**STATE CORONER'S COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the Death of MA |
| **Hearing dates:** | 26 - 30 June 2017, 17 -18 October 2017 |
| **Date of findings:** | 2 February 2018 |
| **Place of findings:** | NSW State Coroner's Court, Glebe |
| **Findings of:** | Magistrate Teresa O'Sullivan, Acting State Coroner |
| **Catchwords:** | CORONIAL LAW –<br>Suicide risk assessments and risk levels<br>Nursing engagement and observation levels in Mental Health Units |
| **File numbers:** | 2014/65501 |
| **Representation:** | Mr M Cahill, Counsel Assisting the Coroner instructed by Ms B Haider, of the Office of the General Counsel, Department of Justice.<br><br>Mr L Fernandez for [redacted] instructed by M Walz of Walz Legal.<br><br>Ms L Boyd for Western New South Wales Local Health District instructed by Abby Talbot of the NSW Crown Solicitor's Office.<br><br>Mr N Dawson for Mr A Thomas, Ms K Schultz, Ms D Hayden and Ms J Rumble instructed by Ms L Toose of the Nurses and Midwives Association<br><br>Mr G Gregg for Dr J Bardon instructed by Ms K Donnelly of Meridian Lawyers<br><br>Mr C Magee for Dr G Hugh and Dr K Smith instructed by Ms J Paterson of Avant Mutual Group Limited |

**Findings:**

**Identity of deceased:**
The deceased person was MA

**Date of death:**
28 February 2014

**Place of death**
MA died at the Mental Health Inpatient Unit, Dubbo Base Hospital, Dubbo, NSW.

**Manner of death**:
MA, whilst he was an inpatient in the Mental Health Inpatient Unit of the Dubbo Base Hospital in Dubbo, died as a consequence of actions taken by him with the intention of ending his own life.

**Cause of death:**
Neck compression consistent with hanging.

**Recommendations**: To the Chief Executive Officer of Western NSW Local Health District ('**WNSWLHD**')

1. I recommend that the WNSWLHD develop policies and procedures to ensure that an appropriate skill mix is available within the nursing staff in mental health units and, in particular, with the MHIPU at Dubbo Base Hospital, to enable patient engagement and observations to be properly performed.

2. I recommend that the WNSWLHD develop practices and procedures to ensure the identification and communication by all mental health clinical staff of the rationale for the setting and/or changing of patient observation status and levels.

3. I recommend that the WNSWLHD develop policies and procedures to clearly identify the nurse assigned responsibility for the conduct and the recording of a patient's engagement and observations under the NSW Health Policy Directive: *Engagement In Mental Health Inpatient Units* and to ensure that the nurse assigned responsibility is clearly identified in the patient's health care record.

4. I recommend that the WNSWLHD develop policies and procedures to ensure that the responsible nurse documents patient engagements and observations when they occur and to avoid the practice of "block recording" of observations where observations are recorded collectively and subsequent to the time of actual observations.

5. I recommend that the WNSWLHD develop and maintain regular ongoing education programs in relation to the development and/or maintenance of procedural knowledge and nursing skill sets relevant to the proper conduct of mental health patient engagements and observations.

6. I recommend that the WNSWLHD develop and maintain an auditing program designed to test compliance with the NSW Health Policy Directive: Engagement and Observation in Mental Health Inpatient Units and, also, compliance with local procedures.

7. I recommend that the WNSWLHD develop and maintain policies and procedures to ensure that the results of the auditing process are used to inform relevant ongoing education programs in relation to compliance by all mental health clinical staff with the NSW Health Policy Directive: *Engagement and Observation in Mental Health Inpatient Units*.

**Non-publication orders:**

- Pursuant to section 74(1) of the Coroners Act 2009 I direct that there be no publication of the names of any of patients mentioned in these proceedings or anything that may identify them.

- Pursuant to section 75(2), I order that there be no publication of the name or identifying information of the deceased or his relatives. Initials may be used as pseudonyms.

- Pursuant to section 75(5) I permit publication of the information contained in these findings in accordance with the above restrictions.

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# REASONS FOR DECISION

## Introduction

1. MA was 28 years old when he died on 28 February 2014 at the Dubbo Base Hospital's Mental Health Inpatient Unit ('**the MHIPU**'). MA had a long history of mental health problems and he had been admitted as an involuntary patient on this occasion. Sadly, he ended his own life on 28 February 2014.

## The inquest

2. Pursuant to s.81 of *Coroners Act* 2009 (NSW) ('**the Act**'), the coroner holding an inquest touching upon the death of a person is required to make a finding as to whether the person the subject of the inquest died and, if so, findings as to:
   a) the identity of the deceased;
   b) the date of death;
   c) the place of death; and
   d) the manner and cause of death.

### *The immediate cause of MA's death*

3. The available medical evidence discloses that MA had a long history of mental illness involving severe depression, persistent suicidal ideation and previous attempts at self-harm and suicide.

4. The circumstances in which MA's body was discovered on the afternoon of 28 February 2014 are consistent with a finding that MA's death was the result of self-inflicted injury.

5. In short, as noted in the External Examination Report dated 21 March 2014 prepared by Dr Leah Clifton (under the supervision of Professor Tim Lyons):

   "*On Friday 28th February 2015 at 5:20pm a nurse entered the room of the deceased and found him hanging by the neck via a bed sheet tied to a mechanical bed raised to the maximum height. The deceased was in the sitting position and was cold to touch. Resuscitation was attempted but was unsuccessful. It is believed that the deceased was left unobserved for a period of two hours and forty minutes and was last seen on CCTV entering his room at 2:40pm on Friday 28 February 2014*"[1]

6. Consistent with the circumstances in which MA's body was found by Registered Nurse ('**RN'**) Donna Hayden[2] (as she then was) and Endorsed Enrolled Nurse ('**EEN'**) Peter Thomas[3], the sole injury identified on the external post mortem examination of MA's body was "… *an asymmetrical faint, broad, featureless pressure abrasion mark around the neck (of the*

[1] External Examination Report for the Coroner dated 21 March 2014. Ex 1 The Brief of evidence Vol 1 tab 6 at page 13.
[2] Statement dated 5 March 2014 prepared by Ms Hayden. Ex 1 Vol 1 tab 16 at page 95.
[3] EEN – Endorsed Enrolled Nurse.
Police Statement dated 8 March 2014 at [20] – [24]. Ex 1 Vol 1 tab 17 at pp102 – 103.

*deceased), most prominent at the front".*[4] *The injury is described as "… consistent with the history of the body being found with a hospital bed sheet used as ligature"*[5] *and the direct cause of death is reported as "consistent with hanging" with "severe depression" identified as a significant condition contributing to the death.*[6]

7. Having regard to all of the evidence, I am satisfied on the balance of probabilities that the immediate cause of MA's death was a compression injury to the neck caused by hanging.

8. Further, having regard to the higher standard of proof required by the test in *Briginshaw v Briginshaw*,[7] I am satisfied to the requisite standard that MA died as a consequence of actions which he took with the express intention of ending his own life.

## *The wider circumstances surrounding MA's death*

9. Having determined the immediate circumstances and the immediate causes of MA's death, it is important that consideration be given by the Court to 'the manner' of MA's death; and that such consideration should not be overly constrained, or too narrowly confined.

10. In the Chief Justice's Law Reform Commission report entitled "*The Powers and Procedures of Coroners at Inquests and Magistrates at Committal Proceedings (Interim Report No 6)"* (10 April 1964) in commenting upon the Coroners Act, 1960 said:
*"The object of an inquest, however, is to place on record all relevant evidence as to the facts and circumstances of death, to provide material for the registration of death in the absence of a certificate by a medical practitioner, to inform the public, through an impartial inquirer of the broad facts of the matter, and to inform all concerned, in appropriate cases, of the precautions desirable to avoid repetitions."*

11. At the time of his death, MA was a vulnerable patient detained, by order of the Mental Health Review Tribunal, in a declared MHIPU where he was meant to have been kept, as far as was reasonably practicable, safe from self-harm.[8]

## *Inquiries and reviews:*

12. Investigations conducted immediately after the incident, in particular, an internal investigation conducted by Sandra Duffy and Adrian Fahy on behalf of the WNSWLHD and an 'external' review conducted by Associate Professor John Allan, then Chief Psychiatrist of New South Wales, with Catherine Montigny, A/Executive Officer of the Mental Health and Drug and Alcohol Office,[9] establish that:

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[4] Ibid page 12. See also: 15.
[5] Ibid.
[6] Ibid.
[7] (1938) 60 CLR 336.
[8] MHIPU Admission/Patient Records – Mental Health Inquiry section 34 Determination of Tribunal dated 12 February 2014 Ex 1 Vol 2 p381.
See also: The Findings in the Inquest into the death of Ahlia Raftery File No 2015/84416 dated 9 June 2017 per DSC Lee M. at [1].
[9] The Report on Review conducted on 6 March 2014 Ex 1 Vol 2 p148-26.

- CCTV footage showed MA entering his room at 1441 on the afternoon of 28 February 2014; and that MA did not exit his room after that time;
- purported Patient Observations of MA were documented on the relevant "Far West and Western Local Health Networks Mental Health Inpatient Unit Observation Sheet GWA6 02550 ('**the MHIPU Observation Sheet'**) by RN Abraham Thomas, then RN Donna Hayden and EEN Julie Rumble at 1500 hours, 1515, 1530 and 1545; and
- the CCTV footage indicates that the 'patient observations' recorded on the relevant MHIPU Observation Sheet by (Abraham) Thomas, Hayden and Rumble at 1500 hours, 1515, 1530 and 1545 did not occur as MA was in his room and no clinical staff attended either in, or near, MA's room in the period between 1441 and about 1720 when Ms Hayden and EEN Peter Thomas found MA on the floor of his room hanging from the foot of the raised bed.

13. The evidence further discloses that, when interviewed as part of the WNSWLHD's ongoing investigations, Ms Rumble stated:
    - she had not left the Nurses Station but, simply signed the MHIPU Observation Sheet;[10] and
    - she would regularly sign MHIPU Observation Sheets for observations she had not made.[11]

14. The Professional Standards Committee constituted under Part 8 of the *Health Practitioner Regulation National Law (NSW)* to hold an Inquiry into a Complaint[s] in relation to Mr Abraham Thomas, Ms Hayden and Ms Rumble observed at paragraph 70 of its findings that:

    *"70. In his statement and in oral evidence RN Thomas spoke candidly of what may be described as a uniformly cavalier attitude to making and recording patient observations in MHIPU (sic) at Dubbo Hospital (sic). His statement reads as follows:*
    *"Prior to Patient A's death, there was a significant culture of lack of adherence to policy and poor professional practice in the unit. It was common practice in the unit not to observe patients for long periods of time, even in the HDU." (RV, Tab 1 p.11.)"*[12]

    And, at paragraph 183 – 184 that:

    *"183. It seems that there was a general culture of worryingly low regard for the seriousness of observation requirement. In an early interview with the hospital Ms Rumble stated:*
    *"Just because a patient in HDU ['the High Dependency Unit'] might be on level 2 observations, doesn't mean we actually see them every 15 minutes – particularly during the night.*

    *184. The expert reviewer, Mr Shaw, noted this comment to be "disturbing", observing:*
    *'…The statement suggests firstly that care levels may not be maintained at the allocated level in the HDU and use of the word "we" would indicate EN Rumble is suggesting this*

[10] WNSWLHD Addendum to Investigation Report – 8 July 2014 - Ex Vol 5 tab 11.
[11] Ibid.
[12] Findings of the Professional Standards Committee Inquiry constituted under Part 8 of the *Health Practitioner Regulation National Law (NSW)* in the Inquiry into a Complaint in relation to Mr Abraham Thomas Registration No. NMW0001711533; Ms Donna Hayden Registration No: NMW0001406174, presently unregistered; and Ms Julie Rumble Registration No: NMW0001010046, presently unregistered [Ref: 4603/17] dated 28 April 2017. Ex 1 Vol 4 tab 76 at p1325-14.

*practice has happened previously and is more widespread than just that of herself. Secondly, if this is the case, then this would suggest that recognition of the importance of the Care Level allocation process, inclusive of the Psychiatrist's assessment of the patient, is somehow diminished within the Nursing team. Thirdly, if this in indeed the practice within the HDU then this would indicate a culture where misreporting clinical activity is accepted by the team…"*[13]

15. Against this background, my attention has been drawn to the observation made at the commencement of the Committee's Findings:

"*1. It must be said at the outset that this case is laced with utter tragedy. It concerns the conduct of nursing staff on the afternoon on 28 February 2014 when a young man tragically took his own life while an involuntary patient in the Mental Health Inpatient Unit ("MHIPU") at Dubbo Base Hospital. By extension, it reveals endemic failures of clinical practice, procedure and culture in the hospital at the time."*

16. Consistent with the findings made in the proceedings before the Committee, the evidence in this inquest concerns the conduct of the nursing staff, in particular, RN Thomas, Ms Hayden and Ms Rumble and, also, the existence of underlying, endemic failures of clinical practice, procedure and culture within the MHIPU.

17. However, given that disciplinary proceedings have been concluded against RN Thomas, Ms Hayden and Ms Rumble, it is the existence of the endemic failures of clinical practice, procedure and culture and a search for the systemic causes of these failures which have been the focus of the inquest. In particular, the bulk of the evidence heard at this inquest relates to the clinical practice, procedure and culture in the MHIPU at the time of MA's admission, particularly in relation to mental health inpatient observations governed by the WNSWLHD Area Standard of Practice, SOP 1.17.3.2.3 (2), "*Patient Care Levels, Specialling and Risk Assessment for Mental Health Inpatients*".[14]

## Anomalies in the Patient Record

18. Associate Professor Allan and Ms Montigny note in their report that a review of the Dubbo Base Hospital ('**DBH**') medical record/inpatient file in relation to MA's admission to the MHIPU from 30 January 2014 to 28 February 2014 disclosed a number of anomalies.

