CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Alan Bugden and Amaru Bestrin
Hearing dates:	19 June 2018, 25 October 2018, 21-23 October 2019
Date of findings:	17 December 2019
Place of findings:	Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in hospital toilet, toilet cleaning and inspection systems, toilet alarm technologies, medically supervised injecting centre, naloxone
File numbers	2015/239954 2016/382203

Representation:	Ms K Edwards, counsel assisting, instructed by Mr J Herrington and Ms L Nash, Crown Solicitors Office
	Ms Furness SC, Mr King SC, Mr Fordham SC, Mr Wood, Mr Sergi, all of counsel (appearing at different times over the course of the inquest) instructed by McCabe Curwood Solicitors for NSW Health and SWSLHD, NSLHD
	Mr Evenden, solicitor for Ms Bestrin (Bestrin Inquest)
	Mr Wooldridge for the commissioner of Police, instructed by Mr Robinson, Office of the General Counsel (NSW Police Force) (Bugden Inquest)
	Clyde & Co Lawyers for Infrasure (Bugden Inquest)
	Meridian Lawyers for ISS Health Services Pty Ltd (Bugden Inquest)

Non-publication orders:

I make the following orders pursuant to section 74 *Coroners Act* 2009 (NSW)

Aside from Mr Bugden and Mr Bestrin, there will be no publication of

1. The names of people who have died in NSW Hospital toilets, mentioned in evidence during this inquest
2. The names of people who have collapsed or become incapacitated in NSW Hospital toilets, mentioned in evidence during this inquest.
3. Details which may identify those people to a reasonable person following evidence in this inquest
4. Exhibit 11, which relates to costing figures expressed in an email dated 19/10/19 from Sally Cordina
5. The evidence of Dr Nicolas Clark, except as set out in these findings.

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Introduction

1. This inquest[1] concerns two deaths which occurred in hospital toilets in NSW.

Alan Bugden

2. Alan Bugden died on 14 August 2015 at Royal North Shore Hospital of a pulmonary thromboembolism after suffering a stroke in a publicly accessible toilet at Royal North Shore Hospital on 10 August 2015.

3. Mr Bugden was happily married to Alexis Bugden for over 40 years. He had two children, Adam and Hayley, as well as four grandchildren, whom he adored. Mr and Mrs Bugden met and fell in love when Mrs Bugden was just 16 years old and they had been inseparable since. Mr Bugden owned and managed a successful swimming pool building company and through hard work, enjoyed financial security. He lived on the upper North Shore, balancing work with golf, travel, taking out his boat and spending time with his family.

4. Mr Bugden had recently overcome some significant medical issues and according to Mrs Bugden, he was looking good, and taking positive action in relation to his health. Mrs Bugden was instrumental in Mr Bugden staying on top of these issues and it is a tribute to the strength of their marriage that Mr Bugden heeded her words and went to his follow-up appointments, including on the day of his death. The decision of Mr Bugden to listen to his wife and to attend Royal North Shore Hospital for follow-up care should have saved Mr Bugden's life. Instead, in a distressing set of circumstances, Mr Bugden did not leave the hospital alive.

5. Since Mr Bugden's tragic death, Mrs Bugden has campaigned to make all disabled toilets safer in the community, and has publicly campaigned for greater safety in public hospital toilets. The efforts of Mrs Bugden should be commended.

Amaru Bestrin

6. Amaru Bestrin died on 19 December 2016 at Liverpool Hospital of combined drug and alcohol toxicity. Mr Bestrin had injected heroin whilst in a publicly accessible toilet within Liverpool Hospital.

7. Mr Bestrin was the first born child of Lorena and Jose Bestrin, having been born at Liverpool Hospital on 18 October 1991. Mr Bestrin had two younger brothers. He was of

[1] In the context of these findings I refer, at times, to the proceedings as an inquest, however in fact two inquests were heard together.

Chilean descent and spoke fluent Spanish. He was cheerful, friendly, polite, generous, honest and caring.

8. Mr Bestrin enjoyed a happy childhood, moving between Sydney, Brisbane and Chile. He was described as a very active boy who would spend most of his time outdoors, playing with neighbourhood children and climbing the huge mango tree in the family's backyard. Mr Bestrin loved food and cooking. He would eat anything prepared for him, and from a very young age learnt to cook. In the months before his death he worked in a prestigious Italian restaurant in Chile. He also enjoyed music, singing and art.

9. Mr Bestrin was very expressive with his emotions and was well loved by family and friends. He had also experienced difficulties with substance use, which he attempted to overcome on numerous occasions. From about 2015, it became evident that he had developed an addiction to heroin.[2] Mr Bestrin's mother, Lorena tried very hard to help her son find appropriate drug treatment in Sydney, but there was nothing available. Arrangements were made for him to return to Chile to access an appropriate and less expensive program. Mr Bestrin returned to Australia after his treatment in Chile. Tragically, just one day after his return, Mr Bestrin died of a heroin overdose in the very hospital where he had been born.

10. Mr Bestrin's mother, Lorena Bestrin attended each day of the inquest. Her great love for her son has driven her to seek greater understanding and compassion for those members of society who are adversely affected by drug issues. Her desire for Mr Bestrin's death to be used as catalyst for change is readily apparent and a great tribute to her character.

11. At first sight the circumstances surrounding these deaths may appear very different. However further examination highlights numerous shared issues and concerns.

12. A decision to hold the inquests of Mr Budgen and Mr Bestrin together is based on these similarities. Each man attended the hospital vicinity for a health related concern, Mr Bugden for an outpatient appointment, Mr Bestrin for clean injecting equipment. Each man died as a result of being discovered collapsed in a publicly accessible single occupancy toilet (SOPAT toilet) with floor to ceiling doors which obscured the fact that they had collapsed. Both toilets were in areas of high pedestrian traffic outside a clinical area, but beyond the direct line of sight of clinical staff who might notice if the toilet was engaged for a prolonged period. Neither man was immediately missed because they were not in-patients at a hospital ward and as a result, neither man was discovered for a

[2] Statement of Lorena Bestrin, Bestrin BOE Vol 1, Tab 16, p. 3

long period of time - over 20 hours in Mr Bugden's case and over 10 hours in Mr Bestrin's case. Both men died of conditions where earlier discovery could have made a favourable outcome more likely. Both men died in circumstances where any checking or toilet monitoring strategies which were in place failed to assist discovery in a timely manner. Finally, neither toilet had a distress button, intercom, alarm, motion sensor or other technological device which could have alerted staff to the crisis within.

13. Given the broad issues raised by these tragic deaths, the court also sought evidence which would place these deaths within a wider context, in attempt to understand the scale of the problem revealed. The issues raised were not isolated, but the data was difficult to obtain. It became apparent that since August 2015 there have been eight deaths in toilets (or after collapse in toilets) and at least 18 other incidents of collapse or incapacitation in hospital public toilets in NSW. All of the collapses involved delay in detection. Some involved significant delay. Surprisingly, there is no current requirement to record that delay in a central place. This year there appear to have been five reported cases of incapacitation and one additional death.

The role of the coroner

14. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death.[3] A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[4]

15. In this case there is no dispute in relation to the identity of either man or to the date, place or medical cause of death. For this reason the inquest focussed on the manner and circumstances of each death and on questions about whether these deaths could have been prevented.

The evidence

16. The court took evidence over five hearing days, between June 2018 and October 2019.[5] The court also received extensive documentary material in over six volumes. This material included witness statements, medical records, photographs, extensive cleaning records and expert reports. While I do not intend to refer to all the material in detail in these findings, it has been comprehensively reviewed and assessed.

[3] Section 81 *Coroners Act* 2009 (NSW)
[4] Section 82 *Coroners Act* 2009 (NSW)
[5] Delays in this matter were affected by a number of factors including the tragic death of counsel for NSW Health and the provision of material related to statewide auditing.

17. A list of issues was prepared before the proceedings commenced. The following questions arose in relation to Mr Mr Bugden's death:

    a. Was the death of Mr Bugden preventable?

    b. What reasons led to Mr Bugden remaining undetected and incapacitated in a hospital public toilet for over 20 hours?

    c. What improvement measures have been undertaken by the North Sydney Local Health District in response to the death?

    d. Has there been an assessment of the efficacy of those improvement measures?

    e. Should further consideration be given to technological harm reduction measures in single occupancy, publicly accessible toilets in the Northern Sydney Local Health District, particularly the 122 toilets without duress buttons?

    f. Are further recommendations pursuant to s. 82 *Coroners Act 2009* necessary or desirable?

18. The following questions arose in relation to Mr Bestrin's death:

    a. Was the death of Mr Bestrin preventable?

    b. What reasons led to Mr Bestrin remaining undetected and incapacitated in a hospital public toilet for over 10 hours?

    c. What improvement measures have been undertaken by the South Western Sydney Local Health District in response to the death?

    d. Has there been an assessment of the efficacy of those improvement measures?

    e. Should further consideration be given to technological harm reduction measures in single occupancy, publicly accessible toilets in the South Western Sydney Local Health District?

    f. Should further consideration be given to specific harm reduction measures to ensure the safety of intravenous drug users who may inject drugs and become incapacitated in public toilets in the South Western Sydney Local Health District?

    g. Are further recommendations pursuant to s. 82 *Coroners Act 2009* necessary or desirable?

19. These questions directed the focus of the evidence presented in court. However as is often the case, a hearing can tend to crystallise the issues which are really at stake. For this reason, after dealing with the facts, I intend to distil my reasons fairly briefly under a small number of broad headings.

20. The focus of the inquest ultimately centred on the systemic challenges, rather than judging the conduct of specific individuals involved in the provision of cleaning, security or medical services. At the end of the day, while no individual is held out for any particular criticism, the systems in place at the time of each death were exposed as in need of review and improvement.

The deaths under investigation – fact finding

21. Counsel assisting prepared a concise summary of the extensive documentary evidence in relation to each death. The summaries were circulated to the parties during the course of the inquest for consideration and comment, prior to finalisation. The summaries were a careful synopsis of the salient facts leading up to the deaths under investigation. I indicated to the parties that I intended to adopt it as the basis of my fact finding and urged comment or correction. I was alerted to no particular controversy. In my view what follows is an accurate and useful distillation of the tendered material.

22. I thank those assisting me for their hard work in the preparation of the following chronologies and for their various *aide memoire* and final submission documents on which I also rely heavily.

The death of Alan Bugden

23. Alan Bugden died on 14 August 2015.[6] He was 66 years of age (DOB 21.11.1948).

24. Mr Bugden died at Royal North Shore Hospital (**RNS**) of a pulmonary thromboembolism after suffering a stroke on 10 August 2015.

Background

25. Mr Bugden had several ongoing health issues. He was diagnosed with diabetes in 1986 and had hypertension and high cholesterol.[7] In 2002 he underwent a triple bypass operation.[8]

[6] P79A Report, Bugden BOE, Tab 1, p. 1.
[7] See medical records generally, Bugden BOE Tab 23. See especially letters from medical professionals outlining medical history. For example, letter from Dr Samantha Hocking, Bugden BOE Tab 23, p. 214 and letter from Dr Dennis Wang, Tab 23, p. 210.
[8] Letter from Dr Samantha Hocking, Bugden BOE, Tab 23, p. 214.

26. Since 2008, Mr Bugden attended the outpatient Diabetic Clinic, which is in the Ambulatory Care Centre (**ACC**) located at RNS. Following gastric bypass surgery on 20 July 2015,[9] he had an appointment scheduled at the Diabetic Clinic with Dr Samantha Hocking for 10 August 2015 at 09:50, for management of his diabetes.[10]

RNS and the ambulatory care centre

27. The Diabetic Clinic is in the ACC on Level 3 of RNS' main building, which is the ground entrance level. It is situated behind the main RNS reception area, a little way along a corridor and to the right.[11]

28. The ACC provides a range of speciality outpatient clinics at RNS.[12] It has its own central reception and information desk and separate check-in areas for each of the specific clinics.[13] Patients attending a clinic can approach the central reception desk, or could bypass the central reception desk and present themselves directly to the check-in area of the clinic they are attending.[14]

29. Clinics are generally run from 08:00 to 17:00, Monday to Friday. Services such as the Medical Day Procedure Unit and the Integrated Hand Unit run from 07:00 to 19:00. Opening hours for the ACC itself, and its staffing hours, are 07:00 to 19:00, Monday to Friday.[15]

30. As at August 2015, the doors of the ACC were often opened by ACC staff members as they arrived.[16] Ideally the ACC was not opened to patients prior to 07:00 as it was not sufficiently staffed prior to this time.[17] In the evening, though the ACC was open until 19:00, staffing levels decreased from 17:00 and the doors were therefore often closed before 19:00.[18]

31. Immediately inside the entrance doors to the ACC and before the ACC reception area, there are three individual toilets in an alcove to the right (the toilets "**inside the ACC**

[9] ICU Discharge Summary from North Shore Private Hospital, Bugden BOE,Tab 23, p. 157.
[10] Statement of Alexis Bugden, Tab 6, [16], [23], [26]; Letter from Dr Samantha Hocking, Bugden BOE,Tab 31.
[11] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [9].
[12] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [7].
[13] Statement of Sharon Lee Lown, Bugden BOE, Tab 11, [13].
[14] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [14].
[15] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [8].
[16] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [25].
[17] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [26].
[18] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [27].

entrance").[19] When the entrance doors to the ACC are shut for the night, these toilets are no longer accessible from the main hospital building.[20]

32. As at 10 August 2015, the evening procedure for ACC nurses was at the conclusion of their shift they would check the clinic and waiting areas in the ACC to ensure patients had departed.[21] This included a check of the toilets within the clinic areas of the ACC, but not the toilets inside the ACC entrance.[22] After the ACC was closed for the evening, cleaning staff would conduct a clean of the building.[23]

Cleaning and security arrangements

33. RNS has a contract with InfraShore, an infrastructure consortium that serves as its parking, support services and retail partner. The contract includes provision of cleaning, security and food services. As at August 2015, InfraShore engaged a subcontractor, ISS Facility Services Australia (**ISS)**, to provide these services.[24]

34. The Support Services Specification, which forms part of the agreement between RNS and InfraShore, stipulates that cleaning and security services must be provided in accordance with the NSW Health "Environmental Cleaning Policy" and the NSW Health "Protecting People and Property Policy".[25]

Cleaning staff and policies

35. Most cleaning staff at RNS are employed by NSW Health, though as at August 2015, ISS employed the Senior Supervisor and additional cleaning staff when required.[26]

36. As at August 2015, approximately 80 to 90 cleaners were rostered to work the morning shift and 65 to 70 cleaners were rostered to work the afternoon shift. These cleaners all started at different times during the shifts.[27] Five cleaners were allocated to the ACC on afternoon shifts.[28]

37. As at August 2015, one of the cleaners appears to have carried out his duties under the expectation that the role of a cleaner scheduled on a shift at the ACC was to patrol, check

[19] See map of the Ambulatory Care Centre, Bugden BOE,Tab 26.
[20] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [28].
[21] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [29].
[22] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [30].
[23] Statement of Sharon Lee Lown, Bugden BOE,Tab 11, [31].
[24] Statement of John Derek Barnard-Richardson, Bugden BOE,Tab 10, [5].
[25] Support Service Specification, Bugden BOE,Tab 10B, [13.5], [20.1]; NSW Health Environmental Cleaning Policy, Tab 10A1; NSW Health Protecting People and Property Policy, Tab 10B; Statement of John Derek Barnard-Richardson, Tab 10, [10], [12], [13].
[26] Statement of Daxesh Kumar Patel, Bugden BOE,Tab 16, [1], [9].
[27] Statement of Daxesh Kumar Patel, Bugden BOE,Tab 16, [6], [7].
[28] Statement of Daxesh Kumar Patel, Bugden BOE,Tab 16, [10].

