STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of CC
Hearing dates:	27 – 29 November 2023
Date of findings:	15 December 2023
Place of findings:	Lidcombe
Findings of:	Magistrate Kennedy Deputy State Coroner
Catchwords:	CORONIAL LAW – High Dependency Unit, psychiatric care, Nepean Hospital, self-harm in psychiatric ward, Mentally ill person, reduction of hanging points, highlighting of events in medical records
File number:	2022/00147991
Representation:	Mr J Harris, Counsel Assisting, instructed by Ms E McGee (Crown Solicitor's Office) Mr S Rees (Aboriginal Legal Service) for the family of CC Mr I Fraser, instructed by Minter Ellison for the Nepean Blue Mountains Local Health District, and Doctors R Deen and S Alex Ms K Doust for CNC M Gumbo
Non-publication orders:	An order pursuant to s. 75(2) of the *Coroners Act 2009* was made on 29 March 2023. A copy is available from the Registry.

Findings:	***The identity of the deceased*** *CC* ***Date of death*** *15 June 2022* ***Place of death*** *Nepean Hospital, Kingswood* ***Cause of death*** *Hanging* ***Manner of death*** *Intentionally self-inflicted*
Recommendations:	*To Nepean and Blue Mountain Local Health District* *That the Nepean Blue Mountains Local Health District consider whether it would be appropriate to implement a process in the mental health ward, whereby nursing staff can highlight events they consider significant in the electronic medical record, with a view to drawing attention to such events for future nursing shifts and/or the treating team.*

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Introduction

1. CC died on 15 June 2022, in the mental health High Dependency Unit at Nepean Hospital. He was just 33, a proud young First Nations man. He was admitted to the hospital on 7 June, initially to the drug and alcohol unit. He was then kept on the basis of mental illness pursuant to a schedule under the *Mental Health Act 2007*.

2. On 15 June 2022, a ripped towel was found in CC's room. He was last observed at 2pm that day, during observation rounds. At 2.20pm, he was found hanging in the ensuite bathroom. It appeared that he had formed a ligature by cutting or tearing a strip of material from his bedsheet.

The nature of an inquest

3. The role of the Coroner is to make findings as to the identity of the person, and the place and date of their death. It is to determine the manner and cause of the person's death. Recommendations can also be made arising from the evidence in accordance with the Act. It is not the role of the coroner to apportion blame.

4. To enable these findings to be made, and to explore the issue of any desirable recommendations evidence was taken over three days at the State Coroners Court, Lidcombe. Evidence was received in written form contained within five volumes of material. This material included extensive witness statements, medical records and photographs. All of these have been considered.

5. The primary function of an inquest is to identify the circumstances of death. At the conclusion of this inquest I am required by s 81 of the *Coroners Act 2009* to record in writing the fact that a person has died and also to record:

    a. the person's identity;
    b. the date and place of the person's death; and
    c. the manner and cause of death.

6. Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death.

That involves identifying any lessons that can be learned from the death, in particular to avoid future deaths.

Background

7. The family statement was of great assistance to the inquest to gain a better understanding of CC. This inquest related to a very short period in CC's life and is no way a reflection of who he was. At the time this occurred he was a mentally ill person, in the midst of a psychosis and unable to think clearly or rationally, thus he needed to be detained in an attempt to protect him.

8. CC was born at Nepean Hospital on 21 November 1988. His biological father had limited contact with CC. When CC was 15 months old, his mother re-partnered, and it was this partner that was his father in all real respects. CC had an excellent and close relationship with his parents.

9. CC excelled at sports at school and was also good at maths and technology. After leaving school in Year 10, he initially commenced work as a cabinet maker, and then obtained an apprenticeship as an electrician. He obtained his Certificate III in 2007 and worked in that trade until 2020.

10. CC was diagnosed with ADHD as a child, which was treated at one stage with medication. Within the material in the brief of evidence other mentioned possible diagnoses included schizophrenia, OCD, PTSD and bipolar affective disorder.

11. CC had a very close relationship with his mother, who was very young when she had him. She gave a moving family statement of how she fell in love with him the moment she saw him. When she met her partner, she knew the three of them would make a wonderful family. She described his love of his motorbike, and learning to ride with his father. She described young CC as a firecracker, free spirited and always challenging himself in sport, excelling at sports generally and in particular motor bike riding.

12. He was described as outgoing and friendly. He worked hard and was popular with his friends and always treated people with respect. He loved his daughter and maintained a good relationship with her mother. He was much loved and is greatly missed.

13. In about 2009, when CC was 21, he met his first long term partner and they formed a relationship. They had a daughter. They lived together, initially with CC's parents at Emu Plains, and later in a rented unit in Penrith. Their relationship ended due to CC's use of synthetic cannabis. His first partner then returned to Bathurst with their daughter. They maintained a friendship, and successfully were able to co-parent their daughter for many years.

14. CC did seek help, and accepted help on many occasions. On 25 February 2012, CC was admitted to Nepean hospital, following erratic behaviour, in the context of amphetamine use.

15. On 22 March 2013, he was admitted again, for detoxification from synthetic cannabis. On 8 April 2015, he attended for drug and alcohol counselling, as an outpatient.

