]

[30] Limited Autopsy Report, dated 30 May 2019, prepared by Dr Little, page 3, Tab 3, Exhibit 1.
[31] Limited Autopsy Report, dated 30 May 2019, prepared by Dr Little, page 4, Tab 3, Exhibit 1.
[32] Limited Autopsy Report, dated 30 May 2019, prepared by Dr Little, page 4, Tab 3, Exhibit 1.

Systemic issues which have required investigation

94. During the course of these coronial proceedings, the Court has sought and received numerous witness statements, hospital and medical records and other documentation to analyse the care and treatment Sam received from various medical and community providers.

95. The Court has attempted to identify and investigate the issues involving Sam in the months leading up to his presentation to hospital on 4 February 2019. By 4 February 2019, Sam was clearly acutely unwell and sought the assistance and protection of a hospital setting, only to die in hospital, a place which was meant to assist his acute distress and provide safety and treatment. In considering those circumstances; as well as the events of 5 February 2019, the coronial proceedings have considered whether these issues were systemic to that Hospital and the relevant community mental health services.

96. To assist with and professionally guide these determinations, expert assistance was sought from Dr Kerri Eagle, Consultant Forensic Psychiatrist. Dr Eagle was provided with the statements, medical records and reports. Dr Eagle acknowledged the inherent difficulties associated with a retrospective psychiatric assessment of any person's presentation, mental state and the presence or absence of mental illness.

97. As noted earlier, Sam had been diagnosed with a range of possible conditions, with the most likely being schizophrenia. Dr Eagle considered the most appropriate diagnosis as follows:

> "[Sam] had a diagnosis of schizophrenia. His illness was characterised by relapses of psychosis resulting in perceptual disturbances (auditory and olfactory hallucinations), bizarre delusions (persecutory beliefs of being monitored or hacked, mental telepathy), referential delusions (receiving messages from television) and disorganisation of his thought processes. He was also described as having negative symptoms including reduced motivation, and social withdrawal. He appeared to have deteriorated significantly in his level of social and vocational function since late adolescence. He had persistent symptoms of psychosis despite treatment with several antipsychotic medications including aripiprazole, paliperidone and olanzapine suggesting that his illness may have been treatment resistant. His cannabis use and other substance abuse would have exacerbated symptoms of psychosis, and potentially precipitated relapses. He had a history of non-compliance with treatment and clinical reviews that had complicated his treatment, requiring treatment with injectable antipsychotic medication under a CTO."[33]

98. Dr Eagle commented that Sam:

[33] Expert report of Dr Kerri Eagle, dated 23 February 2021, [92], Tab 33, Exhibit 1.

> "may have had a major depressive episode at the time of his death. He described a pervasively low mood, with disrupted sleep, hopelessness, high levels of distress, and suicidal thoughts. Depressive symptoms appeared to have evolved in the context of persistent symptoms of psychosis, psychosocial stressors and increasing insight into his diagnosis."[34]

99. Dr Eagle noted that Sam:

> "had a substance use disorder, involving cannabis and stimulants. He had used cannabis and stimulant substances in recreational settings. His use of illicit substances had apparently potentially contributed to financial hardship during the period leading up to his death. The use of stimulants and cannabis would have exacerbated his psychotic symptoms and possibly adversely impacted on his mood.
>
> There was no information or evidence to suggest that Sam had a personality disorder."[35]

100. Dr Eagle then considered a number of care and treatment issues during Sam's attendance in the PECC and HDU at the RNSH from 4 – 5 February 2019.

NSW Health Policy

101. Dr Eagle reviewed the NSW Health Policy Directive PD 2016_007 Clinical Care of People who May Be Suicidal, 1 March 2016.[36] This policy reflects best clinical practice where a person has been identified as being at risk of suicide. It requires that a comprehensive risk assessment is conducted, and that the status of that risk is the subject of continual medical monitoring. It is important that the person's personal circumstances and any changes in those circumstances are considered throughout the period of their care. It is important that a management plan is devised and developed with the assistance of the patient, the patient's family and any other key caregivers. It is vitally important that the patient's assessments and management plans are clearly documented to assist with the continuity of care, particularly if the patient is to be transferred elsewhere; or simply to ensure that crucial information is available at staff/shift handovers.