cleanliness and clean and replace items as required, or when requested.[29] That cleaner indicated that he was not required to follow a set schedule or do a set number of checks of any area in the ACC, including the toilets.[30]

38. Mr John Barnard-Richardson, the Hospital's Public Private Partnership Contract Manager, stated that the ACC toilets fall under the "medium risk" classification level of the NSW Health "Environmental Cleaning Policy".[31] Under the policy, medium risk areas require a daily clean, capacity for spot cleaning, and a toilet check and spot clean at least twice daily.[32]

39. As at August 2015, cleaning staff had no policy for checking off when individual toilets in the ACC were cleaned. There were no individual checklists located at each of the toilets inside the ACC entrance, meaning there was no way for a cleaner to indicate whether a particular toilet had been cleaned or not.[33] There may have been a broader checklist for ACC cleaning covering the whole week, located in the cleaning room.[34] However, this checklist was completed by the ISS supervisor and manager rather than cleaners, and was not of assistance in demonstrating when individual toilets were cleaned.[35]

40. As at 10 August 2015, Mr Daxesh Patel, the Senior Supervisor of cleaning staff and an employee of ISS, stated that the procedure in relation to a locked toilet was for cleaning staff to knock on the door. If occupation was verified, or if there was no answer, the cleaner would then return to that toilet after cleaning the remaining toilets in the area. If they were required to move on to other areas of the hospital due to time pressures, they would return to that toilet at a later point in their shift.[36] If the cleaner was still unable to gain access to clean, he or she would then be expected to notify the supervisor on duty. The supervisor would then either send another cleaner to clean the toilet, go to clean the toilet themselves, or the next cleaning shift would be expected to clean the area.[37]

41. The understanding of cleaning staff was that they were not required to make enquiries of occupants or conduct follow-up checks in relation to apparently occupied toilets.[38] One

[29] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [6].
[30] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [8].
[31] Statement of John Derek Barnard-Richardson, Bugden BOE, Tab 10, [33].
[32] Statement of John Derek Barnard-Richardson, Bugden BOE, Tab 10, [33]; NSW Health Environmental Cleaning Policy, Tab 10A1, p. 8.
[33] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [16].
[34] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [16].
[35] Statement of John Derek Barnard-Richardson, Bugden BOE, Tab 10, [40].
[36] Statement of Daxesh Kumar Patel, Bugden BOE, Tab 16, [11].
[37] Statement of Daxesh Kumar Patel, Bugden BOE, Tab 16, [12].
[38] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [9]; Statement of Sailuza Pathak, Tab 19, [15];

staff member indicated that her usual practice was to continue with other duties and return once the toilet was free.[39]

42. None of the three staff who provided statements in relation to this matter appear to have been aware of any responsibility, described by the Senior Supervisor, to escalate the situation of a locked toilet to a supervisor.

Security Staff and Policies

43. Security Duty Managers are employed by ISS, while the Control Room Operator and Patrol Team are typically employed by NSW Health, though ISS engages a subcontractor to provide additional security personnel when required.[40]

44. As at August 2015, there were two shifts per day at RNS: 06:00 to 18:00 and 18:00 to 06:00. Five security staff were rostered on each shift, including a duty manager, a control room operator and three patrol team members.[41]

45. The "Protecting People and Property Policy" includes patrolling as within the scope of duties of security staff and security staff did conduct walk-throughs of Hospital areas.[42] Security manager, Lee John McLaughlin, stated that the opening and closing of clinical areas was managed by individual hospital departments.[43] The Support Services Specifications state that InfraShore (and therefore its subcontractor ISS) shall, at times nominated by the Project Director for each building at the end of each day and at the beginning of each day, lock and unlock each building (including individual rooms within a building required by the Project Director to be secured or unlocked).[44]

46. The usual practice, as at August 2015, was for ACC clinical staff to shut the centre around 19:00, with cleaning staff attending afterwards.[45] Security's role was then to ensure the ACC entrance doors were securely fastened, however it was the belief of the security staff that they were not required to enter the ACC and check every room.[46] If time permitted, security would sometimes enter the ACC and conduct a sweep along the main corridors, but this did not involve checking rooms.[47]

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[39] Statement of Georgina D'Silva, Bugden BOE, Tab 17, [11].
[40] Statement of Lee John McLaughlin, Bugden BOE, Tab 12, [8].
[41] Statement of Lee John McLaughlin, Bugden BOE, Tab 12, [6].
[42] Protecting People and Property Policy, Bugden BOE, Tab 10A2, ch. 14, p. 13; Statement of Lee John McLaughlin, Tab 12, [5], [11].
[43] Statement of Lee John McLaughlin, Bugden BOE, Tab 12, [11], [14].
[44] Support Services Specifications, Bugden BOE, Tab 10B, [20.8].
[45] Statement of Bruce James Rowling, Bugden BOE, Tab 13, p. 2.
[46] Statement of Bruce James Rowling, Bugden BOE, Tab 13, p. 2; Statement of Simon Hogan, Tab 14, [10], [12]; Statement of Michael John Clayton, Bugden BOE, Tab 15, [10].
[47] Statement of Bruce James Rowling, Bugden BOE, Tab 13, pp. 2-3; Statement of Michael John Clayton, Tab 15, [10].

Attendance at RNS and subsequent events

47. Mr Bugden attended the Hospital at around 09:30 on 10 August 2015 for his 09:50 appointment with Dr Hocking.[48]

48. CCTV footage shows Mr Bugden entering the hospital and speaking briefly with the main reception desk at 09:32, before proceeding into the toilet alcove off the corridor near the entry to the ACC at 09:33.[49]

49. According to the officer-in-charge, it is believed Mr Bugden suffered a stroke shortly after entering one of the three toilets in this alcove.[50]

50. Cleaner, Oscar Valenzuela, was rostered on a 06:00 to 14:30 shift in the ACC on 10 August 2015.[51] He stated to NSW Police investigating Mr Bugden's death that his responsibilities were cleaning on an "as needs" basis, with a major clean of the ACC being done in the evening when the clinic was closed.[52]

51. His duties included checking the three toilets within the main entrance, one of which was the toilet in which Mr Bugden was located.[53] CCTV confirms Mr Valenzuela checked these toilets at around 11:30 and 14:00.[54] Mr Valenzuela stated he assumed that the toilet in which Mr Bugden was located was locked when he conducted these checks and that he likely did not investigate further because he would have thought it inappropriate to interrupt the occupant.[55]

52. Mr Valenzuela stated he would only check toilets if they were unoccupied and that, at the time, he was not required to conduct follow up checks or make enquiries of the person in an apparently occupied toilet.[56]

53. Cleaner, Georgina D'Silva, was rostered on a 18:00 to 22:00 shift on 10 August 2015.[57] She stated she was allocated to clean four of the clinics in the ACC but not the entrance to the ACC or the toilets inside the ACC entrance.[58]

54. Cleaner, Saliuza Pathak, was rostered on a 15:30 to 21:30 shift on 10 August 2015 and at about 17:00, her supervisor, Daxesh Kumar Patel, requested that she attend to clean the

[48] Statement of Luke Sweetman, Bugden BOE, Tab 5, [4]; Letter from Dr Samantha Hocking, Tab 31.
[49] Statement of Senior Constable Luke Sweetman, Bugden BOE, Tab 5, [4].
[50] Statement of Luke Sweetman, Bugden BOE, Tab 5, [5].
[51] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [10].
[52] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [7].
[53] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [9].
[54] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [12].
[55] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [13].
[56] Statement of Oscar Valenzuela, Bugden BOE, Tab 18, [9].
[57] Statement of Georgina D'Silva, Bugden BOE, Tab 17, [6], [9].
[58] Statement of Georgina D'Silva Bugden BOE,, Tab 17, [9], [10].

ACC.[59] Mr Patel attended the ACC with her as it was her first time cleaning the ACC area.[60] CCTV shows Ms Pathak and Mr Patel attending the ACC at 17:24.

55. CCTV shows Ms Pathak entering the toilet alcove inside the ACC entrance at around 18:00. At this time, Ms Pathak cleaned two of the three toilets.[61] Ms Pathak stated that she knocked on the door of the locked toilet but received no response, which she believed was due to embarrassment on behalf of the occupant.[62] Ms Pathak therefore continued with other cleaning duties and did not return to the entrance area toilets during her shift.[63]

56. Cleaning supervisor, Daxesh Patel, was rostered on a 14:00 to 22:00 shift on 10 August 2015.[64] He stated that it was usually a supervisor's role to conduct a general walk-around the hospital, but noted the walk-around did not involve checking rooms.[65] He recalled taking Ms Pathak to the ACC around 17:30 to show her the area she was allocated to clean,[66] but does not state whether he conducted any other walk-around of the ACC that night. The afternoon shift report for that day contains no record of the fact that the toilet in which Mr Bugden was located was not been cleaned.[67]

57. At 18:21, CCTV captures the main doors to the ACC being closed by a clinical staff member.[68] The Support Services Specifications state that InfraShore (and therefore its subcontractor ISS) shall, at times nominated by the Project Director for each building at the end of each day and at the beginning of each day, lock and unlock each building (including individual rooms within a building required by the Project Director to be secured or unlocked).[69] The practice at the time was that clinical staff would check the ACC, but not the toilets inside the ACC entrance, before locking up.[70]

58. Cleaning supervisor, Mr Patel, stated that as at 10 August 2015, night shift cleaners commencing at 22:00 were responsible for cleaning all public areas in RNS, including waiting areas and toilets in the ACC.[71] The CCTV does not appear to indicate any major clean being conducted by any cleaners commencing work in the ACC after 22:00. The CCTV is obstructed after 18:21 due to the ACC doors being closed, with only small panel windows providing any view inside, and the last clearly visible entry of cleaning staff into

[59] Statement of Sailuza Pathak, Bugden BOE, Tab 19, [7], [8].
[60] Statement of Sailuza Pathak, Bugden BOE, Tab 19, [8].
[61] Statement of Sailuza Pathak, Bugden BOE, Tab 19, [11].
[62] Statement of Sailuza Pathak, Bugden BOE, Tab 19, [11].
[63] Statement of Sailuza Pathak, Bugden BOE, Tab 19, [14].
[64] Statement of Daxesh Kumar Patel, Bugden BOE, Tab 16, [15].
[65] Statement of Daxesh Kumar Patel, Bugden BOE, Tab 16, [5].
[66] Statement of Daxesh Kumar Patel, Bugden BOE, Tab 16, [16].
[67] Statement of Daxesh Kumar Patel, Bugden BOE, Tab 16, [19].
[68] Statement of Luke Sweetman, Bugden BOE, Tab 5, [111].
[69] Support Services Specifications, Bugden BOE, Tab 10B, [20.8].
[70] Statement of Sharon Lee Lown, Bugden BOE, Tab 11, [29], [30].
[71] Statement of Daxesh Kumar Patel, Bugden BOE, Tab 16, [17].

the toilet alcove occurred at 17:47. After 22:24, the CCTV appears to show no cleaners entering or exiting the ACC at all until the following morning at 05:13.

59. Simon Hogan was the security officer on duty from 18:00 to 06:00 over the night of 10 August 2015.[72]

60. Mr Hogan stated that on the night of 10 August 2015 he checked that the ACC doors were locked, however he did not go into the ACC because at that time security were not required to enter the ACC to check the rooms.[73]

61. CCTV shows a floor cleaner entering the ACC at 05:13 on 11 August 2015 and another cleaner entering at 05:35. The doors to the ACC were still shut at this stage, and the obstructed view of the CCTV makes it unclear whether the toilets near the entrance to the ACC were checked at this time.

Discovery of Mr Bugden

62. Kerry Davis, a service technician employed by Flick Anticimex Pty Ltd, was responsible for replacing sanitary units in the Hospital toilets.[74] On 11 August 2015, Ms Davis commenced work at around 04:30 and CCTV confirms she attended the ACC around 06:14.[75]

63. Arriving at the toilets near the entrance, she noticed one was locked and stated that she had often found this toilet locked in the mornings when she attended over the past six weeks. She stated that she was therefore in the habit of manually unlocking the toilet from the outside to gain access.[76]

64. Upon unlocking the door on this occasion she noticed it opened about six inches before she felt some resistance.[77] Looking through the door she saw a pair of legs on the ground and could hear no noise or response from the man inside.[78]

65. Ms Davis walked outside and informed a volunteer with the North Shore Cardiovascular Education Centre, Arthur Moreland, about the situation.[79] This person contacted security and nurses and doctors attended, along with security.[80]

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[72] Statement of Simon Hogan, Bugden BOE, Tab 14, [15].
[73] Statement of Simon Hogan, Bugden BOE, Tab 14, [16].
[74] Statement of Kerry Davis, Bugden BOE, Tab 20, [3].
[75] Statement of Kerry Davis, Bugden BOE, Tab 20, [12]; Statement of Luke Sweetman, Tab 5, [113].
[76] Statement of Kerry Davis, Bugden BOE, Tab 20, [15].
[77] Statement of Kerry Davis, Bugden BOE, Tab 20, [16].
[78] Statement of Kerry Davis, Bugden BOE, Tab 20, [17].
[79] Statement of Kerry Davis, Bugden BOE, Tab 20, [18]; Statement of Arthur Moreland, Tab 34.
[80] Statement of Kerry Davis, Bugden BOE, Tab 20, [19]; Statement of Arthur Moreland.

