CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Into the death of Harold Edwards (a pseudonym)
File number:	2017/00160498
Hearing dates:	5, 6, 7, 8 August 2019
Date of findings:	29 November 2019
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E.Truscott
Catchwords:	Coronial Law-Cause and manner of death- involuntary patient-Mental Health- suicide-nurses' failure to carry out observations-falsified Observation Charts sheets- missing documents-time of death- uncertain medical records
Representation:	Counsel Assisting : Ms M Gerace instructed by Mr J Loosley of Crown Solicitors Office Family of deceased: Mr M McAuley instructed by Ms S Curro of McAuley Hawach Lawyers Nepean Blue Mountains Local Health District : Mr M Lynch instructed by Mr L Sara of Hicksons Lawyers Registered Nurses J Watkins E Brown, E Bloom: Ms B Haider for NSW Nurses & Midwives Assoc. Registered Nurses M Dudhela, F Egbufor, P Chikuku: Mr N Dawson of New Law.
Non-Publication Orders:	S75 (1) Name of deceased and names of his family members are not to published.

	S74 (1) Ex 1. Vol4 Tab28 P1456 – the names contained therein S74(1) Ex 1.Vol 7: Tab103 P1927 Address of witness Tab104 P1938, P1943 Address of witness Tab105 P1958,1989 Address of witness Tab105 P1991 Date of birth of witness Tab106 P2009,P2019 Address of Witness Tab106 P2021 date of birth of witness Tab107 P2036, P2038, P2040 Address of witness S74(1) Ex.3 photographs S74(1) Ex. 5 and Ex. 6 S74(1) Ex.7 Name of deceased
Findings:	**Identity** **Harold Edwards (pseudonym)** **Date of Death** **27 May 2017** **Place of Death** **Acute Mental Health Ward Nepean Hospital, Kingswood, NSW** **Cause of death** **Hanging** **Manner of death** **Suicide**
Recommendations:	I recommend that the Nepean Blue Mountains Health Local District install and use Closed Circuit Television cameras throughout the public areas and at the nursing station window in the Acute Mental Health Unit of the Nepean Hospital. I recommend that the Nepean Blue Mountains Health Local District implement a system whereby the allocation of patients to a nurse on each shift is recorded under a system that allows identification of such at any one time to improve quality staff performance monitoring and appraisal.

IN THE CORONERS COURT
LIDCOMBE
NSW

Section 81 Coroners Act 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of a 49 year old man who died whilst a patient in the Acute Mental Health Unit ("ACMHU") at the Nepean Hospital ("the Hospital") in Kingswood. He died during the overnight nursing shift of 26-27 May 2017.

2. His death was reportable under s6 (1) (f) Coroners Act 2009 ("the Act"). This is a "required inquest" under s27 (1) (b) because the patient was "in lawful custody" due to having been scheduled as an involuntary patient and detained under the Mental Health Act 2007. Under s23 (1) (a) the inquest is required to be held by a senior coroner.

3. The deceased's family wish for these findings to be published and due to the requirements of s75 of the Act the deceased is given the pseudonym of Harold Edwards.

Summary of Events

4. On 21 May 2017 Mr Edwards had attended his General Practitioner disclosing that he was contemplating suicide. He was taken by ambulance to the Emergency Department of the Hospital. In the early hours of 22 May 2017, he was admitted to the Hospital as a voluntary patient. There were no available beds in the Acute Mental Health Unit

(ACMHU) so he was accommodated in the Older Persons Mental Health Unit (OPMHU).

5. In the morning of Wednesday 24 May 2017 he had indicated to nursing staff that he wished to be discharged from the Hospital. A bed had become available in the ACMHU and he was transferred to that unit at 1.30 pm. Following his transfer, due to his stated intention to leave the Hospital, an urgent medical review was conducted by a doctor. It was determined that Mr Edwards was suffering from a mental illness and that he was at risk of serious harm to himself.

6. Mr Edwards was scheduled as an involuntary patient under the Mental Health Act 2007. He spent 2 nights in the ACMHU before he was assessed by a second doctor on 26 May 2017. Mr Edwards was diagnosed as suffering from a mental illness, specifically a major depressive episode; he was experiencing significant psychosocial stressors which were impacting significantly on his mental health, specifically suicidality.

7. Throughout his hospitalisation, both as a voluntary patient and as an involuntary patient Mr Edwards was on "Level 3 Observations" which required nursing staff to make observations of him every 20 minutes during the day shift and every 30 minutes during the overnight shift. Those Observations are recorded on an Observation Chart which is kept in a patient's file.

8. On the night of 26 May 2017 the overnight shift was performed by 5 Registered Nurses (RN). This shift commenced at 9.30 p.m. and finished at 7.30 a.m. on Friday 27 May 2017. Handover of patients from the overnight shift nurses to the morning shift nurses was conducted from 7a.m. - 7.30 a.m. The care of Mr Edwards was handed over to the morning shift and allocated to Registered Nurse ("RN") Peter Hickson. RN Hickson entered Mr Edwards' room at about 7.30 a.m. to wake him for breakfast. RN Hickson saw Mr Edwards hanging from a ligature, made from shoe laces, affixed to a high point above his bed.

9. RN Hickson pressed the duress call and quickly collected a resuscitation cart from the nurses' station. All the overnight shift nurses but for the Team Leader RN Emma Brown

had left the Hospital. RN Brown remained in the nurses' station while the medical emergency team (MET) attended.

10. RN Hickson was assisted by RN Christopher Walsh who had also just started the morning shift. They released Mr Edwards from the ligature and with the assistance of the MET team attempted to resuscitate Mr Edwards. However, it was noted that Mr Edwards was deceased; his body was cyanosed, cold to the touch and stiff with *rigor mortis*. It is likely that he had died some hours before RN Hickson opened the door to his room that morning.

11. The forensic evidence is unable to accurately identify the time Mr Edwards died. The range of time could be as little as two hours or as much as eight hours before he was found by RN Hickson. That is from about 11 pm to 5.30 a.m.

12. The account of the nurses and their records for the shift do not adequately disclose the circumstances leading to Mr Edwards' death or explain how it was that his death was not discovered until the morning shift nurse entered his room at 7.30 a.m.

The Summary of the Investigation

13. The police attended the ACMHU on the morning of 27 May 2017 shortly after Mr Edwards was declared deceased. They reported Mr Edwards' death to the coroner. They re-attended the ACMHU that night and interviewed one of the nurses, RN Jill Watkins, who had attended work to commence her next overnight shift. The police have sought to interview the other nurses but they have all declined to be interviewed. They have provided statements prepared on their behalf. Those statements are somewhat cursory.

14. The Nepean-Blue Mountains Local Health District (NBMLHD) instructed the Human Resources/Clinical Governance team to undertake an investigation into the conduct of nursing staff involved in the overnight care of Mr Edwards. Specifically, investigators were to consider whether staff had undertaken the required Level 3 observations, complied with Hospital policies and procedures and whether nursing staff had made

false and misleading entries in the Progress Notes and Observation Charts for Mr Edwards.

15. That investigation resulted in the termination of the employment of 4 of the 5 overnight nurses: RN Mehul Dudhela, Jill Watkins, Emma Brown, and Florence Egbufor. In addition records have been created on the "Service Check Register" in relation to those nurses in accordance with section 4.3(4) of Policy Directive 2013_036: Service Check Register for NSW Health.

16. The NBMLHD made notifications in respect of each of the concerned nurses to the Nursing and Midwifery Council NSW which conducted hearings examining the nursing skills of the relevant nurses. Pursuant to s150 of the Health Practitioner Regulation National Law (NSW), the Nursing and Midwifery Council of NSW, imposed conditions on the registration of those 4 nurses because in each case Council was satisfied that the performance and conduct of the nurses presented ongoing risk to public safety and restrictions on registration were necessary for the protection of the public. The effect of this is that those nurses are unable to be employed in the public health sector however; their registration allows them to be employed in the private health sector.

17. There is currently a Health Care Complaints Commission hearing pending the completion of this Inquest. Under s61 of the Act each of the nurses objected to giving evidence in the inquest. The objections were upheld and they were not required to give evidence.

18. The evidence in relation to what happened on the overnight shift of 26 May 2017 has been limited to the police interview with RN Watkins, the NBMLHD team material including the nurses' interviews and letters to them and the statements prepared on behalf of each nurse for the purposes of the coronial proceedings. Audio recordings of the NBMLHD investigation's interviews, but for the interview with RN Chikuku and the second interview with RN Dudhela form part of the brief. Transcripts of interviews with RNs Watkins, Egbufor and Brown also form part of the brief.

19. RN Hickson was called to give evidence in the Inquest. Statements and interviews given by other nurses who discovered Mr Edwards have also been tendered. Mr Edwards' medical records are tendered as evidence. I have also received evidence from the NBMLHD administrators in relation to changes the Hospital has introduced to address the issues the investigation identified.

The Inquest Issues

20. The Inquest Issues were as follows:

1. What observations and checks did the nursing staff make of Harold Edwards in the period between 10.00pm on 26 May 2017 and 7.30am on 27 May 2017;

2. If checks have been done, what was the nature and quality of those checks as judged by the relevant policies in place at the Hospital at the time and standards of nursing practice?

3. The response to and steps taken since the death of Mr Edwards by the Nepean Blue Mountains Local Health District:
    a. To address factors that may have impacted on any nursing compliance with required observations of mentally ill patients;
    b. To implement measures to monitor compliance by nursing staff with required observations; and
    c. Whether there is a need for any further measures to monitor nursing compliance?

4. Whether relevant CCTV might have been available but was not retained.

5. Where the Fireboard Sheet for the overnight shift was supposed to be filed and why it was not located at the time the Police attended in the morning of 27 May 2017 and has not been located since.