### Communication of the reasons / rationale for changes in Observation Level

19. First, the authors observe that the Clinical/Progress Notes did not disclose the reasons, or rationale for changes in patient observation care levels. For example, the authors observe in the Report that:

*"On 24/2 at 10:20am MA was moved to Level 3 observation (sic) (every 30 minutes). There are no explanations noted on the file for the change and notes from the previous two days indicate that MA's "flat mood and withdrawn state continue."*[15]

[13] Ibid at pp1325-41 -1325-42
[14] Ex 1 Vol 4 pp1137 – 1142.
[15] Report on Review conducted on 6 March 2014 etc. Ex 1 tab 2 p148-32.

And

"*On 25/2 at 10:40am MA's observation level remains level 3 but was charged again on 27/2 to Level 2 without written explanation and it is not clear from the notes how this links to the report on his state that day although this level seems appropriate given his state.*"[16]

20. In relation to the recording of the changes in patient observation levels , the authors conclude that:

*"6.2 Internal communication processes relevant to changes in patient observation levels are unclear."*

21. However, the authors also observe that:

*"The clinical notes indicate a worsening of depression and of his somatic delusion over time. From the reports it appears that [MA] was becoming more distressed about his own state and felt that he would not get better (but the terms "helpless" or "hopeless" are not used in the notes). The incident with his parents the day before was a clear flag and his parents had expressed their concern to medical and nursing staff on that day [i.e. 27 February 2014].* ***It is unclear whether all Dubbo MHIU clinical staff recognised the deterioration of his condition and, if they did, how this was effectively translated in his care at the time (i.e. measures taken and documented).***"[17] [Emphasis added]

## Inconsistency in the recording of the observation level

22. Professor Allan and Ms Montigny were critical of the existence of the multiplicity of documents within the patient record on which patient care levels were recorded.

23. The authors note:

*"There are three types of records where the level of patient observation requirements is documented:*

> *The signed "stamps" [in the Progress/Clinical Notes] (recording risk status, level of observation leave status and observation level) … [which] should be based on decisions made by the clinical team at the review meeting each morning*
>
> *The MHIPU Observation Sheet – which staff is supposed to sign and which should be concurrent with the observation level stipulated in the clinical notes and Patient Care Plan*
>
> *The Patient Care Plan which also documents the level of observation required by the patient according to assessed risks"*

And

[16] Ibid p148-31.
[17] Review conducted on 6 March 2014 Ex 1 Vol 2 p148-29.

*"….. there are significant inconsistencies in MA's file between the 3 above records and it is unclear to which records Dubbo MHIU (sic) staff abided when MA was in their care. This raises significant concerns regarding the level of observations applied by staff in practice."*[18]

24. The submissions made on behalf of [redacted] and the submissions made on behalf of the family also reflect concerns regarding:

    - the proper diagnosis of MA's psychiatric condition/illness;
    - the choice of pharmacotherapy prescribed by the treating psychiatrists, Dr Bardon and Dr Smith;
    - the nature and extent of communication both with MA's family and with [redacted]
    - the nature and extent of communication, within the MHIPU, between medical clinicians; and also, between the medical clinicians and the nursing clinicians concerning the assessed risk of suicide and the 'patient observations' necessitated in light of that assessed risk; and
    - the nursing care provided to MA whilst he was an involuntary patient in the MHIPU.

## A known history of mental illness and suicidality

25. At the time of his admission to the MHIPU as an involuntary patient, MA had a well-established and well-recognised history of mental illness, including severe depressive illness, suicidal ideation and self-harm / attempted suicide.

26. Consistent with the observations of Associate Professor Allan and Ms Montigny regarding the multiplicity of records on the observation level applicable to an inpatient was recorded , it is significant to note at this point the multiplicity of documents on which, as at 0900 on 28 February 2014, MA's Risk Status, Leave Status and Observation Level was recorded and, also, the conflict between those various entries on the face of the records:

    - The "morning multidisciplinary meeting" entry in the Progress / Clinical Notes – which is set out above.
      I note, in particular, that the Leave Status assigned by the meeting is L2 [up from L3]

    - The MHIPU Staff Handover Sheet dated 28/02/2014 6:21am
      "Risk Rating (sic) S2"
      "Leave Level (sic) L3 with family"
      "Obs 2"

    - GWAHS Patient Care Plan dated 28 February 2014
        - Risk Status - not shown [i.e. no provision for the recording of risk status]
        - "Observation Level 2"
        - "Leave Status L3"

    - MHIPU Observation Sheet
        - Risk Status – not shown [i.e. no provision for the recording of risk status]
        - Leave Status – not shown [i.e. no provision for the recording of risk status]
        - Observation Level

[18] Review conducted on 6 March 2014 Ex 1 Vol 2 pp 148-30 - 148-31.

- The MHIPU Observation Sheet contains a Key showing Levels 1 to 4 and makes provision [at the bottom of each sheet] for entry of the date and time of "Initial Care Level and Reviews".

## Diagnosis; pharmacotherapy; and other aspects of the medical care

27. On all of the evidence, as at the date of his death, MA was suffering from a severe depressive illness combined with symptoms indicative of disordered thought and suicidality.

28. On the evidence, the most significant features of MA's presentation were the combination of a persistent, severe mood disorder with:

- a thought disorder involving persistent ruminations that he had contracted a STD / genital herpes, despite test results and medical advice to the contrary, combined also with thoughts: that he had ruined his life; that he had no future; and/or that his life was not worth living; and
- a persistent suicidality.

29. Against this background, it is apparent that both Associate Professor Allan and Associate Professor Robertson are of the view that:

(i) The medical care/management provided to MA whilst he was an inpatient at the MHIPU was of an appropriate or reasonable standard of care.

(ii) MA's diagnoses were frequently and appropriately reviewed.

(iii) MA's pharmacotherapy was frequently and appropriately reviewed.

(iv) The continued prescription of Effexor/Venlafaxine, including the increase in dosage and its augmentation on 27 February 2014 with LiCO3/Lithium Carbonate, represented an appropriate response to the apparently refractory nature of MA's mental illness, particularly, in light of the combination of MA's persistent depression and persistent delusional belief that he had contracted an STI.

(v) Electro Convulsive Therapy ('**ECT**') may have been an appropriate alternative therapy, but, the failure to recommend and/or undertake ECT does not represent a departure from an appropriate or reasonable standard of care.

30. Further, in light of the recognition by both Dr Smith and Dr Bardon of MA's distress concerning the heightened level of restriction associated with placement in the HDU, the decision not to return MA to the HDU on either 27 and/or 28 February 2014 is a decision which was within the range of appropriate or reasonable care options/decisions.

31. In responding to submissions made to the Coroner, [redacted] also takes issue with the timing of increases in the administration of Venlafaxine/Effexor.

32. However, as is observed by Counsel Assisting, the evidence regarding the increase in Effexor/Venlafaxine to 300mg shows contrary to [redacted] submission that:

- on 30 January 2014 MA was prescribed 150mg of Effexor/100mg daily and 15mg of Olanzapine at night.[19]
- on 4 February 2014 the administration of Olanzapine was stopped; 100mg of Quetiapine at night was commenced.[20]
- on 5 February 2014 the dosage of Effexor was increased to 225mg; the dosage of Quetiapine was increased to 200mg at night; and the dosage of Olanzapine was maintained at 15mg at night.[21]
- on 12 February 2014 the dosage of Venlafaxine was increased to 300mg; the dosage of Quetiapine was 200mg at night; and the administration of Olanzapine was stopped.[22]
- on 18 February 2014 the dosage of Venlafaxine was maintained; Olanzapine 15mg at night was recommenced; and the administration of Quetiapine was stopped.[23]
- on 19 February 2014 the dosage of Olanzapine was reduced to 5mg at night.[24]
- on 26 February 2014 the dosage of Venlafaxine was reduced from 300mg to 225mg.[25]
- on 28 February 2014 the dosage of Venlafaxine was increased back to 300mg mane and Lithium, 450mgs Tbd, was added.[26]

33. Although Associate Professor Robertson in his evidence[27] queried why the dose of Effexor was not increased to 300mg earlier, Associate Professor Robertson also stated that this was not a criticism.

34. It follows that there is no evidence that either the choice of Venlafaxine / Effexor or the dosages at which it was prescribed represented a departure from an appropriate standard of care.

35. There is no evidence that the timing of the introduction of Lithium supplementation represented a departure from an appropriate standard of care.

36. I am satisfied on the balance probabilities regarding the level medical/psychiatric care provided to MA during the course of his admission to the MHIPU; and in particular, in relation to the prescribed pharmacotherapy, that the care was of an appropriate or reasonable standard.

37. Having regard to the evidence as a whole, I am satisfied, on the balance probabilities, that the medical/psychiatric care provided by Dr Bardon and Dr Smith was of an appropriate or reasonable standard.

## Risk Assessment and the assignment of a "risk status" or "risk rating"

38. In the New South Wales Mental Health In-Patient Unit Suicide Risk Assessment and Management Protocols the following is observed:

[19] Ex 1 Vol 2 pp410/414/510.
[20] Ibid p42/510.
[21] Ibid p425/510.
[22] Ibid p434/512.
[23] Ibid p442/512.
[24] Ibid p445/512.
[25] Ibid p452/514.
[26] Ex 1 Vol 2 p514.
[27] 18 October 2017.

*"Psychiatric in-patient facilities have a central role in the care of patients presenting with suicide risk. Good therapeutic relationships with patients and their families are key components for the reduction of suicide risk in-patient facilities.*
*Admission to an in-patient facility provides opportunity for a safe and containing environment, supervision commensurate with the degree of risk, direct observation, regular monitoring of mental state and continuous support.*
*An in-patient unit strives for an appropriate balance between the need to manage the person at risk within a safe and containing environment and the need to promote autonomy through therapeutic relationships and an empowering milieu."*[28]

39. Further, the *New South Wales Health Community Mental Health Service Suicide Risk Assessment and Management Protocols* states:

*"The use of the Mental Health Act 1990 (NSW) may be necessary in the following instances to enable the continued observation of the person:*
- *if suicidal thoughts or intentions are persistent or intense, or*
- *the self-harming behaviour is intense in nature, or*
- *there is evidence of serious mental disorder or illness.*

*Management in the community is not appropriate when suicide risk escalates beyond a critical level and there are significant limits in the level of support available for the person. Critical level is indicated by an assessment of high lethality and high intent."*

40. As is noted above, it is apparent from MA's Admission/Patient Records that:

- *On 27 January 2014 MA was admitted to Bloomfield as a voluntary patient with history of depressive illness, suicidal ideation and "suicide risk".*[29]

- *On 28 January 2014 MA self-inflicted a 5cm wound to his neck with a razor whilst a voluntary in-patient; the self-infliction of the wound is recorded in the notes as, ostensibly, a suicide attempt; and, following this act of self-harm, MA was subject to a mental state review which resulted in MA being "scheduled" as an involuntary patient under Schedule 1 to the Mental Health Act 2007 on the basis that "[ MA] needed admission for his own safety, suicidal ideation"; and MA was transferred to the Mental Health Intensive Care Unit [MHICU] for closer monitoring, i.e. observation.*[30]

41. Following his transfer on 30 January 2014, as an involuntary patient, from the Mental Health Intensive Care Unit at Bloomfield to the MHIPU at Dubbo Base Hospital, MA was admitted to the MHIPU as an involuntary patient. MA was assessed as potentially suicidal with a sufficiently high level of immediate risk to himself that MA was admitted to the HDU and placed on Level 1 close observation i.e. MA was placed on 1:1 patient care level observations.[31]

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[28] NSW Mental Health In-Patient Unit Suicide Risk Assessment and Management Protocols – NSW Department of health 2004 Ex1 Vol 4 tab 54 at 1075.
[29] Bloomfield Admission/Patient Records Ex 1 Vol 2 Tab 35 pp236-239, p292, p394.
[30] Ibid p295; p283-p284; p285.
[31] Admission/Patient Records Ex 1 Vol 2 tab 36 p410 and NSW Health Mental Health Care Plan MA Ex 1 Vol 2 tab 36.

- On 7 February 2014 Dr Ranasinghe reported to the Mental Health Tribunal that MA *"need[ed] to be treated as an Inpatient considering the high risk of suicide poor insight and judgment impaired by depression."*[32]

- On 12 February 2014 the Mental Health Tribunal made an order detaining MA as an involuntary patient for a period of 4 weeks to 12 March 2014 noting that MA represented a significant risk to himself and that confinement in a closed ward, in this instance, the MHIPU, represented the least restrictive environment for his safe and effective care.[33]

42. As noted previously, both Dr Smith and Dr Bardon stressed in evidence that MA was significantly depressed, distressed and suicidal throughout the period of his admission to the MHIPU; and that they were concerned about MA's suicide risk throughout his admission.