16. On 20 August 2019, CC presented to Nepean hospital with suicidal ideation, in the context of a relationship breakdown and alcohol use. He was treated with an antipsychotic, olanzapine (Zyprexa). He continued to be prescribed that drug in the community, although it appears he was last prescribed antipsychotics in April 2020. He told treating doctors that he had been taking antipsychotics leading up to this admission, and so it may have been that he sourced antipsychotics in the community in the period prior to his final admission.

17. During the early part of the pandemic in 2020, CC unfortunately lost his job as an electrician. He found this highly distressing and demotivating. He then took over a role as a carer for both his mother and grandmother.

18. In January 2022, CC formed a relationship with a new partner. They had known each other since primary school, and met again through a dating app. His second partner was in the process of getting a divorce. CC moved into her home at Glenmore Park, together with her two children.

19. During this relationship, CC appears to have distanced himself from his family, including from his own daughter. This led to friction between CC and his father. In May 2022, CC, his second partner and her children went to Bathurst to visit his daughter.

20. There is some evidence that CC used drugs when he was with his second partner. She indicated in a draft statement she knew CC used cannabis, spending a few hundred dollars on cannabis each week. She says she did not know he used other drugs.

21. In February 2022, his second partner became pregnant with CC's child, but sadly miscarried a few weeks later.

22. On 13 May 2022, CC failed to attend Blacktown Local Court, on a shoplifting charge. He was convicted in his absence and a warrant was issued. He was also in breach of a conditional release order.

23. On 23 May 2020, CC attended his GP, seeking a medical certificate for COVID, saying he had been ill earlier in the month.

24. Over this period, CC was becoming increasingly paranoid about work, his finances, and police, whom he believed were looking for him. He also became suspicious that his second partner was having an affair.

25. On 5 June 2022, CC told his second partner that he had been using Ice for the last few weeks. She arranged for him to stay at the Astina Hotel in Penrith, as she did not want him around the children. She paid for a few nights' accommodation. She told CC's parents about his drug use.

26. At 10am on 6 June 2022, CC called his father and said, "*I never asked you for help, but I need your help*". They arranged to meet at the hotel. CC told him he had been smoking Ice and produced a glass pipe, and broke it, telling his father, "*I want to be a better dad to (name removed) I'm over this shit."*

27. On the morning of 7 June 2022, his second partner and his mother went to see CC. He appeared paranoid and they suspected he had taken more Ice. At about noon on Tuesday, 7 June 2022, together they presented CC to Nepean Hospital Emergency Department (ED).

Admission to Nepean Hospital – 7 to 15 June 2022

Emergency Department

28. CC was triaged and he indicated he was seeking drug and alcohol support for an "*Ice addiction".* He denied self-harm ideation. He was reviewed by a drug and alcohol nurse, CNC Fraser, who recorded his drug and mental health history. He was given diazepam (Valium) to manage the symptoms of withdrawal, and quetiapine (Seroquel), which he said he took in the community.

29. While CC was in the ED, an ECG trace was taken, which appeared abnormal.

Drug and Alcohol Unit

30. At 9.30pm, CC was moved into the Drug and Alcohol Unit. He described significant drug use: 2 grams of cannabis daily, 1 point of methylamphetamine every 2 days, as well as weekend cocaine and ecstasy used, and injected steroids.

31. His mother and partner spoke with CC and were concerned he was at risk of suicide. His father spoke with a doctor and asked them not to release CC, as he had threatened to kill himself. The doctor told his father that CC was being kept in overnight.

32. CC remained in the Drug and Alcohol unit the next day, 8 June 2022. His mother attended hospital and spoke with Dr Huang. She repeated her concerns about CC's mental health and that he had expressed suicidal ideation. Dr Huang arranged for review by the Consultation Liaison psychiatry team.

33. During the afternoon, there was a concern that CC would discharge himself. The psychiatry review was delayed.

34. Psychiatrist Dr Zhou reviewed CC with CNC Rice at about 5pm. CC wanted to be discharged. CNC Rice spoke with his mother, who said CC had been aggressive, hostile and paranoid for months, and had attacked her and his father. He thought his new partner was trying to poison him. She said CC was a "*compulsive liar"*. The impression was that CC had hypomania or mania, and likely resolving psychotic symptoms, but that he was minimising these. An involuntary admission was required to manage the risks of misadventure, risk to his reputation, and risk of deteriorating mental state.

35. CC was therefore scheduled and admitted as an involuntary patient. He remained an involuntary patient until his death. CC was then transferred with security to the mental health ward, initially to the Triage and Assessment Unit.

Mental health ward

36. His mother and father had limited contact with CC, during his stay in the HDU. His mother spoke to staff a number of times to find out about CC's progress, and also to provide important information about his condition.

37. His partner visited CC often and made frequent calls to him, and to staff. However, that contact appears to have been a stressor for him. His partner was recorded as CC's next of kin, not his parents, although it is unclear when this occurred. As noted, she and CC had only lived together for a short period that year.

38. There was no-one recorded as CC's designated carer. That was a requirement under the *Mental Health Act 2007,* and discussions about this ought to have been documented.