6. Whether the Hospital/NBMLHD has and/or should have a critical incident policy and/or protocol of crime/coronial scene preservations in circumstances where involuntary patients suicide or die in an unusual, unexpected, sudden or unnatural manner, including whether any policy/protocol includes or should include provision for retention of CCTV footage.

21. Pursuant to s 82 of the Act a Coroner has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Mr Edwards Personal Background

22. Mr Edwards is survived by 4 children and his de-facto wife of 30 years. As a child he had learning/reading difficulties, early childhood disadvantage and was subject to abuse. His medical records indicate that his father died in a psychiatric institution. Mr Edwards likely suffered from major depression/PTSD from those early childhood experiences. He had a long history of mental health problems on a background of long-term polysubstance abuse. He had suffered several co-morbidities including Hepatitis C and seizures/jerks (suffered for more than 8 years).

23. Mr Edwards had previously received long term treatment of his drug addiction through the Gateway Clinic run from the Hospital. He had relatively successful treatment of his heroin addiction by Buprenorphine, albeit with ongoing other drug use – daily cannabis, with other drugs (reportedly) on an ad-hoc basis. The records also suggest that Mr Edwards had achieved some relative stability in his mental health up until 2015/2016.

24. By 2017 however, Mr Edward was likely suffering significant depression complicated by concurrent drug use. He had made multiple attempts at self-harm including attempting to end his life. Family were concerned for his safety and ongoing risk of self-harm. On 5 January and 5 April 2017 Mr Edwards attended the Hospital for treatment of his mental health. Each of these presentations followed a suicide attempt, one of which

included an attempt by hanging. In respect of each crisis, Mr Edwards reported they occurred as a result of his perception of relationship difficulties. On both occasions, he was discharged without admission to the Hospital and the last one the Hospital referred him to Blacktown Access for daily monitoring of his mental health in the community.

25. On 21 May 2017, Mr Edwards visited his General Practitioner ("GP") reporting he was experiencing suicidal ideation with intent to self-harm and planning. Mr Edwards reported that his relationship had purportedly broken down, he was separated and living in his car, and the notes record that he was facing criminal charges arising from domestic violence and a previous suicide attempt. His GP arranged for him to attend Nepean Hospital Emergency Department for further assessment.

Admission into Nepean Hospital

26. On the afternoon of 21 May 2017, Mr Edwards was taken by ambulance from the GP's surgery to the Hospital and after a medical assessment, he was advised that he should be admitted to receive inpatient care for treatment of his depression and suicidality. He accepted that advice and as there was no bed available in the ACMHU he was admitted, on Level 3 observations, into the Older Patients' Mental Health Unit ("OPMHU").

27. Medical and other staff Progress Notes ("PN') and statements indicate that Mr Edwards' mood and behaviour was changeable. Assessment identified a fluctuating moderate to high risk for suicide and moderate risk of self-harm. He was admitted into the OPMHU at about 1.30 am on 22 May 2017 and the Progress Note written at 05:45 am states that Mr Edwards "had a settled night, slept for long periods, made a phone call to his employer first thing this morning".[1]

28. Around midday on 22 May 2017, Mr Edwards was reviewed by Dr Yichao Liang and placed on Level 4 Observations (hourly).[2] However, he remained on Level 3 Observations according to the nursing PN entries which also note that during this

[1] Exhibit 1: Vol 4, Tab 28, P1374
[2] Exhibit 1: Vol 4, Tab 28, P1390

morning *"Pt displays hope for the future… Pt denies TOSH SI however appears flat and depressed in mood. Settled and orientated to ward. Nil issues ATOR Continuing level 3 Observations".*[3]

29. By the evening of 22 May 2017 Mr Edwards' mood had deteriorated. A PN written at 7.22 p.m. cites that Mr Edwards reported that his mood was "shit", his Affect was reactive but agitated, his Speech: Regular rate, louder volume and standard quantity. He was unable to be further assessed as he was "pissed off" because he wanted to contact his sister and could only do so by looking at a map to figure out her address and when advised that there were no maps and no mobile phones for patients to use he became angry and refused to engage in further conversation. He spent most of the shift in his room, was compliant with staff, accepting of nursing care and hostile on approach. He was to continue on Level 3 Observations.[4]

30. At 11 p.m. on 22 May 2017, Mr Edwards was given 10 mg Temazepam to sleep.[5] The PN written at 06:05 am on 23 May 2017 notes *"Pt was observed regularly overnight and found to be sleeping in bed. He slept well throughout the night without any issues. No changes recorded in his condition overnight"*.[6] However the midmorning PN says that Mr Edwards had a problem with the mattress and reported that he could sleep better in his car compared to the hospital bed.[7]

31. On 23 May 2017, a social worker, Ms Green met with Mr Edwards. She helped him organise some things including trying to locate his sister and providing paperwork for his employer.[8] Mr Edwards did not undergo a medical review on 23 May 2017. At 10 p.m. Mr Edwards was dispensed 10 mg Temazepam.[9]

[3] Exhibit 1: Vol 4, Tab 28, PP1392, 1398.
[4] Exhibit 1: Vol 4, Tab 28, PP1391-1932
[5] Exhibit 1: Vol 4, Tab 28, P1393
[6] Exhibit 1: Vol 4, Tab 28, P1394
[7] Exhibit 1: Vol 4, Tab 28, P1395
[8] Exhibit 1: Vol 4, Tab 28, P1399
[9] Exhibit 1: Vol 4, Tab 28, P1396

32. The PN written at 6:29 a.m. on 24 May 2017 sets out that the objective for the previous night shift was *"to ensure that patient has adequate night rest, patients bedroom area is noise free & minimise any factors that could cause sleep disruption, offer PRN medications as required".* The assessment was that *"Level 3 Observations Patient had desired settling effect from earlier PRN medication given for insomnia, noted to have rested well and breathing spontaneously for the rest of the night".*[10]

33. However, the PN made at 10.45 a.m. on 24 May 2017 records *"Patient has been settled when this morning medications were being administered patient started swearing and verbally abusive stated that he did not sleep well night staff kept disturbing him flashing lights on him. Reassured and he took his medications tolerated diet well vital obs stable. Patient remains on level 3 Obs*".[11]

34. PNs written at 11:20 a.m. and 11:49 a.m. respectively on 24 May 2017 state that Mr Edwards was quite agitated. The first PN noted that: *"Patient request discharge and has been verbally argumentative with staff. Refusing to stay in hospital, requesting discharge, smoking in courtyard".* The first PN also recorded that Dr Liang was requested to review Mr Edwards but that he was unable to due to time that Mr Edwards would be transferred to the ACMHU as had earlier been arranged and "*Awaiting Dr to review patient to consider his voluntary rights or instruction to nursing staff by treating team if schedule is required".*[12]

35. The second PN recorded: *"PRN 10 mg diazepam given patient has been agitated wanted to sign himself out stated it was useless in here he has been waiting for the social worker and felt would never attend to him. Reassured, patient settled there after".*[13]

36. The social worker Ms Green again attended Mr Edwards shortly thereafter and her notes indicate that she explained why she was later than expected and he told her he

[10] Exhibit 1: Vol 4, Tab 28, P1397
[11] Exhibit 1: Vol 4, Tab 28, P1398
[12] Exhibit 1: Vol 4, Tab 28, P1400
[13] Exhibit 1: Vol 4, Tab 28, P1402

had just made a phone call to complain about her to the Official Visitors. While she was assisting him to find his sister's contact details, Dr Liang attended and spoke with Mr Edwards in her presence. According to Ms Green's record, Mr Edwards said that *"there was no point in anything and he wouldn't be here in a week…didn't want to take medication as he wouldn't be here and he wanted to make a will to make sure his children received his share of the matrimonial property. He said his mood was 0 out of 10 but it didn't matter because he wasn't going to be here".* After Dr Liang left, Mr Edwards told the social worker he no longer required her assistance because he was being discharged and wasn't going to be around to need anything.[14]

37. At 1.30 p.m. on 24 May 2017 Mr Edwards was transferred from OPMHU to the ACMHU. Dr Liang returned and then engaged Mr Edwards in a lengthy assessment and review where Mr Edwards is recording as having *"expressed acute suicidal ideation…he wants to go because he is not happy with the services…he wishes to see a lawyer to write a will because he will die within one week…he had nothing left".*[15]

38. Dr Liang considered he was at sufficient risk of self-harm that he should be detained involuntarily for his own protection. Mr Edwards was informed that he would be detained under the Mental Health Act 2007. Dr Liang assessed that Mr Edwards required ongoing nursing Level 3 Observations due to his high risk of self-harming. Ms Green, the social worker, revisited Mr Edwards and contacted his family members and made arrangements for them to collect his car and visit him.[16]

39. According to a PN at 3.39 p.m. on 24 May 2017, Mr Edwards was dispensed 10 mg diazepam at his request to aid with anxiety/agitation[17] and at 9 p.m.: *"observed mood upset, reports depressed, affect restricted, patient superficially settled in mood and behaviour, underlying anxiety and agitation. Can be easily upset, when demands are*

[14] Exhibit 1: Vol 4, Tab 28, P1403
[15] Exhibit 1: Vol 4, Tab 28, P1404
[16] Exhibit 1: Vol 4, Tab 28, P1411
[17] Exhibit 1: Vol 4, Tab 28, P1407

not met, demanding for PRN…".[18] In contrast, the Observation Chart describes that throughout the day Mr Edwards was "settled".[19]

Acute Mental Health Unit

40. There are 32 beds in the ACMHU, 5 of which are for Level 1 patients who require 1:1 nursing care. The remaining beds are supposed to be allocated amongst the Nurses so that 1 Nurse might have 6 or so patients. In addition to the area where those 5 beds are, there is a corridor for female patients and a corridor for male patients. There is no CCTV camera situated in the ward, though there is a camera at the entrance doors. There is no CCTV camera that observes the nurses' station.