43. When questioned about his concern about MA's suicide risk on 27 February, Dr Bardon stated in evidence:

*"Well, as I said before, we had a very high concern about his suicide risk right throughout the admission. The fact he was angry on that particular day was certainly - you know noteworthy, but it didn't necessarily mean there was higher suicide risk as a result of that. The suicide risk was if he left the unit, that was, that was what we were trying to prevent."*[34]

And also in same context:

*"Q. You agree that you have used the words " very high concern about suicide risk", in your progress notes, that' s the case, isn't it?*
*A. That's the case, but, what I am saying is, you're trying to conflate the fact he was agitated and distressed, as indicating that he had a higher suicide risk. I'm saying he had a high suicide risk throughout the admission and that was what we were concerned about."*[35]

44. Dr Bardon also gave evidence that, as at 27 February 2014, MA's suicide risk *"was the main concern at that stage."*[36]

45. Dr Smith stated in her evidence that she considered MA *"… suicidal on a regular if not daily basis".*[37]

46. Also, at least as of about 24 February 2014, Dr Smith and Dr Bardon both considered MA *"… might minimise risks to avoid going back to HDU …".*[38]

47. Dr Smith also stated in her evidence that, as at 26 February 2014, *"[she] didn't see [MA] as deteriorated at that point. [She] saw him as having failed to respond to treatment at that point."*[39]

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[32] Ibid Dubbo Mental Health Inpatient Unit – Tribunal Board Report Ex 1 Vol 2 tab 36 p372.
[33] Ibid – Determination of Tribunal ino MA dated 12 February 2014. p381.
[34] T/script 28/06/17 p62 line 47ff.
[35] T/script 28/06/17 line 19 -24.
[36] T/script 28/06/17 p35 line 12 -13.
[37] T/script 29/06/17 p28 line 45 – 50; p29 line 32 -35.
[38] Ibid and also at 29/06/17 at p33 line 40 – 43.
[39] T/script 29/06/17 p36 line 5 - 8.

48. Associate Professor Allan notes in his report that:

*"From the clinical notes and discussion with Ms Kerry Schultz, Dr Bardon and Dr Clark, during the month prior to his death, MA's somatic symptoms appeared to worsen and so did his depression although on a few occasions staff expressed the view that his depression lessened based on his improved mood and interactions with others improving momentarily."*[40]

49. On the evidence, as noted above, on 28 February 2014 the "*morning multidisciplinary team meeting*" assigned MA a Risk Status or rating of S2, that is a "*moderate risk of suicide*"; a Leave Status of L2, that is "staff escorted leave" (up from L3, "*family escorted leave*" on 27 February); and an Observation Level of L2. There is no explanation for the change in status.

50. On all of the evidence, where there is a change in Risk Status, Leave Status or Observation Level, the rationale for the change in status should be reflected in the clinical records, including the Progress/Clinical Notes and in other documentation on which the Risk Status, Leave Status and Observation Level are recorded. This is even more important where there is a change in Status or Observation Level which reflects a perceived increase of risk to patient safety or security.

51. For the reasons set out above, it is now evident that concerns held about MA minimising his expression to clinical staff of suicidal ideation and suicide risk, because MA did not want to be placed on the HDU, should have been expressly noted in MA's Progress / Clinical Notes and expressly communicated to nursing staff charged with his care.[41]

52. Nonetheless, on all of the evidence, there is no current rating scale or clinical algorithm that has proven reliable in predicting suicide.

53. This proposition was put by Ms Boyd on behalf of the WNSWLHD to, and accepted by, Associate Professor Robertson in his evidence on 17 October 2017.

54. It is also accepted that, to quote Professor Wand, *"…. no matter how well prepared individual nurses are with post graduate qualifications and experience this will not circumvent let alone prevent all adverse events such as self-harm or suicide" and, also, that "… medication and hospitalisation do not magically mend mental health problems and that complete safety is never guaranteed."*[42]

55. In theory, the risk was to be managed, if not eliminated, in the MHIPU by a combination of appropriate medical and nursing care, including an appropriate level of risk management.

56. In theory, from a psychiatric nursing point of view, in the MHIPU the risk was to be managed through a combination of therapeutic nursing engagement and patient observations.[43]

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[40] Report on Review conducted on 6 March 2014 Ibid Ex 1 Vol 2 tab 30 p148-27.
[41] See: Dr Smith T/script 29/06/2017p32 Line 50 – page 34 Line 34.
[42] Report date 19 June 2017 prepared by Professor Timothy Wand Ex 1 Tab 9A at p21-221.
[43] NSW Health Mental In-Patient Unit Suicide Risk Assessment and Management Protocols Ex1 Vol 4 Tab 54.
NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff – NSW Department of Health 2004 Ex 1 Vol 4 Tab 55.

57. It is also apparent that suicide risk may be both fluid, i.e. subject to change or fluctuation and impulsive or opportunistic.[44]

58. For example, it is noted in the NSW Health Mental Health In-Patient Unit Suicide Protocols that in the Inpatient Unit environment:

*"Periods that are particularly dangerous for a person who is at risk of suicide include times of transition, such as staff hand-over, busy times when staff may be distracted and during the quiet hours of the night."*[45]

59. In this context, I note the incident which occurred when MA was *"on family escorted leave"* on 27 February 2014, described by [redacted] in conference with Dr Bardon on that day,[46] in which MA was asking about the family car, looking at his mother's handbag in what [redacted] interpreted as an attempt to abscond. Associate Professor Allan, Associate Professor Robertson and Dr Bardon all agree that this incident represented "a flag" or a marker indicating, or at very least suggestive of, a deterioration in MA's state of mind and an increase in suicidality.

60. Further, on the evidence, there was a concern that MA had not responded to the pharmacotherapy previously prescribed.[47]

61. On the evidence, Dr Bardon responded by introducing a change in MA's medication, namely the introduction of Lithium augmentation.

62. As noted above, this change in pharmacotherapy, on all of the evidence, falls within the scope of acceptable medical practice.

63. It was also put to Dr Bardon that, having regard to the apparent change in MA's mental status, the circumstances called for MA to be returned to the HDU where it might be expected that, all other matters being equal, MA would have been accorded a more stringent level of observation.

64. However, in this context, both Dr Bardon and Dr Smith emphasised in their evidence that, consistent with the requirements of the *Mental Health Act*, one of the principal purposes, if not the principal purpose of MA's involuntary hospitalisation was to treat MA's mental illness in the least restrictive environment in which, in their opinion, MA's suicidality/suicide risk could be safely managed.

65. As was observed, by Dr Smith in her evidence:

*"Q. Given what [redacted] had told you about MA's thoughts about killing himself every day, did you think to yourself that MA should go back to the … high-dependency unit?*

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GWAHS Area Standard of Practice Patient Care Levels, Specialling and Risk Assessment for Mental Health Inpatients SOP Number 1.17.3.2.3 (2) Date reviewed: August 2009 Vol 4 Tab 56.

[44] NSW Health Mental Health Inpatient Unit Suicide Risk Assessment and Management Protocols ibid Ex 1 Vol 4 tab 53 p1083.

[45] Ibid Ex 1 Vol 4 tab 54 p.1083.

[46] Admission/Patient Records ino MA Ex 1 Vol 2 tab 35 p453 27/2/14 - medical entry made by Dr Bardon.

[47] Ibid – p452 – 26/2/2014 4.30pm - medical entry made by Dr Smith.

*A. I did give it consideration, yes.*

*Q. Did you think that the level of care that he would be given at the high-dependency unit would be more appropriate given what [redacted] had told you about MA?*

*A. Making decisions about where to manage somebody who is suicidal is complicated. If I'd returned MA to the high dependency unit then, yes he would have been in a safer environment but he had also had not a very good experience of being [in] a high-dependency environment and I thought that we could manage his risk appropriately on the sub-acute unit with 15 minutely (sic) observations and that that was a balance between safety but also not putting him into a place that he had found unpleasant and difficult to manage."*[48]

66. Further, consistent with the evidence which he gave in Court on 17 October 2017, Associate Professor Robertson observes in his report as follows:

*"To utilise a further hypothetical, if the mental state described in the notes was posed to experienced clinicians blinded to the final outcome, I suspect the majority would indicate that 15 minute observations (performed properly) would have been a sufficient level of clinical vigilance."*[49]

I note that Professor Hazelton is of the same opinion.[50]

67. Against this background and considering the evidence as a whole, I am satisfied that as at 28 February 2014:

- the placement of MA in the Sub-acute unit/side of the MHIPU was appropriate;
- the assignment by the 'multidisciplinary team meeting' of a Risk Status of S2 was appropriate; and
- the assignment by the 'multidisciplinary team meeting' of a Leave status of L2, i.e. staff escorted leave, was also appropriate.

## *Communications*

68. The submissions made on behalf the family and on behalf of [redacted], raise concerns regarding communication.

### Communications between the medical staff

69. Both the submissions made on behalf of [redacted] and the submissions made on behalf of the family take issue with the adequacy of the communications:
    - as between the two Visiting Medical Officers ('**VMO**') charged with MA's care whilst he was an inpatient in the MHIPU; and
    - between the two VMOs and the Nursing Staff working in the MHIPU.

[48] T/script 29/06/17 p30 line 19 -28.
[49] Report dated 24 October 2016 prepared by Associate Professor Robertson for the Coroner Ex 1 Vol 1 tab 8 p20-10.
[50] Report dated 21 November 2016 prepared by Professor Hazelton Ex Vol Tab p21-18 at [47].

70. Dr Bardon and Dr Smith share one VMO position within the MHIPU:[51]
    - Dr Bardon and Dr Smith work in the MHIPU as consulting psychiatrists;
    - Dr Smith works Monday, Tuesday and Wednesday;
    - Dr Bardon works Thursday and Friday;
    - on weekends, either Dr Smith or Dr Bardon was on-call; and
    - the psychiatric registrars manage day to day patient care.

71. Dr Bardon and Dr Smith each live in Sydney and each undertakes their VMO duties in the MHIPU on what may be described as a "*fly-in / fly-out*" basis.

72. In the circumstances, perhaps not unsurprisingly, the evidence indicates that communications between Dr Bardon and Dr Smith concerning MA relied on the medical entries each made in MA's patient records; primarily, the medical entries in the Progress / Clinical Notes.

73. The evidence also establishes that the VMOs [Dr Bardon and Dr Smith], together with various psychiatric registrars [including Dr Ranasinghe], attended a multidisciplinary team meeting that was held each weekday morning in the MHIPU at which the progress of each patient was discussed, and each patient was assessed assigned a risk status, a leave status and an observation level.

74. The results of the morning meetings were recorded in the patient records by the entry of a "MHIPU DBH – Morning Meeting" Stamp in the Progress/Clinical Notes. The stamp was to be entered, completed and signed by a registrar.[52]

75. An analysis of the Progress/Clinical Notes discloses, also, that MA was reviewed by Dr Ramaswarame on 30 and 31 January 2014;[53] by Dr Smith on 4, 5, 10, 17, 19, and 26 February 2014;[54] by Dr Bardon on 6 and 27 February 2014;[55] and by a psychiatric registrar on 31 January 2014; and 4, 12, 13, 17, 18, 24, 25, 26 and 28 February 2014.[56]

76. On 30 January 2014, when MA was transferred from Bloomfield at Orange to the MHIPU, Dr Bardon was on leave.[57]

77. As a consequence, following his transfer from Bloomfield, MA was assessed and, then, admitted to the High Dependency Unit ('**HDU**') within the MHIPU by another VMO, Dr Kaneyson Rameswarame.[58] But, MA was admitted to the MHIPU, nominally, under the care of Dr Bardon.

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[51] T/script 28/06/2017 p31 Line 17 – 35.
[52] See, for example the "MHIPU – Morning Meeting Stamp" for 31/1/14 Ex 1 Vol 2 at p415; and the stamp for 28/2/14 at p455.
[53] Ex 1 Vol 2 pp 408 – 410; and 416.
[54] Ex 1 Vol 2 pp 420; 423; 429; 441.
[55] Ex 1 Vol 2 pp 424 – 425; 453 – 454.
[56] Ex 1 Vol 2 pp ; 431; 433; 434; 435; 440; 441; 442; 448 – 449; 451; and 455.
[57] Tscript 28/06/17 p66 Line 26 – p6.
[58] Form 1 Medical Report as to the Mental State of a Detained Person dated 30 January 2014 signed by Dr Kaneyson Rameswarame FRANZCP Ex 1 Vol 2 page 386; and, also, the initial medical entry in the Progress/Clinical Notes recording that MA had been seen by Dr Ramaswarame and a psychiatric registrar, Dr Cunningham Ex 1 Vo 2 pp408 – 415.

78. In addition, Dr Bardon was consulted on Saturday 15 February 2014 regarding an apparent deterioration in MA's presentation and the administration of an additional anti-psychotic medication, Accuphase, by injection.[59]

79. I accept the observations of Associate Professor Robertson in relation to the medical entries in the Progress Notes that:

> *"For the most part, the records of Dr Smith and Dr Bardon are detailed and thoughtful. They [the entries] appear to reflect what appear to be a thorough degree of engagement with the deceased's clinical situation and management options…"*[60]

80. I accept also the observations of Associate Professor Allan and Ms Montigny, regarding recognition in the Progress/Clinical Notes of the deterioration in MA's mental state in the days immediately preceding his death and, also, the response of Dr Bardon and Dr Smith to that deterioration.[61] In particular, the authors note in the summary of the two major findings of their review that:

> *"7.1 Recognition of deterioration in a patient's mental status and appropriate response*
> *There were clear flags in MA's case – his despair and desire to leave, his ongoing ambivalence about his delusional beliefs, his parents/ concerns and his behaviour then previous day. There was a lot of appropriate staff contact which noted his mental state and he was answering direct questions about risk in the negative whilst giving indirect concerns about risk. There were responses in the change of his leave status and observation levels but not his risk status which indicate that this was understood [i.e. that MA was giving direct answers about suicidal ideation and intent in the negative whilst he was giving indirect concerns about that risk] ..."*

81. Further, I accept Dr Bardon's evidence[62] that in treating MA he relied upon the Clinical Progress/Notes; and, in particular, I accept that, in determining on 27 February 2014 to increase MA's dose of Venlafaxine back to 300mg mane and to supplement the Venlafaxine by the introduction of LiCo3 [Lithium Carbonate], Dr Bardon was aware of the entries Dr Smith made in the Clinical/Progress Notes on 25 February 2014[63] and on 26 February 2014[64] respectively; including Dr Smith's plan to change MA's medication.