39. On admission to the mental health ward, CC was assessed by RN Patel, who removed "*prohibited items*" from him, including his mobile phone. He denied thoughts of self-harm at that stage. He continued to do so throughout his admission whenever asked.

40. Shortly after arrival, his mother contacted the HDU, to warn staff that CC was highly manipulative, and would say the right things to get discharged. She wanted to be contacted prior to his discharge.

41. At about 7.30pm, CC damaged an electrical panel in a seclusion room, causing it to smoke and set off a fire alarm. He initially denied he had done this, and when challenged by staff became aggressive and demanded to be discharged. He was placed in seclusion and given midazolam. CC remained in seclusion, on Care level 1, until the following afternoon.

42. Later that evening, the Duty Operations Manager (DOM) RN Koonathan spoke with his partner. She also stated CC was "*highly manipulative", "impulsive"* and "*a risk to everyone".* She wanted to be involved in care and discharge planning.

43. On Thursday, 9 June 2022, CC was reviewed for the first time by the psychiatrist, Dr Rila Deen, and registrar, Dr Sandy Alex. CC again said he wanted to be discharged, claiming he needed to manage his business, although he had not worked for some time. The team's impression was that CC had hypomania, drug induced psychosis or bipolar affective disorder, or schizophrenia. The schedule was continued.

44. Dr Alex made contact with his parents and partner. It was standard practice to speak to the family after a new admission. They said CC had been paranoid for over 12 months. They thought his symptoms were not just drug-related. They wanted a program that would require drug tests.

45. Dr Alex reviewed CC again at 2.45pm, and ended the seclusion. He determined CC should be placed in the High Dependency Unit (HDU), in Room 41 on the north side, a more restricted part of the ward. He was placed on Care level 3, requiring 30-minute observations. He remained on that care level throughout his stay. That evening, he was commenced on diazepam, lorazepam and olanzapine.

46. His mother contacted the hospital again and spoke with RN Patel. She repeated her concern that CC felt suicidal, and was "*not feeling safe here*."

47. The following day, Friday, 10 June 2022, CC appeared more settled. He was reviewed by Dr Deen and Dr Alex. They noted the concerns that CC was just saying the right things to get discharged, and that his family had reported he was threatening suicide. CC said his family was supporting him, and it was discussed with him that there was a plan to hold a family meeting the following week. However, when he found out he had to stay in hospital, he said he no longer wanted his family involved in his care, and said they were "*crazy*".

48. Neither Dr Deen nor Dr Alex were present over the weekend, 11 and 12 June, or on Monday 13 June, which was a public holiday. There were a few significant events over the weekend, and prior to the next review.

49. On Saturday, his partner visited CC. During the visit, CC was found smoking in the bathroom, and when he was searched, cigarettes and a lighter were found. She initially denied giving these to him, although in her draft statement she

admits that she did. Her visits were initially suspended, but were reinstated the following day.

50. On Saturday evening, CC became agitated, after a phone call with his partner. He complained to staff he was not getting his evening medication.

51. His partner made further calls to CC the following morning, Sunday 12 June 2022. He again appeared agitated after the calls.

52. His partner visited CC again on Sunday evening. It appears that the visit proceeded without incident, although afterwards he needed to have PRN diazepam, because he felt "*worked up.*"

53. On Monday, 13 June 2022, his partner visited CC again. He was again given diazepam for *"feeling anxious".*

54. During this visit, she reported to staff that CC had been voicing paranoia to her, saying he was watching her under surveillance and tracking her. She said he had not voiced thoughts to harm himself since Saturday. She was concerned CC would be discharged prematurely, as he was minimising his symptoms. She said she raised a concern about Valium, that it had a paradoxical effect on CC and made him more agitated. She warned the team not to tell CC if his mother called, as this was elevating him.

55. In the afternoon, Sen Constable Brimfield contacted the hospital. She had attended CC's home, to execute the warrant that had been issued following CC's failure to attend court. She told the hospital to contact her in the event of CC's discharge, as he was going to be arrested. CC became aware he was wanted by police the following day

56. On Tuesday, 14 June 2022, RN Mitchell observed CC in the main area wearing a pair of Converse shoes with laces in them. This was not permitted under the policy of the HDU. CC told her he had "*ripped up a towel*" to make the laces. RN Mitchell took the laces and threw them out, and taped CC's shoes together instead. She later located multiple towels in CC's room, which she removed. There was no evidence that these were torn. She recorded this in a progress notes, and reported this to other nurses at the nursing station.

57. His partner visited CC again that day. He appeared agitated and upset about not being released, and blamed his parents. She says she arranged to be recorded as his next of kin. She also told RN Barton that CC was planning to abscond when he was planned to be taken for a heart and brain scan that day. As a result, those procedures were postponed.

58. In the afternoon, Dr Deen and Dr Alex reviewed CC. This was the first review since the previous Friday, and the last review prior to CC's death. They had become aware of CC's threats to abscond, although it does not appear they were aware of the shoelace incident. CC reported he had been happier over the last 24 hours. He said his family was supportive. He said he wanted to engage with drug and alcohol support. The team decided to add a further medication, Valproate, a mood stabiliser. The plan was to continue the involuntary admission, continue other medication, perform the heart and brain scans, and refer CC for drug and alcohol support.