41. It would be expected that many of the patients in the ACMHU were, like Mr Edwards, involuntary patients, that is, so mentally unwell; they had to be detained against their will to receive medical treatment and nursing care.

42. They are most vulnerable members of our society and they are owed a high level of duty of care by those charged with providing that health service.

Allocation of Nursing Duties

43. The nurses on the overnight shift of 26-27 May 2017 were RN Brown who was the Team Leader, RNs Watkins, Dudhela, Egbufor and Chikuku. As the Team Leader, RN Brown held the role to co-ordinate patient allocations, organise bed allocations for incoming patients and take the lead role in any critical or aggressive incidents.[20]

44. There is no requirement for the Team Leader to document which nurse has the allocation of which patients – that should be reflected at any given time on the patient's Observation Chart. However, to identify the patients who a particular nurse had the

[18] Exhibit 1: Vol 4, Tab 28, P1408
[19] Exhibit 1: Vol 4, Tab 28: P1446.
[20] Exhibit 1: Vol 1, Tab 13 (Statement of RN Emma Brown dated 19 December 2017), P219

responsibility for would entail investigating each of the patient files. The coronial investigation has not engaged in that process.

45. RN Brown told the NBMLHD investigation panel that the allocation of patients was made by the afternoon shift team leader. She said she had 4 patients and the other nurses had seven patients each.[21] However, there is no evidence to support this claim. RN Dudhela told the NBMLHD investigation panel that there were no allocations on the overnight shift.[22]

46. RN Watkins claimed that RN Dudhela was responsible for allocating the patient files but if that was so it is clear that the patients were not allocated to any nurse when handover commenced, rather the files were distributed, probably by RN Dudhela at the end of the shift so that the Observation Charts could be placed on each file and so that a PN could be written for each patient. Other than those tasks there was no nursing care provided to a patient by an allocated nurse.

47. RN Brown stated that she allocated the task of medication duties to RN Watkins and RN Chikuku. She said she allocated the Fireboard rounds to RN Egbufor and Dudhela.[23] She did not elaborate how she, RNs Watkins and Chikuku then became involved in those rounds.

48. A Fireboard is a document which is an administrative rather than a clinical document. The staff member is required to record where patients are every hour so that in the event of an emergency evacuation the patient and their whereabouts is accounted for.

49. The daytime shift would often record whether the patient was awake or asleep or absent from the ward. The overnight shift would place a tick against the name of the patient. The Fireboard Sheet is not placed on a patient file as it has no clinical significance. Rather they are stored in a large folder kept in the nurses' station.

[21] Exhibit 1: Vol 7, Tab 107, P2056
[22] Exhibit 1: Vol 7, Tab108 (USB).
[23] Exhibit 1: Vol 1, Tab 13, P220

50. The evidence establishes that though RN Dudhela and RN Egbufor were allocated the Fireboard rounds all of the nurses engaged in these rounds. They called it team nursing but there are numerous contradictions and inconsistencies from the nurses as to who performed those rounds, when and what they saw.

Level 3 Observation Charts

51. The Hospital's Mental Health Observations Procedure stipulate that where a patient had been assessed as requiring Level 3 Observations, during the day nursing staff are required to make 20-minute observations of the patients' health safety and wellbeing. Those observations change to every 30 minutes during the night-shift.

52. The Level 3 Observation Chart is a table containing rows for each half hour of the shift. There are 9 columns. The first column had the times pre-printed on the chart with each row being on the hour and half hourly. Each of the next 6 columns contains a behaviour which can be ticked as applicable: "Threatening", "Agitated", "Anxious", "Labile", "Settled", "Sleeping". The next 2 columns relate to the identity of the staff member responsible –the first requiring their initials and the second requiring the name of the nurse whom the care is handed over to.

53. The Mental Health Observations Procedure expressly stipulated that observations were required to monitor and aid the patients' health safety and wellbeing and that:

    1. Daytime observations were to be considered an opportunity for active engagement with or support of the patient; and
    2. Observations made of the patient when the patient was sleeping required nursing staff to confirm active respiration- that is, the patient was alive and breathing.

54. As would be expected, the Observation Chart is to be completed by the RN who actually made the observation.

55. However the ACMHU overnight shift nurses had developed a longstanding practice whereby they would not perform the Level 3 Observations. They would however, record on the Observation Chart that they had performed the observation. They would do this soon after they had performed the hourly Fireboard round.

56. The way the hourly rounds were conducted involved two nurses conducting the round simultaneously and each apparently making visual observations of half of the patients on the unit. One nurse would travel one side of the corridor and the other nurse would travel the other side of the corridor. They would look into each patient's room through a glass window in the door or perhaps open the door and stand at the door way. Sometimes they would shine a torch on the patient.

57. At the completion of the round, one nurse would tick and sign the Fireboard Sheet even though s\he only saw half of the patients. The other nurse would then use that Fireboard Sheet and record an Observation and sign each patient's Observation Chart as if she had made observations of each of the patients. The information was obtained from the Fireboard which were in addition to the other clinical observations and records regarding the patient's heath, behaviour and wellbeing. Each of the 32 Observation Charts would be placed on each patient file at the completion of the shift.

58. By looking at the Fireboard Sheet and a patient's Observation Chart, the identification of each of the 2 nurses engaged in each hourly round could be determined. However, the Fireboard Sheet for this night and the previous night are both "missing". The only explanation is that one of the overnight shift nurses, realising the significance of the document to this investigation has removed it. The previous Fireboard Sheet was only significant in so far as one of the overnight shift nurses claimed to have signed it at 9.30 p.m. on 26 May 2017. That nurse is RN Watkins. That time is significant because RN Watkins told the NBMLHD investigation panel she performed the 9.30 p.m. Fireboard round with Enrolled Nurse Jayden she thought his name was.[24] Whether there was a 9.30 p.m. Fireboard round is unlikely given that the evidence suggests that the rounds were only performed on the top of the hour.

[24] Exhibit 1: Vol 7, Tab 106, P2023

59. If the observations had been performed according to nurse/patient allocation the Observation Chart would contain entries made by that allocated nurse only, except when they were unable to do so such as when they were off the ACMHU having a meal break. In that circumstance the Observation Chart would be handed over to another nurse to make the required observation. The name of the nurse the care was handed over to would be recorded as would the name of the allocated nurse when it was handed back at a time when the observations were continued by that nurse.

60. Mr Edwards' Observation Chart was signed by all nurses except RN Chikuku.[25] Any NBMLHD audit of the ACMHU overnight shift Observation Charts would have noted that they indicated that the observations were not being carried out on the basis of a patient/nurse allocation.

61. The 10 p.m, record was the last round noted on the Observation Chart to have been performed by RN James Ganzo (the previous shift) noting that Mr Edwards was asleep as he had been since 8 p.m.[26] However, RN Egbufor told the NBMLHD investigation panel on 30 June 2017 that she performed the 10 p.m. round with RN Dudhela. She said she saw Mr Edwards was asleep in his room.[27]

62. RN Dudhela signed the Observation Chart that Mr Edwards was asleep at 10.20 p.m. and 10.40 p.m.[28] That cannot be correct because no overnight shift nurses performed any checks other than the hourly Fireboard round. The practice was that the nurse would "back fill" the non-performed observation. RN Dudhela would have done this when he made the 11 p.m. entry.

63. It is unlikely that the 10 p.m. round was performed by the afternoon shift because handover would be from 9.30-10.00 p.m. If the 10 p.m. observation was performed by the overnight nurses, the entry on Mr Edwards' Observation Chart suggests that RN

[25] However, RN Chikuku in her statement says that she was involved in the rounds; accordingly her ticks and initials must have been on the Fireboard Sheet.
[26] Exhibit 1: Vol 4, Tab 28, p. 1450; Exhibit 5 (Medication signature list).
[27] Exhibit 1: Vol 7, Tab 105, P1969, 1971
[28] Exhibit 1: Vol 4, Tab 28, p. 1450; Exhibit 5 (Medication signature list).

Ganzo has pre-initialled the Observation Chart prior to ending his shift at 10.00 p.m. RN Ganzo was not called as a witness in the Inquest. Evidence indicating that RN Ganzo did pre-sign documents is evident on the Medication Chart in relation to the Temazepam which he charted as being administered at 10.30 p.m.[29] He could not pre-sign a PN because they have an electronic time-stamp.

64. The 11 p.m. record signed by RN Dudhela noted that Mr Edwards was settled. RN Egbufor says that she performed this round.[30] RN Watkins claimed to the NBMLHD investigation panel that she performed this round.[31] Only two nurses would perform rounds together. It is unclear why a nurse would claim to perform a round when they had not. It could be that RN Watkins was not saying that she performed the round but rather than she actually saw Mr Edwards at 11 p.m. RN Egbufor says at this time Mr Edwards was outside his room. She was asked whether he was requesting medication and she said she did not know.[32]

65. RN Egbufor says that at some time before 11 p.m. or 10 or 10.30 pm but definitely before 11 p.m. she saw Mr Edwards at the nurses' station window. He was asking for something. RN Chikuku provided a statement dated 16 June 2017 which states that her task for the night was medication and that Mr Edwards attended the nurses' station at 10:30 p.m. requesting his sleeping tablet. She says that the medical chart indicated he had just received it so she told him he couldn't have anymore and she advised him to engage in deep breathing instead.[33]

66. RN Brown told the NBMLHD investigation panel that she saw Mr Edwards talking with patients in the loungeroom before lights out at 11 p.m.[34] RN Brown provided a statement on19 December 2017 in which she claimed to have seen Mr Edwards at the commencement of the overnight shift interacting with other patients and showing no

[29] Exhibit 1: Vol 4, Tab 28, p. 1437; Exhibit 5 (Medication signature list).
[30] Exhibit 1: Vol 7, Tab 105, PP1971-1972
[31] Exhibit 1: Vol 7, Tab 106, P2025
[32] Exhibit 1: Vol 7, Tab 105, PP1971-1972
[33] Exhibit 1: Vol 7, Tab 88, P1893
[34] P2052

overt signs of distress.[35] However, at the commencement of the shift Mr Edwards was asleep in his room according to RN Ganzo's PN and Observation Chart entries.