82. I am satisfied that as at 28 February 2014, Dr Bardon and Dr Smith shared a common concern regarding MA's apparent failure to respond, as hoped,[65] to the pharmacotherapy prescribed up to that date; and in particular, to the anti-depressant, Venlafaxine or Effexor. Dr Smith's approach was to consider a change in anti-depressant therapy.[66] Dr Bardon's

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[59] Ex 1 Vol 1 pp 437 – 438.
Bardon Tscript 28/06/17 lines 10 - 31
[60] See: Associate Professor Robertson: Report dated 24 October 2016. Ex 1 Vol 1 p20-13 – 20-14.
[61] The Report on Review conducted on 6 March 2014 Ex 1 Vol 2 p148-28; p148-29; and at 148-33.
[62] Tscript 28/06/17 p47 lines 15 – 50.
Tscript 28/06/17 p59 at 32 – 35.
[63] Ex 1 Vol 2 pp451 – 2.
[64] Ex 1 Vol 2 p452.
[65] Tscript 29/06/17 line 30 – 35.
See also: Tscript 29/06/17 line 6 – 26.
[66] Tscript 29/06/17 p31 line 27 – 31.
See also: Dr Smith's medical entry 26/4/2014: "Now 4 weeks into admission/treatments – 2/52 at modest venlafaxine dose …. ? continue higher dose or change anti-depressant. ***If*** he is have another antidepressant …" [Emphasis added].

approach was to maintain MA on Venlafaxine, increasing the dose back to 300mg mane, and to supplement the Venlafaxine with Lithium Carbonate.

83. Associate Professor Robertson notes in his initial report that, "*[o]ver the course of his illness [which commenced in 2009], [MA] had trialled numerous anti-depressant strategies, including fluoxetine, escitalopram, duloxetine and venlafaxine, as well as varying doses of quetiapine"*; and that "*[a]ll attempts at pharmacological management seem to have had equivocal results."*[67]

84. Both Associate Professor Allan and Associate Professor Robertson are of the opinion that the pharmacotherapy adopted over the course of MA's admission to the MHIPU was appropriate; and neither Associate Professor Allan nor Associate Professor Robertson take issue with Dr Smith's failure to call Dr Bardon to discuss a possible change in MA's pharmacotherapy.

85. In the circumstances, I am satisfied there is no evidence indicating that the failure of Dr Smith to call Dr Bardon, on either 27 or 28 February 2014, to discuss MA's pharmacotherapy represented a departure from appropriate medical practice; nor that it played any causative role in the events leading up to MA's death on 28 February 2014.

86. I am satisfied, also, that throughout MA's admission to the MHIPU, Dr Bardon and Dr Smith shared a common concern regarding the risk of suicide; and that their common concern regarding MA's suicide risk informed the risk status, leave status and observation level on review at the Morning Meeting held each week day in the MHIPU; and, also, from time to time, during the course of MA's admission, when MA was reviewed by Dr Bardon, Dr Smith and the various psychiatric registrars.

87. I accept that it was not the practice at the time of MA's admission to document the discussions at the MHIPU Morning Meeting otherwise than a registrar entering and, then, completing the pro-forma "MHIPU DBH – Morning Meeting" stamp in a patient's Progress/Clinical Notes.

88. It follows, as is observed by Associate Professor Allan and Ms Montigny, that:

*"From the notes: On 24/2 at 10:20am MA was moved to L3 (observation every 30 minutes). There are no explanations noted on the file for the change and notes from the previous two days indicate that MA's 'flat mood and withdrawn state continue" On 25/2 at 10:40am MA's observation remains level 3 but was changed again on 27/2 without written explanation and it is not clear from the notes how this relates to the reports on this day ..."*

89. Considering the evidence as a whole, where a MHIPU Morning Meeting changed a patient's risk status, leave status and/or observation levels, it would have been preferable if the LHD's practice required the rationale for changes in a patient's risk status, leave level and/or patient observation level to be recorded in the Progress/Clinical Notes and confirmed by the relevant medical officer.

90. That was not the system which was in effect at the time of MA's admission.

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[67] Ex 1 Vol 1 p20-2.
See also: Dr Smith's medical entry on 26/2/2014: " Previous trials of Effexor …. Etc. " Ex 1 Vol 2 at p452.

## Communications between the medical staff and the Family

91. At paragraph 12 of the submissions on behalf of [redacted], Dr Bardon is criticised for failing to make contact personally with MA's family prior to Dr Bardon meeting with MA and the family on 27 February 2014.

92. To the extent that the issue was raised with Dr Bardon, his evidence was to the effect that it was a matter of importance that the treating team, that is, the consulting psychiatrists and registrars, communicate with the family. The primary point of contact for the treating team, on the evidence, was the psychiatric registrars and, in particular, Dr Ranasinghe.[68]

93. Further, on the evidence, it is apparent that:
    - Dr Smith interviewed [redacted] on 24 February 2014;[69] and
    - Dr Bardon saw MA in company with his parents on 27 February 2014.[70]

94. Also, there is nothing in the reports of either Associate Professor Allan and/or Associate Professor Robertson which indicates in these regards any departure from an appropriate standard of psychiatric care or practice.

95. I am satisfied that no criticism should be made of Dr Bardon in this regard.

## *A systemic failure in the delivery of nursing care*

96. As at 28 February 2014 the relevant Area Standard of Practice, or Standard Operating Procedure ('**SOP'**), applicable was the Greater Western Area Health Service Area Standard of Practice Patient Care Levels, Specialling and Risk Assessment Mental Health Inpatients SOP 1.17.3.2.3 (2) devised May 2007; reviewed August 2009; and due for review as at August 2012.

97. MA had been assessed at the 'morning multidisciplinary meeting' on 28 February 2014 and, as noted above, MA was assigned a Risk rating or status of S2, a medium suicide risk; a Leave status of L2; Staff escorted leave; and an Observation level of L2. This was recorded clearly in the Clinical/Progress notes at 09:00 on the 28 February 2014.

98. The requirements applicable to all levels of observation under the SOP are clearly described in a guide printed on the rear of the MHIPU Observation Sheet. The guide is taken directly from the SOP.[71]

99. A further medical entry in the Progress/Clinical Notes at 13:40 on 28 February 2014 reconfirmed the requirement for Level 2 Observations:

    *"Still ruminating'*
    *Feeling depressed*
    *Sleeps Ok No suicidal feeling/thoughts*

[68] T/script 28/06/2017 p53 line 5ff.
[69] Ex 1 Vol 2 p449 – 50.
[70] Ex 1 Vol 2 p453 – 54.
[71] GWAHS Area Standard of Practice Patient Care Levels, Specialling and Risk Assessment for Mental Health Inpatients SOP No 1.17.3.2.3 (2). Ex 1 Vol 4 tab 56.at p1141.

*Appetite good*
*No s/e [side effects] to Li [Lithium]*
*Plan – continue Same treatment - Obs 2*
*Increase Li later."*[72]

100. The SOP is clear, patient care level observations were to be determined by the patient's treating psychiatrist, in consultation with the NUM / the In-Charge of Shift Nurse or a delegate.[73]

101. It follows that the entries in the Progress/Clinical Notes make plain that on 28 February 2014 the observation level assigned by Dr Bardon to MA, in accordance with the SOP, required nursing staff to perform Level 2/15 minute observations.

102. This is a clear and simple directive with the safety and well-being of the patient at its core.

103. The directive as to Level 2/15 minute observations is repeated in the Staff Handover Sheet prepared for the morning handover meeting, albeit, as a carry-over from 27 February 2014.

104. It is equally clear from the MHIPU morning meeting entries in the Progress/Clinical Notes that MA was assigned Level 2/15 minute observations at 10.20am on 10 February 2014; at 11.40pm on 12 February 2014; at 10.00 on 13 February 2014; at 10.40am on 25 February 2014, with no changes to his status on 26 February 2014 and at 10:05am on 27 February 2014.

105. Nonetheless, the MHIPU Observation Sheets indicate that the patient care level observations recorded on the relevant dates did not comply with the Observation Level set by MA's treating psychiatrist and recorded in the Progress/Clinical Record.

106. As noted by Associate Professor Allan it is not possible to tell retrospectively which of the other entries represent patient care level observations performed, or not performed, in accordance with the SOP.

107. Having regard to the evidence as a whole, the Court is satisfied on the balance of probabilities that prior to and as at 28 February 2014 nursing staff within the MHIPU were routinely conducting patient care level observations in a manner which was non-compliant with the SOP; and that there was routine non-compliance in relation to both the making and the recording of Patient Care Level Observations.

108. In practice, it appears to have been a procedure which was either routinely misapplied, or routinely ignored.

109. The fact that the record remained uncorrected over an extended period of time is consistent with a widespread acceptance within the MHIPU of a mode of nursing practice which neither satisfies applicable professional nursing standards, nor the record keeping standards of NSW Health.[74]

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[72] Admission/Patient Records into MA Ex Vol 2 tab 36 p435.
[73] Ibid p1138.
[74] See also in this regard, the Professional Standards Committee of Inquiry reasons for decision, Op cit, Ex 1 Vol 4 tab 76 p1325-40ff at [183] – [184].

110. Further, it is apparent from a simple inspection of MA's Admission/Patient records that the defects in the record keeping are spread across the bulk of MA's admission, involving multiple nursing shifts and multiple non-compliances that relate to the completion of multiple aspects of MA's patient record.

111. On the evidence, retrospective auditing of 27 patient files performed by the WNSWLHD after the subject incident, in accordance with Associate Professor Allan's recommendations, were reported as a 100% failure, that is, every file disclosed a defect in the recording of patient observations.[75]

112. There is a common theme in the evidence given by the nursing staff involved in the subject incident which is consistent with the documentary record.

113. As at 28 February 2014, non-compliance with the SOP was routine practice within the MHIPU.

- The SOP, at paragraph 1.12 required the MHIPU observation sheet to be signed by nursing staff allocated to the patient's individual care[76] but, in practice, as at 28 February 2014 a "*team nursing*" approach was adopted by the LHD and any nurse on a shift could perform and record a patient's care level observations.[77]

- Patient care level observations were routinely conducted by *"en masse*" or *"grouped*" sightings of patients performed by a single nurse in common areas such as the lounge area on the Sub Acute Unit ('**SAU'**); and MHIPU observation sheets were completed, also, "*en bloc*" and retrospectively when the nurse returned to the Nurse's Station later in the shift.[78]

- Patients are reported to have been routinely left unobserved for extended periods of time, even on the HDU.[79]

- "*Phantom*" entries were routinely made on MHIPU observation sheets where no observations, even mere patient sightings had been made.[80]

114. RN Thomas, Ms Hayden and Ms Rumble each gave evidence that prior to 28 February 2014 they had not been provided by their employer with any formal training or instruction in relation to the conduct of patient care level observations.

115. At best, the evidence indicates that prior to 28 February 2014, on the introduction of new policies, staff members were asked to read policies such as the SOP and to sign an

[75] Mr Fahy Tscript 29/06/2017 p74 line 22 – p75 line 34.
[76]GWAHS Area Standard of Practice Patient Care Levels, Specialling and Risk Assessment For Mental Health Inpatients SOP Number 1.17.3.2.3 (2) Ex 1 Vol 4 tab 56 p1138 paragraph 1.12.
[77] RN Thomas T/script 26/06/17 p38 Line 21 – p40 at Line 38 and in particular, p40 Lines 19 – 38;
See also, for example, Statement dated 5 March 2016 of Kerry-Anne Maree Wadley Ex 1 Vol 1 tab 18 p111 at [24] and [26] and Statement dated 3/11/2016 of Kerry-Anne Wadley Ex 1 Vol 1 tab 19 p119-2 at [10] and p119-3 at [15].
[78] Ibid.
[79] Ms Hayden Tscript 27/06/17 p55 lines 9 – 40.
[80] Ms Rumble Tscript 27/06/17 p77 lines 43 – 50.

acknowledgement that the subject policy had been read. Similarly, during induction, new staff members were asked to read policies such as the SOP and sign an acknowledgement that the subject policy had been read.[81]

116. RN Thomas, Ms Hayden and Ms Rumble each gave evidence that, as at 28 February 2014, patient care observations were routinely undertaken on the basis that a "*visual check*" was sufficient; patients merely needed to be sighted.

117. The conduct of care level observations as mere patient sightings is a phenomenon which is not restricted to the MHIPU. In the Findings in relation to the *Inquest into the death of AA*, Deputy State Coroner Beattie made the following comments regarding the conduct of patient care level observations:

*"Firstly, the terminology "care level observations" carries a suggestion of more than simply the location check that it really was at the time of AA's death. It gives a false comfort to those less familiar with the system, by suggesting a level of frequent review and observation. Secondly, it is apparent from the evidence that the doctors had a different expectation of the reality than what the nurses were doing in accordance with their training, practice and policy. Better communication between doctors and nurses about actual practices should enable doctors to better understand what would actually be done on the ward in carrying out care level observations and better inform them in determining the appropriate Care Level for a patient."*[82]

118. RN Thomas, Ms Hayden and Ms Rumble also gave evidence that, prior to 28 February 2014, nursing staff routinely completed MHIPU observation sheets "*en bloc*"; and Ms Hayden and Ms Rumble also gave evidence that entries were routinely made in MHIPU observation sheets without a patient observation being performed; not even a mere sighting of the subject patient.[83]

119. Further, RN Thomas,[84] Ms Hayden[85] and Ms Rumble[86] gave evidence that prior to 28 February 2014, within the MHIPU, defects in patient medical records were common, including, for example, incomplete and absent patient care plans; and incomplete patient care level observation sheets.