66. Mr Bruce Rowling and Mr Michael Clayton were the two security officers rostered on duty on the morning of 11 August 2015 when Mr Bugden was found and the "Code Blue" was activated.[81] A "Code Blue" is a medical emergency.[82]

67. The role of security in the event of a "Code Blue" was to go to the resuscitation bay and collect the necessary equipment and then take the doctor and nurse emergency team to the incident site.[83]

68. The security officers did this and then at the scene assisted the emergency team in moving Mr Bugden out of the toilet and onto a trolley so that he could be taken to the Emergency Department.[84]

Treatment post discovery

69. Mr Bugden was immediately assessed by Emergency staff and an urgent CT scan was performed.[85]

70. The CT scan showed a stroke involving the left side middle cerebral artery territory of his brain with some haemorrhagic transformation (small micro-bleeds into the area of dead brain).[86]

71. Mr Bugden was admitted to the Stroke Unit at the Hospital under Dr Herkes.[87] He received regular assessment of his condition, intravenous fluids and monitoring of his diabetic state.[88]

72. Mr Bugden continued to receive treatment under the stroke pathway, but on 14 August his condition deteriorated.[89] He was transferred to intensive care and an echocardiogram revealed he had a large pulmonary embolus.[90]

73. Dr Geoffrey Herkes explained to the family that there is an opportunity for stroke thrombolysis in the first four and a half hours after a stroke, and that Mr Bugden was

[81] Statement of Bruce James Rowling, Bugden BOE, Tab 13, p. 3; Statement of Michael John Clayton, Tab 15, [13].
[82] Statement of Lee John McLaughlin, Bugden BOE, Tab 12, [5].
[83] Statement of Michael John Clayton, Bugden BOE, Tab 15, [15].
[84] Statement of Michael John Clayton, Bugden BOE, Tab 15, [16].
[85] Progress Notes, Bugden BOE, Tab 21, p. 181.
[86] Stroke and TIA Medical Assessment Form, Bugden BOE, Tab 21, p. 29.
[87] Progress notes, Bugden BOE, Tab 21, p. 156.
[88] See generally medical notes, Bugden BOE, Tab 21.
[89] Progress notes, Bugden BOE, Tab 21, pp. 185-191.
[90] Progress notes, Bugden BOE, Tab 21, p. 194.

outside this window when found.[91] The family was also informed that the period of collapse likely contributed to Mr Bugden's deep vein thrombosis/pulmonary embolus.[92]

74. After discussion with the family, a decision was made to keep Mr Bugden comfortable and he died at 16:29 on 14 August 2015.[93]

Post mortem analysis

75. Pathologist Kendall Bailey conducted an autopsy at 10:30 on 17 August 2015. The cause of death was recorded as pulmonary thromboembolus.[94]

Expert evidence

76. The expert report of cardiologist, Associate Professor Mark Adams, states that though Mr Bugden had been at risk of a stroke for some time due to the same risk factors involved in his severe coronary artery disease, Mr Bugden's specific cardiac condition is unlikely to have played a significant role in the mode of his death.[95]

77. Further, Professor Adams does not believe that Mr Bugden's sleeve gastrectomy to assist with weight loss on 20 July 2015 was relevant to his death, stating it appeared to be appropriate surgery in Mr Bugden's circumstances.[96]

78. Professor Adams states that the most likely sequence of events leading up to Mr Bugden's death was the sudden occurrence of a large stroke leading to loss of mobility and speech.[97]

79. In terms of Mr Bugden's subsequent development of a deep venous thrombosis, Professor Adams states that although Mr Bugden had several underlying risk factors for venous thromboembolism including his obesity, recent surgical procedure and his reduced left ventricular ejection fraction, "by far and away the largest factor" was the long period during which Mr Bugden remained immobile in the bathroom.[98]

80. Treating neurologist, Dr Herkes, states that thrombolytic therapy through administration of intravenous TPA (a clot-busting drug) was not available to Mr Bugden because he was discovered outside the four and a half hour therapeutic window and, if discovered within this window, Mr Bugden would have been a candidate for serious consideration of this

[91] Progress notes, Bugden BOE, Tab 21, p. 195; Discharge summary, Tab 21, pp. 181-2.
[92] Progress notes, Bugden BOE, Tab 21, p. 195; Discharge summary, Tab 21, pp. 181-2.
[93] Progress notes, Bugden BOE, Tab 21, p. 195; Discharge summary, Tab 21, p. 181.
[94] Autopsy Report, Bugden BOE, Tab 2, p. 2.
[95] Expert Report of Associate Professor, Mark Adams, Bugden BOE, Tab 32, p. 2.
[96] Expert Report of Associate Professor, Mark Adams, Bugden BOE, Tab 32, p. 3.
[97] Expert Report of Associate Professor, Mark Adams, Bugden BOE, Tab 32, p. 2.
[98] Expert Report of Associate Professor, Mark Adams, Bugden BOE, Tab 32, p. 2.

therapy.[99] Dr Herkes notes that the approval process for thrombolysis notes that those who can be administered this agent according to the guidelines will have a substantially more favourable outcome in functional recovery after a stroke than those who do not receive the treatment.[100]

81. Dr Herkes also gave oral evidence at the hearing regarding the cause of death of Mr Bugden. Dr Herkes reiterated that had Mr Bugden presented within four and half hours of the onset of the stroke, there would have been treatment available to dissolve the clot causing the stroke.[101] However due to the length of time Mr Bugden remained undetected and the size of the stroke, such treatment was precluded.[102] This evidence underscored the tragedy of Mr Bugden remaining undetected for such an extended period of time.

Search conducted for Mr Bugden by NSW Police

82. Mr Bugden's wife stated that she contacted Hornsby Police in relation to Mr Bugden being missing at around 21:15 on 10 August 2015.[103]

83. About 02:35 on 11 August, Constable David Ulherr and Senior Constable Bennett ("**SC Bennett**") attended Mr and Mrs Bugden's house in Turramurra.[104] Constable Ulherr and SC Bennett spoke to Mrs Bugden who informed them the family had not made successful contact with Mr Bugden since the morning of 10 August.[105] Mrs Bugden stated the family had attempted to call Mr Bugden's mobile phone and had also contacted several hospitals, including RNS, where Mr Bugden had an appointment scheduled on 10 August, as well as the Wyong, Gosford and Hornsby Hospitals.[106]

84. SC Bennett states that Mrs Bugden informed police that Mr Bugden had no mental health history and that, though he had diabetes and had previously undergone a bypass operation, there were no other present concerns for his health.[107] Possible triangulation of Mr Bugden's phone was also discussed.[108] In a further statement provided to police on 20 April 2018, SC Bennett states that she told Mrs Bugden she would endeavour to speak to her superiors regarding the possibility of utilising the triangulation service.[109] SC Bennett

[99] Statement of Geoffrey Herkes, Bugden BOE, Tab 29.
[100] Statement of Geoffrey Herkes, Bugden BOE, Tab 29.
[101] Dr Herkes, Transcript 19/6/18, page 21, line 1 onwards
[102] Dr Herkes, Transcript 19/6/18, page 21, line 11 onwards
[103] Statement of Alexis Bugden, Bugden BOE, Tab 6, [41].
[104] Statement of Senior Constable Renee Bennett, Bugden BOE, Tab 8, [4]; Statement of Senior Constable David Ulherr, Tab 38, [4].
[105] Statement of Senior Constable Renee Bennett, Bugden BOE, Tab 8, [5].
[106] Statement of Senior Constable Renee Bennett, Bugden BOE, Tab 8, [8].
[107] Statement of Senior Constable Renee Bennett, Bugden BOE, Tab 8, [5], [7].
[108] Statement of Alexis Bugden, Bugden BOE, Tab 6, [45]; Statement of Senior Constable Renee Bennett, Tab 8, [9].
[109] Further statement of Senior Constable Renee Bennett, dated 20 April 2018, Tab 37, p. 2.

also informed Mrs Bugden that she would be unable to create a COPS report straight away because the COPS system was being maintained from 02:00 until 05:00 that night.[110] This is supported by a statewide message, annexed to SC Bennett's statement, regarding a system outage scheduled for Tuesday 11 August 2015 from 01:30 til 05:30.[111]

85. About 05:30 on 11 August, SC Bennett created a COPS Event report in relation to the incident.[112] The report noted that specialist doctor, Samantha Hocking, should be contacted to ascertain if Mr Bugden attended his appointment on 10 August.[113] In her further statement provided on 20 April 2018, SC Bennett stated that she made further enquiries with hospitals in the area but all of these advised that Mr Bugden had not checked in or made himself known to staff.[114] As such, she states she did not consider attending the hospitals or requesting CCTV footage from RNS.[115] She states that her supervisors advised her that further follow up would occur during the day shift.[116] The next entry in the COPS Event Report stated that Mr Bugden had been found.[117]

86. The VKG Sydney Local Operating Procedure in relation to triangulation states that s 287 of the *Telecommunications Act 1997* (Cth) requires triangulation only be utilised to obtain information when "reasonably necessary to prevent or lessen a serious and imminent threat to the life or health of a person".[118] SC Bennett states that her supervisors advised her that triangulation of Mr Bugden's phone would not be granted as he had no known serious health issues and did not suffer mental health conditions.[119]

Hospital and LHD actions post incident

87. Following Mr Bugden's death, the Hospital conducted an internal review. The court was informed of a number of subsequent changes in policy and procedure.

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[110] Further statement of Senior Constable Renee Bennett, dated 20 April 2018, Bugden BOE, Tab 37, p. 2.
[111] Annexure to further statement of Senior Constable Renee Bennett, dated 20 April 2018, Bugden BOE, Tab 37.
[112] Statement of Senior Constable Renee Bennett, Bugden BOE, Tab 8, [10].
[113] COPS Event Report E211402297, Bugden BOE, Tab 27.
[114] Further statement of Senior Constable Renee Bennett, dated 20 April 2018, Bugden BOE, Tab 37, pp. 2-3.
[115] Further statement of Senior Constable Renee Bennett, dated 20 April 2018, Bugden BOE, Tab 37, pp. 2-3.
[116] Further statement of Senior Constable Renee Bennett, dated 20 April 2018, Bugden BOE, Tab 37, p. 2.
[117] COPS Event Report E211402297, Bugden BOE, Tab 27.
[118] Local Operating Procedure: Triangulation Procedures for the Duty Operations Inspector, Bugden BOE, Tab 33.
[119] Statement of Senior Constable Renee Bennett, Bugden BOE, Tab 8, [10].

88. Significantly, on 13 August 2015, the Hospital installed nurse call bells in the two, single occupancy, publicly accessible toilets in the ACC that did not already have call bells.[120] One of these was the toilet in which Mr Bugden collapsed.

89. In September 2016, a Work Instruction was developed and disseminated to switchboard staff and after-hours nursing managers concerning in-hours and out-of-hours patient location enquiries.[121] If there is a telephone enquiry about a patient attending an ACC appointment, the Work Instruction directs that records be checked for patient attendance.[122] If the patient cannot be located, the situation is then escalated to senior nursing staff and security, with potential activation of the procedure for missing patients, which can involve security searching the Hospital Campus.[123]

90. The Hospital's review also recommended an audit of publicly accessible toilets across the entire NSLHD. This was completed in October 2016,[124] and included a review of whether toilets had a call bell, placement of the call bell and call bell response.[125] The audit found that of 118 publicly accessible toilets across the NSLHD, 32 had call buttons and 21 of these were responded to when pressed.[126] The audit identified that toilets in isolated areas were a particular risk and found that some staff experienced confusion around ascertaining the location of toilets from which alarms originated.[127] Additional call bells have now been installed in some single occupancy toilets across NSLHD hospitals.[128] In all NSLHD hospitals, there are now schedules for monthly testing of call bells in public toilets aimed at ensuring call bells are operational and are responded to by staff when triggered. Staff should be aware of, and able to identify, the location of call bells when activated.[129]

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[120] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Bugden BOE, Tab 35, p. 5.
[121] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 9 and attachment 27.
[122] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 9 and attachment 27.
[123] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 9 and attachments 27 and 28.
[124] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 6 and attachment 15.
[125] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 6.
[126] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, attachment 15.
[127] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 6.
[128] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 6.
[129] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Tab 35, p. 7.

91. The Hospital's review also considered potential follow-up arrangements for patients who fail to attend their ACC appointments.[130] However, the review made no recommendations in this area because the number of outpatients failing to attend their ACC appointments was viewed as so large as to make routine, real time follow up impractical.[131] The practice therefore remains that patients who fail to attend their ACC appointments receive a follow up letter and in addition, an individual patient can be followed up if there is a clinical indication to do so.[132]

92. The Hospital's review also recommended investigation by the NSLHD Executive Leadership Team, Information, the Communications & Technology team and eHealth & Health Infrastructure, into a possible technological solution that alerts staff of toilet occupation for a prolonged period.[133] Ultimately, NSW Health concluded, in "Health B Note – Safety in Toilets in Publicly Accessible Areas of Health Facilities", that technological and infrastructure solutions including automatic alarms triggered through lock mechanisms or motion sensors should not be pursued because the expense was not justified.[134] While the potential consequences of an incident such as Mr Bugden's are significant, the likelihood of these types of events occurring was viewed as rare and better managed with operational responses.[135]

93. NSLHD have also undertaken various other relevant changes in response to the events involving Mr Bugden's tragic death. These include:

    a. Changes to the sign-in procedure. There is now a sign-in procedure at the ACC, which is complemented by a letter to all outpatients, encouraging them to immediately sign-in when they arrive for their appointment. There are also multilingual signs within the ACC encouraging people to sign-in[136];

    b. There have been changes to the cleaning policies within the ACC. Cleaners must now check the toilets during four windows of time between 6:30 am and 10 pm. There is also a welfare check policy where cleaners

[130] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Bugden BOE, Tab 35, p. 10.
[131] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Bugden BOE, Tab 35, p. 10.
[132] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Bugden BOE, Tab 35, p. 10 and attachment 29.
[133] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Bugden BOE, Tab 35, p. 3 and attachment 8.
[134] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Bugden BOE, Tab 35, p. 3 and attachment 8.
[135] Letter from Deborah Wilcox and attachments, Submission to the Deputy State Coroner from Northern Sydney Local Health District, Bugden BOE, Tab 35, p. 3 and attachment 8.
[136] Transcript 19/06/18, page 11, line 44 onwards

knock to see if the toilet is occupied, and an escalation procedure to nursing staff or security depending. There are also signs on the external toilet doors indicating that cleaners may knock if the toilet is occupied[137];

c. The cleaning cards are now displayed on the outside of the door so people know whether or not the toilets have been cleaned during the previous shift[138];

d. The shut-down procedure for the ACC has been amended. There is now a very clear policy, including a documented sign-off, about closing the ACC and conducting checks of the ACC area. In addition, security have various requirements to conduct checks of toilets and rooms in the ACC overnight[139];

e. Throughout 2018, a risk assessment was conducted in relation to each of the 199 SOPAT toilets accessible to the public within NSLHD.[140] It was worth noting that NSLHD concluded that the current systems in place are adequate in mitigating the risk posed by publicly accessible toilets and that deaths like Mr Bugden's are rare[141];

f. In 2016 and 2018, there were audits undertaken of the duress and call systems to see if they were working correctly and if nurses were responding accordingly. In January 2018, it was identified that 18 call bells needed repair, including ten which needed to be properly connected to issue a 'back to base' alert. A further 11 call bells went unanswered. Certain measures appear to have been implemented as a result of those tests[142].

94. It is clear that some significant changes have been made, including a call button in the toilet where Mr Bugden died and the application of various new cleaning and administrative policies. Proper local auditing will be necessary to secure safety results on an ongoing basis.