67. The 12.00 a.m. round contains RN Watkins' signature[36]. She told the NBMLHD investigation panel that Mr Edwards was in his room sleeping. She was not asked his position on the bed. RN Egbufor told the NBMLHD investigation panel that she saw Mr Edwards awake in his room.[37] The Observation Chart indicates that Mr Edwards was both settled and sleeping. RN Egbufor did not recall who she performed the round with.[38] RN Dudhela told the NBMLHD investigation panel that he performed all the rounds before going off the unit for his meal break at 12.30.

68. RN Dudhela said that Mr Edwards was in his room appearing to be asleep or nearly asleep. RN Dudhela stood at the door and shone his torch on him and Mr Edwards would stir so he found it difficult to say sleeping or settled. He said that "settled" usually indicated a patient to be awake walking around the unit. He was asked by the NBMLHD investigation panel if he saw Mr Edwards ask about medication. Initially he said he could not remember and then he said he saw Mr Edwards have a sleeping tablet. Then he said Mr Edwards had a sleeping tablet because every night he did. He couldn't say what time what it was, he said he didn't know what time but it was sometime after 10 p.m. He said he was confused, that it was the second night on ACMHU that Mr Edwards had the sleeping pill.[39]

69. RN Dudhela said that he did not see Mr Edwards after 12.30 a.m. Later he was uncertain as to whether he might have been the second nurse involved in two rounds between 1.30 and 3.00 a.m.[40] He was asked to describe what kind of night it was on the unit and he said that there were no incidents during the night.

[35] Exhibit 1: Vol 1, Tab 13, P220
[36] RN Watkins' signature isn't contained in the list provided at Exhibit 5. However, the signature is consistent with the fireboard sheet tendered as Exhibit 6 (which purportedly contains RN Watkins' co-signing the 0700 Fireboard round on 27 May 2017).
[37] Egbufor interview with hospital panel 1972, 1973
[38] P2023
[39] Exhibit 1: Vol 7, Tab 108.
[40] Ibid. There was no 1.30 a.m. round, there is no evidence about who performed the round at 3.00 with RN Egbufor

70. The Fireboard Sheet would have identified the nurse who was said to have accompanied RN Watkins on the rounds. Alternatively RN Watkins did not perform the round at all and signed the Observation Chart because RN Dudhela did not want to – as she had claimed to have done for the 12.30, 5.30 and 6.30 a.m. rounds.

71. The 1.00 a.m. record was signed by RN Brown. On any account there were no rounds at 1.30 a.m. but she signed that as well. RN Brown says she performed the round but did not observe Mr Edwards. She was unable to identify the other nurse who performed the round; she thought either RN Watkins or RN Chikuku. Neither RN Chikuku nor RN Watkins have ever claimed to have performed a round at 1.00 a.m. and sighting Mr Edwards. The Observation Chart has Mr Edwards as settled, which according to RN Dudhela, could mean that he was seen in the unit rather than his room.

72. The 2.00 a.m. record was signed by RN Brown. RN Brown says she performed the round but did not observe Mr Edwards. She was unable to identify the other nurse who performed the round; she thought either RN Watkins or RN Chikuku. Neither RN Chikuku nor RN Watkins has ever claimed to have performed a round at 2.00 a.m. sighting Mr Edwards. The Observation Chart has Mr Edwards as settled, which according to RN Dudhela, could mean that he was seen in the unit rather than his room.

73. The only evidence about this time period comes from RN Watkins who told the NBMLHD investigation panel that between 12.00 a.m. and 1.00 a.m. Mr Edwards came out of his room yelling at a patient on the phone outside his room claiming that she had woken him up. RN Watkins says he then went back into his room.

74. RN Watkins told the NBMLHD investigation panel that at some stage when Mr Edwards kept coming to the counter and asking for his medication RN Brown spoke with him and told him that he could not have any until a few hours' time.[41] RN Brown says that at no

[41] Exhibit 1: Vol 7, Tab 106, P2023

time did she ever speak with Mr Edwards. She said that the only time she ever saw him was early on in the shift when he was in the lounge area at the start of the shift.[42]

75. The 3.00 a.m. record indicates that Mr Edwards was asleep. It was signed by RN Egbufor. She said she did not open the door because it was broken.[43] The door was not broken the blind on the window of the door was broken. The door may have been barricaded by a lounge chair that Mr Edwards at some stage had retrieved and taken into his room, an incident that no nurse has been asked about. The chair was observed in Mr Edwards' room the following morning.[44]

76. The 4.00 a.m. record indicates that Mr Edwards was asleep. It was signed by RN Egbufor. She said that though she signed the 4 a.m. observation she has no recollection of doing so or seeing Mr Edwards.[45] She suggested that given her signature is on the Observation Chart it is likely that she had performed the rounds.[46] She told the NBMLHD investigation panel that on the Saturday night (26 May 2017) at work RN Watkins told her that she had had an altercation with Mr Edwards at 4.00 a.m. the previous morning.[47]

77. RN Watkins says that she performed that round with RN Dudhela. RN Dudhela denies having done so. RN Watkins describes that she saw RN Dudhela check on Mr Edwards and go to the next patient's room. She claims that she then checked Mr Edwards. She says she opened Mr Edwards' door and entered his room. She claims her torch light woke him up and he jumped off his bed and abused her so she left locking the door.[48]

78. It is inconsistent for her to have checked on Mr Edwards because on her version she had already seen RN Dudhela do so. RN Watkins said that RN Dudhela was within a distance to have heard the incident. The NBMLHD investigation panel did not ask RN

[42] Exhibit 1: Vol 7, Tab 107, P2051-2052
[43] Exhibit 1: Vol 7, Tab 105, P1978
[44] Exhibit 1: Vol 7, Tab 99, P1912
[45] Exhibit 1: Vol 7, Tab 105, P1976
[46] Exhibit 1: Vol 7, Tab 105, P1978
[47] Exhibit 1: Vol 7, Tab 105, PP1985-1986. That was 27 May 2017; after RN Watkin's interview with the police.
[48] Exhibit 1: Vol 1, Tab 10, P106

Watkins why she had not caused a note of the incident in either the Observation Chart or a PN. Nor was she asked who, if anyone, she reported the incident to and what the terms of that report were.

79. RN Brown said that the first indication that there was an issue with Mr Edwards was when she heard the morning shift duress alarm.[49] In contrast to that position, the NBMLHD investigation panel asked RN Brown whether RN Watkins had spoken to her about what occurred. She replied: *"She mentioned that in the morning but I was on my break at that time so I wasn't there when she had come back to the office doing that round"*.[50]

80. She said RN Watkins mentioned it at about 5.00 a.m. But she was unable to recall the nurse who did that the round with RN Watkins.[51] The panel did not ask RN Brown to elaborate about what it was that RN Watkins had said to her. RN Brown denied hearing any conversations between RN Watkins and RN Dudhela.

81. The NBMLHD investigation panel pointed out to RN Watkins that RN Egbufor signed the Observation Chart. RN Watkins said that she did not know why RN Egbufor had done so as she did not perform the round with her because RN Dudhela did. The panel pointed out that RN Egbufor had indicated that Mr Edwards was asleep. RN Watkins said that he had been asleep and she had woken him up. That answer tends to support a finding that RN Egbufor must have performed the observation to have "correctly" indicated that Mr Edwards was asleep. However, the evidence would not allow for any finding of an observation or a claim to have been either truthful or correct.

82. The 5.00 a.m. record indicates that Mr Edwards was asleep. It was signed by RN Watkins. She says that RN Dudhela performed that round with her. He denies having done so. She said she did not go into the room in case she disturbed him as she had done at 4.00 a.m. I note that she claims that the light was on.[52] If that was so there was no need to fear disturbing him by torch light. RN Watkins claimed to the NBMLHD

[49] Exhibit 1: Vol 7, Tab 105, PP1985-1986.
[50] Exhibit 1: Vol 7, Tab 107, P2054
[51] Ibid
[52] Exhibit 1: Vol 1, Tab 10, P110

investigation panel that Mr Edwards was asleep sitting on the bed with his feet on the floor. She believed she could see that he was breathing.

83. The 6.00 a.m. record indicates that Mr Edwards was asleep. It was signed by RN Watkins. She says that RN Chikuku performed that round with her. She does not suggest that RN Chikuku saw Mr Edwards. RN Chikuku does not identify what rounds she performed. RN Watkins reported to the NBMLHD investigaton panel that Mr Edwards was in a similar position as at 6.00 a.m. but had moved slightly back. She claims to have believed he was sleeping.

84. The overnight shift nurses in the Hospital are managed by an "After Hours Nurse Manager". RN Nishidh Patel provided a statement to the NBMLHD investigation on 6 June 2017. RN Patel said there was no clinical information or indication of risk relating to Mr Edwards given to him at the handover at 10 p.m. on 26 May 2017. Mr Edwards had been in the ACMHU for 2 days, he had been scheduled as an involuntary patient due to a risk of serious harm to himself, and he was on Level 3 observations. RN Patel also said that he did not receive any reports from the ACMHU Team Leader RN Brown about any issue or any clinical incident in the ACMHU during the evening when Mr Edwards died. RN Patel handed over to the morning shift Nurse Manager RN Alana Kelly.[53]

Progress Note

85. The only time patients' files were allocated to a nurse during the ACMHU overnight shift was when it was nearing the shift's end and it was time to enter the electronic PN for each patient. It is unknown how it was decided which nurse would complete which patient's PN. It may have been that RN Dudhela handed a pile of files to each nurse.