120. Ms Hayden[87] gave evidence that, prior to 28 February 2014, the Acting NUM of the MHIPU, Clinical Nurse Consultant ('**CNC'**) Schultz was aware that nurses within the unit were not performing patient care level observations in a manner that complied with the SOP; but, to Ms Hayden's knowledge, no corrective action was taken.

121. Ms Hayden[88] also gave evidence that, in her experience prior to 28 February 2014, nurses were neither re-trained, nor disciplined, for failing to properly complete patient care level observation sheets and/or patient care plans.

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[81] RN Thomas tscript 26/0617 p44 line 36 – 46.
[82] Inquest into the death of AA Findings published 11 September 2014 at pp21-22.
[83] See also Wadley at [14] on 119-3
[84] Tscript 26/06/17 p41 line 40 – p42 line 14.
[85] Tscript 27/06/2017 p53 line 33 – p54 line 50.
[86] Tscript 27/06/17 p78 line 1ff; p80 line 43ff; p80 Line 1ff.
[87] Tscript 27/06/17p56 lines 10 – 27.
[88] Ibid.

122. CNC Schultz[89] gave evidence that, both as the Acting NUM and in her substantive position as the CNC, she had a supervisory function to perform in relation to the conduct of the nursing staff working in the MHIPU.

123. CNC Schultz also gave evidence that her supervisory role within the MHIPU extended to both the conduct and the recording of patient care observations.

124. However, on the evidence, prior to 28 February 2014, CNC Schulz had not been provided by her employer with any training in relation to the conduct of her supervisory functions, particularly in relation to the conduct of patient care observations.[90]

125. Also, CNC Schultz denied any knowledge, prior to the subject incident, of any non-compliance with the relevant SOP; and/or of any significant defects in the record keeping practices within the Unit.[91]

128. Also, on the evidence, CNC Schultz had not received any formal training in relation to the conduct of patient record audits; and whilst, some aspects of the patient admission records were audited by her prior to 28 February 2014, CNC Schultz stated in evidence that:
- there was no auditing of patient care plans;
- there was no auditing of patient care level observation sheets; and
- she did not take any steps to ensure that patient care level observations were properly conducted and/or that records of patient care level observations were properly made and/or properly kept.[92]

129. In the Outline of Submissions on behalf of WNSWLHD, Ms Boyd submits that:
- there is an "*underlying assumption in Counsel Assisting's submissions that there were **no** therapeutic engagements by nursing staff with MA and there are no contemporaneous records of these engagements*";[93]
- the assumption that there were no therapeutic engagements is erroneous; and
- the Court would not be comfortable making a finding that there were no therapeutic engagements between nursing staff in the MHIPU and MA.

130. In submissions in reply, Counsel Assisting accepted that the patient record reflects the fact that therapeutic engagements did take place between nursing staff and MA during the course of his admission to the MHIPU; and that therapeutic engagements between nursing staff, which took place, were recorded as part of the nursing entries in MA's Progress/Clinical Notes.

131. I am satisfied that, whilst having regard to all of the evidence it is not open on the evidence to find that there was no therapeutic engagement and/or observation by nursing staff across the period of MA's admission, it is open on the evidence to find that, both prior to and during the period of MA's admission to the DBH MHIPU, there was routine, systemic non-compliance

[89] Tscript 27/06/17 p87 line 43 – p88 line 5.
[90] Tscript 28/06/17 p9 lines 15 - 21.
[91] Tscript 28/06/17 p9 line 34 – p12 line 34; Tscript 28/06/17 p18 line 20 – 27; Tscript 26/06/17 p73 line 33 – p75 line 48.
[92] Tscript 28/06/17 p 18 line 32ff.
[93] Outline of submissions on behalf of WNSWLHD dated 29 Nov 17 at page 2 at [9].

within the MHIPU with the SOP which governed the making and recording of patient observations.[94]

## The absence of a formal auditing program

132. On 21 December 2012 the NSW Department of Health introduced the Policy Directive *"Health care Records – Documentation and Management"*.[95]

133. The Policy Directive provides that:

> *Documentation in health care records must provide an accurate description of each patient/client's episode of care or contact with health care personnel. The policy requires that a health care record is available for every patient / client to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.*
> *Health care record management practices must comply with this policy.*

134. The policy goes on to provide who is responsible:

> **Chief Executives are responsible for:**
> - Establishing mechanisms to ensure compliance with the requirements of this policy.
> - Ensuring health care personnel are advised that compliance with this policy is part of their patient/client care responsibilities.
> - Ensuring line managers are advised that they are accountable for the implementation of this policy.
> - Ensuring implementation of a framework for auditing of health care records and reporting of results.
> - Ensuring health care records are audited and results reported within the PHO.
>
> **Facility / service managers are responsible for:**
> - Ensuring the requirements of this policy are disseminated and implemented in their hospital / department / service.
> - Ensuring health care personnel within their facility / service have timely access to paper based and electronic health care records.
> - Monitoring compliance with this policy, including health care record audit programs and acting on audit results.
>
> **Health care personnel are responsible for**
> - Maintaining their knowledge, documentation and management of health care records consistent with the requirements of this policy.
> - Ensuring they are aware of current information about the patient / client under their care, including where appropriate reviewing entries in the health record."

135. Further, it is quite clear that the Policy Directive has application in the context of the present case:

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[94] Counsel Assisting's initial submissions at [93]. Counsel Assisting's reply submissions at [64]-[65].
[95] Policy Directive Health Care Records – Documentation and Management PD2012_069. Ex 1 Vol 4 tab 64.

**"2.4 Documentation by nurses and midwives**

*Documentation by nurses and midwives must include the following:*

*a) Care / treatment plan, including risk assessments with associated interventions.*

*b) Comprehensive completion of all patient / client care forms.*

……."

136. The Policy Directive was introduced on 21 December 2012, yet there was no explanation as to why, at the very least, an audit program was not developed by the WNSWLHD and applied in relation to the MHIPU prior to 28 February 2014.

137. In all of the circumstances, I am satisfied, on the balance of probabilities, that prior to MA's admission to the MHIPU on 30 January 2014, the WNSWLHD should have developed and promulgated[96] each of the following:

- a formal patient record audit program for the MHIPU in accordance with the NSW Department of Health introduced the Policy Directive "*Health Care Records – Documentation and Management*";[97]
- a framework and schedule for the auditing of the health care records maintained by the MHIPU, including but not limited to: Mental Health Inpatient Unit Patient Care Plans; NSW Health Suicide Risk Assessment Worksheets [re] Probability of Attempt; Mental Health Inpatient Unit Observation Sheets; and Clinical Handover of Patients in Mental Health In-Patient Units of the types in use both prior to and at the time of MA's admission;[98] and
- designated and approved audit tools and processes.[99]

138. Further, I am satisfied that prior to MA's admission to the MHIPU on 30 January 2014, in accordance with the Policy Directive, the WNSWLHD should have developed and promulgated:

- a framework for the development and delivery of an education program for the MHIPU on the documentation and management of health care records in use in the Unit, including but not limited to Mental Health Inpatient Unit Patient Care Plans; NSW Health Suicide Risk Assessment Worksheets [re] Probability of Attempt; Mental Health Inpatient Unit Observation Sheets; and Clinical Handover of Patients in Mental Health In-Patient Units of the types in use both prior to and at the time of MA's admission;[100]

- education programs that provided all health care professionals within the MHIPU who documented and/or managed health care records with appropriate orientation and appropriate ongoing education in relation to the health documentation and the management of health care records;[101] and

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[96] As to management responsibilities and accountability, I note the requirements set out at Part 3.1 of the Policy Directive at p1234.

[97] Policy Directive Health Care Records – Documentation and Management PD2012_069. Ex 1 Vol 4 tab 64.

[98] Ibid 1.4 Auditing at p1233; 2.4 Documentation by nurses and midwives at p1237

[99] Ibid.

[100][100] Ibid 1.4 Education at p1234.

[101] Ibid.

- education programs informed by the results of healthcare record audits, including but not limited to education programs targeted to problem areas.[102]

139. Based on the evidence before me, it is to be expected that a nurse conducting patient care level observations will make a clear, accurate and contemporaneous entry in the patient's records in relation to both the time at which each observation was made and the fact that an observation was made.

140. This is the very type of clinical situation and the very type of entry in the medical record to which this Policy Directive is directed.[103]

141. In the circumstances, having regard to Mr Fahy's evidence, I am satisfied that in the period between the commencement of the Policy Directive on 21 December 2012 and the date of MA's death, 28 February 2014, little, if anything, was done within the WNSWLHD Mental Health, Drug and Alcohol Service to give effect to the NSW Department of Health Policy Directive *"Health Care Records – Documentation and Management*" in relation to the management of the MHIPU at the Dubbo Base Hospital.

142. The failure of the WNSWLHD to ensure compliance with the NSW Health Policy Directive *"Health Care Records – Documentation and Management"* in the manner disclosed in the evidence represents a most significant and entirely unexplained systemic failure in relation to the management and operation of the MHIPU.

## *The immediate circumstances surrounding MA's death*

143. On the morning of 28 February 2014, RN Thomas was rostered on as the Nurse-in-charge of the A Shift (morning).[104]

144. As the Nurse-in-Charge, RN Thomas was responsible for the overall supervision of both the HDU and the SAU. On 28 February, there were four patients assigned to the HDU; and 12 patients on the SAU including, as noted above, MA.[105]

145. RN Thomas was also responsible for the administration of all medication to the patients assigned to the SAU; the discharge of three patients from the MHIPU [one from the SAU and two from the HDU]; and the specific care of five patients assigned to the SAU.[106]

146. Having obtained a Bachelor of Science in Nursing from the Indian Academy College of Nursing, RN Thomas first registered as a nurse in India. Between 2009 and 2011 RN Thomas worked as a RN in India, and, then, moved to Australia in 2012. At that time RN Thomas undertook a three-month bridging course, upon completion of which he became qualified to practise as a RN in Australia, and registered.[107]

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[102] Ibid.
[103] See: the Response dated 19 December 2014 to the Findings and recommendations in the *Inquest into the Death of BB*.
[104] Statement dated 7 April 2016 of RN Abraham Thomas Ex 1 Vol 1 tab20 p121 at [6].
[105] See the MHIPU Staff Handover Sheet 28/02/2014 6:21 am – Ex 1 Vol 1 tab 18 p116.
[106] Thomas Ibid at [9] –[11].
[107] Statement dated 7 April 2016 of RN Abraham Thomas Vol 1 tab 20 p120 at [3].

147. In 2012, RN Thomas commenced employment at MHIPU. He had been working in that unit approximately seventeen months at the time of MA's death.[108]

148. Following an investigation by the WNSWLHD into the subject incident, RN Thomas was suspended from practice by the WNSWLHD for a period of three months and then, required to undergo a period of supervised retraining at Bloomfield.

149. In addition, as noted, disciplinary proceedings were commenced against RN Thomas before a Professional Standards Committee constituted under Part 8 of the *Health Practitioner Regulation National Law (NSW)* and an inquiry was conducted in relation to complaints arising out of the subject incident.

150. The findings of the Professional Standards Committee Inquiry are in evidence before the Inquest.[109]

151. Significantly, in the evidence that was before the Professional Standards Committee Inquiry, RN Thomas stated:

> *"On reflection, I should not have accepted the responsibility to act as in-charge that day. At the time of the incident, I did not possess the skills and knowledge necessary to undertake the additional responsibilities that came with the role…"*[110]

152. The CNC/Nurse Educator, CNC Sheahan was rostered on in her role as a Nurse Educator. As a consequence, on 28 February 2014, CNC Sheahan was not working in the MHIPU and was not available to provide any clinical or nursing support or supervision within the Unit.[111]

153. The Acting NUM, CNC Schultz, was working in her office in the administration area which was located outside the MHIPU and physically separated from the Unit by a corridor and locked door.[112]

154. As a consequence, on 28 February 2014 CNC Schultz was not physically present in the MHIPU; CNC Schultz was not readily available to provide either clinical or nursing support within the Unit; and CNC Schultz was not providing any active clinical guidance or supervision within the Unit.

155. Rostered on duty with RN Thomas in the SAU were a recent graduate, RN Kaur;[113] and a cadet or trainee, Trainee Enrolled Nurse ('**TEN**') Wadley.[114] RN Kaur was undergoing orientation.[115]

156. As a consequence, both RN Kaur[116] and TEN Wadley[117] were not to be rostered on shift as staff; and neither RN Kaur, nor TEN Wadley[118] was permitted to be assigned patient loads.

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[108] Ibid at [4].
[109] Findings of the Professional Standards Committee Inquiry re Mr Abraham Thomas; Ms Donna Hayden; and Ms Julie Rumble. Published 28 April 2017. Ref: 4603/17. Ex 1 Vol 4 Tab 76.
[110] Ibid p1325-15.
[111] Statement dated 3 November 2016 of Catherine (Cate) Sheahan Ex 1 Vol 1 tab 24 p136-1[3] – [7].
[112] Mr Fahy Tscript 30/06/17 p18 lines 26 – 41.
[113] Statement dated 31 January 2017 of Beant Kaur Grewall Ex 1 Vol 1 tab 23 p135 at [3] – [7].
[114] Statement dated 3 November 2017 of Kerry-Anne Wadley Ex 1 Vol 1 tab 19 p119-2 at [10].
[115] Kaur Op cit p 135 at [3] – [4].