Dr Brahmbhatt's assessment

102. Dr Eagle reviewed Dr Brahmbhatt's care and treatment of Sam at the PECC.

103. Dr Eagle noted that Dr Brahmbhatt acknowledged that Sam was:

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[34] Expert report of Dr Kerri Eagle, dated 23 February 2021, [93], Tab 33, Exhibit 1.
[35] Expert report of Dr Kerri Eagle, dated 23 February 2021, [94]-[95], Tab 33, Exhibit 1.
[36] Clinical Care of People Who May Be Suicidal PD2016_007, Tab 35, Exhibit 1.

> "at high risk of suicide due to the presence of a number of apparent risk factors and a reported suicide attempt. She undertook a comprehensive mental health assessment, taking into account her pre-existing knowledge of Sam's psychiatric history. She determined that Sam was a mentally ill person at risk of harm and commenced the process to detain him as an involuntary patient under the Mental Health Act 2007. She detailed a plan that involved administering medication to alleviate his distress, transferring him to the High Dependency Unit for increased monitoring and containment as soon as possible, increasing his acuity level to 'level 2', requiring 15 minute observations, requesting that he remain in the common area until transfer to HDU for continuous observation by staff, and that he be reviewed by the inpatient treating team on HDU."[37]

104. Dr Eagle noted that:

> "In the circumstances, the interventions appeared reasonable and directed at the identified risk factors, apparent at the time Dr Brahmbhatt assessed Sam. The only additional step that Dr Brahmbhatt may have taken to reduce Sam's risk would have been to have immediately placed him on an acuity level 1 requiring constant observation of him by a member of the nursing staff." Dr Eagle noted, however, that Dr Brahmbhatt "essentially did this, by requiring a period of constant observation until he was able to be transferred to a more secure unit. This level of observation can be perceived as highly intrusive and distressing by a patient, and may exacerbate the person's mood disturbance, potentially increasing their risk."[38]

Communication of the proposed treatment plan between the PECC and the HDU

105. It is clear that given Sam's identified high risk presentation, it would have been preferable if Dr Brahmbhatt had communicated directly with the psychiatry registrar or consultant on duty in the HDU on 5 February 2019. It is unclear why this did not occur; however, it may have been that it was not apparent which psychiatrist or psychiatry registrar would take over his care in the HDU. Dr Eagle noted that Dr Brahmbhatt's plan:

> "was documented in the electronic medical record and the treating team, including nursing staff on the ward, would be expected to review Dr Brahmbhatt's review and treatment plan form the medical record, following Sam's admission to the HDU. It would also be expected that the treatment plan, including his clinical progress on PECC, would have been directly handed over by nursing staff caring for [Sam]."[39]

[37] Expert report of Dr Kerri Eagle, dated 23 February 2021, pages 15-16, Tab 33, Exhibit 1.
[38] Expert report of Dr Kerri Eagle, dated 23 February 2021, page 16, Tab 33, Exhibit 1.
[39] Expert report of Dr Kerri Eagle, dated 23 February 2021, page 16, Tab 33, Exhibit 1.

106. Section 19 of the *Mental Health Act 2007* requires that a patient who has been scheduled as an involuntary patient, (in this case by Dr Brahmbhatt in the PECC at 09.54 hours on 5 February 2019), is to be reviewed within 12 hours of his/her involuntary detention. Dr Brahmbhatt made a notation requesting a "*team review for further Ax*" (assessment). Dr Eagle commented that Dr Brahmbhatt:

> "did not indicate the timing but it would be appropriate for a patient transferred to a ward to be reviewed by the registrar and/or psychiatrist on that ward as soon as possible. This would ensure that all regular and PRN (pro ra nata) medications were charted and appropriate; that the acuity level was adequate given the risks and resources on the ward; the patient's family or principal care provider were aware of the transfer; and that the patient's mental state had not changed or deteriorated during the period of transfer. The need for the review was flagged by the admitting nurse (RN Ventigan) on admission to the HDU……..It is not apparent from the clinical records why Sam had not been reviewed by the psychiatry registrar or psychiatrist on HDU prior to his death. It may have been due to competing demands on the ward or in the hospital."[40]