59. His partner spoke with Dr Alex while still at hospital. According to the doctor, she told him that CC was very aggressive and threatening to his parents, and he blamed them for being in hospital. She said in her unsigned evidence that he was suicidal, although she says he did not make any specific threats. She says CC was upset the doctors were discussing his welfare with his mother. She says the doctor told her, "*we can't hold him involuntarily"*. She says Dr Alex reassured her CC would not be released until the family was ready.

60. His partner returned that evening with a bag of clothes. This included a dressing gown, and she told a nurse to remove the waist band. She also says she told the nurse to make sure CC did not have anything to hurt himself. She says she specifically told staff to "*check his bedding, and his bed sheets"* for items he could use to self-harm.

Events of Wednesday, 15 June 2022

61. In the morning, at around 7am, CC asked RN Revadulla for some shaving cream. She told CC it should wait until after breakfast. There is no evidence as to whether he was given shaving equipment that day. However, he did appear to have been clean shaven at the time of his death.

62. CC spent time in the main lounge area in the HDU, mixing with other patients.

63. At about 8.15am, CC asked to make a call to his partner. A number of calls were made, but she did not answer. She said that when she woke up, she saw missed calls and called the hospital. She told CC she had cancelled her midday visit, and would come at 6.30pm instead.

64. EEN Sampson reviewed CC at about 9.05am. He did not note any concerns at that time. At about 11am, RN Revadulla collected wet towels from CC's room. She did not recall seeing anything suspicious.

65. However, at some point mid-morning, a cleaner found a ripped towel in CC's bathroom. The cleaner informed the nursing station. RN Barton, who was present, noted that CC had torn a towel to make shoelaces the day before. The team leader, CNC M Gumbo, told the cleaner they should throw the towel away.

66. This information was potentially significant. There was much evidence about this issue which will be discussed below. It was not recorded in the medical notes. CNC Gumbo states it was recorded on CC's "journey board", an electronic device used to handover information between shifts in the HDU. It does not appear that any other record was kept.

67. CNC Gumbo also states she handed over the information about the ripped towel to the afternoon shift. However, it does not appear that this information, or the shoelace incident of the previous day, was conveyed to the doctors.

68. At 1.40pm, CC called his partner. He reportedly said, "*I am sorry for hurting you. I have lost you."* He also said, "*what I do next has nothing to do with you."* She reassured him and said she would see him at 6.30pm. She says in her draft statement that she did not think he was going to go and actually hurt himself. EEN Sampson observed CC appeared agitated following a phone call.

69. His mother received a call from his partner that day who told her that she and CC had had another row. She says she thought CC was going to commit suicide.

70. At around this time, Dr Alex spoke with CC's mother. He explained the plan to start mood stabilisers, and the plan to refer CC to the Penrith community mental

health team on discharge. His mother told Dr Alex that his partner did not feel safe to have CC discharged.

71. According to his mother, she told the doctor that CC's partner had said CC was planning to kill himself. She recalled in her statement that the doctor said, *"oh no, he is joking with other patients".*

72. At about 2pm, EEN Sampson says he went to make observations. He entered CC's room, but could not see him, and knocked on the bathroom door. CC said he was using the toilet. He came out and asked if there was something wrong. EN Sampson said he was joking with CC, and CC started laughing. He had no concerns about CC's mental health at that stage.

73. At 2pm, there was a multidisciplinary team (MDT) meeting, during which CC's case was to be discussed. Dr Deen and Dr Alex saw CC prior to the MDT. Dr Deen said CC would be reviewed in the afternoon. CC reportedly gave a thumbs up and said "*good*".

74. During the MDT meeting, the team agreed that CC should continue to be managed in the HDU while his medication was titrated. Social work input was sought, to try to organise a family meeting, to assist with discharge planning.

Discovery of death

75. At 2.20pm, RN Revadulla was performing the next scheduled observations. She went to CC's room but could not see him. She went to open the bathroom door, but could not. She returned to the nurses station to get assistance, and EN Sampson attended. He noticed a piece of fabric was wedged in the top of the door jamb. He pushed open the door and caught CC as he fell to the floor. CC had a ligature made from bedding tied around his neck.

76. EN Sampson started CPR promptly and a MET call was made. A 911 tool (or noose cutter) was used to remove the ligature. The MET team attended and followed the Advance Life Saving protocol. CPR was continued for almost an hour, before the team agreed to cease.

77. Tragically, CC was declared deceased at about 3.18pm.

Post death

78. A call was made to Penrith police station at 3.40pm. Police attended the hospital soon after and the room was processed by crime scene officers. A torn or cut blanket was located on the bed in Room 41, which was the one removed from CC's neck, and a second ligature was found on the floor. The two ligatures had the same appearance as the blanket. No cutting items were located in the room, despite a thorough search.

79. A note was also found in CC's room, in which he sought to raise concerns about his partner's care for her children, alleging she had overdosed on medication. He described her as his "*ex-girlfriend"*.

Autopsy

80. An autopsy, by way of external examination, CT and toxicology only, was conducted by Dr Pokorny on 17 June 2022 (2 days after the death). She records the direct cause of death as "*hanging*".