157. Effectively, the rostering of RN Thomas with RN Kaur and TEN Wadley on 28 February 2014 created a situation in which RN Thomas was the Nurse-in-Charge with responsibility for supervising the MHIPU; responsibility for the administration within the SAU of all pharmacotherapy responsibility for caring for the 12 patients on the SAU, including three discharges; and also supervising and training two trainee nurses.[119]

158. Despite her status as a cadet/trainee, TEN Wadley had been included on the roster since December 2013; and had been routinely assigned a patient load since some time in December.[120]

159. On 28 February 2014, RN Thomas assigned TEN Wadley to care for MA, together with four other patients.[121]

160. In her statement dated 3 November 2016 TEN Wadley states that her practice was "*to sight*" the patient in accordance with the relevant care level and to complete the MHIPU Observation Sheet retrospectively.[122]

161. TEN Wadley also states it was her understanding that, on 28 February, MA was on Level 4 observations and that *"he needed to be physically sighted every 2 hours*".[123] Level 4 Observations is assigned where there is "*no foreseeable risk of harm*".[124]

162. This is consistent with the circling of Level 4 = 2 hours in the Key on the MHIPU Observation Sheet.[125]

163. It follows, on the evidence, that on the morning of 28 February 2014:
    - MA's care was allocated to a cadet nurse;
    - the cadet nurse was operating without any direct supervision and/or control;
    - the cadet nurse was operating under the misapprehension MA represented no foreseeable risk to himself; and
    - the cadet nurse was operating under the misapprehension that MA need only be "*sighted*" by any member of the nursing staff once every two hours.

164. By contrast, as outlined above, MA's treating psychiatrists were of the opinion that MA was seriously suicidal; and, because of MA's desire not to be returned to the HDU, MA was likely

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[116] Kaur Op cit p135 at [3].
[117] Statement dated 3 November 2013 of Kerry-Anne Wadley Ex 1 Vol 1 tab 19 119 -1at [5].
[118] Ibid.
[119] In his report dated 21 November 2016 Professor Hazelton observes that the staffing numbers "seem appropriate". Ex 1 Tab 9. For example at [12]; [16] – [21].
Professor Hazelton's concern, which is clearly supported by the evidence, surrounds staff mix. As noted, two of the staff rostered on A Shift RN Kaur [the new grad] and TEN Wadley were not qualified to be rostered on shift and RN Thomas was, on his own admission, was unqualified to be working as the Nurse-In-Charge.
Professional Standards C'ee Inquiry Ex 1 Vol 4 tab 76 p1325-15.
[120] Ibid p119 – 2 at [6].
[121] Ibid p119-2 at [10].
Statement dated 7 April 2016 of RN Abraham Thomas Ex 1 Vol 1 tab 20 p121 at [11].
[122] Ibid p119-2 at [9].
[123] Ibid p119-3 at [14].
[124] See the rear of the MHIPU Observation Sheet Ex 1 Vol 2 tab 36 p490.
[125] Ex 1 Vol 2 tab 36 p489.

to downplay or minimise any suicidal ideation and/or his level of suicidality in the course of interactions with nursing staff allocated to his care.

165. Further, against this background, it is noted that TEN Wadley appears on the patient record to have been the last clinician who had a "*therapeutic interaction*" with MA.

166. At 14:20 on 28 February 2014 TEN Wadley made the following entry in the Progress/Clinical Notes:

"*Nursing: Pts lows mood, isolative, pacing hallways, insisting on weekend leave, diet/fluid  obs  ADL's  participating in group time. Nil management issues nil complaints voiced signed (TEN Wadley).*"[126]

167. The entry is not countersigned.[127]

168. In making the observations set out above, I make no criticism of TEN Wadley. TEN Wadley was an inexperienced trainee who was left without proper supervision and control.

169. Nonetheless, the circumstances do suggest that, as a consequence of the fact that TEN Wadley was assigned the care of MA and TEN Wadley was required to undertake that task without an appropriate level of supervision and control by an appropriately qualified and experienced RN, opportunities for effective therapeutic engagement and/or intervention were lost.

170. Further, there is no explanation as to how TEN Wadley came to be routinely rostered on staff from about December 2013; and/or how TEN Wadley came to be routinely assigned a patient load.

171. There is no explanation as to how RN Thomas came to be rostered-on on 28 February 2014 as Nurse-in-Charge on the Day Shift with two trainee nurses who were both supernumerary and excluded from being allocated a patient load.

172. Equally there is no explanation for the allocation to TEN Wadley, by RN Thomas, of MA, a patient with a strong history of severe depression, suicidal ideation and a mental state which, at best, was refractory and, potentially, deteriorating.

173. On the evidence before me I find on balance that:

- it was inappropriate for TEN Wadley to have been treated as staff, as opposed to a supernumerary trainee;
- it was inappropriate for TEN Wadley to have been allocated a patient load at any time during her traineeship, including 28 February 2014;[128] and
- TEN Wadley should have been assigned to and should have worked at all times under the direct supervision of a RN with sufficient experience to properly carry out the role of a cadet supervisor/trainer.[129]

[126] Patient/Admission records ino MA Ex Vol 2 tab 36 p456.
[127] Policy Directive Health Care Records – Documentation and Management PD2012_069.at 2.2 Standards for documentation - sub paragraph h). Ex 1 Vol 4 tab 64 p1235.
[128] Statement dated 3 November 2016 of Kerry-Anne Wadley Ex 1 Vol 1 tab 19 p119-1 at [5].

174. Further, given the seriousness of the suicide risk as assessed by his treating psychiatrists, it was particularly inappropriate for MA to have been assigned to TEN Wadley's care.

175. The NSW Health guidelines applicable to TEN Wadley's placement in the MHIPU are set out in the *NSW Health Aboriginal Cadetships Information for Western NSW Host Facilities*. The guidelines provide:

> *"Cadets must be rostered in a supernumerary position. No cadet is to be rostered to replace vacancies or counter in staffing numbers; cadets are in a learning role and must not be seen as an additional staff member."*[130]

176. Further, under the guidelines, TEN Wadley was to be rostered Monday to Friday on morning or afternoon shifts on the basis that supervision, support and mentoring, commensurate with the placement as a learning opportunity, would be readily available.[131]

177. I note also in this context, the requirement under the NSW Policy Directive Health Care Records – Documentation and Management, that all entries in the patient record be counter-signed by the student's supervising clinician:

> *"h) Entries by students involved in the care and treatment of a patient/client must be co-signed by the student's supervising clinician."*[132]

178. The requirement for the co-signing of entries made by students in the patient record clearly highlights and reinforces the need for direct clinical supervision of students in the context of both the provision of care and the documentation of "*student/patient interactions*" in the patient's health care records.

179. Throughout TEN Wadley's placement in the MHIPU as a cadet, up to and including 28 February 2014, it was the responsibility of the WNSWLHD to ensure:

- TEN Wadley was treated as a trainee who was supernumerary to the number of staff allocated to any given shift on which TEN Wadley was rostered on in the MHIPU for training;
- TEN Wadley was not counted as an "*extra*" member of staff rostered on to any given shift, let alone as a member of staff within the base minimum number of qualified nurses required to be on-duty within the MHIPU;
- TEN Wadley was assigned, on each shift, a supervisor with an appropriate level of training and experience and provided with ongoing direction by that supervisor in relation to TEN Wadley's involvement in the care of inpatients within the MHIPU; and
- all entries made by TEN Wadley in patient records were countersigned by the relevant supervising clinician.

180. In evidence in the course of the Inquest, Mr Fahy conceded that the staffing mix rostered on in the SAU on the A (Day) Shift on 28 February 2014 was an entirely inappropriate mix.[133]

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[129] Statement dated 3 November 2016 of Kerry-Anne Wadley Ex 1 Vol 1 tab 19 p119-1 at [5].
[130] Ex 1 Vol 1 tab 19 p119-12.
[131] Ibid.
[132] Op Cit at 2.2 Standards for documentation - sub paragraph (h). Ex 1 Vol 4 tab 64 p1235.

181. Mr Fahy conceded in his evidence at the Inquest that it was a staffing mix that he would not have rostered.

182. On the evidence before me, I am satisfied, on balance, that the manner in which the WNSWLHD Mental Health, Drug and Alcohol Service managed TEN Wadley's placement in the MHIPU discloses systemic failures in relation to the following:

- failures in relation to the allocation of Nurse-in-Charge to RN Thomas, both generally and, in particular, on 28 February 2014;
- failures in relation to rostering, including on 28 February the rostering of two trainee nurses on the A shift as part of the staffing allocation to the SAU;
- failures in ensuring that there were rostered-on and working on the ward, on any given shift, at least the minimum number of qualified nursing staff qualified to be counted as members of staff;
- failures in ensuring that the Nurse-in-Charge was adequately qualified, trained and experienced to properly carry out that role;
- failures in relation to the development and provision of a proper system of supervision and training for TEN Wadley as a trainee; and
- failures in relation to the allocation of patient loads to TEN Wadley, including but not limited to the allocation MA's care on 28 February 2014.

183. RN Thomas last signed the MHIPU Observation Sheet at 1500 hours.[134]

184. After the event, RN Thomas stated:

> *"20. During the afternoon, I observed patient MA walking up and down the corridor past the nurses' station. I observed this while preparing another patient for discharge. While I was not aware of the exact time, I understood that the time was close 1500 hours(sic) and I signed my initials on his observation sheet in the blank space for 1500 hours. This space was blank and the next available space available after my initials at 1430 hours. …"*[135]

185. RN Thomas' shift ended at 1530 hours or 3:30pm.[136]

186. The CCTV footage does not indicate that such an observation occurred.

187. RN Thomas asserts that this entry was an approximation; and that he more likely observed MA at about 14.40hours, at or about the time that MA was making his way to his room.[137]

188. On the CCTV footage, MA can be seen entering his room at approximately 1440 hours.

189. At about 1500 hours, TEN Wadley was serving afternoon tea. TEN Wadley was working alone and, as a consequence, TEN Wadley was unable to leave the kitchen to check on MA

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[133] Tscript 30/06/2017 p11 line 48 – p18 line 41.
Re the specific concession regarding the inappropriate staffing mix see Tscript p17 line 23 to line 28.
[134] Patient/Admissions record ino MA Ex 1 Vol 2 tab 36 at p489.
[135] Statement dated 7 April 2016 of Abraham Thomas at [20]. Ex 1 Vol 1 tab 21.
[136] Statement dated 2 April 2016 of RN Abraham Thomas Ex 1 Vol 1 tab 20 at [20].
Handwritten Notes dated 5 March 2014 prepared by Ms Hayden Ex 1 Vol 1 tab 16 at p94
[137] Ibid.

when she realised MA had not attended in the kitchen area for afternoon tea. TEN Wadley sent another patient, [redacted], to tell MA that afternoon tea was on.[138]

190. On the CCTV footage, [redacted] can be seen approaching the door to MA's room at about 15:05 hours; and [redacted] can be seen to walk away from the door to MA's room a few moments later.

191. TEN Wadley stated after the event that [redacted] returned to the kitchen area and "… *said something like "he didn't want any he's sitting on his floor".*[139]

192. When spoken to after the event, [redacted] reported:

*"7. I knocked 3 times. I didn't say anything I knocked. The door is solid and you can't see through it. The door was fully shut. I saw MA sitting on the bottom of the bed. He wasn't on the mattress, he was on the floor.*

*8. I have drawn a picture of MA's room. When he didn't answer I opened the door a little bit to look. I did not go inside the room I just looked around the door and I just saw his legs that's how I know he was sitting with his legs crossed. He had shoes on I could not see the rest of his body just his shoes and his legs crossed."*

193. EEN Thomas stated that when he attended upon MA at about 17:20 hours or 5:20pm, MA's hips were stiff; MA's lips were blue; and MA's neck was stiff. These observations by EEN Thomas suggest that MA had died well before about 17:20 hours.

194. Further, the description of MA on the floor at the foot of the bed provided by [redacted] is consistent with the evidence of Ms Hayden and EEN Peter Thomas.

195. On the evidence before me, I am satisfied, on the balance of probabilities, that MA had already taken steps to end his life by the time that [redacted] attended at the door of MA's room at about 15:05 hours or 3:05pm on 28 February 2014.

196. On 28 February 2014, Ms Hayden commenced work on the B (Evening Shift) at 13:30 hours.

197. On the evidence, Ms Hayden was first registered as an Enrolled Nurse in 2007 and, then, as a RN in 2010.

198. Ms Hayden commenced working in the MHIPU in 2007; and worked in the Unit from 2007 until the subject incident.

199. Following investigation of the incident by the WNSWLHD, Ms Hayden's employment was terminated; and Ms Hayden has permitted her nursing registration to lapse.

200. In addition, disciplinary proceedings were commenced against Ms Hayden before a Professional Standards Committee constituted under Part 8 of the *Health Practitioner Regulation National Law (NSW)* and an inquiry was conducted in relation to complaints arising out of the subject incident.

[138] Police Statement dated March 2014 ino Kerry-Anne Maree Wadley Ex Vol 1 tab 18 p112 at [28].
[139] Ibid.