107. Despite the abovementioned concerns, Dr Eagle did express the following view:

> "[Sam] did appear to be provided with appropriate meaningful interventions following his admission to hospital. He was reviewed by a medical officer and a psychiatrist. He was provided with mental health support by nursing staff on the PECC unit and then subsequently on the HDU. He was also provided with mental health support by his case manager on the ward. He was given antipsychotic and anxiolytic medication to reduce his symptoms including distress and agitation, and to assist with sleep. He was placed in a contained unit for his safety and observation. The goals of the initial period of the admission would have primarily been assessment, observation, reduction of acute distress and containment of risk."[41]

Response to Sam repeatedly closing the door to his room

108. As indicated above, RN Gunter noted that Sam had again closed the door to his room after being asked to leave the door open. Sam had apparently been placed in a room which was close to the nursing station, no doubt to assist and enable closer, but less intrusive, observations of Sam. It would appear from medical notes, that Sam was regularly observed in both the general communal areas of the ward; as well as his room.

[40] Expert report of Dr Kerri Eagle, dated 23 February 2021, page 17, Tab 33, Exhibit 1.
[41] Expert report of Dr Kerri Eagle, dated 23 February 2021, page 18, Tab 33, Exhibit 1

109. Clearly, the nursing staff appeared to be cognisant of the risks associated with Sam's behaviour at this time. It is clear that he was being observed and monitored. It is less clear why his persistent presentation was not urgently assessed by a psychiatrist. If that assessment had been conducted, it may have resulted in a formal increase to continuous observations, a CL1 status.

110. Dr Eagle considered this situation and opined:

> "It would have been inherently difficult to interpret [Sam's] behaviour in shutting his door with certainty or to predict that he planned a suicide attempt. In the circumstances, it was not unreasonable to continue the acuity level 2 observations subject to a further review of Sam by the treating psychiatrist and/or registrar."[42]

Appropriate or inappropriate clothing in a hospital setting

111. Dr Eagle considered the issue of the suitability of the clothing provided to Sam. It would appear that Sam was given a pair of pyjamas. It had been reported on the morning of 5 February 2019 to the nursing staff by Sam that he had used his pyjamas to engage in self-harm. It is unclear from the medical notes, how Sam had utilised his pyjamas in this attempt.

112. As stated above, this was an unobserved attempt. In light of Sam's self-report to the nursing staff, it would appear that objects and items presumed to be of assistance to commit acts of self-harm were removed from his environment. He was noted to have no linen made available to him, owing to the concern that linen may have been conductive to being made into a ligature.

113. Dr Eagle considered that:

> "A tear resistant smock (sometimes referred to as safety gowns) can be used, in place of a person's clothing, in some circumstances to prevent using clothing as a ligature. It is not apparent that safety gowns were available at the facility and they can negatively impact on a person's privacy or modesty. However, a safety gown may have been a short term strategy that might have reduced the identified risk."[43]

The response by the Hospital to concerns raised during the inquest

114. Dr Kathryn Drew, Clinical Director at the North Shore Ryde Mental Health Service provided a statement dated 10 November 2020, together with a number of annexures.

[42] Expert report of Dr Kerri Eagle, dated 23 February 2021, page 18, Tab 33, Exhibit 1.
[43] Expert report of Dr Kerri Eagle, dated 23 February 2021, page 19, Tab 33, Exhibit 1.

115. Dr Drew had been employed as a psychiatrist since 1998 and had been employed in clinical director roles since 2010. Since July 2018, she has been working as the clinical director for the North Shore Ryde Mental Health Service.

116. Dr Drew confirmed that she had not been involved in the clinical care and treatment of Sam at any time, including early February 2019.

117. As a result of Sam's death, the Hospital undertook a review of the systems and processes, in an attempt to identify and improve those systems.

118. The first area reviewed as part of this process related to the relevant departmental policies, procedures and guidelines. A number of these policies and procedures have undergone changes. Some changes have been implemented and some are continuing to be reviewed and are the subject of ongoing refinement and assessment.

119. The Hospital conducted an internal investigation. As a result of that investigation, the clinicians involved with Sam's care and treatment; as well as other members of staff in the relevant wards, undertook further practical reviews and ongoing education and practice to enhance their individualised approach to suicide prevention. This process also included enhancing a collaborative approach with a patient's family and carers. These education sessions occurred on four occasions, with 20 staff from the nursing and allied health disciplines in attendance on those occasions.