81. Toxicology revealed the presence of cannabis metabolites, which Dr Pokorny says is consistent with recent use. Olanzapine, and diazepam and lorazepam and their metabolites were also detected.

82. A report was obtained from pharmacologist Dr Pieternel van Nieuwenhuijzen, who states that it is possible that the cannabis would have had an effect on CC at the time of his death, but it is not possible to determine when the cannabis was used. The olanzapine, diazepam and lorazepam were consistent with therapeutic use.

Issues

83. An issues list was prepared, with the following issues:

(1) What was the nature of CC's mental health condition?
(2) Was the care and treatment provided to CC during his admission to the High Dependency Unit at Nepean Hospital appropriate?

(3) Was the communication between CC's family, his partner and the treating team adequate? Was information provided adequately documented, and was appropriate consideration given to that information by the treating team?

(4) Should there have been a re-assessment of CC's risk of self-harm after the following events occurred? Were those events adequately documented? Was information appropriately communicated to the treating team?

(a) On 14 June 2022, when CC was found to have ripped a towel to form shoelaces.

(b) On 15 June 2022, when a second ripped towel was located in his room.

(5) Was CC's death intentionally self-inflicted?

(6) Is it necessary or desirable to make any recommendation in relation to any matter connected with CC's death?

The evidence

Dr Alex

84. Dr Alex was the Registrar working with Dr Deen. He gave evidence that he was answerable to Dr Deen in his role. He would gather information from nursing staff, notes, hospital records and the patient and family where possible. Before he would see a patient, he would talk to the nursing staff who were best placed to provide information about how the patient was behaving. He indicated that at that time he would look for entries made by doctors, which were significant, and time permitted he would go through some of the notes. If a doctor had made a note, he indicated that would carry significance to perhaps signify a change in medication, diagnosis or behaviour.

85. Dr Alex would have his decisions and documentation reviewed by Dr Deen. They would discuss patients together, however the ultimate decision making rested with Dr Deen.

86. When he first saw CC, CC had been placed in the seclusion room. This he described as a safety room, with little more than a mattress in it, with people being placed there only when there is an increased risk of harm to the self or

others. It is low stimulus environment, and they are reviewed within the first hour and then 4-hourly.

87. On first review, CC reported that he owned an electrical company, with many people working under him. It was apparent that he held delusions of grandiosity, that being a fixed idea that can't be changed. Through discussions with family the staff were able to understand that what CC was saying in that regard was not the true position.

88. Dr Deen was able to speak to CC's mother, and was given important information such as the ability of CC to be manipulative. He was reviewed again, and a discussion was had with him about acceptable behaviours on the ward. He became more settled, and agreed to the basic rules of the hospital, and a decision was made to move CC to the north side of the ward, which was the lower stimulus environment. He was reviewed again and appeared more settled, walking around the unit with no agitation or aggression the following day.

89. It was decided by the treating team that CC needed to remain detained. He lacked insight, continued having delusions and wanted to be discharged, but was not deemed to be safe as he was a risk to himself and others There was a continued concern that he would self-harm or harm others, suffer misadventure, or suffer financial mis-management.

90. A brain scan was ordered as part of the psychosis episode, together with an echocardiogram of the heart, as upon admission he had reported chest pain and the doctors wanted to ensure proper investigations had occurred. The doctors had already discussed it with cardiology and CC had been scheduled for an echocardiogram.

91. Dr Alex was not made aware of the ripping of towels, the making of shoelaces or the ripped towels found in his room. He said this information was all relevant and of interest to him. He would have wished to discuss this with CC, and eliminate concerns that he was behaving this way with any self-harm thoughts.

92. Dr Alex was asked whether his recorded version of discussions with CC's mum just prior to the MDT meeting was accurate. He did not have a clear recollection of the conversation, and did not deny he may have been told that day that she

was concerned that CC would self-harm. Her account of that conversation was that she reported that CC had said he would self-harm. She reminded him that CC could be a "master manipulator and is not himself". She was told not to be concerned, and that he has been in a jovial mood joking around with the nurses. This account sits consistently with Dr Alex's contemporaneous notes. He doesn't recall specifically that CC's mother told him that his partner held concerns that he was suicidal. However, EEN Michael Sampson did see CC around 2 o'clock, and at that time CC was joking and laughing with him. His mother raised that his partner did not feel that he was safe to discharge.

93. Dr Alex recalled that during the morning, he and Dr Deen were in HDU with another patient, and they saw CC on the ward. He appeared settled, was talking normally and Dr Deen asked how he was, and he said he was "good". They told him that they would review him later in the afternoon.

94. Overall Dr Alex had a strong recollection of CC and appeared caring and concerned for CC. He reflected that he now would prepare better documentation, at that time he was only 9 months into the position and that has been something in his own practice that he has modified.

95. Dr Alex agreed that if he had been made aware of the information relating to the ripped towels, that would that have had a bearing on his assessment of CC's risk of self-harm.

Dr Deen

96. Dr Deen was the Visiting Medical Officer, Psychiatrist, at Nepean Hospital, and treated CC. His role was to oversee the treatment of CC while he remained in the HDU. He confirmed much of the evidence given by Dr Alex. He recalled that because CC was in seclusion, he was a top priority patient. He appeared to Dr Deen to be agitated, and angry about being detained. He was able to establish some rapport with CC. He determined that CC was exhibiting attributes consistent with grandiosity, he had pressured speech, was irritable and experiencing a hyper manic episode.