86. A PN was written by RN Dudhela at 6.20 a.m. at which time Mr Edwards was likely deceased. RN Dudhela wrote: *"Patient observed to be asleep during each rounds*

[53] Exhibit 1: Vol 7, Tab 93, P1901

(sic)".[54] RN Dudhela says in his statement: "I documented my entries on eMR based on what was reported to me".[55] He does not say who it was that he asked or who it was that reported that Mr Edwards was asleep at every round.

87. RN Dudhela can't have had any reference to the Observation Chart or if he did he disregarded it because it is inconsistent with the PN written at 6.20 a.m. It is also inconsistent with any incidents occurring around Mr Edwards being upset about being refused Temazepam by the medicating nurses and requiring being spoken to by the Team Leader RN Brown, or Mr Edwards yelling at a patient, or Mr Edwards jumping out of bed and yelling at RN Watkins.

Where is the truth – Temazepam- Medication Charts-Progress Notes-Observations?

88. The following exchange occurred between the NBMLDH investigation panel and RN Watkins at the commencement of her interview:[56]

> Interviewer: Can you just detail for me any care that you provided to (Mr Edwards) from the time that you started on shift?
>
> RN Watkins: I can't say I gave him much care at all; I was one of the nurses that was medicating him. Are you asking me what time or what happened with the medication?
>
> Interviewer: If you think of it in chronological order from the time you started, what was your first interaction with the patient in the sense of did you do any observations, medications, what you actually did.
>
> RN Watkins: I did the first check with one of the pm shifts that was on and I did a round, a fireboard round, he's an EN but I 'm not quite sure of what his name is, I don't know whether its Jayden but we did a round and checked in on (Mr Edwards) and he was in his room.
>
> Interviewer: What time was that?

[54] Exhibit 1: Vol 4, Tab 28,P1424
[55] Exhibit 1: Vol 1, Tab 15, P233
[56] Exhibit 1: Vol 7, Tab 106, P2022

RN Watkins: That would have been the 9.30 check, the 21.30 check. It's not on this (Observation Chart) one. It's on the fireboard.

Interviewer: So the fireboard check at 9.30 p.m. and (Mr Edwards) was in his room awake, is that right?

RN Watkins: Yes, yes he was in his room awake. *Settled*.[57]

Interviewer: So from there is there any other…

RN Watkins: (RN Chikuku) and myself were doing medication for that shift and (he) came up on a couple of occasions to request medication and he'd been told that the pm shift had given him his regular and all his PRN that he could have and he went away, he accepted that and he went away back to his room. He came back out later on and asked for medication again and the team leader Emma Brown had told him that he'd had all the medication that the doctors had charted for him and we could give him some more in a few hours. So he went back to his room.

I did a 12 o'clock fireboard round with (RN Egbufor) and (Mr Edwards) was in his room settled and I observed (him) to be sleeping. After that, after midnight, I'm not quite sure what time it was, between midnight and 1.00 a.m. one of the other patients ... (identifies who) was on the payphone outside his room and she was arguing loudly with someone on the payphone and (Mr Edwards) came out of his room and yelled at her and said that she'd woken him up and he went back into his room and closed the door.

I didn't have any other interaction with him until I came back from my break at 4 o'clock and I logged onto my computer and I asked (RN Egbufor) and (RN Dudhela) if the fireboard check had been done and neither of them answered me. So I got up and had a look and saw that it hadn't been done and I asked (RN Dudhela) to do the check with me and he did.

[57] Exhibit 1: Vol 7, Tab 106, PP2022-2023. "Settled" is not transcribed on the transcript but is clearly audible on the audio recording.

> …RN Dudhela was a little in front of me so when I got to (Mr Edwards) room I'd saw (RN Dudhela) with the torch looking through the window. So he then went over to the other patient's rooms and I could see him laying (sic) on the bed, (Mr Edwards) laying on the bed; I opened the door and went in to see whether he was sleeping and I disturbed him, I though woke him up and he jumped off the bed and came towards me and I apologised to him. He was yelling and telling me I'd woken him up and swearing at me to *get out of his f'ing room and to turn the f'ing torch off.* So I backed out of the room and closed and locked the door and just kept doing the rest of the checks."

89. That version differs in material respects when compared to the version RN Watkins told the police when they interviewed her at the ACMHU at 11:19 p.m. on 27 May 2017.[58] I have highlighted what I find are the significant inconsistencies.

90. RN Watkins' told the police that she had come in early as the shift starts at 9.30 p.m. and she had done the round with one of the "pm shift"[59] to check all the patients were there and make sure they were all right.[60] At no time did she say that she had seen Mr Edwards in his room settled. She said *"and when I came back in (Mr Edwards) was at the window requesting medication…and because I was one of the medicating nurses I hadn't started at that stage* ***one of the pm shifts asked me if we could give them and I said I hadn't started and that they would have to do that. So um, yeah, two of the pm shift gave him his regular Temazepam that was supposed to be at 10 o'clock but because he was quite agitated, unsettled, and screaming some, um unsettled, saying he wanted to go to bed, they gave it to him about 20 past 9.00, I'd say"*** [61]

91. She was asked what her next interaction with Mr Edwards was (after he had been given the Temazepam): *"He came up to the window probably 2 times after we,* ***after he'd had that medication requesting more medication****...we told him we couldn't give him anymore because he had obviously had his PRN medication before we'd started.* ***He'd***

[58] Exhibit 1: Vol 1, Tab 10, P95
[59] RN James Ganzo's shift
[60] Exhibit 1: Vol 1, Tab 10, PP100-101 (Q56)
[61] Exhibit 1: Vol 1, Tab 10, PP100-101(Q55-59)

had um, um Diazepam, I think he'd had and I'm not quite sure what other medication he's had *but* ***we*** *looked at his medication chart and told him* ***we*** *couldn't give any more medication. He wasn't due for it."* [62]

92. She said that **he next came up for a drink and she gave him a drink of water. She said that while she was sitting down at the end of the nurses station "*he kept coming out of the room and he <u>was quite agitated and pacing</u>*** *and another patient had a phone call, it would have been <u>well after midnight</u>, he came out of his room screaming at her, telling her that she was making too much noise and* ***disturbing him****".*[63]

93. The police officer then said: "You mentioned to me on the phone that he was pretty annoyed at about 4 a.m."[64] RN Watkins responded: *"I did the 4.00 a.m. check with Mehul* (RN Dedhula), *I opened the door. He always locked the door. So I unlocked his door and opened it and looked in with my torch and he screamed out at me to shut the fucking door…turn the fucking (phone) torch off me face and* ***<u>ya wouldn't give me fucking medication</u>*** *and get out of my fucking room and he got off the bed and sort of started to step towards me so I said "I'm sorry" and walked out and locked the door as I locked the door* ***he threw something at the door****".*[65]

94. The version RN Watkins provided to the NBMLHD investigation panel at no stage suggests that Mr Edwards exhibited any distress or agitation about his medication. She reported that his only distress was due to being woken up by a patient at 1.00 a.m. and by herself at 4 a.m. The other nurses also do not suggest to the NBMLHD investigation panel or within their statements that Mr Edwards displayed any signs of agitation or distress. Their silence in this regard speaks volumes.

[62] Exhibit 1: Vol 1, Tab 10, P104 (Q88-92)
[63] Exhibit 1: Vol 1, Tab 10, P104 (Q931-93); This version does not suggest that at any time Mr Edwards had been in his room settled /asleep
[64] Exhibit 1: Vol 1, Tab 10, P106 (Q106)
[65] Exhibit 1: Vol 1, Tab 10, P106 (Q107-111).

95. It is remarkable that RN Watkins did not tell the NBMLHD investigation panel that she witnessed Mr Edwards being administered Temazepam at 9.20 p.m. If that had in fact occurred RN Watkins would have told the panel.

96. RN Watkins would have been aware of the PN written by RN Ganzo at 9.31 p.m. in which he recorded that Mr Edwards had requested to have the Temazepam at the same time as he had had Quetiapine (Seroquel) but was told he would need to have that dispensed by the overnight shift nurses– which he was happy to accept.[66]

97. RN Ganzo records on the Observation Chart that Mr Edwards was anxious at 7.20 and 7.40 p.m.[67] In his PN RN Ganzo recorded that and said that the medication was to "good effect". The Observation Chart records made by RN Ganzo notes that Mr Edwards was asleep from 8 p.m. until 10 p.m. when RN Ganzo left his shift.[68] That is consistent with the medication having "good effect". It is inconsistent with RN Watkins' claim to the NBMLHD investigation panel that Mr Edwards was in his room at 9.30 p.m. awake and settled. Even that claim is inconsistent with what she told the police that between 9.15 (when she arrived on shift) and 9.20 p.m. "***he was* (at the window) *quite agitated, unsettled, and screaming some".***[69]

98. It makes no sense that if Mr Edwards had been administered Temazepam at 9.20 p.m. that he would be asking for it shortly over an hour later. I am sure that Mr RN Chikuku's suggestion that Mr Edwards had "just had it" and to do "deep breathing exercises" would have been met by some response other than an acceptance and returning to his room.

99. The course of events over the previous two evenings and days (though difficult to rely on entirely) does provide some picture of Mr Edwards' behaviour during his time on the ACMHU particularly the overnight periods.

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[66] Exhibit 1: Vol 4, Tab 28, P1423
[67] Exhibit 1: Vol 4, Tab 28, P1456
[68] Ibid
[69] Exhibit 1: Vol 1, Tab 10, P101 (Q59)

100. On his first night in the ACMHU on 25 May 2017, according to the PN written at 12.04 a.m. by RN Watkins, 20 mg Temazepam was dispensed to Mr Edwards at 10.05 p.m.[70] The PN completed at 06:22 by RN Tom Kizhakkeppurathu stated: *"NOCTE REPORT: Pt was in bed at the start of the shift. Observed to be sleeping during all regular rounds".*[71] This is contradicted by the observation for that first night where RN Watkins records in the Observation Chart that Mr Edwards was settled (as opposed to sleeping) at 4.00 and 4.30 am.[72] In any event, given the malpractice adopted by the overnight shift it can be safely inferred that RN Kizhakkeppurathu's PN does not bear any resemblance to reality.