201. The Findings of the Professional Standards Committee Inquiry in relation to Ms Hayden are in evidence before me.[140]

202. On the B (Evening) Shift on 28 February 2014, Ms Hayden was rostered as the nurse-in-charge of *the shift and assigned, with Ms Rumble, to work in the SAU*.[141]

203. Like RN Thomas on the A (Day) Shift, as the nurse-in-charge, Ms Hayden was responsible for supervising both the HDU and the SAU within the MHIPU; Ms Hayden was also responsible for and the administration of all pharmacotherapy in the MHIPU. She was also responsible for a patient load within the SAU.[142]

204. On 28 February 2014, Ms Rumble was rostered to perform a double shift in the MHIPU. On the A (Day) Shift, Ms Rumble had been assigned to the HDU; whilst on the B (Afternoon) Shift, Ms Rumble was allocated to work with Ms Hayden in the SAU. Ms Rumble commenced work MHIPU on the HDU at 07:00 hours. Ms Rumble's day shift finished at 1420 hours; and then, she transferred to the SAU, commencing the evening shift at 1450 hours.[143]

205. Ms Rumble was first registered as Enrolled Nurse in 2008. Ms Rumble commenced working in the MIHPU in 2009.[144]

206. At the time of MA's death, Ms Rumble was studying a Bachelor of Nursing through Central Queensland University and had almost completed the course.[145]

207. Following investigation of the incident by the WNSWLHD, Ms Rumble's employment was terminated; and Ms Rumble has permitted her nursing registration to lapse.[146]

208. In addition, disciplinary proceedings were commenced against Ms Rumble before a Professional Standards Committee constituted under Part 8 of the *Health Practitioner Regulation National Law (NSW)* and an inquiry was conducted in relation to complaints arising out of the subject incident.

209. The Findings of the Professional Standards Committee Inquiry in relation to Ms Rumble are in evidence before me.[147]

210. In her handwritten notes dated 5 March 2014[148] and in her statement dated 4 November 2016,[149] Ms Hayden notes that at about 1:30pm on 28 February 2014 she attended a nursing

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[140] Findings of the Professional Standards Committee Inquiry re Mr Abraham Thomas; Ms Donna Hayden; and Ms Julie Rumble. Published 28 April 2017. Ref: 4603/17. Ex 1 Vol 4 Tab 76.
[141] Handwritten Notes dated 5 March 2014 prepared by Ms Hayden Ex 1 Vol 1 tab 16 p94.
Statement dated 13 April 2016 prepared by Ms Rumble Ex 1 Vol 1 tab 21 p126 – 127 at [4] – [5].
[142] Statement dated 4 November 2016 prepared by Ms Hayden ex 1 Vol 1 tab 16 p98-2 at [10] –[11].
[143] Statement dated 13 April 2016 prepared by Ms Rumble Ex 1 Vol 1 tab 21 at [4].
[144] Ibid p126 at [3].
[145] Ibid.
[146] Reasons of the Professional Standards Committee Inquiry re Mr Abraham Thomas; Ms Donna Hayden; and Ms Julie Rumble. Published 28 April 2017. Ref: 4603/17. Ex 1 Vol 4 Tab 76 at p1325 – 9 at [176].
[147] Reasons of the Professional Standards Committee Inquiry re Mr Abraham Thomas; Ms Donna Hayden; and Ms Julie Rumble. Published 28 April 2017. Ref: 4603/17. Ex 1 Vol 4 Tab 76.
[148] Ex 1 Vol 1 tab 16.
[149] Ibid.

handover meeting at which the A Shift handed-over nursing care of the patients in the MHIPU. The handover was conducted by RN Thomas and TEN Wadley was in attendance.

211. Ms Rumble, who was working the double shift, did not attend the handover meeting.

212. In her handwritten notes, Ms Hayden states:

*"It was handed over that MA had requested weekend leave but it was not granted by treating team (sic). MA was given escorted leave with family only, which was level 3 observations, however, on the handover sheet it was stated MA was level 2 observations. In handover, it was reported there was no change in patient's presentation (sic), his mood remained low but there was nothing that stated he was a high risk of suicide by morning staff (sic)."*[150]

213. The reference to the handover sheet is a reference to an MHIPU Handover Sheet[151] of the type that is attached to TEN Wadley's Police Statement; and that, on the evidence, was in use, generally, at staff handover meetings within the MHIPU prior to and at the time of the subject incident.

214. Ms Hayden also states in her handwritten notes dated 5 March 2014 that she read all the patient notes for her patients, including MA's patient notes.[152]

215. In this context, the handwritten notes make specific reference to the medical entry made by Dr Ranasinghe in MA's Clinical/Progress Notes on 28 February 2014. Significantly, as noted above, Dr Ranasinghe's medical entry in the notes made at 13.40 on 28 February 2014 makes specific reference to continuing patient care observations at level 2:

"*Still ruminating'*
*Feeling depressed*
*Sleeps Ok No suicidal feeling/thoughts*
*Appetite good*
*No s/e [side effects] to Li [Lithium]*
*Plan – continue Same treatment - Obs 2*
*Increase Li later."*[153]

216. Like RN Thomas, Ms Hayden did not seek to clarify MA's Risk Status and/or the Observation level assigned to MA despite the apparent conflict on the face of the records. The handover sheet recorded MA's observation level as L2; the MHIPU morning meeting stamp in the progress notes recorded the observation level as L2; Dr Ranasinghe's medical entry at 13:40 on 28/2 which confirmed patient care observations at L2. However, the MHIPU Observation Sheet showed varying levels of observation: L4 (2 hourly) observations overnight from 27 to 28 February 2014; and L3 (30 minute observation) on A (Day) Shift on 28 February 2014.

217. In her statement dated 4 November 2016, Ms Hayden notes that, in her capacity as the nurse-in-charge, she allocated the care of patients in the SAU, allocating herself the patients

[150] Handwritten Notes dated 5 March 2014 prepared by Ms Hayden Ex1 Vol tab 16 p94.
[151] Ex 1 Vol 1 tab 18 at p116.
Ms Hayden Tscript 27/06/17 at p38 line 39.
[152] Ibid.
[153] Admission/Patient Records ino MA Ex Vol 2 tab 36 p435.

in beds 8, 9 and 10; and the patients in beds 10 – 18 were allocated to Ms Rumble. Ms Rumble's allocation included MA.[154]

218. On 28 February 2014, Ms Hayden signed MA's MHIPU Observation Sheet in the box marked 1500 hours on the B (Evening) Shift chart.[155]

219. Any such observation is inconsistent with the CCTV footage.

220. In her statement dated 4 November 2014, Ms Hayden states:

> *"13. During this time, I reviewed the observation charts for my patients, including MA. I had seen MA walking around outside the activities room so I signed the observation chart to indicate I had sighted him.*
>
> *14. The observation chart has pre-signed times. There are two spaces for an observation to be signed off at 1500 hours, one for the morning "A" shift and one for the afternoon "B" shift. As it was approximately 1500 hours and 1500 hours space for the "A" shift had been signed. I signed my initials under the 1500 hour time for the "B" shift."*[156]

221. In a written response, placed before Professional Standards Committee Inquiry the following explanation, Ms Hayden provided the following by way of an explanation:

> *"…Although RN Hayden sighted Patient A closer to 14:45 hours, someone had already signed next to that pre-printed time and so RN Hayden signed in the next available space. RN Hayden recalls seeing Patient A walk down the hallway past the nurses' station shortly before 15:00 hours. After reviewing the CCTV footage, RN Hayden accepts that she saw him at approximately 14:41 hours. It was RN Hayden's understanding at the time that she could sign next to the pre-printed time when she had seen the patient within the 15 minutes either side of that time…"*[157]

222. As noted, signing the MHIPU Observation Sheet in the manner described by Ms Hayden that is, without a proper time reference,[158] is contrary to applicable professional nursing standards; and, also, contrary to NSW Health's applicable policies, practices and procedures.

223. On 28 February 2014, Ms Rumble signed the MHIPU Observation Sheet in the boxes provided in the B Shit (Evening) chart for 1515, 1530 and 1545 hours.[159]

224. In her statement dated 13 April 2016, Ms Rumble states that she received a verbal handover from the nurse-in-charge of B Shift, Ms Hayden; and that she [Ms Rumble] understood that MA was "… *on level 3 observations which requires a nurse to sight a patient every 30 minutes."*[160]

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[154] Statement dated 4 November 2016 prepared by Ms Hayden Ex 1 Vol 1 tab 16 p98-2 at [10].
[155] Ex 1 Vol 2 tab 36 p489.
[156] Ex 1 Vol 1 tab 16 pp 98-2 – 98-3.
[157] Ex 1 Vol 4 Tab 76 p1325-31 at [152].
[158] Ex 1 Vol 2 tab 36 p489.
[159] Statement dated 13 April 2016 prepared by Ms Julie Rumble Ex 1 Vol 1 tab 21 p127 at [7].
[160] Ibid at [8].

225. Ms Rumble notes in her statement that Ms Hayden had allocated her responsibility for the care of the patients in beds 7 through 12 on the SAU; and that Ms Hayden had allocated herself responsibility for the patients in beds 13 to 18 which included MA.[161]

226. Ms Rumble states at paragraphs 9 - 10 of her statement dated 13 April 2016 that:

"9. *On or about 1530 hours, handover finished and from the Nurse's station, I recall seeing patient MA walking in the corridor. I mentioned to RN Thomas that I thought patient MA had a flat affect and was looking depressed. EN Thomas responded by saying that patient MA had been that way since his transfer from the HDU.*

*10. On or about 1530 hours, I initialed patient MA's observation chart for 1530 hour observation. I briefly reviewed patient MA's progress notes and found that he was on Level 2 Observations, which require a nurse to sight a patient every 15 minutes. It was at this point in time that I also initialed for patient MA's 1515 hour and 1545 hour observations. While I was not directly allocated to the care of patient MA, it was common practice for nursing staff to share recording of clinical observations."*[162]

227. That Ms Rumble observed MA in the corridor of the SAU from the Nurse's Station at 15:30 on 28 February 2014 is contrary to the CCTV footage.

228. By contrast, in a letter dated 18 June 2014, Ms Rumble stated:

*"At the time I initialed MA's observation chart I believe I had seen him. I now know that is not correct and I am really sorry for not making sure I had actually seen him at the times I initialed (sic)."*[163]

229. On 2 July 2014, in the course of an interview with Linda Griffiths (NSW Nurses and Midwives Association), Adrian Fahy, A/Director Mental Health Drug and Alcohol, and Ms Sandra Duff, Director Workplace and Culture, Ms Rumble is reported to have a made comments to the effect that:

*"just because a patient in HDU might be on level 2 observations, doesn't mean we actually see them every 15 minutes – particularly during the night."*

230. Also, Ms Rumble gave evidence that in the course of her employment in the MHIPU that it was a routine practice for her and, also, for other nurses to sign MHIPU Observation Sheets where no observation had been performed:

*"Q. In relation to the completion of that form, you can see there on page 479 that under the A Shift initials have been placed on that sheet at various points, indicating what appears to be an indication that observations were performed every 15 minutes?*
*A. Yes, that's correct.*

[161] Ibid at [8].
[162] Ex 1 Vol 1 tab 21 at p128.
[163] Letter dated 18 June 2014 signed by Julie Rumble. HCCC Subpoenaed material Vol 2 tab 34.

*Q. In your experience, was it the case that initial (sic) were placed on the sheets like this in January and February 2014 and before that when you were working in the unit even when observations were not performed?*
*A. (No verbal reply)*

*Q. You shook your head. You need to answer.*
*A. Sorry. Yes, sir.*

*Q. – because you're being recorded. Was that something that you routinely observed in terms of your own practice, that is, that you would fill out a sheet like that putting your initial on it knowing that you'd not performed the observation?*
*A. Yes, sir."*[164]

231. As noted, signing the MHIPU Observation Sheet in the manner described, that is, without having conducted any actual observation or even a mere sighting, is contrary to applicable professional nursing standards; and, also, contrary to NSW Health's applicable policies, practices and procedures.

## *Changes in practice and procedure post incident*

232. On the evidence, a number of changes were introduced after the incident in response to the following:

- Associate Professor Allan's review and recommendations;[165]
- investigations conducted by the WNSWLHD Mental Health, Drug and Alcohol Service;[166] and also
- an RCA [Root Cause Analysis] Report.[167]

233. As an initial response, commencing 12 March 2014, Mr Fahy caused the changes in practice outlined at paragraph 29 of his initial letter to be introduced.[168]

234. In addition, the WNSWLHD took the following steps:

- In the period between July 2014 and December 2014, Ms McIntyre took up the role as A/NUM in the MHIPU to provide additional support to nursing staff within the MHIPU; and oversee changes in practice and procedure within the unit with a view to enhancing both nursing standards and the delivery of nursing care within the Unit.
- On 12 July 2016 an updated patient observation procedure was introduced across the service;[169] and
- There has been a rationalisation and standardisation of the forms used in relation to the recording of care and leave levels across all MHIPU's within the WNSWLHD. For

[164] Tscript 27/06/17 at p76 line 16 – 34; See also: Tscript 27/06/17 at p17 line 43 – 50.
[165] Report on Review conducted on 6 March 2014 by Associate Professor Allan and Catherine Montigny Op Cit Vol 2 tab 30 p148 – 26. The recommendations appear p148-33 – 34.
[166] Letter to the Deputy State Coroner (Undated) from Mr Fahy Ex 2 Vol 1 tab 30.
[167] Memorandum dated 25 July 2014 re Observation Levels documentation Ex 1 Vol 2 Tab 30 p148-164. Summary of changes – Nursing Observation Procedures. Ex 1 Vol 2 tab 30 p148-164.
[168] Ex 1 Vol 2 tab 30 page 148-6 -148-7 at [29] a. – j.
[169] WNSWLHD SOP: Patient Care Levels, Specialling and Risk Assessment for Mental Health Inpatients. Document No WN_PD2016_008; Ex 1 Vol 2 tab 30 pp148-17 to 148-25.

example, a standardised Care and Leave Level Authorisation form has been introduced.