97. Dr Deen held concerns for CC's safety, but decided he should be placed on the north wing, a low stimulation unit. Seclusion is a place of last resort, and it was

important to move CC from that space. He presented better on the second review by Dr Deen. He placed CC on care level 3, which involved 30 minute observations.

98. There was the intervening long weekend, and following that CC's ECG was cancelled because family had flagged that he was planning to abscond when being taken to that.

99. Dr Deen could not recall whether he became aware of the shoelaces incident at the time or later. He observed that this was unusual behaviour, and in his view was high risk behaviour, and deserving of further questions. He considered that this type of information would be worth considering in determining whether CC was receiving the appropriate level of care.

100. He determined that CC was not ready for step down, and certainly not ready for release. After the MDT meeting, Dr Deen was intending to see CC. Prior to the meeting, Dr Deen recalls CC appearing stable, he responded with his thumbs up when asked how he was feeling.

101. Again, Dr Deen had a good recollection ofC C. He would have been assisted in his treatment had he been told about the shoelaces, and about the towels found in CC's room. He would have at the very least made enquiries of CC about this unusual behaviour. He indicated that he would not have necessarily have made any changes, depending on the responses he received.

RN Patel

102. Registered Nurse Patel was a nurse who had the care of CC on a number of occasions. He admitted CC into the HDU. He made notes of his observations and recorded a plan of care in the hospital records. This was a preliminary plan until CC could be allocated a treating medical team.

103. Shortly after CC's admission, a duress alarm was activated due to an electrical fire. RN Patel recalls CC became agitated, verbally aggressive and intimidating. He demanded discharge and threatened further damage if that did not occur. CC refused oral medication, as such a decision was made to administer an intramuscular sedative and to place him in seclusion.

104. RN Patel made a series of notes following this. CC was considered to be in the highest need of care, level 1. He was observed constantly for 30-45 minutes and then reviewed every 10 minutes.

105. The next day, RN Patel was also allocated primary care of CC, who left seclusion and was placed back on Level 3 nursing, and was reviewed every 30 minutes. He also performed a mental state examination. Although CC remained angry, he denied any thoughts of sell-harm or harm to others.

106. RN Patel had conversations with CC's mother and partner. They were expressing concerns about CC and he conducted a further mental state examination, finding no change. He was told that CC could be manipulative and passed that information on. RN Patel worked on 12 June 2022 but was not allocated care of CC, and had limited observations of him.

107. On 13 June, RN Patel was allocated primary care of CC. During this shift CC was superficially settled and his mood appeared good. He also noted there was evidence of improving insight and judgement. He recorded in detail his observations.

108. On 14 June 2022, RN Patel was again allocated primary care of CC. Again, during a mental state examination that day, he noted that CC was superficially settled and his mood was good.

109. On 15 June he also worked, but did not have primary care of CC.

110. When asked in evidence, RN Patel expressed that he didn't think anything of concern attached to the issue of the shoelaces. He based this view on the fact that upon observation, CC was not showing any increased risk of self-harm, however he did note that ripping sheets can allow a patient to make a noose for themselves. He would have gone to CC's room to remove them.

111. Nurse Patel had a thorough recollection of CC, he took detailed notes and performed his role in accordance with the directed level of care as determined by the treating team.

CNC Moreblessing Gumbo

112. CNC Gumbo was not directly involved in CC's care, she was the unit manager supervising the other staff. She was told about the finding of towels in CC's room, and since she was attending to other duties, she was satisfied that the nurse caring for CC could deal with the situation. There was an assumption that any ripped sheets located in his room related to the shoelace incident. She ensured that the journey board was updated so staff would be aware of the incident. The reality for the nurses was that although the shoelaces and ripped sheets were of concern, they were not seeing any other behaviour from CC to cause them to speak to doctors or escalate the level of his care.

113. Her responsibility was to co-ordinate the shift and to obtain updates about what happened during the shift. She would deal with phone calls, urgent matters and staff could present for assistance and advice in their cases.

114. CNC Gumbo assumed that she wrote "unpredictable – ripped towel found in room" or something along those lines on the journey board. She recalled telling the afternoon staff on handover. CNC Gumbo agreed that it was preferable for this information to be contained in the notes.

115. However, it must be recognised that the loss of CC on the ward that day changed her general practice. Ordinarily she would have checked to see that the notes were updated. She would now escalate an incident like that ripped towel to the treating team. She also noted that although a search of his room would be indicated, on this particular day a deep clean was happening in the ward.

116. CNC Gumbo showed deep insight into the loss of CC, and his loss has greatly affected her, and the way she now practices.

Mr Russell

117. Director of Mental Health, Mr Russell attended the inquest and gave evidence. He described the ward as being a 9 bedroom unit, with 6 in the South Ward and 3 bedrooms in the north. The units are divided by the shared nursing station.