120. The Hospital acknowledged that a medical handover had not occurred when Sam was transferred from the PECC to the HDU (referred to in Dr Drew's statement as the Mental Health Inpatient Unit, or MHIPU). As a result of this, the Hospital has now implemented a system where a duty psychiatrist is available in the MHIPU, formerly the HDU. This change means that every time a patient is transferred from the PECC to the HDU (MHIPU) during business hours, a medical handover occurs. Outside of business hours, a system has been implemented, whereby, the same registrar and consultant cover both the PECC and the HDU (MHIPU), effectively streamlining the system so that a handover is not required. Dr Drew stated in her statement that:

> "The Duty Psychiatrist position was created in 2019 and remains in place. This identifies a rostered psychiatrist in MHIPU to receive handover for any patients being transferred into the unit."[44]

121. To ensure compliance with the changes referred to above, the Hospital conducted an audit on 22 August 2019. Annexed to Dr Drew's statement are the records of that audit, confirming handovers between the PECC and the HDU.

122. Code Blue Management training is now conducted every second week of the month with mental health inpatient staff. Part of that training has focused on the reporting of a critical incident, together with the preservation of the

[44] Statement of Dr Kathryn Drew, dated 10 November 2020, [12], Tab 31, Exhibit 1.

emergency scene for police and coronial investigations. All staff have been re-educated on the importance of their responsibilities in preserving these scenes.

123. The adequacy of staffing numbers has been reviewed, including when staff take rostered meal breaks. The review has recommended that at least three staff always remain on duty on the HDU. Staff are now required to routinely document meal breaks on their shift allocation form. This form is routinely audited to ensure compliance. Monthly audits from June to September 2020 indicated 100% compliance with the requirement that meal breaks are being staggered to ensure at least three staff are always present and on duty within the HDU.

124. Dr Drew considered a number of specific issues relating to Sam's case as follows:

a. Dr Drew confirmed that there were no specific rooms allocated to patients who had been placed under Level 1 observations. Dr Drew confirmed that Sam had been placed in a HDU room within direct sight from the nurse's station.[45]

b. Dr Drew confirmed that Sam had not been allocated different clothing despite his earlier reported attempt to self-harm using his pyjamas. Dr Drew stated that "all items of clothing pose some form of a ligature risk".[46]

c. Dr Drew considered whether staff should have responded differently when Sam was seen closing the door to his room. Dr Drew concluded that as Sam had been recently assessed and was under close observation, a further assessment was not necessarily required at that time. Dr Drew confirmed, that despite nursing staff recalling other staff telling Sam to keep his door open, this was not documented in the electronic medical records.[47]

125. Dr Drew acknowledged that the procedures reported by the investigating police had been reviewed and the Hospital accepted that staff needed to receive clear directions as to their mandated requirements relating to notifying the appropriate authorities (the police) and preserving the scene for police investigations.

126. Dr Drew confirmed that a memorandum:

> "was sent to all inpatient staff, after hours nurse managers and executive on call advising them of their required responsibilities following the death of the patient on the mental health unit." [48]

In addition, a further memorandum was forwarded to staff:

[45] Statement of Dr Kathryn Drew, dated 10 November 2020, Tab 31, Exhibit 1.
[46] Statement of Dr Kathryn Drew, dated 10 November 2020, Tab 31, Exhibit 1.
[47] Statement of Dr Kathryn Drew, dated 10 November 2020, Tab 31, Exhibit 1.
[48] Statement of Dr Kathryn Drew, dated 10 November 2020, [17], Tab 31, Exhibit 1.

> "regarding the importance of ensuring a 'crime scene' is maintained."[49]

127. In April 2021, the Hospital commissioned a review of safety clothing, as suggested by Dr Eagle, and specifically related to Sam's circumstances. The report was titled, "Safety Clothing, Exploration of the feasibility of anti-suicidal clothing". The report noted that safety clothing is currently used in the justice health system (for persons in a custodial setting), and as such, is designed to be rip resistant and aimed to reduce the use of the clothing to fashion a ligature.[50]

128. The report noted that:

> "research is lacking regarding the efficacy of safety clothing in preventing inpatient suicides. If safety clothing is introduced, systems for the development and implementation of standarised operating procedures and auditing is required and should cover the following: ordering, issuing, replacement and inspection of suicide prevention clothing and bedding."[51]

129. The review team consulted with Justice Health and Forensic Mental Health Network (JHFMN). JHFMN currently source and distribute safety clothing to custodial inmates accessing their service. JHFMN do not distribute tear resistant smocks, as suggested by Dr Eagle, but rather issue shorts and tops, as these have been assessed by them as providing a more dignified option. JHFMN indicated that all inmates are not issued with the safety clothing and that a comprehensive assessment of each patient is conducted on arrival at the clinical units and safety clothing is allocated to patients who present during the comprehensive assessment as having an identified risk of self-harm.