101. The late morning (11.04 a.m.) PN on 25 May 2017 stated *"Pt req (requests) discharge, agitated, elevated in mood and behaviour. Pt given 10 mg diazepam as a PRN medication. Pt remorseful regarding suicide attempt"*[73]*.* In the afternoon Mr Edwards engaged in a Diversional Therapy group activity.[74]

102. On his second night in the ACMHU on 26 May 2017, according to her PNs, RN Brown dispensed 20 mg Temazepam at 10 p.m. and also 10 mg Diazepam[75] at 5.30 a.m. as Mr Edwards was *"c/o (complaining of) agitation, unable to settle, restless and irritable"*[76].

103. RN Dudhela wrote the PN at 6:23 a.m. saying Mr Edwards *"slept on and off during the round. Pt requested PRN around 0100 for more PRN which he cannot access until 0400 hours."*[77] The Observation Chart records that Mr Edwards was asleep from 10.20 p.m. to 3.30 a.m. There is no explanation as to why RN Brown provided medication at 5.30 a.m. rather than at 4.00 a.m. RN Dudhela's PN is not consistent with the Observation Chart but at least records the medication request.

[70] Exhibit 1: Vol 4, Tab 28, P1409
[71] Exhibit 1: Vol 4, Tab 28, P1410
[72] Exhibit 1: Vol 4, Tab 28, P1446
[73] Exhibit 1: Vol 4, Tab 28, P1412
[74] Exhibit 1: Vol 4, Tab 28, PP1414-1415
[75] Exhibit 1: Vol 4, Tab 28, P1415
[76] Exhibit 1: Vol 4, Tab 28, P1416
[77] Exhibit 1: Vol 4, Tab 28, P1417

104. The late morning PN (commenced at 10.46 a.m. and modified at 1:08 p.m.) on 26 May 2017 indicates that Mr Edwards was dispensed 10 mg Diazepam at 11.30 a.m. for *"severe agitation".* It records that he slept through breakfast despite prompting by staff; he ate lunch and was reviewed by the Registrar Dr Paul Hetman. The nurse's notes record the mental state examination thus: *"Behaviour: Superficially settled; abrupt and demanding in engagement with nursing staff; nil interaction with co-patients. Mood: dysphoric. Affect: restricted; mood congruent. Speech: appropriate rate, tone and volume. Thought Form: Nil formal thought disorder. Thought Content: Denies thoughts of harm to self or others at present; strong discontent with inpatient admission. Perception: Denies perceptual disturbances. Cognition: not assessed. Insight & Judgment: Poor".*[78]

105. Dr Hetman determined that Mr Edwards was mentally ill and should be a detained patient and on Level 3 observations.[79] Mr Edwards left the ACMHU to have his back X-rayed at about 3.30 p.m. After his return to the ACMHU, Mr Edwards spoke to his sister by telephone at about 7 p.m. where he told her that he expected to remain in hospital until the following Monday (29 May 2017) but that he thought he would stay longer until he felt better.[80]

106. RN Ganzo wrote a Progress Note between 9 and 9.31 p.m. on 26 May 2017. He recorded *"Pt observed to be quite dishevelled and unkempt refusing to have a shower. Pt reported mood is "not quite good" congruent with his affect. Denies current TOSH/SI/perceptual disturbances stated that he feels angry and agitated because the patients are distressing him, requested for PRN given 10 mg Diazepam at 1600 hours with minimal effect requested another 25 mg Seroquel with good effect Pt. Requesting if he can have his Temazepam early-* ***informed that the night staff will have to give it to him. Pt agreed to it.*** *Tolerated diet and fluids well, taken meds with concordance.*

[78] Exhibit 1: Vol 4, Tab 28, P1418
[79] Exhibit 1: Vol 4, Tab 28, PP1421-P1422. This was the additional second assessment required to Dr Liang's assessment to detain Mr Edwards as a mentally ill person under the Mental Health Act 2007.
[80] Exhibit 1: Vol 4, Tab 28, P1433

Pt was escorted to medical imaging for back x-ray by a nursing staff and security guard with nil issues. Level 3 obs attended nil issues."[81]

107. The medication chart records[82] indicate that on 26 May 2017 Dr Hetman prescribed Mr Edwards regular medication and "as patient requires" ("PRN") medication. The regular medications included Temazepam 20 mg (taken nightly) and Quetiapine (Seroquel) 25 mg (taken twice daily). The PRN medication included Diazepam 10 mg (limited to a total of 30 mg over a 24 hour period).[83] He had also been earlier prescribed Fluoxetine 20 mg (to be taken in the morning).

108. The medication charts indicate Mr Edwards being dispensed with the following Regular and PRN medication on 26 May 2017: Fluoxetine 20 mg at 8.00 a.m.; Diazepam 10 mg at 11.25 a.m. and 4.00 p.m., Temazepam 20 mg at 10.30 p.m. and Quetiapine (Seroquel) 25 mg at 7.30 p.m. That RN Ganzo dispensed 10 mg Diazepam at 4 p.m.[84] and 25 mg Quetiapine (Seroquel) at 7.30 p.m.[85] The Regular Medication chart[86] indicates that RN Ganzo signed and dispensed 25 mg Quetiapine at 8 p.m. and a 20 mg dose of Temazepam at 10.30 p.m.

109. It is unlikely that the Regular Medical Chart time of any dispensing of Temazepam is correct as RN Ganzo was not on shift at that time. Further, the Observation Chart has Mr Edwards asleep from 8 p.m. to 10 p.m. by RN Ganzo which is consistent with RN Ganzo's PN that the Quetiapine had good effect.

110. It is unclear whether RN Ganzo also gave Mr Edwards the Regular dose of 25mg of Quetiapine at 8 p.m. Given his PN written between 9 p.m. and 9.31 p.m. suggested that he did not give Mr Edwards any Temazepam at all though he has initialled dispensing it on the Regular Medication sheet at 8 p.m. and 10.30 p.m. It is likely that he gave Mr Edwards the PRN at 7.30 and then the Regular at 8.30 as he uses the phrase in the PN

[81] Exhibit 1: Vol 4, Tab 28, P1423
[82] Exhibit 1: Vol 4, Tab 28, PP1438-1440
[83] Ibid
[84] Exhibit 1: Vol 4, Tab 28, P1438
[85] Exhibit 1: Vol 4, Tab 28, P1440
[86] Exhibit 1: Vol 4, Tab 28, P1437

*"requested PRN given 10 mg Diazepam at 1600 with minimal effect requested for **<u>another</u>** 25 mg of Seroquel with good effect"*.[87] (Emphasis added)

111. It would seem that the Regular Medication chart[88] is not an accurate document at least in so far as the time or the fact that Mr Edwards was given Temazepam.

112. After I adjourned to determine findings, in an attempt to obtain clearer evidence about whether Mr Edwards had the Temazepam dose, at my request, those assisting me instructed Macdonald Christie, Professor of Pharmacology at the School of Medical Sciences, University of Sydney. He provided a report dated 7 October 2019 and a supplementary report dated 28 October 2019. Following distribution of the reports to the interested parties they were tendered (in Chambers) without objection as evidence. Professor Christie's reports are Exhibit 7.

113. Professor Christie was asked to address the following issues in his report:

> 1.1 To what extent are the levels of Temazepam (0.08 mg/L) detected in [Mr Edwards'] post-mortem femoral blood consistent with him receiving a 20 mg dosage at 9:30 pm on 26 May 2017?
>
> 1.2 To what extent are the levels of diazepam (0.28 mg/L) detected in [Mr Edwards'] post-mortem femoral blood consistent with him receiving a 10 mg dosage at 4:00 pm on 26 May 2017? Do the levels detected indicate any possibility that a subsequent dosage may have been ingested by Mr Edwards?
>
> 1.3 To what extent am I able to provide an opinion as to the likely time of [Mr Edwards'] death and/or the period of time that had elapsed between [Mr Edwards'] death and his discovery by RN Hickson at 7:30 am on 27 May 2017?

114. Professor Christie notes the medication chart records as set out at paragraph [110] above but rather than the dispense time of Temazepam at 10.30 p.m. he records that as at 9.30 p.m. (as instructed). He notes that there is no Electronic Medical Record ("EMR") record that Mr Edwards was dispensed Temazepam on 26 May 2017.[89]

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[87] Exhibit 1: Vol 4, Tab 28, P1423 (My emphasis)
[88] P1437
[89] Exhibit 7 at [4.12]

115. In relation to PRN medication Professor Christie notes:

> "two doses of diazepam 10 mg, were signed for in the chart but not noted in the EMR, *i.e* a dose was signed for on 23 May but not included in the EMR, and a dose was signed for on 26 May (not clearly written but appears to be12:03 am) but also not included in the EMR. I note that the times noted in the EMR do not all match well with the chart. It should also be noted that the dose of diazepam noted in the EMR on 26 May at 4:00 pm was not signed for in the manual chart. It is unclear whether the dose of diazepam signed for on the Once Only Pre-Medication and Nurse Initiated Medicine chart (2.17 above, p. 1438) is included in the EMR. It is also unclear whether that dose was given on 25 or 26 May at 11:25 am because the date prescribed was noted as 26/5 but the date and time appears to be 5/25".