118. He addressed the issue of the torn fabrics, and was able to indicate that there is a degree of tear resistance in the current bedding. However, non-tear linen is not pleasant, it feels like plastic and can't be tucked in. It does not provide a great

deal of warmth or comfort. He gave evidence that there is a constant tension between providing a safe unit and a therapeutic unit – to provide emotional security, and be welcoming and kind. He commented on the difficulty of making the unit physically safe without out become gaol-like. He also noted that this environment is there to try and protect people who are at their most vulnerable.

119. Mr Russell engaged fully with the Coronial process. He has taken on board the matters raised by Dr Ryan (discussed below) and issues that arose in oral evidence relating to communication practices. Prior to the inquest starting, Mr Russell had taken steps to address the door design as a result of Dr Ryan's report. After much consideration and consultation with psychiatrists and other HDU staff, he determined the best available method to reduce ligature options on doors of this type.

120. The work has commenced however in the course of the work, other problems arose which are now being addressed. Regardless, Mr Russell considers this work a priority.

121. Mr Russell took the opportunity of addressing the family and extending his condolences in a meaningful way, and importantly has demonstrated his commitment to making improvements by starting the work prior to the inquest commencing, which in real terms at least allows the family to see that CC's loss has already prompted change.

Dr Ryan

122. Dr Ryan is an adjunct Associate Professor at the University of New South Wales a Clinical Associate Professor at the University of Sydney and a Consultation-Liaison Psychiatrist at St Vincent's Hospital in Sydney where he is Clinical Lead. For almost three decades prior to June 2022 he was the Director of Consultation-Liaison Psychiatry at Westmead Hospital.

123. He was engaged as an independent expert to assist the Coronial investigation in consideration of the treatment of CC. Dr Ryan completed a thorough review of the treatment of CC, and found areas of improvement for the future.

124. Dr Ryan has recommended and been embraced to create significant change at the hospital by focusing on the practical matters that can be altered to improve outcomes for vulnerable patients. Dr Ryan is an expert, leading author and researcher and practicing psychiatrist with extensive knowledge in the difficult and complex area of intentional self-harm.

125. Dr Ryan provided the following opinions:

(1) CC suffered a long-standing methamphetamine use disorder and at the time of his death he likely suffered methamphetamine-induced bipolar disorder.

(2) It was reasonable for the doctors to have found that CC was suffering a mental illness, as defined in section 4 of the *Mental Health Act*, by the presence of delusions and a serious disturbance of mood. He required protection from serious harm, being at least the serious psychological harms that were a consequence of his distressing delusions and, other than involuntary admission, there was no less restrictive alternative reasonably available for his safe and effective care.

(3) In his opinion each of the following components of the treatment plan enacted for CC were appropriate to address his risk of self-harm:

(a) The decision on 8 June 2022 to detain and continue to detain CC under the *Mental Health Act*.

(b) The decision on 8 June 2022 to accommodate CC initially in a High Dependency Unit bed.

(c) The decision to nurse CC at observation level 3.

(d) The decision on 8 June 2022 to increase CC's dose of quetiapine, and then on 9 June 2022 to commence the antipsychotic medication olanzapine.

(e) The 14 June 2022 decision to commence CC on the mood stabiliser valproate.

(f) The 8 June 2022 administration of benzodiazepine midazolam.

(g) The periodic administration of the benzodiazepines, diazepam and lorazepam over the course of his stay.

(h) The decision on 8 June 2022 to place CC in seclusion.

(4) Further, given the frequency of contacts between members of the treating team and the members of CC's family, Dr Ryan noted there was adequate communication with CC's family. Indeed, he says in his experience the number and quality of communications between CC's family during his admission was unusually high.

(5) In relation to the policies operating at the time, the treating team's response to CC manufacturing shoelaces from a ripped towel was considered by him to be adequately managed.

(6) Further, in response to the discovery of the ripped towel in CC's room the action was considered appropriate.

(7) Dr Ryan did not support tear resistant blankets. They are not routinely used in psychiatric units in New South Wales, and further more he opined it would be of limited utility to use them for some psychiatric patients and not others.

(8) In Dr Ryan's opinion the systematic elimination of useable hanging/anchor points such as door jambs is the most critical and the most evidence-based step in environmental approaches to suicide prevention on inpatient psychiatric units. He urged that a deal of effort should be expanded to consider further the issue of removing functional ligature points from doors.

(9) CC's father requested the issue of CCTV in patient rooms be explored. In response, Dr Ryan raised that this year an English study had reported some success in a "vision based patient monitoring and management system". Using artificial intelligence algorithms in reducing the rate of self-harm incidents occurring in the bedrooms of inpatient psychiatric units.

126. In essence Dr Ryan was not critical of any practitioner involved in the care and management of CC. There was a large and appropriate engagement with his family.

127. Dr Ryan did however note that in relation to the shoelace incident and ripped towels he would have liked, as a treating psychiatrist to have been made aware of that. He could not say that information would have changed the clinical management of CC, but he would have taken that information and had a conversation with CC about it.

128. His evidence was that he is reviewing the matter in hindsight and although he has formed an expert opinion of appropriate diagnosis, he nonetheless agreed with the alternate differential diagnosis of the treating team.

129. Dr Ryan was able to assist with some evidence of a communication system put in place at St Vincent's to improve communication. He agreed that clear communication between treating staff is critical in patient care.