[137] Transcript 19/06/18, page 12, line 37 onwards
[138] Transcript 19/06/18, page 12, line 44 onwards
[139] Transcript 19/06/18, page 13, line 13 onwards
[140] Transcript 19/06/18, page 14, line 2 onwards
[141] Transcript 19/06/18, page 14, line 8 onwards
[142] Transcript 19/06/18, page 15, line 29 onwards

The death of Amaru Bestrin

95. Amaru Bestrin died on 19 December 2016.[143] He was 25 years of age (DOB 19.10.1991).

96. Mr Bestrin died at Liverpool Hospital (**LH**) of combined drug and alcohol toxicity.

Background

97. Mr Bestrin lived in Canley Vale with his brother, mother and grandmother.[144] His parents moved to Australia from Chile prior to his birth.[145]

98. Mr Bestrin suffered from a heroin addiction. He had a history of overdoses including one requiring admission to Liverpool Emergency Department on 27 June 2016. In July 2016, he went to Chile at the encouragement of his mother, Lorena Bestrin, to attend a two month rehabilitation program.[146]

99. Around 18:00 on 18 December 2016, Mr Bestrin returned to Australia from Chile and spent time with his mother in her Canley Vale home.[147] His mother observed him to be in a euphoric mood, though she was unsure whether this was due to illicit substance use.[148] Mr Bestrin spent the night of 18 December at his friend Michael Cowell's house.[149]

100. Mr Cowell described Mr Bestrin's behaviour as normal, although he seemed energetic, which Mr Cowell understood at the time to be due to his arrival home.[150] Mr Cowell and Mr Bestrin walked to a nearby pub, "Richards on the Park". On their way there, Mr Cowell recalls Mr Bestrin saying he had taken some tablets to take the edge of his flight,[151] however he does not recall the name of the tablets other than that they were said to be accessible over the counter in Chile but required a prescription in Australia.[152] Mr Bestrin told Mr Cowell that he had taken quite a few.[153]

101. Another friend of Mr Bestrin's referred to as Milos joined Mr Cowell and Mr Bestrin while they were at the pub. Mr Cowell observed Mr Bestrin consume approximately three alcoholic drinks over the course of the three or four hours spent at the pub. Mr Bestrin, Mr Cowell and Milos then went back to Mr Cowell's house. Mr Cowell's housemate Nick was also at the house. Mr Bestrin and his friends spent the evening drinking, talking about music, playing the guitar and speaking about Mr Bestrin's future, which Mr Bestrin

[143] P79A Report, Bestrin BOE Tab 1, p. 1.
[144] Statement of Lorena Bestrin, Tab 16, [5].
[145] Statement of Lorena Bestrin, Tab 16, [3].
[146] Statement of Lorena Bestrin, Tab 16, [17].
[147] Statement of Lorena Bestrin, Tab 16, [20].
[148] Statement of Lorena Bestrin, Tab 16, [20]-[21].
[149] Statement of Lorena Bestrin, Tab 16, [23].
[150] Statement of Michael Cowell, Tab 16A, [4].
[151] Statement of Michael Cowell, Tab 16A, [5].
[152] Statement of Michael Cowell, Tab 16A, [5].
[153] Statement of Michael Cowell, Tab 16A, [5].

seemed eager to begin. Mr Bestrin eventually fell asleep on the couch. Mr Cowell went to bed at 2:30 am and at that time saw Mr Bestrin asleep on the couch. Mr Cowell had Mr Bestrin in his sights from the time they arrived at his house until he went to bed, save for approximately 30 – 40 mins where Mr Cowell left the house to get some food.[154]

102. On the morning of 19 December 2016 Mr Bestrin left Mr Cowell's house at approximately 10:00. Mr Bestrin indicated to Mr Cowell that he would see his family that day.[155] Mr Cowell expected to see him that evening as he had told Mr Bestrin that he could temporarily live with him.[156]

Attendance at hospital and subsequent events

103. Mr Bestrin attended LH. He entered the ground floor disabled toilet adjacent to Lift B at 10:47 and locked the door.[157] Mr Bestrin was not an inpatient at LH and was not registered for any appointments that day.[158]

104. It appears most likely that Mr Bestrin attended LH to obtain syringes from the outlet of the NSW Needle and Syringe Program at LH. The outlet is located outside the Emergency Department. Users can obtain new syringes from a dispensing machine.[159] The syringes are dispensed in a black plastic box.[160] A black plastic syringe box of a similar kind as that dispensed by the outlet was found beside Mr Bestrin's body and another box of a similar nature was found on the sink of the bathroom.[161] CCTV footage from the Emergency Department is no longer available as it has been overwritten.[162]

105. The cleaning checklist for the disabled toilet in which Mr Bestrin was found indicates that on 19 December 2016, the toilet was marked as cleaned at 07:00 and 10:10.[163] Following the 10:10 clean, staff did not clean the toilet in which Mr Bestrin was located because the red lock on the door was activated, indicating the toilet was potentially occupied.[164] The cleaning checklist for the adjacent disabled toilet indicates it was marked as cleaned at

[154] Statement of Michael Cowell, Tab 16A, [9].
[155] Statement of Michael Cowell, Tab 16A, [9].
[156] Statement of Michael Cowell, Tab 16A, [9].
[157] South Western Sydney Local Health District SAC 2 Investigation Report, Tab 21, p. 4.
[158] Letter from Amanda Larkin, Chief Executive of South Western Sydney Local Health District to Susan Dawson, Health Care Complaints Commissioner, dated 4 July 2017, Tab 20, p. 1.
[159] See photographs of Liverpool Hospital taken on 1 May 2018 by Senior Constable Anna Williams, Tab 19.
[160] See Tab 19, photos 7-13.
[161] Statement of Senior Constable Anna Williams, Tab 6, [27].
[162] Letter from Andrew Bridges-Webb of Curwoods Lawyers, instructed by South Western Sydney Local Health District, to the Crown Solicitor's Office, dated 24 May 2018, p. 1.
[163] Toilet Cleaning Checklist for the toilet in which Mr Bestrin was found, Tab 29.
[164] South Western Sydney Local Health District SAC 2 Investigation Report, Tab 21, p. 4.

05:30, 07:00, 10:05, 11:10 and 13:30.[165] Neither disabled toilet checklist was marked off after 13:30 on 19 December 2016.

106. Cleaning staff members, Nimishaben Patel and Dianne Harkness were the cleaners on duty for the day shift on the ground floor 19 December 2016.[166] The day shift runs from 06:00 to 14:30.[167] This was Ms Patel's first day of employment at LH. Ms Harkness had been employed with SWSLHD since 2003.[168] Both Ms Patel and Ms Harkness believe that at the time of Mr Bestrin's death, there was no instruction for cleaners' duties to include follow-up checks on toilets that were occupied at the time of cleaning.[169]

107. Cleaning staff member, Avealalo Iese, states that on 19 December 2016, she was rostered on the 14:00 to 23:00 shift as cleaning staff supervisor.[170] She states that although staff were generally tasked to clean the toilets around 3-4 times per shift, no staff attended the relevant public toilets during the afternoon shift on 19 December 2016 because they were very busy completing terminal cleaning, which takes priority over other duties.[171] Terminal cleaning is the cleaning of the isolation rooms in the wards.[172] The Hospital's terminal cleaning records show that on 19 December 2016 there were 61 terminal cleaning requests between 01:25 and 21:22, 44 of which were completed during the afternoon shift from 14:00 to 23:00.[173]

108. Around 22:00 on the evening of 19 December, Ms Iese attended the public toilets located on the ground floor near Lift B to undertake cleaning.[174] Cleaning staff member, Gyan Chand, attended shortly afterwards to assist.[175]

109. Upon commencing cleaning, Ms Iese and Mr Chand noticed that one of the disabled toilets was occupied.[176] Around 20 minutes later, the disabled toilet was still occupied.[177] The cleaners knocked and waited for a response.[178] Ms Iese then used a key to unlock

[165] Toilet Cleaning Checklist for the toilet adjacent to the toilet in which Mr Bestrin was found, Tab 30.
[166] Statement of Nimishaben Patel, Tab 15A, [4]; Statement of Dianne Harkness, Tab 15B, [6].
[167] Statement of Nimishaben Patel, Tab 15A, [5]; Statement of Dianne Harkness, Tab 15B, [6].
[168] Statement of Nimishaben Patel, Tab 15A, [5]; Statement of Dianne Harkness, Tab 15B, [4].
[169] Statement of Nimishaben Patel, Tab 15A, [6]; Statement of Dianne Harkness, Tab 15B, [7].
[170] Statement of Avealalo Iese, Tab 14, [4].
[171] Statement of Avealalo Iese, Tab 14, [5].
[172] Statement of Avealalo Iese, Tab 14, [5].
[173] Liverpool Hospital Terminal Cleaning Records, Tab 28.
[174] Statement of Avealalo Iese, Tab 14, [6].
[175] Statement of Gyan Chand, Tab 13, [4]-[5].
[176] Statement of Avealalo Iese, Tab 14, [7]; Statement of Gyan Chand, Tab 13, [5].
[177] Statement of Avealalo Iese, Tab 14, [8].
[178] Statement of Gyan Chand, Tab 13, [6]; Statement of Avealalo Iese, Tab 14, [8].

the door.[179] Upon unlocking the door she pushed against it, however she felt a weight against the door which prevented her from opening it completely.[180]

110. Through the gap between the door hinge and the door frame, Ms Iese observed the outline of a male figure crouched down behind the door.[181] Ms Iese then walked to the security office and used a wall mounted phone beside it to contact security at 22:30 and inform them of the incident.[182]

111. Security staff members Damien Taylor, Wayne West, Stephen Lelevaga and Yehya Haouchar were dispatched to the scene.[183] When Mr Haouchar arrived, he announced his presence, knocked on the door of the disabled toilet and then pushed it open.[184]

112. Upon accessing the toilet, security staff observed a male (later confirmed to be Mr Bestrin) crouched behind the door, with his back against the door frame and his body facing in towards the middle of the room.[185] The male was slumped slightly forward and holding an uncapped syringe in his right hand, which was pointed towards his body.[186] Mr Haouchar removed the syringe from the male's hand and Mr West retrieved it and placed it in the sharps container on the wall of the toilet, noticing as he did so that the syringe was empty.[187]

113. At 22:32, Mr Haouchar used his radio to request the Medical Emergency Team be called urgently to the toilet.[188]

114. CCTV footage shows the Medical Emergency Team arriving at 22:34. Accordingly, there was a period of over 11 hours between Mr Bestrin first entering the toilet at 10:47am and the attendance of emergency medical personnel at 22:34.

115. Attending doctor, Dr Patrick Pender, noted in his statement that Mr Bestrin was displaying no signs of life when he attended and that Mr Bestrin's body was cold to the touch and showed signs of rigor mortis. No attempts at resuscitation were made.[189]

116. Officer in Charge, Senior Constable Williams, attended the scene around 22:57.[190] She stated that she observed an open syringe packet on the floor of the toilet next to Mr

[179] Statement of Avealalo Iese, Tab 14, [9].
[180] Statement of Avealalo Iese, Tab 14, [9].
[181] Statement of Avealalo Iese, Tab 14, [10].
[182] Statement of Avealalo Iese, Tab 14, [10]; Statement of Andrew Andreou, Tab 9, [5].
[183] Statement of Andrew Andreou, Tab 9, [6]; Statement of Damien Taylor, Tab 10, [5]-[6]. Statement of Wayne West, Tab 11, [6].
[184] Statement of Damien Taylor, Tab 10, [6]-[7].
[185] Statement of Wayne West, Tab 11, [9]; Statement of Damien Taylor, Tab 10, [7].
[186] Statement of Wayne West, Tab 11, [9].
[187] Statement of Wayne West, Tab 11, [10]-[11].
[188] Statement of Wayne West, Tab 11, [12]; Statement of Andrew Andreou, Tab 9, [7].
[189] Statement of Dr Patrick Pender, Tab 15, p. 2.

Bestrin, as well as an open black plastic box which is utilised to keep syringes in.[191] She also observed another similar black plastic box on the sink.[192] Photographs were taken by Senior Constable Williams depicting the boxes.[193]

117. Neither the disabled toilet in which Mr Bestrin was found, or the adjacent disabled toilet, had any call button or alarm installed at the time of Mr Bestrin's death. While emergency assistance buttons were available in toilets in the clinical areas of the Hospital, they were not available in public toilets.[194]

Post mortem analysis

118. Pathologist, Dr Rebecca Irvine, conducted an autopsy at 08:45 on 22 December 2016. The cause of death was recorded as mixed alcohol and drug (heroin, clonazepam) toxicity. Among the drugs detected were morphine: 0.15 mg/L; clonazepam: 0.006 mg/L; and alcohol 0.04 g/100mL.[195] Dr Irvine noted that the presence of 6-monoacetylmorphine indicated that heroin was the parent drug of the morphine that was present on toxicological examination.

119. Though the concentrations of morphine and clonazepam were individually within "non-toxic" range concentrations, Dr Irvine notes that the concentrations may have been higher during the hours before death and have continued to be broken down by the body, even in a setting of possibly severe sedation.[196] Further, she notes that the combination of opioids and clonazepam can lead to profound sedation, respiratory depression, coma and death, and that the alcohol in Mr Bestrin's system would also have contributed to the depression of brain function.[197]

120. Dr Irvine is unable to provide an opinion as to Mr Bestrin's likely time of death and specifically "cannot say whether the deceased died almost immediately after injecting the drugs, survived an interval, or in fact re-injected and died almost immediately or after another survival interval".[198]

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[190] Statement of Senior Constable Anna Williams, Tab 6, [27].
[191] Statement of Senior Constable Anna Williams, Tab 6, [27].
[192] Statement of Senior Constable Anna Williams, Tab 6, [28].
[193] Crime Scene Photographs, Tab 17.
[194] Sac 2 Investigation Report, Tab 21, p. 4.
[195] Autopsy Report, Tab 4, p. 2.
[196] Autopsy Report, Tab 4, p. 3.
[197] Autopsy Report, Tab 4, p. 3.
[198] Further letter from Dr Irvine, Tab 37, p. 2.

Hospital and LHD actions post incident

121. Mr Bestrin's death was referred for investigation by the South Western Sydney Local Health District on 1 March 2017 and a "SAC 2 Investigation Report" (the **Investigation Report**) was produced.[199] One "contributing factor" to Mr Bestrin's death was identified by the Investigation Report, being the absence of formal systems in place to determine an occupant's welfare in disabled single cubicle toilets.[200] Four recommendations were made for improvement:

    a. that the Cleaning of Public Toilets procedures be reviewed to include measures to determine an occupant's welfare in disabled single cubicle toilets if the toilets are engaged;[201]

    b. that alternative strategies be considered to ensure public toilet occupant welfare is monitored when Terminal Cleaning staff workload prohibits regular checking of public toilets during their shift;[202]

    c. that a discussion be held at a General Services staff meeting regarding the importance of notifying Security promptly when staff are unable to illicit an occupant response to determine welfare, in case urgent medical attention is required;[203] and

    d. that consideration be given to portable syringe disposal units.[204]

    These recommendations were scheduled for completion by April 2017.[205]

122. A preliminary risk assessment of the bathroom facilities where Mr Bestrin was located was conducted on 15 March 2017 by the Drug Health Service Harm Reduction Manager.[206] This resulted in the March 2017 review of the Liverpool Hospital General Services: Cleaning of Public Toilets procedure to include welfare checks in the procedure.[207]

123. On 3 April 2017, it appears that a more comprehensive risk assessment was completed by the Drug Health Service Harm Reduction Manager in relation to the bathroom facilities

[199] Sac 2 Investigation Report, Tab 21.
[200] Sac 2 Investigation Report, Tab 21, p. 6.
[201] Sac 2 Investigation Report, Tab 21, p. 7.
[202] Sac 2 Investigation Report, Tab 21, p. 7.
[203] Sac 2 Investigation Report, Tab 21, p. 7.
[204] Sac 2 Investigation Report, Tab 21, p. 7.
[205] Sac 2 Investigation Report, Tab 21, p. 7.
[206] Letter from Amanda Larkin, Chief Executive of South Western Sydney Local Health District to Susan Dawson, Health Care Complaints Commissioner, dated 4 July 2017, Tab 20, p. 1.
[207] Letter from Amanda Larkin, Chief Executive of South Western Sydney Local Health District to Susan Dawson, Health Care Complaints Commissioner, dated 4 July 2017, Tab 20, p. 1.

where Mr Bestrin was located.[208]However, this assessment also examined Mr Bestrin's death in isolation, rather than as one incident among others. This risk assessment identified that prior to Mr Bestrin's death there were no systems in place for people to activate emergency medical assistance if they became unwell while in the disabled toilets. The assessment noted it was not the responsibility of cleaning staff to monitor and verify the welfare of an individual utilising the disabled toilets for an extended period of time. The assessment also noted that there had been reports that the disability toilets on the ground floor next to lift B may at times be utilised by people for the purpose of injecting drugs. The assessment identified that this poses a risk of overdose as the doors are locked and occupants are not visible by other visitors and are unable to be monitored by staff.