130. Staff within the Towards Zero Suicides Team identified some issues associated with the safety clothing, including that it was[52]:

a. Cold to wear

b. A majority of the time the inmates refused to wear the clothing when asked to wear it, and this had resulted in causing conflict which negatively impacted on building rapport as part of the therapeutic engagement with the inmate.

c. If the clothing became contaminated with human fluids, the clothing had to be disposed with as it was unable to be suitably cleaned.

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[49] Statement of Dr Kathryn Drew, dated 10 November 2020, [17], Tab 31, Exhibit 1.

[50] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, Tab 37, Exhibit 1.

[51] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 1, Tab 37, Exhibit 1.

[52] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 3, Tab 37, Exhibit 1.

131. The Northern Sydney Local Health District, Mental Health Drug and Alcohol service (NSLHD MHDA) Towards Zero Suicide team then consulted with two consumer peer workers with lived experience of suicide and mental health, a social worker and a psychiatrist.

132. The consultation process evoked an:

> "overwhelming response and recommendation from both those with lived experience and the clinicians was that if a person is considered at a risk level that would require this clothing, the most trauma informed and beneficial treatment is close observation and therapeutic engagement with the person to work through the distress they are experiencing."[53]

133. It was unclear from the report, whether the Team was assessing the anti-tear smocks, or the shorts and tops allocated to prison inmates. It would appear more likely considering the reference to "safety smock"(s) and "gowns" that this was the item being assessed.[54]

134. The Team noted that there was the potential for patients to perceive that the clothing was associated with a punitive response. In addition, there were concerns expressed by the team that the:

> "small potential benefit of the anti-rip clothing does not outweigh the detrimental impact this will have on the person's dignity and mental state."[55]

135. The following concluding comments were made:

> "With reticence, the team identified the possibility to have these items available on the ward for a consumer who is feeling unsafe in their clothing to voluntarily choose to wear them, for a time limited period when going to bed. With particular emphasis on the voluntary and time-limited elements. They recommended they be used only in the consumer's room, and involve an inclusive process with the consumer in the decision making for their use alongside staff and if available peer workers and for young people the parents/guardians."[56]

136. The Team also noted that the clothing may be offered as a last option prior to moving the patient to an observation Level 1 status. The report noted that:

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[53] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 3, Tab 37, Exhibit 1.
[54] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 4, Tab 37, Exhibit 1.
[55] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 4, Tab 37, Exhibit 1.
[56] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 4, Tab 37, Exhibit 1.

> "The final message from the group was that it was important to maintain a trauma informed and recovery oriented practice which helps consumers work towards their own version of recovery. In order to do this there will inherently be risk to delivery on these principles when the safety clothing is issued/worn. In this situation the risk is best managed with therapeutic observation and engagement."[57]

137. The NSLHD MHDA contacted and purchased some clothing and linen available locally. These items were described as being "designed with the purpose for providing users more dignity which minimising incidences of self-harm".[58] The fabric was a heavier weave fabric and were sewn with techniques designed to make the fabric more tear resistant. These samples have been supplied to Blacktown, Nepean and Hornsby Hospitals.

138. Other items were referred to, although these were not examined during this review. The Team acknowledged that "The lack of suitability of these products is only speculation and has not been tested."[59]

139. The Team also noted that "There is potential for custom made products to be made that might be less clinical, this option has not yet been fully explored or costed."[60]

140. The Report considered a number of options and associated issues with the provision of tear resistant clothing in the hospital setting. It did not appear to consider whether a number of the concerns raised by the review team, particularly as it related to the perceived stigma that may attach to these garments, could be overcome by issuing all patients with a standardised anti-rip garment.

141. The Team appeared to focus on their preference of medical observation rather than hospital issued clothing. Whilst appropriate medical observation is no doubt the preferred option, it does not appear to take into account the day to day practicalities of providing such rigorous observation. Close observation of patients identified to have high needs, requires adequate staffing levels, suitably trained individuals and no competing needs of other patients in close proximity in a hospital setting.