Summary of evidence

130. CC became mentally ill and was taken to hospital by his family. This was the only course open to his family to try and protect him. He was a mentally ill person at the time, and was a risk to himself and others. He remained mentally ill throughout his stay in the High Dependency Unit at Nepean Hospital.

131. It was clear that the treating team and nursing staff were committed to CC. They proceeded to care for him, engage with him, treat him. It was evident that this was undertaken with compassion, kindness and respect.

132. It was also evident that his family were fiercely protective of CC, and fully engaged to achieve the best possible outcome for him. The nature of his illness, his delusions and mental illness caused him to reject family members. Nonetheless they remained engaged with the hospital and were critical in providing very important observations and information.

133. The great sadness for the family was that they put him where they believed he would be safe, and even given this environment, he could not be kept safe.

134. CC had formed an incorrect belief that he thought his parents were keeping him within hospital. This may explain in part why during the height of his mental illness he did shut his very caring parents out.

135. The evidence form Mr Russell and Dr Ryan highlights the tension in keeping a safe environment while maintaining an environment that assists in patient recovery by being a nurturing, warm and inviting place.

136. The expert evidence supports a finding that the level of care was in keeping with appropriate standards, and no criticism can be made of the treating team.

137. However, two important areas were highlighted during the inquest. The first is the observations of Dr Ryan that the elimination of obvious hanging points should be an urgent priority, and is a proven factor in adjusting the risk of loss of life in a psychiatric ward.

138. The hospital has already responded to this, with the Director of Mental Health taking urgent steps to correct this. The hospital is in the process of custom making doors that are more suitable and safe for the unit. Although due to unforeseen safety issues that arose during the course of this work, they have been unable to complete the work, it is clear that it will be done. As a result of this inquest, CC has prompted reaction and significant change that although sadly cannot benefit him has made the ward safer for all future patients.

139. As a result I do not need to make a recommendation about this.

140. The second issue was the issue of a "flagging" system, to allow nurses to quickly and easily bring to the attention of the medical team matters that might not escalate to a phone call or direct approach to the team immediately, but might be something out of the ordinary, unusual and of interest to the team.

141. This was embraced by each of the psychiatrists and by nursing staff during the inquest.

142. Submissions were made on this point, and it appears that the hospital has already commenced investigations as to what that might ultimately look like. Currently there is a "Shift Summary" document available within the electronic medical records for use by clinicians within the mental health unit. It is intended to modify the template, with a major change being the inclusion of a box entitled "issues for treating team to consider".

143. It is proposed that the template will be mandatory across all in-patient units, it will be completed once per shift by the primary care nurse and completed near the conclusion of the shift. Treating teams will be directed to review it. Treating teams will note following the review that they have considered the matters and if necessary addressed those issues.

144. To formalise this process further consultation is required with the medical staff. Education is necessary about the change to the process. A realistic time for implementation is 1 March 2024.

145. In relation to the proposed recommendation from CC's mother to consider whether a review of the information sharing policies and procedures in the Mental Health Ward are appropriate, I note the submissions in reply, and consider the practical approach now being taken by the Hospital in implementing the recommendation to flag important matters is sufficient to cover the underlying intention of this proposed recommendation.

146. Again, the unusual issue of the shoelaces and ripped towels is something that the doctors each believed they would have liked to know, and the nurses would have liked this to be communicated to the team. As a result I do intend to make a recommendation to support the Hospital's efforts. I particularly thank them for their engagement in this process and reaction to those important matters. They have demonstrated a willingness to engage proactively with the Coronial process and attempt to make changes for the betterment of the community.

Concluding remarks

147. The loss of CC was a tragedy. As a mentally ill person at the time of his death he was among our most vulnerable. There is no mechanism to adequately console his parents in the face of a loss that they will now live with, and feel every day. It is particularly hard for them because he reached out to them for help, and they took him to hospital, and he was not safe even there. However, they did the right and best thing at the time. He asked for help and they gave it. He was not safe within the community and so they asked the hospital to keep him in the safest place he could be. They have engaged in this difficult and heartbreaking process, to encourage and promote change for the safety of others, and they have achieved that. Great thanks is extended to them for their courage. Equally, my deepest condolences for such a significant loss.

Recommendations

To Nepean and Blue Mountains Local Health District

That NBMLHD consider whether it would be appropriate to implement a process in the mental health ward, whereby nursing staff can highlight events they consider significant in the electronic medical record, with a view to drawing attention to such events for future nursing shifts and/or the treating team.

Findings

148. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it:

The identity of the deceased

CC

Date of death

15 June 2022

Place of death

Nepean Hospital, Kingswood

Cause of death

Hanging

Manner of death

Intentionally self-inflicted

Acknowledgements

149. To the officer in charge for setting aside time and effort to produce an excellent brief of evidence.

150. To the legal practitioners for appropriate presentation and exploration of issues.

151. To the team assisting, Ms McGee and Mr Harris for a thorough review of the brief and excellent presentation of the inquest.

152. Finally to the family, for thoughtful involvement, contribution to issues to be explored and for a thoughtful and moving family statement.

153. I close this inquest.

Magistrate E Kennedy

Deputy State Coroner

15 December 2023