124. The risk assessment identified several controls in place at the time of the assessment.[209] These included a sharps disposal unit in the disability toilet cubicles[210], toilet log sheets inside cubicles to record cleaning, welfare checks of occupants when there is no response after knocking on occupied toilets, signs inside toilets informing occupants of the welfare check process and emergency release door stops in disabled toilets to enable emergency entry in the event of internal obstructions.

125. The risk assessment outlined a range of possible controls which could minimise further harm.[211] These included that the NSW Ministry of Health develop guidelines and procedural standards for the monitoring of inpatient, outpatient and visitor wellbeing in public health organisations and that General Services develop a contingency plan to offer relief when the terminal cleaning staff workload prevents regular maintenance of the public toilets. Further possible controls included that General Services implement systems for the effective handover by staff of incidents requiring follow-up or investigation, that signs be displayed on external doors of disability toilets advising people to contact security if they are concerned about a person's welfare, that public toilet log sheets be displayed on the external side of the disability toilet cubicle doors instead of inside the cubicles, that cleaning staff be familiar with procedures to contact the Medical Emergency Team and that use of sharps disposal bins be monitored and removal of sharps appropriately undertaken.

126. The risk assessment also identified the possible installation of emergency assistance buttons within all disability toilets with the possibility of two-way communication to the Security Department to activate an emergency response. It was noted that even with

[208] Risk Assessment of the Drug Health Service Harm Reduction Manager, dated 3 April 2017, Tab 23.
[209] Risk Assessment of the Drug Health Service Harm Reduction Manager, dated 3 April 2017, Tab 23.
[210] I am not sure how the provision of a sharps disposal unit is a relevant control.
[211] Risk Assessment of the Drug Health Service Harm Reduction Manager, dated 3 April 2017, Tab 23.

these possible controls in place, the likelihood of risk occurring was possible and the consequence was major, resulting in an overall risk rating of high.[212]

127. The risk assessment then identified several of the possible controls as requiring implementation.[213] These included:

- That the Ministry of Health, South Western Sydney Local Health District (**SWSLHD**) and stakeholders develop guidelines and procedures to prevent and reduce the risks of death in hospitals by 2017; and
- That General Services staff activate welfare check procedures with security without delay when an occupant response is not obtained and that General Services ensure there are appropriate human resources to meet the standards of effective environmental cleaning and welfare monitoring.

It was also noted that the Harm Reduction Program would conduct a campaign to promote overdose awareness at Liverpool Hospital and disseminate information to service users regarding the legalities and dangers of injecting within the hospital building or grounds.

128. Following Mr Bestrin's death, SWSLHD issued a new procedure on 15 September 2017, entitled "Public Toilet Cleaning and Safety Checks Procedure" (**SWSLHD procedure**).[214] In January 2017, LH issued the "General Services: Cleaning of Public Toilets" (**Liverpool Hospital procedure**) procedure and this was reviewed in March 2017.[215] The SWSLHD procedure requires that checks be conducted on allocated toilets on a regular basis, at minimum, three times per day.[216] All public toilets within the SWSLHD have been allocated as requiring these regular checks, with the exception of toilets in low usage areas at Bowral and District Hospital, and toilets located at satellite sites at Fairfield Hospital.[217]

129. The Liverpool Hospital procedure requires toilets in high usage areas of LH to be checked for cleaning four times daily during the morning shift (between 06:00-14:30) and checked an additional three times during the afternoon shift (14:30-23:00).[218] Toilets in other areas of the Hospital are to be checked at a minimum three times daily.[219]

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[212] Risk Assessment of the Drug Health Service Harm Reduction Manager, dated 3 April 2017, Tab 24.
[213] Risk Assessment of the Drug Health Service Harm Reduction Manager, dated 3 April 2017, Tab 24.
[214] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, Tab 36.
[215] Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31.
[216] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, Tab 36, Section 4.1.
[217] Letter from Andrew Bridges-Webb of Curwoods Lawyers, instructed by South Western Sydney Local Health District, to the Crown Solicitor's Office, Tab 27, p. 2.
[218] Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31, p. 1.
[219] Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31, p. 1.

130. Both the SWSLHD procedure and the Liverpool Hospital procedure state that all single cubicle public toilets must have a sign fitted on the inside of the door stating that cleaners will knock prior to entering and that if no response is received, a check by security may follow.[220]

131. Both the SWSLHD procedure and the Liverpool Hospital procedure also state that if a toilet is occupied, a hospital assistant is required to knock and, if no response is received, to announce "Cleaner here! Is anyone there?"[221] If the hospital assistant does not receive an answer, they are to notify Security that a safety check is required.[222] The SWSLHD procedure states security must respond to requests for safety checks within 20 minutes.[223]

132. When prioritisation of other tasks precludes the performance of the regular toilet checks by hospital assistants, the SWSLHD procedure requires the acting leading hand to organise support or an alternative arrangement to check the toilets.[224] The Liverpool Hospital procedure states that when checks cannot be conducted by cleaners of the public toilets between Entrance A/B & J, the leading hand on shift or a cleaner must contact security to conduct a welfare check and document this contact on the terminal cleaning log sheet.[225]

133. It was reported that staff had training in relation to the Liverpool Hospital procedure. Current staff members were apparently required to read the procedure and sign a sheet to confirm they had received, read and acknowledged their responsibilities as outlined in the procedure and new staff now receive a copy of the procedure as part of their induction and training.[226]

134. Training has also been conducted in relation to contacting the Medical Emergency Team. Cleaning staff are now required to sign a sheet to confirm they have read and understood their responsibilities when contacting the Medical Emergency Team.[227] New staff receive an identification badge outlining the procedure for contacting the Medical Emergency

[220] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, Tab 36, Section 2; Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31, p. 2.
[221] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, Tab 36, Section 4.2; Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31, p. 2.
[222] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, Tab 36, Sections 4.2, 4.3 Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31, p. 2.
[223] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, Tab 36, Section 3.1.
[224] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, Tab 36, Section 4.4.
[225] Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31, p. 2.
[226] Staff sign-on sheet acknowledging responsibilities under Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 32; Letter from Andrew Bridges-Webb of Curwoods Lawyers, instructed by South Western Sydney Local Health District, to the Crown Solicitor's Office, dated 24 May 2018, Tab 27, pp. 2-3.
[227] Staff sign-on sheet acknowledging responsibilities in relation to contacting the Medical Emergency Team, Tab 35; Letter from Andrew Bridges-Webb of Curwoods Lawyers, instructed by South Western Sydney Local Health District, to the Crown Solicitor's Office, dated 24 May 2018, Tab 27, p. 3.

Team via internal hospital phones.[228] As outlined in the Liverpool Hospital procedure, cleaning staff can also radio security, who will then contact the Medical Emergency Team.[229]

135. As is the case with the current state-wide policy, which will be further discussed below, there is no minimum and maximum spacing required between cleans, something that was confirmed by David Ryan, Director of Capital Works and Infrastructure at SWSLHD. Mr Ryan gave oral evidence at the inquest and explained that cleans can often be conducted on an *ad hoc* basis. He also confirmed that there is no requirement within SWSLHD policy which would mandate that cleans need to be spaced out in any particular way.[230]

136. Mr Ryan highlighted that security undertake a check of the toilets at 21:00 in the evening, however he accepted that the SWSLHD and Liverpool Hospital procedures would be complied with if no cleaning were to occur overnight.[231]

137. This presents a significant period of time for a person to remain undetected, particularly in areas such as where Mr Bestrin died which are open and available 24 hours a day.

138. The escalation processes itemised in the SWSLHD procedure and in the Liverpool Hospital procedure in the event that a toilet cannot be accessed, are slightly different to the new state-wide Guideline, discussed further below. The SWSLHD procedure and Liverpool Hospital procedure require cleaning staff to knock three times. If no verbal response is received, the cleaning staff is to knock a further three times. If there is still no response, then *security* is to be notified, as oppose to clinical staff.[232]

139. It is significant that the newest state-wide Guideline calls for cleaning staff to escalate any welfare concerns to clinical staff as opposed to security staff. This may be in recognition that some smaller hospitals will not have 24 hour security onsite. Yet the SWSLHD and Liverpool Hospital procedures continue to escalate welfare concerns to security staff, notwithstanding that security staff are only required to respond within 20 minutes.[233] This

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[228] Photograph of quick reference guide for non-clinical staff contacting the Medical Emergency Team, located on staff identification badges, Tab 34; Letter from Andrew Bridges-Webb of Curwoods Lawyers, instructed by South Western Sydney Local Health District, to the Crown Solicitor's Office, dated 24 May 2018, Tab 27, p. 3.

[229] Liverpool Hospital General Services Procedure: Cleaning of Public Toilets, Tab 31, p. 2; Letter from Andrew Bridges-Webb of Curwoods Lawyers, instructed by South Western Sydney Local Health District, to the Crown Solicitor's Office, dated 24 May 2018, Tab 27, p. 3.

[230] Transcript 21/10/19, page 59, line 30 onwards

[231] Transcript 21/10/19, page 58, line 35 onwards

[232] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, SWSLHD_Proc2017_003, Bestrin BOE Vol 1, Tab 36, 4.2, Liverpool Hospital Cleaning and Public Toilets Policy, Policy No.AO3.19, Bestrin BOE, Vol 1, Tab 31, page 2

[233] SWSLHD Public Toilet Cleaning and Safety Checks Procedure, SWSLHD_Proc2017_003, Bestrin BOE Vol 1, Tab 36, 3.1

seems an obvious oversight and should be corrected by SWSLHD and Liverpool Hospital immediately.

140. There are no auditing requirements itemised in the SWSLHD procedure or Liverpool Hospital procedure in relation to cleaning compliance. However each hospital in NSW is subject to both the state-wide policy and the new Guideline and, as discussed later both of these documents itemise specific auditing requirements.

141. In addition to issuing new procedures both at the LHD and Hospital level, certain recommendations were taken up by SWLHD as a result of the risk assessment undertaken by Mr Sessions. As outlined above, the risk assessment suggested that signs be displayed on external doors of disability toilets advising people to contact security if they are concerned about a person's welfare and that public toilet log sheets be displayed on the external side of the disability toilet cubicle doors instead of inside the cubicles. These measures appear to have been adopted.

142. Although it is pleasing that SWSLHD and Liverpool Hospital have implemented some changes, there continue to be outstanding issues with the cleaning systems currently in place as well as the auditing for compliance. The fundamental problem with all of the policies is that they rely on human based systems, which do not appear to be consistently audited.

143. 45 pages of cleaning sheets were provided to the court detailing cleaning conducted at Liverpool Hospital in the Lift B toilets between May – June 2018, this being the same toilets where Mr Bestrin died.[234] Just under half of the cleaning sheets had entries indicating that the cleaning had not been undertaken in compliance with the Liverpool Hospital Procedure. Two entries were 15 hours apart[235] and on one day there were no entries at all.[236]

144. Updated cleaning sheets for the Lift B toilets were received for the week 23 September 2019. Unfortunately these cleaning records suggest that there continue to be systemic problems with compliant documentation of cleaning attendances. In the bundle of 17 pages of 2019 cleaning sheets, again about half of the cleaning sheets showed that the cleaning had not been undertaken in compliance with the Liverpool Hospital Procedure.[237] There were also numerous instances of entries that appeared up to 19 hours apart.

[234] Statement of David Ryan, Bestrin BOE, Vol 3, Tab 54(D), pages 2, 5,6,7,10,11,14,17,19,21,24,30, 31, 33,25,36,37,39,41,42,45
[235] Statement of David Ryan, Bestrin BOE, Vol 3, Tab 54(D), pages 6 and 35
[236] Statement of David Ryan, Bestrin BOE, Vol 3, Tab 54(D), page 7
[237] Statement of David Ryan, Bestrin BOE, Vol 3, Tab 54(D), pages 1,4,5,8,9,12,14,17

145. This is not to suggest that it can be clearly established that cleaning did not take place, but that there are simply no entries confirming that it did. This is particularly concerning, as is the fact that there is no requirement for cleaning to occur between 23:00 and 6:00, creating a window of at least seven hours where a person could remain undetected.

146. Similarly troubling is the lack of oversight regarding compliance with the mandated cleaning requirements. No written documentation has been provided to the court documenting that any audit that has been undertaken by SWSLHD with respect to its cleaning schedules, in compliance with policy. Mr Ryan provided oral evidence that he was not aware of a separate documented system of monitoring of cleaning frequency apart from the cleaning sheets provided to the court. [238] He suggested that there was likely a review of the cleaning sheets and verbal escalation to a cleaning supervisor should any issues arise. [239] He was unsure whether there was any documented check of emergency call bells, relying on hearing them as the basis for them having been checked.[240]

147. It also became evident throughout Mr Ryan's evidence that he was unaware of any external auditing of the cleaning procedures of SWSLHD or Liverpool Hospital, notwithstanding the state-wide policy requiring this every two years.[241] Similarly it appears that the three monthly audit stipulated by the new Guideline has not been complied with.

148. The combination of a demonstrated lack of compliance with the various cleaning policies in addition to the lack of auditing, show a troublingly lack of appreciation of the risks posed by publicly accessible hospital toilets at LH. It appears that there is a heavy reliance on a human based system which is inadequately monitored.

Evidence of other similar deaths and "near misses" in NSW

149. The court heard that for a variety of reasons people may fall ill or collapse in toilet areas. Dr Herkes noted that with the timing of strokes "there may be a slight pattern where people might be straining" for example[242]. It is also generally recognised that when people feel unwell or faint from a viral illness, diabetes, epilepsy, a cardiac condition or a range of other ailments they may retreat to a bathroom. Unfortunately, as Dr Herkes explained, the environment is "inherently dangerous" both because of the hard surfaces and because it is likely a person will be isolated from help.[243]

[238] Transcript 21/10/19, page 60 line 39 onwards
[239] Transcript 21/10/19, page 60 line 44 onwards
[240] Transcript 21/10/19, page 63 line 10 onwards
[241] Transcript 21/10/19, page 65 line 16 onwards
[242] Dr Herkes, Transcript 19/6/18, page 24, line 48 onwards
[243] Dr Herkes, Transcript 19/6/18, page 25, line 1 onwards

150. Aside from the cohort of people who may retire to the toilet when they feel ill, there is another group who may use the bathroom to find the privacy to inject or use drugs. The court heard from Mr Mark Sessions, Harm Reduction Manager, SWSLHD in relation to this issue. He explained that the use of toilets for injecting often arises out of "situational necessity". He explained that there are a number of factors which can underlie the practice including "homelessness, socioeconomic disadvantage, drug dependence and a sense of urgency to avoid detection."[244]

151. Dr Jauncey, Medical Director of the Medically Supervised Injecting Centre (MSIC) in Kings Cross, spoke of the well-known phenomenon of using toilets as a place to take drugs when there is no other safe space to do so. She confirmed Mr Sessions' observation that a toilet may provide the only private space available to a drug user, "especially if they're homeless or in unstable housing"[245]. She explained that drug use "is considered quite a private activity and it's often very stigmatised and people can feel very ashamed of what they are doing and also may wish to avoid other people such as police, for example, seeing them."[246] She explained that prior to the establishment of the MSIC in Kings Cross, "it was well known that people were using the public toilets in and around the Kings Cross area in order to inject themselves with an illicit substance…[the issue was noted by] a number of police officers, a small number of security guards, and various members of the local community who had all come across people who had overdosed."[247]

152. While all toilets were described as inherently dangerous, SOPAT toilets, such as the ones Mr Bugden and Mr Bestrin died in, certainly possess additional risk by their inherent features, such as floor to ceiling doors, which privilege privacy over safety. The court received evidence that there are 1430 SOPAT toilets across the NSW Health System.[248]

153. Evidence gathered during the inquest demonstrated that the two deaths under investigation are not isolated events.

154. While it was difficult to obtain accurate information, it appears that since Mr Bugden's death, a further seven deaths have occurred in publicly accessible hospital toilets throughout NSW. The most recent death occurred after this inquest began, in June of this year. Of the eight deaths overall, half of the deaths involved the deceased person suffering a medical event whilst inside the relevant toilet and half of the deaths involved the deceased person experiencing a drug overdose.