116. Professor Christie sets out in his report the factors involved in determining the significance of the Post Mortem levels of Temazepam and Diazepam in Mr Edwards' blood. He posits the time of death as 5.30 a.m. based on the evidence of a 2 hour minimal period before the 7.30 a.m. discovery. Professor Christie posits that a likely peak blood concentration of blood Temazepam of 0.18-0.41 mg/L within an hour of ingestion.

117. Professor Christie identifies that the half-life for Temazepam has a very large range namely 7-12 hours. He proceeds on the basis of a 7 hour half-life[90] and says that on the basis of ingestion of 20 mg at 9.30 p.m. and on the basis of an elimination half-life of 7 hours, and death occurring at 5.30 a.m. without considering post-mortem distribution a blood concentration of 0.09-0.20 mg/L would have been likely. If death had occurred earlier or the elimination half-life was slower, then the expected concentrated would have been higher than the 0.08 mg/L, reducing the likelihood of ingestion at 9.30 p.m. on 26 May 2017. It must be noted that this calculation does not take into account the effects of post mortem distribution. It also must be noted that had Mr Edwards died before 5.30, the level of 0.8 mg/L would be viewed as at the most lower range militating against the likelihood of the 26 May 2017 dose.

[90] I take this as the fastest elimination period to provide the most conservative calculation

118. Professor Christie opines that it is likely that the blood concentration of Temazepam increased due to post-mortem distribution suggesting that the 0.08 mg/L was likely slightly below the lower expected levels for a 9.30 p.m. 26 May 2017 ingestion. He also considered whether the 0.8 mg/L level was consistent with Mr Edwards having not been given the 26 May 2017 dose. He opined that the range was within but in the upper end of the range had there been a lapse of 30 hours since the ingestion of Temazepam, namely at 10.10 p.m. on 25 May 2017.[91]

119. Professor Christie also notes that the Diazepam ingested by Mr Edwards could have produced metabolites of Temazepam and thus contributed to the 0.8 mg/L by up to 20 %. Taking into account that factor would lessen the possibility of a 26 May 2017 dose of Temazepam.

120. Professor Christie was unable to answer 1.2 due to the duration of the half-life and the complication of post-mortem distribution of Diazepam

121. Likewise, Professor Christie was unable to answer 1.3.

122. Accordingly, Professor Christie's findings are that the level of 0.8 mg/L of Temazepam blood concentration is consistent with Mr Edwards having received the 26 May 2017 dose if he had died at 5.30 a.m. as well as being consistent with him not having received any dose since 10.10 p.m. on 25 May 2017. Based on those findings it is unclear as to whether Mr Edwards received any dose. However, it would be likely that he did not receive the dose had his time of death been earlier than 5.30 a.m., by what extent is unclear.

123. The evidence contained in RN Ganzo's PN, the failure of RN Watkins to inform the NBMLHD investigation panel that she witnessed Mr Edwards being dispensed with 20 mg Temazepam by two afternoon staff members at 9.20 p.m. and the discrepant pre-signed dose of 10.30 p.m. lead me to find that that it is most unlikely that Mr Edwards received the dose of 26 May 2017.

[91] 5.1 Professor Christie Report 7 October 2019

124. On any evidence there is no suggestion that Mr Edwards ever received a dose of 10.30 p.m. As Professor Christie notes there was no entry on any PN that the 20 mg was dispensed and there is no other EMR record entry made. It was obviously not possible that RN Ganzo provided that dose to Mr Edwards because he was not there at 10.30 p.m. and a 9.20 p.m. dose was inconsistent with his PN of 9.30 p.m. That this is an issue about what happened to Mr Edwards that night is confirmed by listening to the audio of recording of RN Dudhela. He told the NBMLHD investigation panel that he did not recall Mr Edwards receiving medication and then said he saw him having his tablet. That was obviously as untruthful as the PRN he made on the EMR – that Mr Edwards was seen to be asleep every hour of rounds.

When did Mr Edwards die?

125. The ability to determine the time of death is extremely imprecise. Dr Brouwer, a forensic pathologist suggests that Mr Edwards had been deceased for at least 2 hours and the medical and clinical literature would suggest that he had been deceased for about 6 hours.

126. The description of the extent of Mr Edwards' *rigor mortis,* the fact that he had a complete absence of any cardiac output, was unable to be intubated, his body was cold blue (cyanosed) and rigid and his arms were set in a curved position caused the NBMLHD investigation panel to believe that he had been deceased for about 8 hours.

127. Professor Christie's analysis of the Temazepam suggests that any time of death greater than 2 hours would cast doubt on whether Mr Edwards had received that medication as suggested by RN Watkins to the police.

128. The descriptions of Mr Edwards' mental state and behaviour on ACMHU given to the NBMLHD investigation panel are in stark contrast to the description RN Watkins gave the police. They are also starkly different to the reports of what occurred over the previous 2 nights.

129. According to what each nurse has told the NBMLHD investigation panel nobody seems to have seen Mr Edwards that night in any agitated state. Indeed hardly anyone admitted to seeing him much at all.

130. RN Brown said that she did not see Mr Edwards after 11 p.m. Her version that there was no time that Mr Edwards was agitated is inconsistent with the previous overnight shifts – even when he had his dose of Temazepam. It is inconsistent with Mr Edwards hauling in an armchair into his room. However, given that Mr Edwards took his own life and had spent a considerable period of time attempting to do so by moving the chair into his room, removing the ceiling panel and fashioning what appears to have been a failed ligature and then anchoring it above the bedhead, it can be reasonably concluded that he was highly distressed and agitated for a considerable period of time. His death occurred occurred in circumstances which appear to involve an abject failure of nursing care.

131. RN Dudhela claims that he did not see Mr Edwards after midnight on 27 May 2017. His claim that he couldn't remember if Mr Edwards had a sleeping pill and then that he did is as contradictory and untruthful as his PN for that night. RN Dudhela was asked what it was like on the ACMHU on the night of 26-27 May 2017 and he replied that it was a fairly settled night and there had been no aggression on the ward. He didn't know what time he wrote his last level 3 observation. After handover he left the unit - before the duress alarm was activated.

132. RN Chikuku claims she did not see Mr Edwards at any time after she told him that he had "just had" the Temazepam after looking at his medication chart showing administration at 10.30 p.m by a nurse who was not on duty at that time. Though RN Brown nominates RN Chikuku as being the nurse who would have observed Mr Edwards at either 1.00 or 2.00 a.m. RN Chikuku's position is that she never did so.

133. RN Egbufor says that she saw Mr Edwards asleep in his bed asleep at 3.00 a.m. and though she signed the observation at 4.00 a.m. she has no recollection of seeing him

then. There is no basis to conclude that RN Egbufor saw Mr Edwards asleep at 3.00 a.m. She said that she did not enter the room because the door was broken. It was not.

134. RN Watkins' claim to the NBMLHD investigation panel[92] as well as to the police[93] was that she had very little to do with Mr Edwards. However, she appears to have been the nurse who had the most to do with him. If taking the version of events of all the nurses and herself into account RN Watkins performed every round and saw Mr Edwards except at the 10 p.m. and 3.00 a.m. rounds on 27 May 2017 – certainly inconsistent with her position that she had very little to do with him.

135. On the state of the evidence in this matter, it is reasonable to suspect that at some stage prior to 4 a.m. one of the nurses on the overnight shift discovered that Mr Edwards had died after he had been displaying a significant degree of agitation which had gone unmet by any nursing kindness and preparedness to give him sedating medication or call a doctor for medical review.

136. Whether the circumstances involved his protest that he had not received his Temazepam against a nurse taking the stance that he had had it because the medication chart said he had is unknown but very much a possibility.

Collusion and Inculpation from the Outset and Document Access and Tampering

137. The untenable shroud of silence engaged in by all nurses behind RN Watkins' version smacks of collusion. RN Watkins has accessed the Fireboard folder and signed the morning shift's Fireboard Sheet, likely after participating in the police interview. This access indicates that she had an opportunity to remove the sheets from the previous two shifts. She has likely accessed hospital records to learn what some nurses had said about the finding of Mr Edwards deceased.

[92] Exhibit 1: Vol 7, Tab 106, P2022
[93] Exhibit 1: Vol 1, Tab 10, P117, Q208-211

138. After her police interview RN Watkins sought out RN Dudhela to tell him that the police were asking questions about the Observation Sheet.[94] She then sought out RN Egbufor to tell her that there had been the 4.00 a.m. incident (she knew that RN Egbufor had signed the Observation Chart for that time). She told the NBMLHD investigation panel that on 30 May 2017 she spoke with RN Brown after hearing that Mr Edwards had probably died by 4.30 a.m.[95] She told RN Brown that she had **heard** two nurses[96] saying and she told RN Brown that she hadn't opened the door; he'd frightened her when he had got off the bed at her and she hadn't gone back in and opened the door because she didn't want to disturb and wake him again and have the same thing happen.[97]

139. RN Kelly wrote to the Hospital on 8 June 2017 in relation to overhearing a discussion between RN Brown and RN Watkins where she states that she heard RN Watkins say "**from the notes** by Femi and Deo[98] he was probably dead from 4.30 a.m. onwards, and if I had my time again I still wouldn't open the door".[99] If RN Kelly is correct, this would suggest that RN Watkins had improperly accessed computer file records to read what other nurses had said about Mr Edwards.

140. There is evidence that RN Watkins has after her police interview accessed the Fireboard folder. The police were given a copy of the 27 May 2017 morning shift Fireboard Sheet which by that time had only had been completed at 7.00 a.m. and 8.00 a.m. on 27 May 2017.[100] That copy has the initial of RN Emma Bloom at 7.00 a.m. and RN Brown at 8.00 a.m.[101]

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[94] Exhibit 1: Vol 7, Tab 106, P2025; Though RN Watkins told the NBMLHD investigation panel the police asked her about why RN Dudhela had not signed the fireboard entries, RN Watkins must have been referring to the Observation Chart because they did not have the Fireboard Sheet from the overnight shift.
[95] The interview transcript incorrectly records July.
[96] The interview transcript incorrectly records ministers (my emphasis)
[97] Exhibit 1: Vol 7, Tab 106, P2025
[98] Who were two nurses involved in the discovery of Mr Edwards body (my emphasis)
[99] Exhibit 1: Vol 7, Tab 99, P1915
[100] Exhibit 1: Vol 4, Tab 28, P1456
[101] RN Brown had remained at the ACMHU during the duress.