235. Significantly, the new procedure included the following "*Performance Measures":*

- *"Random patient audits of all wards requiring 100% compliance over a three month period of time, in addition to 100% staff knowledge of the patient observation procedure"*[170]
- An operational procedure has been introduced in relation to the conduct of Clinical Handover's in the MHIPU;[171] and, on the evidence, formal nursing patient handover meetings have been supplemented through the introduction of a ward-based "*walking handover*". The walking handover involves nursing staff walking through the MHIPU with patient introductions and patient information discussed.

236. I note that, on the evidence, the introduction of this local operational procedure is part of a broader process which has been commenced to develop service-wide, standardised operational procedures.

- An Electronic Patient Board has been introduced in the MHIPU. The board is located at the Nurse's Station and it is a live system and it is updated when changes in patient care are required; and an updated copy of the patient board is distributed to all staff members and utilised in the course of shift/patient handovers. Patient Risk Status, Patient Leave Status and Patient Care Observation Level is detailed on the board and updated as and when details of risk status, leave status and/or observation level are changed.[172]
- Random monthly auditing of patient care level observations introduced in the MHIPU following Associate Professor Allan's Review conducted on 6 March 2014. The auditing process utilised was adopted from the MHIPU's at Bloomfield.[173]

237. Issues, if any are identified, are addressed with the relevant staff; and a system of "*follow up*" with individual nursing staff is in place;[174] and audit non-compliances are also noted in MHIPU staff meetings.[175]

- A second level of auditing and reporting in relation to the conduct of patient care level observations was introduced into MHIPU as a consequence of the application of the Quality Auditing Reporting System ('**QARS**') initially developed for use at Bloomfield. QARS is a comprehensive auditing and reporting system which, on the evidence, aligns with independent accreditation standards.

[170] Ex 1 Vol 2 Tab 30 p148-23.
[171] WNSWLHD Operational Procedure Mental Health Drug & Alcohol Dubbo & Region Mental Health Clinical Handover Ex 1 Vol 2 tab 31 p148-12.
[172] Letter (Undated) to the Deputy State Coroner from Mr Fahy Ex 1 Vol 2 Tab 20 at [10]. Photographs showing a screen shot of the Electronic Journey Board. Ex 1 Vol 7 tab 83 p1897 -1898.
[173] Letter dated 14 February 2017 from Mr Crisp to the Deputy State Coroner Ex 1 Vol 2 tab 31 p148-40 at [5]. See: Mental Health Inpatient Unit Observation Level Audit form Ex 1 Vol 2 tab 31 p148-169.
[174] Schultz Tscript 28/06/17 p25 line 45 – p26 line 18.
[175] MHIPU – Staff meeting Minutes 16 March 2017 Item Agenda 8 Audits. Ex 1 Vol7 tab 89 at page 1918

238. The program includes auditing and reporting in relation to specific items including, relevantly: clinical documentation audits; medication audits; observation audits; and clinical handover audits.

239. Auditing under QARS system includes both knowledge auditing and a practical observation/viewing of nursing staff on in various mental health inpatient units conducting a patient care level observation.

240. CNC Shultz described the auditing process in her evidence, including the conduct of the practical observation/viewing of a patient care level observation:

*"Q. Can you just explain to her Honour how it is that you conduct these – I'm not suggesting to you that you don't, it's just not reported in the document, and I'm just trying to understand what it is that you do when you make this physical observation of the nurses doing their observations, how is it done?*

*A. Well, I like, we run through the questions and then, when it comes to the I, I check them doing the round, I watch them doing their observation round with their patients.*

*Q. In terms of compliance, what is it that you look for when you report 100%.complaince?*
*….*
*A. They go in and speak to the patient, if the patient is in the bedroom they, you know, go to the bedroom and engage in a brief conversation with the patient and then they sign off on their audit.*

*Q. The nurse has actual contact with the patient, there is interaction and a signing of the form at the time that the observation is made?*

*A. Yes"*[176]

241. Further, the evidence indicates that the WNSWLHD has taken steps to enhance the relationship between the Bloomfield campus and the MHIPU with, for example, the inclusion of the MHIPU in the Bloomfield campus training calendar; and the provision of additional training sessions via teleconference from the Bloomfield campus; staff attending training programs at Bloomfield.[177]

## A change in Policy - NSW Health Policy Directive: Engagement and Observation in Mental Health Inpatient Units

242. On 26 July 2017 NSW Health promulgated a new MHIPU patient engagement and observation policy entitled "*Engagement and Observation in Mental Health Inpatient Units*".

243. The "*Summary*" notes as follows:

[176] Schultz T/script 28/07/2017 p22 line 43 ff.
Tscript 28/06/17 at p25 Line 12 – 32.
[177] Letter dated 24 March 2017 from Ms McIntyre Acting Deputy Director of Nursing WNSWLHD to the Deputy State Coroner. Vol 2 tab 30B at p148-21

*"The Policy Directive Engagement & Observation in Mental Health Inpatient Units has been developed to identify a standardised approach to the allocation and review of observation levels within mental health inpatient units. The policy outlines requirements of mental health clinicians in their undertaking of engagement and observation to inform ongoing care planning and clinical decisions."*

244. As noted in a commentary on the policy provided by NSW Health:

- the policy departs from the use of timed visual observations/location checks of each inpatient within a MHIPU as the basis of identifying/establishing patient safety;
- rather, the policy requires an active and collaborative engagement with patients "… supported by visual observation";
- active engagement is intended to have an active therapeutic purpose/element, that is, engagement and observation is intended to reflect the "targeted rationale for observation" [i.e. where the issue is suicidal ideation/suicidality and suicide risk, the assessment and management of that risk]; and
- active engagement is to involve an assessment of the patient's mental state; a consideration/assessment of current risk(s) and concerns.[178]

245. Significantly, the policy calls for an enhanced level of communication and co-operation between treating psychiatrists and the nursing staff responsible for providing ongoing psychiatric nursing care within mental health inpatient units across the State:

- medical practitioners are to determine the level of patient engagement and observation, together with its rationale; and
- the medical practitioners are to guide nursing staff in the ongoing engagement and assessment of each patient so that the ongoing assessment and review of each patient is being informed by information/observation gathered and recorded from each engagement/observation.
- Patient observations are, primarily, to be conducted by nursing staff as active, therapeutic engagements.

246. On the evidence, the new policy came into effect in the WNSWLHD as and from 9 October 2017.

247. I note that the new Policy draws heavily on the Victorian Department of Health Guideline entitled "Nursing observation through engagement in psychiatric inpatient care". For example, the core principles identified in the Policy, under "Key Definitions" are drawn from the Victorian Guideline, as is acknowledged, directly, in the new Policy.

248. It is significant in this context to note that the Victorian Guideline highlights the sophisticated, nuanced nature of psychiatric nursing observations conducted through patient engagement. The emphasis in the Victorian Guideline is on the exercise of highly developed psychiatric nursing skills by well trained, experienced nurses or by well trained, less experienced, but mentored, nurses:

[178] NSW Health: Observations on the Engagement and Observation in Mental Health Inpatient Units. Attachment to the letter dated 26 June 2017 from Adam Phillips Director of Clinical & Regulatory Services NSW Ministry of Health to the Deputy State Coroner. Ex 5.

*"Nursing observation involves the performance of highly developed skills in several areas of practice, including building therapeutic relationships and attending to psychosocial, physical and safety needs. As such, experienced nurses and those with access to adequate mentoring are well suited to performing purposeful observation."*

# Recommendations

249. Consistent with the new Policy and informed by the Victorian Guideline, I am of the view that the WNSWLHD should give consideration to developing local procedures aimed at:

- ensuring that an appropriate skill mix is available within MHIPU's to enable observations to be properly performed;[179]
- development and provision of clear processes for the identification and communication of the rationale for the setting and/or changing of patient engagement and observation status/levels;[180]
- where a patient is under formal observation, provision of a procedure which clearly identifies the nurse responsible for the conduct and recording of that patient's observations;[181]
- when visual sighting is required as a safety factor, provision of procedures designed to ensure that the responsible nurse conducts and documents the observations when they occur;[182]
- development and maintenance of ongoing education programs aimed at the development and/or maintenance of procedural knowledge and relevant nursing skill sets; and
- development and maintenance of an auditing program which is designed to test compliance with the NSW Health Policy Directive and, also, local procedures, as well as utilising the results of the auditing process to inform relevant ongoing education programs.[183]

## Back to base pulse oximetry

250. On the evidence, consideration is being given to the use of new technology as a means of enhancing nurse/patient engagement through the introduction of electronic systems designed to assisting in the monitoring of in patients at risk of self-harm, suicide and absconding.

251. In a letter from Nicholas O'Connor and Michael Paton published in Australian Psychiatry 2016 Vol 24(2), the learned authors, two public sector psychiatrists, argue that a

[179] Victorian Department of Health guideline: Nursing observation through engagement in psychiatric inpatient care. Ex 1 Vol 7 tab 95 p2070.
[180] Ibid Ex 1 Vol 7 tab 95 at p2062.
[181] Ibid ex 1 Vol 7 Tab 95 at p2070.
[182] Ibid.
[183] As per NSW Health Policy Directive – Documentation and Management Ex 1 Vol 4 tab 64 – generally but, in particular at section 1.5 Education at p1234.

technological response which permits the remote monitoring of some of an inpatient's vital signs, for example, back to base pulse oximetry monitors, may be used to monitor inpatients who are considered relevantly at risk. The relevant categories of risk might include persons with a history of suicidality and/or active suicidal ideation and/or thoughts of self-harm.

252. Back to base pulse oximetry allow for continuous, remote monitoring of blood oxygen levels such that, if a patient's blood oxygen level drops below a pre-determined level (or if the monitor is removed by the patient or the patient moves outside beyond the monitor's effective range) an electronic alert or alarm will activate alerting nursing.

253. Such a system may provide a reliable technological back-up to nursing engagement and observation, providing a second layer of protection via the alert mechanism.

254. However, as was observed in evidence by both Associate Professor Robertson and Professor Hazelton, the proposed technological solution is not without its limitations. There is a possibility that, rather than enhancing protection, such a system may result in over reliance, resulting in a reduction in nursing vigilance.

255. As part of the funding application round which closed on 9 May 2017, the Black Dog Institute made an application under the NSW Health Ministry's Mental Health Reform Innovations scheme for funding of a proof of concept trial. Four Local Health Districts (the Hunter New England Local Health District, Mid North Coast LHD, Sydney LHD and Illawarra Shoalhaven LHD) as well as Justice Health & Forensic Mental Health Network have agreed to participate in the trial if funding is forthcoming.

256. I note also that in the Inquest touching upon the death of Ahlia Raftery, a young person who took her own life whilst an inpatient in mental inpatient unit, Deputy State Coroner Lee made the following recommendations:

    Recommendation 7: In the event that the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts is unsuccessful, I recommend that the HNELHD give consideration to independently conducting its own trial to access the acceptability and feasibility of using pulse oximetry units to continuously monitor inpatients in mental health intensive care units within the district.

    Recommendation 8: I recommend that a copy of these findings be forwarded to the Minister for Health for consideration in conjunction with the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts.

257. Recent announcements by the NSW Department of Health indicate that the Black Dog Institute's proposal for a clinical trial of back to base pulse oximetry has been approved.

258. Having regard to both the facts and circumstances of this matter, and having regard to the recommendations made by Deputy State Coroner Lee in the inquest into the death of Alia Raftery, I commend the NSW Department of Health for funding the Black Dog Institute's clinical trial of back to base oximetry.

# Conclusion

259. MA's tragic death has highlighted serious shortcomings in relation to the LHD's policies and compliance with them.

260. Since MA's death, there have been significant state wide changes made in the area of nursing engagement and observation of patients in mental health units and that is to be commended. I propose to make recommendations to further address this important aspect of patient care.

261. This has been a long and complex inquest. I am grateful to my counsel assisting, Mr Mark Cahill for his extremely thorough preparation and conduct of this inquest. His written submissions have been of enormous assistance to me in preparing these findings. I am also grateful to his instructing solicitor, Ms Benish Haider, for her assistance before during and after this inquest.

262. I would also like to thank the officer in charge of this investigation, Detective Senior Constable Su-Ellen Scott for her excellent work and for the support she has provided to the MA family.

263. Finally, I would like to thank MA's family. Participating in the inquest process can be extremely distressing, exhausting and painful yet they were here every day. Their quest was to raise issues that concerned them, to get some answers and to make the system better for others going through it. I hope that this inquest has answered some of their questions. I am sure that their efforts have helped to change the system, especially in relation to how nursing observations are now done for patients in mental health units in NSW.

# Findings

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

## *Identity*

The person who died was MA

## *Date of death*

28 February 2014.

## *Place of death*

MA died at the Mental Health Inpatient Unit, Dubbo Base Hospital, Dubbo NSW.

## *Cause of death*

Neck compression consistent with hanging.

## *Manner of death*

MA, whilst he was an inpatient in the Mental Health Inpatient Unit of the Dubbo Base Hospital in Dubbo, died as a consequence of actions taken by him with the intention of ending his own life.

I close this inquest.

Magistrate Teresa O'Sullivan
A/State Coroner

2 February 2018