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[244] Mark Sessions, Transcript 22/10/19, page 19, line 30 onwards
[245] Dr Marianne Jauncey, Transcript 21/10/19, page 15, line 2 onwards
[246] Dr Marianne Jauncey, Transcript 21/10/19, page 15, line 3 onwards
[247] Dr Marianne Jauncey, Transcript 21/10/19, page 16, line 20 onwards
[248] Report of Jennifer Green, Bestrin BOE, Vol 3, Tab 57, page 3

155. Four persons experienced an ultimately fatal medical event whilst inside the toilet. Mr Bugden tragically suffered a stroke, whereas the three other persons suffered a cardiac event. One person experienced a ruptured aortic aneurysm,[249] one person suffered a cardiac episode whilst apparently going to the toilet[250] and one person experienced a cardiac episode and was not found for approximately eight hours.[251]

156. Of the four persons who experienced a drug overdose whilst inside the toilet, aside from Mr Bestrin's tragic death, one other person died as a result of injecting drugs within a SWSLHD publicly accessible toilet having not been found for approximately two to three hours. That person lived in transient housing and was found after loud banging noises initiated by the deceased were heard by security officers.[252] One person died from an overdose, with a 'fit pack' found next to him. That person was known to police as being homeless, with a history of drug use and mental illness.[253] The last person who died from a probable drug overdose was also known to police as being homeless and was not discovered for approximately two hours, despite that person's legs protruding from under the cubicle stall door.[254]

157. All of these deaths confirm the observations of both Dr Herkes and Dr Jauncey regarding the risk people can be exposed to when using publicly accessible hospital toilets.

158. Equally troubling is the number of 'near misses' that have occurred since Mr Bugden's death, which have continued to occur since the commencement of this inquest. Across NSW, at least 18 people have been found either collapsed or incapacitated in publicly accessible hospital toilets since Mr Bugden's death.[255] Seven of these incidents have occurred since this inquest started on 19 June 2018.[256]

159. It is notable that throughout 2017 and 2018 there were eight incidents where persons became incapacitated in toilets within the SWSLHD. Of those incidents, seven of the incapacitated persons used or were suspected to have used drugs.[257] Six of the incidents occurred in Liverpool Hospital – four incidents occurred in the very same toilet bank where Mr Bestrin was found near Lift B, and two incidents in the bank of toilets further along the concourse near Lift D.[258]

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[249] P79A of [redacted], Bestrin BOE, Vol 2, Tab 52(4); Transcript 21/10/19, page 6, line 8s-9
[250] P79A of [redacted], Bestrin BOE, Vol 2, Tab 52(1), page 3
[251] Death of [redacted]
[252] P79A of [redacted], Bestrin BOE, Vol 2, Tab 51(1), page 3
[253] P79A of [redacted], Bestrin BOE, Vol 2, Tab 52(2), page 2
[254] P79A of [redacted], Bestrin BOE, Vol 2, Tab 52(3), pages 2-3
[255] Transcript 21/10/19, page 7, line 43
[256] Statement of Samantha Hocking, Bestrin BOE, Vol 2, Tab 53, Appendix A
[257] Statement of David Ryan, Bestrin BOE, Vol 3, Tab 54 at para 20.
[258] Transcript 22/10/19, page 37, line 39 onwards

State-wide policies and changes

160. As well as local changes made at NSLHD and at SWSLHD, the court looked at the overall state-wide response. The state-wide policy, titled 'NSW Health Environmental Cleaning Policy' is an overarching policy document that aims "to identify the functional areas in a healthcare facility that require cleaning and/or disinfection and outline the frequencies to achieve the minimum cleaning standard for those areas"[259]. The policy is to be read in conjunction with the *Environmental Cleaning Standard Operating Procedures*[260]. It also defers to each healthcare facility, stating that the health facility itself must determine the frequency and intensity of cleaning that is required to meet the internal cleaning standards.[261]

161. In addition, the state-wide policy outlines clear requirements for internal auditing of cleaning outcomes. Such an internal audit "must be performed in all functional areas across all risk categories" within certain time periods (depending on location) and "must be clearly documented".[262] The cleaning staff should also be engaged in the audit result process so that they may understand any areas of non-compliance and, where relevant, their role in rectifying these.[263]

162. In addition to internal audits it is recommended that facilities undertake an external audit every two years, conducted by a qualified auditor not employed by the healthcare facility or cleaning provider.[264]

163. On 22 December 2016, three days after Mr Bestrin's death, a state-wide memorandum was issued by the Department of Health. That required all Local Health Districts to firstly ensure that routine cleaning schedules were adhered to and documented. The memorandum stated this should include periodic auditing to ensure compliance. It also required clear escalation procedures to be put in place for cleaning staff and other relevant staff in situations where toilets are occupied and no response is received from the occupant.[265]

164. In addition to the above policy, a new state-wide guideline was promulgated by NSW Health on 6 June 2019 (the **Guideline**). It provides a "standard approach to monitoring public toilets in NSW Health facilities for the safety of people who may be unwell and

[259] NSW Health Environmental Cleaning Policy, PD2012_061, Bestrin BOE, Vol 1, Tab 25
[260] NSW Health Environmental Cleaning Policy, PD2012_061, Bestrin BOE, Vol 1, Tab 25, page 4
[261] NSW Health Environmental Cleaning Policy, Bestrin BOE, Tab 25, Page 6
[262] NSW Health Environmental Cleaning Policy, Bestrin BOE, Tab 25, Page 9
[263] NSW Health Environmental Cleaning Policy, Bestrin BOE, Tab 25, Page 9
[264] NSW Health Environmental Cleaning Policy, Bestrin BOE, Tab 25, Page 10
[265] Transcript 19/06/18, page 9 line 18

need assistance".[266] A notable feature of the new Guideline is that it emphasises that every healthcare facility should have a routine, documented cleaning schedule for public toilets which is in line with the NSW Health Environmental Cleaning Policy.[267]

165. The Guideline also sets out the procedure that is to be followed if a toilet is occupied. In the event that a toilet cannot be accessed during cleaning, the cleaner will knock on the door to announce that they are there to clean the toilet. If no verbal response is received in response to the initial attempt, staff are to knock on the door again. If no verbal response is received on the second attempt, the cleaner will report the situation to clinical staff for immediate review and action.[268]

166. In terms of auditing, the Guideline stipulates that a three monthly audit of compliance with the requirements of the Guideline should be undertaken.[269] This includes in relation to documentation and monitoring of the toilet cleaning.[270]

167. Although the introduction of the Guideline is pleasing, as is the circulation of the memorandum alerting hospitals to the state-wide requirements, it is clear that certain deficiencies remain.

168. A notable feature of these policies is that there is no minimum or maximum time mandated between cleans required. Although the total number of cleans are itemised within any given period, there remains the potential for extended time periods to exist between cleans, which of course will impact on the time for potential discovery of any incapacitated person.

169. The court heard evidence relating to the death of [redacted], [redacted] suffered a ruptured aortic aneurysm in a hospital toilet at Auburn Hospital. The CCTV footage captured a cleaner attending at around midday to clean the toilets where [redacted] was located. The cleaner remained at the toilets for quite a long period of time, which may give rise to the inference that the cleaner was waiting for that toilet to become unoccupied. The cleaner then departs and returns shortly after 13:00. A short while later, the cleaner can be seen to get help and a security guard eventually attends. A code blue was activated at 13:26. [redacted]' death occurred on 7 June 2019 only one day after the new Guideline was promulgated. It appears that the escalation procedure stipulated in the new Guideline was not followed and it raises concerns about the communication and implementation of this Guideline and ultimately, compliance.

[266] NSW Health Public Toilet Safety Check Guideline, GL2019_005, Bestrin BOE, Vol 2, Tab 53, summary page
[267] NSW Health Public Toilet Safety Check Guideline, GL2019_005, Bestrin BOE, Vol 2, Tab 53, page 1
[268] NSW Health Public Toilet Safety Check Guideline, GL2019_005, Bestrin BOE, Vol 2, Tab 53, page 1
[269] NSW Health Public Toilet Safety Check Guideline, GL2019_005, Bestrin BOE, Vol 2, Tab 53, page 3
[270] NSW Health Public Toilet Safety Check Guideline, GL2019_005, Bestrin BOE, Vol 2, Tab 53, page 1

170. It is also apparent that the auditing process outlined in both the state-wide policy and also the new Guideline is not always being followed at a local level and it appears there is limited oversight as to the requirements that both documents outline.

171. Finally, it is important to note that the court had considerable difficulty in obtaining comprehensive information to assess the number of incidents occurring on a state-wide basis. This information is necessary to calculate risk. There is no doubt a central register of incidents would be a useful tool going forward.

Scope for recommendations arising from the evidence

172. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the circumstances of each death.

173. The evidence arising during this inquest demonstrated a strong need to consider recommendations in relation to public safety. There was evidence demonstrating a systemic problem with undetected collapse in hospital toilets in NSW, but particularly in the ground floor area of the Concourse at Liverpool Hospital where immediate measures appear called for. The evidence demonstrated that while the consequences of collapse can be catastrophic, effective early intervention can and does save lives across a variety of medical conditions. The court is concerned that there is a real possibility that the level of collapse is presently underreported, given the way incidents are recorded. Current systems to detect collapse across a variety of locations appear unlikely to trigger a response within a time frame that will consistently lead to the best chance of patient survival.

The need to improve human based systems for cleaning, inspection and auditing

174. As we have already seen, at present one of the principle ways that risk is managed throughout the system is through the application of cleaning policies. For this reason, the court examined in some detail the current policies which govern the cleaning of hospital toilets. Evidence was provided that there are in effect three layers of cleaning policies that relate to any particular hospital in NSW, state-wide, LHD specific and hospital specific. These policies set out the minimum amount of cleaning attendances that need to be achieved within certain defined hospital areas, documentation of cleaning attendances, escalation procedures if a toilet cannot be accessed, as well as auditing procedures so as to ensure compliance with the respective policies.

175. The court received extensive evidence about changes that have been made to all three levels of policy since the deaths under investigation. Although there are welcome developments, it remains evident that there are still further changes that need to be implemented to reduce the risk that still exists.

176. To properly evaluate the policies currently in place, there needs to be better record keeping so that a comprehensive audit and ongoing risk assessment can be undertaken. In my view this should occur at a state-wide level. There is also evidence which suggests Liverpool Hospital has a specific problem which needs ongoing management. A central register should be kept at Liverpool Hospital and comprehensive auditing must take place.

The need to further investigate technological strategies

177. The court had the benefit of an independent expert's review of the systems in place at the time of Mr Bugden and Bestrin's deaths. Mr Love, an expert in occupational health and safety reviewed the strategies and systems already developed for checking and monitoring toilet use. In short he expressed the view that relying on administrative controls and implementing checking procedures as the Hospitals had done, was not "an adequate or effective means of risk mitigation, when weighed against the potential level of harm involved."[271] He expressed the view that an appropriate response would be for SOPAT toilets "to be fitted with timed monitored door locks, integrated with an alarm and/or notification system. The alarm and notification system ought to involve activation of warning light/s outside the SOPAT, as well as a delayed audible alarm. Notification of the alarm ought to also go to a security control room for responding to the alarm. The door lock time limit ought to be set at no more than 20 minutes."[272]

178. The court also heard evidence in relation to other possible technological solutions. It is beyond the scope of these findings to review in detail all of the options available. There are a variety of technological solutions on the market, including door lock timers, LIDAR technology, call bells and movement sensors.

179. Dr Nicolas Clark, the Medical Director of the Medically Supervised Injecting Room at North Richmond, Victoria gave brief evidence at the inquest. He provided information regarding some of the considerations that the health service took into account regarding the installation of technology that could prevent an undetected overdose in the onsite toilets onsite at that facility. He stated that although there is a system in place where nobody is allowed to be in the toilets for more than three minutes without being checked on, they wanted a back-up system. A system is due to be installed where an alarm is

[271] Report of Mr Love, Bestrin BOE, Tab 49, page 33 [82]
[272] Report of Mr Love, Bestrin BOE, Tab 49, page 34-5 [87]

sounded “as a kind of an additional failsafe mechanism if somebody was in the toilet for whatever time period [the health centre] chose just to kind of provide a backup”.[273]

180. The interest in this technology arose out of Dr Clark’s awareness of previous overdoses in the North Richmond Health Service prior to the new injecting centre opening. As a result of these overdoses, the toilets had been locked. He explained that there was a general awareness that “some public toilets pose a risk of people overdosing in them”.[274]

181. Dr Clark explained that they wanted a system installed that would reliably detect if somebody has been in the toilet for a period of time without exiting and for an alarm to sound alerting people outside to that fact. They wanted to avoid the alarm sounding without an occupant inside the toilet.[275]The system that will be installed at the North Richmond Health Centre will use LIDAR technology, which is the same technology used in autonomous vehicles. It monitors the environment and analyses the shape of the person’s outline through an infrared detector. It can then detect, for example, if a person is slumped on the floor, or if there is a lack of movement for a period of time.[276] However Dr Clark also pointed out that there are many other options with respect to suitable technologies, such as a heat detector or a motion detector linked to the door.[277]

182. This kind of sophisticated technology of course comes at a cost. The court heard evidence that the cost could in certain circumstances be regarded as prohibitive. A report written by Jennifer Green and provided by the Ministry of Health pointed out the cost involves a recurrent as well as a capital component. The report states that to retrofit a door lock timer integrated to an alarm or notification system would be estimated to cost between $6,000 - $9000. The cost of retrofitting an emergency call button was estimated as costing between $4,000 - $6,500.[278] Ms Green noted that the overall cost of installing this technology would be between $14.3 million to $22.2 million, if applied to all 1430 SOPAT toilets across NSW.[279] The report made cost comparisons, suggesting the amount spent on finding a technological solution could be used for other projects such as building three to four rural ambulance stations or purchasing between 14 and 22 MRI machines which could in turn provide between 20 000 and 30 000 examinations a year.[280]

183. There is no suggestion that it would be necessary to retrofit a door lock timer on every SOPAT toilet in NSW, but it is clear that it would be appropriate to target particular high-

[273] Transcript 21/10/19, page 50, line 44 onwards
[274] Transcript 21/10/19, page 51, line 10 onwards
[275] Transcript 21/10/19, page 51, line 36 onwards
[276] Transcript 21/10/19, page 52, line 19 onwards
[277] Transcript 21/10/19, page 51, line 40 onwards
[278]Cost report attached to statement of Jennifer Green, Bestrin BOE, Vol 3, Tab 57, pages 4-5
[279] Statement of Jennifer Green, Bestrin BOE, Vol 3, Tab 57, page 3
[280] Cost report attached to statement of Jennifer Green, Bestrin BOE, Vol 3, Tab 57, pages 4-5

risk areas. From the evidence heard throughout the course of this inquest, the SOPATs in the concourse area of Liverpool Hospital, and specifically those situated outside of Lift B and Lift D, are clearly located in such a high-risk area.