142. The Court would encourage the further assessment and implementation of appropriate clothing in high needs and specialist wards by NSW Health.

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[57] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 5, Tab 37, Exhibit 1.
[58] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 3, Tab 37, Exhibit 1.
[59] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 3, Tab 37, Exhibit 1.
[60] Safety Clothing – Exploration of the feasibility of anti-suicide clothing: NSLHD, Mental Health Drug and Alcohol (MHDA) prepared by the Governance Support Unit and Towards Zero Suicide Team, page 3, Tab 37, Exhibit 1.

Conclusions

143. It is so important that when considering the factors surrounding a person's death, that their life, their dreams and aspirations and their importance to those that knew them and loved them is not lost and is clearly acknowledged.

144. It is clear that Sam had struggled with an extremely difficult and an all consuming diagnosis of schizophrenia. His condition eked into every aspect of his daily life. It dashed his aspirations to become a pilot. At times, it compromised his ability to engage with friends and family.

145. His diagnosis was exacerbated by the fact that his condition appeared to be resistant to treatment with anti-psychotic medications. Sam had tried numerous medications with varying degrees of success. Sometimes, these medications would produce a marked increase in his functionability. Almost always, there would be side-effects, including weight gain.

146. At times, it is clear that Sam was acutely unwell. He attempted to deal with his condition by self-medicating with illicit substances, which is not uncommon. This of course, exacerbated his illness.

147. Despite all of the above, it is clear that Sam's family and friends in Japan and in Australia did not fail to continue to love and support him. At times, this was made even more challenging owing to the physical distance between Japan and Australia. At times it was made even more challenging because of Sam's symptoms and his response to his condition, which would exclude those support persons.

148. At various times since Sam's illness was diagnosed, he possessed an insight that his condition may endanger others and sought assistance in hospital.

149. It is particularly significant that during Sam's response to treatment he was able to establish a meaningful and supportive therapeutic relationship with Mr Kimber. Owing to the nature of a diagnosis of schizophrenia, this is often an outcome which cannot be achieved. Mr Kimber was able to successfully liaise with Sam's family and friends with the permission of Sam, a hallmark of the quality of the therapeutic relationship between the two men.

150. Since Sam's unfortunate death, the RNSH has acknowledged that their systems and policies in place in February 2019 could have provided greater support to Sam. These systems and policies appear to have been investigated and recommendations have been implemented to reduce the possibility that Sam's circumstances are replicated. In particular, the communication of the transition of care and treatment between units; as well as the documentation of that transition and the ongoing observation and assessment of patients, has been reviewed and education and training has been deployed. Consideration has been given to the assessment of safety clothing. It is highly suggested that this assessment of appropriate clothing continues to be considered and implemented.

151. I commend the changes outlined by the Hospital and do not propose to make any additional recommendations.

152. Sam's family provided a statement during these proceedings. They told the Court that Sam would take on any challenge. He had a gentle heart and a pure soul. He was dearly missed by both his family and friends. Photographs depicting him as a young boy and a young man were presented, depicting his humanity.

153. The death of a person who, like Sam, was an involuntary patient, raises particular concerns for coroners. I hope that Sam's family and friends will be reassured that this Court has listened to their concerns and attempted to ensure that those concerns have been addressed. I hope that Sam's family and friends will accept my sincere and respectful condolences for their loss of a young man who dealt with such a difficult medical condition.

154. I would like to acknowledge and thank Counsel assisting and her instructing solicitor for their extensive assistance in this matter.

155. I would also like to acknowledge and thank Leading Senior Constable Stephen Smith for his diligent efforts during the coronial investigation into Sam's death and for compiling the initial brief of evidence.

FINDINGS

156. The findings I make under section 81(1) of the Act are:

Identity

The person who died was Sam Cain.

Date of Death

Sam died on 5 February 2019.

Place of death

Sam died at Royal Northshore Hospital, located in St Leonards in NSW.

Cause of death

The cause of Sam's death was hanging.

Manner of death

The manner of Sam's death was an injury inflicted with the intention of committing self-harm.

I formally close this inquest.

Magistrate J Baptie

Deputy State Coroner

11 June 2021