184. There was also consideration given to a variety of simple physical solutions which could be described as "low tech". These included altering or shortening the toilet door so that it would be more likely that any collapse would be noticed by passers-by. However significant concerns were raised in relation to privacy and odour management.

The prevalence and danger of intravenous drug use in hospital toilets in SWSLHD

185. As I have already stated, there is clear evidence that there is a known connection between areas of frequent drug use and the use of public toilets for injection, worldwide.[281] What became clear during the inquest was that this connection was recognised by many working in the vicinity of Liverpool Hospital at the time of Mr Bestrin's death. Specifically, it was already well-known that the toilet where Mr Bestrin died was frequently used for administration of intravenous drugs.

186. Senior Constable Anna Williams was in the officer in charge of investigating the tragic death of Mr Bestrin. She had been stationed at Liverpool Police Station since September 2016. She told the court that it was well known to Liverpool Police that the toilet where Mr Bestrin died was an established venue for injection. She stated "sometimes people will take fit packs [boxes of injecting equipment] from the dispensing machine and go to those particular toilets at lift B."[282] She stated that Liverpool Police as well as the local police transit command were aware of the practice and had even conducted an operation that involved following them from the dispensing machine. She was aware of another overdose occurring at the same toilet on 4 March 2017.

187. Mark Sessions, Harm Reduction Manager at SWSLHD also gave evidence regarding the use of the toilets at Liverpool Hospital by illicit drug users. He stated that he was "aware that injecting takes place probably within most of the toilets" at the hospital.[283] He stated that "even with the education and information that we've shared about the illegalities of using, of injecting in toilets, the people will continue to do that".[284]

188. Mr Sessions gave further moving evidence regarding one his younger clients from the Needle Syringe Program (NSP), who had attended the NSP seeking syringes. The client already appeared intoxicated and he shared with Mr Sessions that he was going to use.

[281] See discussion of this issue in a North American context by Dr Jauncey, Transcript 21/10/19, Page 15, line 15 onwards
[282] Senior Constable Anna Williams, Transcript 19/6/19, page 43, line 45 onwards
[283] Mark Sessions, Transcript 22/10/19, page 13, lines 22-23
[284] Mark Sessions, Transcript 22/10/19, page 18, line 39 onwards

Mr Sessions spoke with him about the potential dangers and about how to keep safe. He felt the client was "one of those impetuous clients who was…there was some immediacy that he was going to undertake [drug use]".[285] Mr Sessions asked him to come back in 15 minutes so as to let Mr Sessions know that he was safe. When he did not return, Mr Sessions was worried enough to immediately look for him. With many years of experience in NSPs, when the young client did not return, Mr Sessions went directly to the nearest hospital toilet. When his client was not there he went straight to the toilets on the concourse where Mr Bestrin had died and began knocking on doors. When Mr Sessions did not get a response, he looked through the crack and saw somebody on the floor. The MET team was immediately called and the young man, although initially blue and lifeless, was eventually resuscitated. The experience clearly had a profound effect on Mr Sessions.

189. There was also evidence from cleaning staff at Liverpool Hospital, Ms Patel and Ms Harkness, in relation to drug use in the toilets at Liverpool Hospital. Ms Patel indicated that "in the course of [her] cleaning duties [she] had on occasions found needles in the toilets which have not been disposed of in the sharps container.[286] She also is aware that the sharps bins have required replacement frequently. Ms Harkness provided similar evidence. Although she could not recall specific instances, she does recall "in general terms drug use being a problem in the toilets in Liverpool Hospital". Ms Harkness no longer works there but recalls seeing "individuals obviously affected by drugs entering a standalone toilet, sometimes with more than one person entering the toilet and so clearly for the purpose of taking drugs".[287] She similarly recalled finding syringes in the hospital toilets that had not been disposed of into sharps bins.[288]

190. Ms Iese, a cleaning supervisor, provided oral evidence at the inquest. She was also aware that the toilets were sometimes used for drug taking. She stated that she had seen some rubbish from people using drugs such as needles and 'fit packs'.[289]

191. Lorena Bestrin, Mr Bestrin's mother also gave evidence that she had attended Liverpool hospital on several occasions after Mr Bestrin's death. She said that on her first visit in February 2017, she went to the bathroom where Mr Bestrin died and after she came out of the toilet, she saw a person enter, who appeared to be a drug user. She waited for 20 minutes and became increasingly worried about the person, eventually knocking on the door, at which time the person came out, in her mind, drug-affected.[290] She then returned

[285] Mark Sessions, Transcript 22/10/19, page 26, line 5 onwards
[286] Statement of N Patel, Bestrin BOE, Vol1, Tab 15A, p. 4
[287] Statement of D Harkness, Bestrin BOE, Vol 1, Tab 15, pages 2-3
[288] Statement of D Harkness, Bestrin BOE, Vol 1, Tab 15, pages 3
[289] Transcript 23/10/19, page 8, line 12 onwards
[290] Transcript 19/06/18, pages 36-37, line 42 onwards

in April 2018. She noticed the sharps container was quite full and she also saw a 'fit pack' sticking out of the sanitary bin.[291] She took photographs during this visit which were provided to the court.[292] Ms Bestrin was left in no doubt that the bathroom where Mr Bestrin was found was "serving as an unsupervised injecting room".[293]

192. As discussed above, since the death of Mr Bestrin, there were eight incidents of persons becoming incapacitated in publicly accessible toilets in the SWSLHD. Of those incidents, seven of the incapacitated persons used or were suspected to have used drugs.[294] Six of the incidents occurred in Liverpool Hospital – four incidents occurred in the very same toilets where Mr Bestrin was found near Lift B, and two incidents in the bank of toilets further along the concourse near Lift D.[295] One of those incidents related to the young man that Mr Sessions found.

193. The evidence of Liverpool Police, Mark Sessions, cleaning staff and Lorena Bestrin regarding the ongoing use of publicly accessible toilets at the concourse at Liverpool Hospital by drug users for the purposes of intravenous drug use suggests further harm minimisation strategies are needed.

194. It should also be noted that the prevalence of intravenous drug use at Liverpool Hospital appears to sit within a broader context of high levels of intravenous use within local area.

195. The court received evidence from Dr Sarah Larney, an expert in the epidemiology of illicit opioid drug use and related harms such as overdose, blood borne viral infections and mortality at the National Drug and Alcohol Research Centre. Dr Larney was the lead researcher on a recent project aimed at estimating the number of people who inject drugs in NSW and in each NSW Local Health District. In 2016, she produced a report for NSW Ministry of Health and published a peer-reviewed paper on this topic[296].

196. Dr Larney examined the following data when preparing her paper:

    1. Opioid overdose mortality and the rate of recorded opioid deaths;

    2. Needle and syringe distribution;

    3. Ambulance attendances where naloxone was administered;

    4. Arrests for opioid and other drug possession;

[291] Transcript 19/06/18, page 37, line 2a 4 onwards
[292] Bestrin BOE, Vol 1, Tab 38
[293] Transcript 19/06/18, page 39, line 35
[294] Statement of David Ryan, Bestrin BOE, Vol 3, Tab 54 at para 20.
[295] Transcript 22/10/19, page 37, line 39 onwards
[296] "Estimates of people who inject drugs in NSW and Australia", Larney, S. et al, Bestrin BOE, Vol 2, Tab 50

5. Treatment of opioid dependence; and

6. Hospital separations related to illicit drug use.[297]

197. Dr Larney's research showed that within Sydney, other than Sydney Local Health district, SWSLHD had the highest estimated numbers of people who inject drugs. State-wide only Hunter New England Local Health District had a higher estimation. She further clarified that the estimates are based on the Local Health District where treatment was received and not where the person injecting resided.[298]

198. To ensure that the court had the most recent available evidence regarding the underlying data that Dr Larney used for the basis of her report, updated material was provided from a variety of sources, including:

1. BOCSAR information regarding drug offence rates across NSW and Local Government Areas (**LGA**s) between June 2018 – July 2019;

2. ambulance services attendances to overdoses involving opioids throughout SWSLHD between 2011 - 2018;

3. coronial data in relation to deaths and overdoses in the SWSLHD area;

4. the number of injecting equipment distributed throughout 2018 within each Local Health District; and

5. the number of persons on the Opioid Treatment Program as at 1 October 2019.

199. Although the evidence was not exhaustive, it showed some clear trends in relation to significant drug-related issues within South West Sydney. Fairfield LGA and Liverpool LGA (both of which fall within the SWSLHD catchment) had the highest rates of opioid related use/possession offences throughout all Sydney LGAs, other than Sydney LGA itself, which of course is well known to have significant issues related to drug use.[299] SWSLHD also had a particularly high number of injecting equipment dispensed throughout 2018 when compared to the rest of Sydney and indeed within NSW. The data shows that other than Sydney LHD, SWSLHD had the highest total number of injecting equipment dispensed in Sydney and the third highest within NSW only behind Hunter

[297] Letter from Dr Sarah Larney, Bestrin BOE, Vol 2, Tab 49A, pages1-2
[298] "Estimates of people who inject drugs in NSW and Australia", Larney, S. et al, Bestrin BOE, Vol 2, Tab 50, page 3
[299] BOCSAR statistics relating to use/possession offences June 2018- July 2019, Bestrin BOE, Vol 2, Tab 50D, pages, 2 and 7-8

New England LHD and Sydney LHD.[300] In addition, almost 15% of all persons on the Opioid Treatment Programs reside in the SWSLHD.[301] Within the SWSLHD Bankstown, Fairfield, Liverpool and Campbelltown had the highest rates of ambulance attendances relating to opioid overdoses.[302]

200. This data was supplemented with anecdotal information provided by Dr Jauncey, who explained that within the public health sector, the background assumption is that "when you think of areas where injecting drug use and public injecting are problems in Sydney … people think of the inner city so they think of Kings Cross, Darlinghurst, Surry Hills, Central, maybe Redfern and then they tend to think of out west and specifically South Western Sydney LHD".[303]

201. The court also heard from the general manager of Drug Health Services within SWSLHD, Stephanie Hocking. As part of her role, Ms Hocking is responsible for the strategic operations of drug health across South Western Sydney. Her job is to ensure that people who use substances are treated equitably and fairly and receive quality health care in a safe way.[304] Ms Hocking noted that Liverpool has the highest prevalence of people released from justice and forensic mental health, meaning that Liverpool's pharmacotherapy program "has the highest referrals in the state" and that people being released from custody are particularly at risk if they have had a pre-existing drug and alcohol problem.[305]

How does overdose death occur ?

202. Once we accept that SWSLHD has a high level of intravenous drug use and that a significant proportion of users will have limited access to a safe space to inject in, it is necessary to understand how overdose deaths occur and to look at the strategies which currently exist to reduce potential harm.

203. Dr Marianne Jauncey, the medical director of the Medically Supervised Injecting Centre (**MSIC**) in Kings Cross gave compelling evidence at the inquest. She explained what happens when a person overdoses on opiate medication and what the window for successful treatment of an overdose is likely to be. She also outlined the type of treatment options available to increase the likelihood of a favourable outcome for the person who has overdosed.

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[300] 'Total number' includes the combined figures of public and pharmacy based needle distribution, NSW Health annual data report 2018, Bestrin BOE, Vole 2, Tab 50E, page 30
[301] Email from A Bridges-Webb dated 18 October 2019, Bestrin BOE, Vol 2, Tab 50E, page 1
[302] Summary of Ambulance call outs related to overdoses in the SWSLHD, Bestrin BOE, Vol 2, Tab 50F, page 1
[303] Transcript 21/10/19, page 40, line 5 onwards
[304] Transcript 22/10/19, page 43, line 16 onwards
[305] Transcript 22/10/19, page 53, line 34 onwards

204. Dr Jauncey explained that when a person dies of an opiate overdose, they "basically stop breathing".[306] An "opiate overdose causes a reduction in somebody's drive to breathe…. Their level of consciousness or alertness becomes reduced and how frequently they breathe and how deep they breathe in also reduced".[307] Ultimately, once respiratory depression begins, hypoxia sets in and the lack of oxygen eventually causes someone's heart to stop beating. [308]

205. Dr Jauncey stated that there is quite a range in terms of how sudden and how severely this process can set in. It is possible for a person to stop breathing when they still have a needle in their arm, however it is equally possible that somebody's clinical deterioration is much more gradual, whereby they slowly become less and less alert, gradually put their head down, gradually slow in their breathing, depth and frequency.[309]

206. Dr Jauncey told the court that although an overdose can cause death straight away, evidence relating to opioid overdose deaths reviewed over a period of time suggests that it seems "much more common that [overdose death] happens over time rather than on the end of a needle".[310] She cited several studies which varied in their estimation of survival times. A 1996 review found that less than a quarter of fatal overdoses occurred where the person collapsed right after the injection. The same review found that additionally about a quarter of deaths occurred three or more hours after injection. A more recent study from 2016 estimated that the average survival times after heroin overdose was estimated to be around 20-30 minutes.[311] In many cases there is thus a clear window of opportunity to provide life-saving treatment.

207. Ultimately, Dr Jauncey explained that the timeframe for successful intervention will depend on how long the hypoxia has been going on for. If somebody stops breathing altogether, then it can be a "matter of minutes before they might go into cardiac arrest after respiratory arrest". However, it can be a prolonged process over many hours – a very slow steady decline.[312] She explained that "clearly the longer someone is hypoxic, and the more severe that hypoxia is, the more likely that person is to have significant and severe injuries as a result. And conversely, the earlier the intervention, the more likely

[306] Redacted transcript of evidence provided by Dr Jauncey at the Opioid inquest, Bestrin BOE, Vol 2, page 69
[307] Transcript 21/10/19, page 13, lines 13-14
[308] Statement of Dr M Jauncey, Bestrin BOE, Vol 1, Tab 42, page 1, at 6
[309] Transcript 21/10/19, page 13, line 17 onwards
[310] Transcript 21/10/19, page 18, line 39 onwards
[311] Statement of Dr M Jauncey, Bestrin BOE, Vol 1, Tab 42, page 2, at 17
[312] Transcript 21/10/19, page 19, line11 onwards

the person is to be fully resuscitated without significant or severe injuries, or indeed without any injury at all."[313]

208. Dr Jauncey stated that most opioid overdose deaths have known risk factors present. Common risk factors include the effects of other drugs (typically central nervous system depressants such as benzodiazepines and alcohol), as well as reduced tolerance, for example, due to a recent period of abstinence based rehabilitation treatment or time served in gaol.[314] A clear risk factor is using alone or in an isolated place such as a SOPAT. Workers at NSP attempt to educate users of these risks.[315]

209. Dr Jauncey explained that medical intervention for opioid overdoses centres around respiratory/ventilator support. Treating an overdose is medically "not that complicated", "you just need to manage someone's airway".[316] She explains "this is the AB in the ABC of first aid – specifically Airway and Breathing…. If a person is not breathing adequately external airway resuscitation needs to begin. In a medical setting this may involve supplemental oxygen if breathing [is] still present…alternatively it may involve bag, valve mask resuscitation with oxygen and using specific equipment if no spontaneous breathing is present. In a non-medical setting this will involve mouth to mouth or mouth to mask assisted breathing.[317] If there was no other treatment available, a person who is experiencing an opiate overdose will be fine if their airway can be managed.[318]

A safe injecting room for SWSLHD

210. Dr Jauncey explained that the benefit of the MSIC is that whatever the presentation of a person experiencing an overdose, the staff "are immediately present in order to intervene appropriately".[319]

211. She explained that since the MSIC was established in 2001, it has overseen 1.1 million injections and although there have been 2438 overdoses at the MSIC, there have been no deaths.[320] She reported that in fact there have been no deaths at any of the 110 similar services now operating worldwide.[321]

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[313] Statement of Dr M Jauncey, Bestrin BOE, Vol 1, Tab 42, page 2, at 14
[314] Statement of Dr M Jauncey, Bestrin BOE, Vol 1, Tab 42, page 1, at 6; Transcript 21/10/19, page 18, line 12 onwards

[316] Redacted transcript of evidence provided by Dr Jauncey at the Opioid inquest, Bestrin BOE, Vol 2, page 69, line 34
[317] Statement of Dr M Jauncey, Bestrin BOE, Vol 1, Tab 42, page 1, at 8
[318] Redacted transcript of evidence provided by Dr Jauncey at the Opioid inquest, Bestrin BOE, Vol 2, page 69, line 38
[319] Transcript 21/10/19, page 13, line 40 onwards
[320] Redacted transcript of evidence provided by Dr Jauncey at the Opioid inquest, Bestrin BOE, Vol 2, page 69, line 50 onwards; transcript 21/10/19, page 30, line 14 onwrads
[321] Tab 50B, page 70

212. Until recently, the MSIC at Kings Cross was the only one of its kind in Australia. However, recently a new centre has been established in Victoria. That centre was designed with the particular locality in mind. The medical director of that centre, Dr Nicolas Clark, provided evidence that the starting point for planning a medically supervised injecting centre should be a consideration of a location that is close to people who will use the service.[322] Dr Clark stated that the majority of people who use the North Richmond Community Health Centre walk there, having "either spent the night close to the Richmond area or the Melbourne CBD".[323] He also explained that there had been a very busy needle exchange program in Richmond for many years prior to the opening of the supervised injection facility.[324] The needle exchange and the supervised injection facility have recently been merged into one health care facility.[325]

213. The publicly available data flowing from the North Richmond Community Health Centre appears to suggest there has been a strong uptake of the services the Health Centre provided. Over the first 12 months of operations to 30 June 2019, 2908 users have registered to use the service. There have been 61,823 supervised injections with an average of 172 visits per day. There have been 1,232 overdoses, 150 of which required naloxone treatment.[326] There have been 5,082 on-site services to registered clients. This includes health promotion in relation to injecting, and on-the-spot health and social support. In addition, there have been 1,393 referrals to co-located services and clinics, and external services. This provides a gateway to supports including alcohol and other drug treatment, primary care, oral health, blood-borne virus treatment, mental health support, housing and homelessness services and legal support.[327]

214. This evidence was of particular interest to Mr Bestrin's mother. She engaged in the inquest process with enormous grace and intelligence. She told the court that although she was grateful for the local NSP and its role in disease prevention, "it plays no consideration to the actual person because we need to perceive that they are in need and that there's a reason why they're doing that. So we need to support them as well, the drug users, so to me it's like we're giving the syringes but [just] hoping for the best, *I don't want to know what you're doing or it's your problem*, but they are people that are not able to make that judgment (sic), you know, correctly, so they are very disadvantaged and it

[322] Transcript 21/10/19, page 53, line 10 onwards
[323] Transcript 21/10/19, page 53, line 20 onwards
[324] Transcript 21/10/19, page 53, line 11 onwards
[325] Transcript 21/10/19, page 53, line 7 onwards
[326] Exhibit 11, Transcript 21/10/19, p.55, line 13 onwards; transcript 21/10/19, page 18, line 33 onwards
[327] Exhibit 11, Transcript 21/10/19, p.55, line 13 onwards

feels that have total disregard for them or lack of compassion as humanity, and that perpetuates in everything because they get, you know, neglected or rejected."[328]

215. Ms Bestrin explained that in her view providing clean syringes to drug users is only the first part of the job of providing appropriate harm minimisation services to drug users. In Ms Bestrin's opinion, the second part of the job should be to provide drug users with a suitable space where they can inject safely in a medically supervised environment. This would also offer an opportunity for access to counselling or referral to rehabilitation centres. I understand her view. Mrs Bestrin told the court her son's death could have been prevented if such a scheme had existed. – he could have "been given a chance to live".[329] There is great force and logic to her words.

216. This view was also echoed by Mr Sessions and Ms Hocking. Mr Sessions explained the inherent tension in his role. He is unable to offer any adequate suggestion to a client he knows is about to inject. Instead he is limited to encouraging a user to wait until they get home to inject or "in the safest place that you can", notwithstanding the recognition that some users may be homeless or may have "a great urgency to inject as soon as they possibly can".[330] Ms Hocking acknowledged that although the NSP has had a significant and positive impact on containing blood-borne viruses and ensuring safe injecting practices, realistically it may also mean that some users will experience a sense urgency to use whilst still on hospital grounds. She acknowledged that as part of her remit as general manager of drug services she is very keen to reduce the risk of health damage if people use drugs on hospital grounds, particularly in relation to undetected overdoses.[331] However, this is challenging, without properly knowing where people are going to use those drugs and equipment. She was also careful to alert the court to the complexity of the situation, pointing out that deterring people from using on hospital grounds may lead people to "go to public parks, they'll go to places, public toilets in places that are less monitored… where they are less likely to be have access to health care, so we're going to see more deaths and more people that are at risk of significant harm".[332]

217. It appears obvious to this court that there should be serious contemplation given to establishing a medically supervised injecting centre in or near Liverpool Hospital.

218. The court is of course aware that there are current legislative restrictions in place which would prevent the immediate development of such a centre. However, these are political issues which should not stand indefinitely in the way of sound health policy. In my view

[328] Transcript 19/06/18, page 39, line 48 onwards
[329] Transcript 19/06/18, page 40, line 26 onwards
[330] Transcript 22/10/19, page 39, line 6 onwards
[331] Transcript 22/10/19, page 52, line 5 onwards
[332] Transcript 22/10/19, page 52, line 19 onwards

there is clear evidence arising from this inquest which supports a recommendation for an immediate feasibility study in relation to the establishment of a medically supervised injecting centre in the SWSLHD. The available statistics reveal a high number of intravenous drug users in the local area. Recent near misses recorded in Liverpool Hospital reveal another fatality remains possible at any time.

219. It is important that any feasibility study carefully reviews the most appropriate model for the local area, including whether it should be co-located with an existing health service or NSP, or established as a stand-alone facility. Wide consultation should take place to ensure community engagement and support. In my view a MSIC in the local area has the potential to save lives and its feasibility should be urgently explored.

Increasing the speed with which naloxone is available to a patient

220. Dr Jauncey also discussed the use of Naloxone or Narcan.[333] She explained that Naloxone is a life-saving medicine that can reverse opiate overdose. It is regarded as a very safe drug. Currently most naloxone is administered in a medical or paramedical context.[334] However Naloxone is now available as an over the counter medication and research shows that provision of naloxone more widely in the community has also been very successful. Dr Jauncey described the success of programs to train lay people to provide Naloxone in an overdose emergency. These programs may be even more effective once naloxone is rolled out in a nasal spray form.

221. It became clear that many overdoses are reversible with quick detection, airway management and naloxone. I see no reason why frontline hospital staff should not be trained in basic first aid and the provision of naloxone. I note that Ms Hocking showed a willingness to involved in Naloxone training. In my view, training could go beyond those working in the NSP and reach those who are currently most likely to find someone in need. For this reason I intend to recommend that cleaning and security staff are involved in the roll out of nasal spray naloxone and basic first aid.

The way forward

222. At the commencement of this inquest, the court was struck with the difficulty in obtaining statistics on a state-wide basis. One positive result of the inquest has been the state-wide policy development and the subsequent state-wide audit. Since the deaths of Mr Bestrin

[333] Statement of Dr M Jauncey, Bestrin BOE, Vol 1, Tab 42, page 2, at 11
[334] Statement of Dr Jauncey, Tab 42 [12]

and Mr Bugden, there is evidence of increased interest in the potential dangers of hospital toilets. The challenge will be ensuring the ongoing implementation of the state-wide policy and that appropriate auditing takes place.

223. The evidence arising from the inquest identifies some particularly high-risk toilets on the concourse at Liverpool Hospital. The toilets are open 24 hours a day and are located on a busy thoroughfare. They are well known to people needing a place to inject. The toilets have no emergency buttons and are completely enclosed and private. There were six recorded collapses on the concourse within a 12 month period.

224. The risks are currently mitigated by a cleaning and security schedule that is not adequately audited. In my view, at the very least, there is an urgent need to cost an interim solution such as shortening doors or placing a perspex panel in the door. Amenity and privacy are important but at times they must yield to safety. Steps can be taken to reduce noise and odour but still allow a collapse to be quickly detected by a passer-by. The risk to children is low and exists with all cubicle toilets.

225. It would be even better to investigate one of the higher tech solutions, such as LIDAR or a door lock timer as a small pilot project at Liverpool Hospital. The cost of retrofitting devices on four toilets is both manageable and proportionate to the risks involved.

Findings

226. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Alan Bugden

The person who died was Alan Bugden.

Date of death

He died on 14 August 2015.

Place of death

He died at Royal North Shore Hospital, St Leonards, NSW.

Cause of death

He died of a pulmonary thromboembolism after suffering a stroke on 10 August 2015.

Manner of death

He died having collapsed in a hospital toilet. He was not located for many hours.

Amaru Bestrin

The person who died was Amaru Bestrin

Date of death

He died on 19 December 2016.

Place of death

He died at Liverpool Hospital, Liverpool NSW.

Cause of death

He died from combined drug and alcohol toxicity.

Manner of death

He died having collapsed in a hospital toilet. He was not located for many hours.

Recommendations pursuant to section 82 *Coroners Act 2009*

227. For reasons stated above, I make the following recommendations:

Documentation

1. That NSW Health create a central register of incidents of death or collapse in publicly accessible and clinical toilets (based on data to be requested from each Local Health District) which includes details regarding:
    a. the cause of medical problem underlying the collapse or death;
    b. the layout and structure of the toilet, including information regarding
        i. whether the toilet is a SOPAT or part of a bank of toilets;
        ii. design of door (does it swing outwards e.g.)
        iii. location of toilet;
        iv. any technological alert systems present in toilet.
    c. time frame prior to discovery;
    d. the time when the last clean/ check of the toilet was undertaken;
    e. the relevant cleaning policy applicable to the toilet in question and the level of compliance with the relevant cleaning policy on the day of the incident and in the most recent three monthly audit (in accordance with NSW Guideline GL2019_005, section 5).

2. That Liverpool Hospital create a central register of incidents of death or collapse in publicly accessible and clinical toilets which includes details regarding:

a. the cause of medical problem underlying collapse or death;
b. the layout and structure of the toilet, including information regarding
    i. whether the toilet is a SOPAT or part of a bank of toilets;
    ii. the design of the door (does it swing outwards e.g.)
    iii. location of toilet;
    iv. any technological alert systems present in toilet.
c. time frame prior to discovery;
d. the time when the last clean/ check of the toilet was undertaken;
e. the relevant cleaning policy applicable to the toilet in question and the level of compliance with the relevant cleaning policy on the day of the incident and in the most recent three monthly audit (in accordance with NSW Guideline GL2019_005, section 5);

3. That Liverpool Hospital notify General Health Services, the manager of General Services, the General Manager of Drug Health Services and the Harm Reduction Manager regarding any incidents entered in the central register involving a collapse or death in a publicly accessible or clinical toilets involving drugs.

4. That Liverpool Hospital amend page 2 of the Liverpool Hospital 'Cleaning of Public Toilets' Policy to escalate welfare concerns to the MET team and/or clinical staff rather than Security.

5. That the NSW Department of Health conduct an annual review of the central register to determine if risk mitigation measures are warranted in particular areas.

Auditing

6. That Liverpool Hospital undertake a **documented** internal audit of the toilet audit sheets every three months, in accordance with the NSW Guideline GL2019_005, so as to determine any areas of non-compliance with the Liverpool Hospital 'Cleaning of Public Toilets' Policy. That audit should include documented compliance rates.

7. That Liverpool Hospital undertake a documented external audit of its toilet audit sheets every two years.

8. That SWLHD conduct a documented internal audit of the operation of the cleaning system including recorded rates of compliance

Risk Assessment

9. That Liverpool Hospital undertake an overall risk assessment of its publicly accessible toilets, which includes consultation with cleaning and security staff, the General Manager of Drug Health Services and the Harm Reduction Manager.

10. That Liverpool Hospital undertake an immediate costing regarding the shortening of the doors to the disability toilets located on the Concourse Level near Lift B and Lift D so as to provide visibility of a potential collapse inside the toilet, in the least intrusive manner possible.

11. That Liverpool Hospital implement structural changes to the doors of the disability toilets located on the Concourse Level near Lift B and Lift D so that they open outwards.

12. That Liverpool Hospital, as a matter of urgency, undertake costings for toilets identified in the risk assessment as being 'high risk', in addition to the disability toilets located on the Concourse Level near Lift B and Lift D, regarding:
    a. door lock timers;
    b. LIDAR technology; or
    c. any other technological measures that would assist in detecting a collapsed person,

    and to give immediate, documented consideration to prompt installation of those measures.

Training

13. That Liverpool Hospital provide:
    a. First Aid training to all cleaners and security staff, with a particular focus on how to respond in the event of an overdose and, at a minimum training include identifying an overdose and use of the recovery position.

    b. A training package be provided to all new and existing cleaners to include:

        i. a simplified summary of the Liverpool Hospital 'Cleaning of Public Toilets' Policy and any other LHD wide and state-wide cleaning policies that may be relevant, including but not limited to the NSW Guideline GL2019_005;
        ii. details regarding the escalation procedure if a toilet is not accessible and that the new escalation is to go to clinical staff/MET team rather than security;

iii. best practice when responding to overdoses including how to best access a locked toilet;
iv. a tests and minimum pass rate regarding the understanding of the cleaning policy; and
v. details regarding feedback and performance management should areas of non- compliance with cleaning policies arise as a result of periodic audits of cleaning sheets.

14. That Liverpool Hospital train all cleaners and security staff in the use of Naloxone nasal spray and that upon completion of the training, all cleaning and security staff are provided with Naloxone nasal spray, in order for it to be used in the event of a suspected overdose.

Medically supervised injecting space

15. That NSW Health, in consultation with Liverpool Hospital, undertake a feasibility study regarding a supervised injecting space within the grounds of Liverpool Hospital.

Conclusion

228. Finally, I offer my sincere thanks the many witnesses who came to court and relived difficult events. I thank those assisting me, Ms Kirsten Edwards of counsel and her solicitors, Ms Lena Nash, Mr James Herrington and Ms Harriet Radford for their enormously hard work in the preparation of this inquest. Their dedication to this matter went well beyond what could be expected.

229. Once again, I offer my sincere condolences to the friends and family of Mr Bugden and Mr Bestrin. I acknowledge that the pain of losing a loved one in these circumstances is profound and that their grief is ongoing.

230. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
17 December 2019
NSW State Coroner's Court, Lidcombe