141. There has also been tendered a Fireboard Sheet completed 7.00 a.m. to 9.30 p.m. on 27 May 2017.[102] I note RN Watkins' initials have been placed in the 7.00 a.m. column underneath RN Bloom's signature. RN Watkins must have placed her initials on that document after her interview with the police. There is no evidence about who removed the 25-26 and 26-27 May 2017 Overnight Fireboard Sheets from the folder. Whoever removed the Fireboard Sheets was aware of the significance of the documents to the investigation into Mr Edwards' death.

142. RN Watkins inculpated every nurse on duty including RN Chikuku who does not support RN Watkins' claim that she observed Mr Edwards through the door window at 6.00 a.m. on 27 May 2017.

143. RN Watkins inculpated the recently graduated RN Bloom by requiring her to look through the broken blind to confirm that Mr Edwards was asleep at 7.00 a.m. She told the police "*I did the 7 o'clock with one of the morning staff Emma Bloom...**I drew her attention to the fact** that he was sitting on the side of the bed and he'd been aggressive and we weren't going to open the door because he was aggressive and he'd been like that for the last 3 nights, swearing and carrying on so you learn to back off when they get as bad as he was*".[103]

144. RN Watkins said to the NBMLHD investigation panel: "*so I asked her [RN Bloom] to observe him through the blind that was open because that blind is broken and its stuck open a little bit so I asked her to observe him which she did…he was still sleeping. So we finished our shift and went home."*

145. RN Watkins said Mr Edwards was in a different to the earlier position – she said he had moved and he was sitting up towards the top of the bed sort of leaning back on the back of the bed. She was asked if she had interacted with him and she said: *"No we didn't even open the door **we just both** looked in and checked that he was sitting up in bed".*[104]

[102] Exhibit 6
[103] Exhibit 1: Vol 1, Tab 10, PP106-107 (Q113-121)
[104] Exhibit 1: Vol 1, Tab 10, PP111-112 (Q161-170) (my emphasis)

146. In her statement dated 21 December 2017, RN Bloom describes how RN Watkins checked patients when they did the Fireboard Round together at 7.00 a.m. She said *"RN Watkins visually checked each patient and I ticked the Fireboard checklist. During this round, RN Watkins would either open the patient's door and enter the room or just look through the blinds on the window of the door. When we came to [Mr Edwards]) room, RN Watkins looked through the window and said he was sleeping, she also requested that I look through the window. RN Watkins said [Mr Edwards] had been agitated throughout the night and he went to bed late and this was the reason why she did not open the door, to allow him to sleep. On all other Fireboard rounds I have ever conducted with the other nurses, one person checks the patient and the other person ticks off the Fireboard's checklist. On this occasion I also checked [Mr Edwards] because RN Watkins had asked me to do so; otherwise I would not have observed him at that time".*[105]

147. RN Bloom goes on to describe Mr Edwards' position: *"When I looked through the window, I saw (Mr Edwards) sitting with his face towards me, his eyes were shut as if he was sleeping. He was sitting on the bed resting the left hand side of his head on the wall. I could not see the cord around his neck".* She left and 10 minutes later the duress alarm was sounded and she returned to Mr Edwards' room. She says: *"When I arrived I saw Mr Edwards sitting in the same position as he was on the 0700 round but this time I could see a cord around his neck which was tied to the bed head".*

Some "telling" differences in the version given to the Police and those given to the NBMLHD Investigation Panel

148. RN Watkins misled the police about the allocation of patients. It is unclear whether that was to avoid discovery of the longstanding malpractice adopted by the overnight shift nursing staff at the ACMHU or was an attempt to minimise her role with Mr Edwards. Whatever the reason behind her attempt she contradicted herself on many occasions.

[105] Exhibit 1: Vol 1, Tab 16, PP228-229

149. She said..."*we've got 'em on a level 3 and we've got to observe them all the time...every 20 minutes, half an hour…we do checks on them every hour…we do checks and there's always two to do the checks to do the rounds Um, and they are quite psychotic at times. In the case of (Mr Edwards), he was quite aggressive, violent, threatening….they all differ their moods and it depends on what's happening at the time. We've had quite volatile patients the last 3, 4 nights…throwing chairs on the night before, yeah so they're all different..."*[106] Despite claiming that she had no allocated patients other than the task to dispense medications[107] she said that all her patients were level 3... "*a whole set of them".*[108]

150. RN Watkins said that due to her medication duties it "might be 2 or 3 o'clock"[109] before she could help other RNs depending upon when they go on their breaks.[110] This is inconsistent with her claim to the NBMLHD investigation panel that she performed rounds at 11.00 p.m. (not on the Observation Chart) and 12.00 a.m. (signed the Observation Chart) – both claims disputed by RN Egbufor and RN Dudhela and according to RN Brown observations at either 1.00 or 2.00 a.m.

151. RN Watkins' evidence about the 4.00 a.m. incident does not stand scrutiny. The interviewer gave a copy of the Observation Chart to her and asked RN Watkins: ***"Can you confirm for me, on the Observation Charts that are here and the times that you've signed, which times did you actually view [Mr Edwards]?"*** RN Watkins replied: *"On the 2300 one, the 0500 and the 0600 one on this one and the 0700 with Emma Bloom".*[111]

152. The interviewer then informed RN Watkins that Mr Edwards may have been deceased for 6 hours at the time he was found to which RN Watkins replied "*He was still alive at 4 o'clock".*[112]

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[106] Exhibit 1: Vol 1, Tab 10, PP99-100 (Q38-47)
[107] Exhibit 1: Vol 1, Tab 10, P118 (Q213-216)
[108] Exhibit 1: Vol 1, Tab 10, P100 (Q53)
[109] Exhibit 1: Vol 1, Tab 10, PP117-118 (Q211)
[110] Ibid. If that was so, it is difficult to reconcile her later claim that she was performing the round at 11.00 p.m.
[111] Exhibit 1: Vol 7, Tab 106, P2025
[112] Exhibit 1: Vol 7, Tab 106, P2026

153. It is most significant that that when RN Watkins was asked to identify the times she actually saw Mr Edwards she did **not**[113] say 4.00 a.m. One explanation could be that she thought she was being asked to identify where she had signed, but given that she hadn't signed the 11.00 p.m. entry (RN Dudhela had) that explanation cannot stand.

154. RN Watkins was asked whether anyone else witnessed the interaction she claims to have had with Mr Edwards at 4.00 a.m. She said that RN Dudhela *"was out in the hallway as he'd gone on and was checking the other patients so I should imagine he was aware and I did say to him that he had been aggressive and swearing at me because I woke him up".* She was asked whether RN Dudhela would have heard that interaction to which she replied: *"Well I think he should have because he had gone across to the room across from and never walked out to go to the other rooms".*[114]

155. The evidence of all other nurses is that the rounds practice on the overnight shift in the ACMHU involved only one nurse observing one patient whilst the other nurse observed the patient in the opposite room. RN Watkins' version always has two nurses observing Mr Edwards from 4.00 a.m. onwards.

156. The police asked her if she opened Mr Edwards' door at 5.00 a.m. to which she replied: *"**We** looked through the blinds **again**[115]…through there because um, he didn't want the door open and he was quite aggressive but he was sitting on his bed.*[116]

157. RN Watkins said that when she checked Mr Edwards at 5.00 a.m. he was sitting on the side of the bed; she wasn't sure if he had his head in his hands or not but she did say that he was facing towards the door with his head down. She was asked if his eyes were open and she said: *"He look, he looked like, 'cause I always shine the torch to see*

[113] My emphasis
[114] Exhibit 1: Vol 7, Tab 106, P2026
[115] My emphasis
[116] Exhibit 1: Vol 1, Tab 10, P123

if they're breathing and he looked like he was breathing".[117] She later contradicted that claim and said she couldn't use the torch because his room light was on.[118]

158. She said that when she was with RN Chikuku at 6 a.m., she saw that Mr Edwards *"was sitting on the side of the bed in a different position, he was sort of sideways but still facing halfway towards the door".*[119] She said that he had the light on in the room and that **they** could see through the blinds... you couldn't see with the torch because the light was on in the room. [120] RN Chikuku does not say that she ever looked through the door and saw Mr Edwards.

159. RN Watkins said: *"**we** did the checks, cause I did the 4, 5, 6, 7 ...I think the 5 o'clock was with Mehul* (RN Dudhela) *and we checked again and he was sitting on the side of his bed and then I did the one with Phoebe* (RN Chikuku) *at 6 and he was sitting on half on half off his bed with his feet on the ground and **we** didn't disturb him... ".*[121]

160. It is unclear whether RN Watkins has relied on events from the previous night to disguise the events on the night or had sought to double down on Mr Edwards' behaviour to support her contention of what occurred on the night he died. She told the police that Mr Edwards had *"been quite volatile for the whole 3 nights*[122] *when, when we were doing the checks on Wednesday night, I think it was, with one of the other um RNs, um he screamed out at us and told us to lock the fucking door and get out of his room".*[123]

161. She was asked whether the nurses let the doctors know he had been volatile for 3 nights to which RN Watkins replied: *"We write it down in the notes...and the doctors review them…if it's anything really really bad we have to try and get the doctors over there…to review them...from… the general part of the hospital or TAC which is down*

[117] Exhibit 1: Vol 1, Tab 10, PP109-110 (Q139-145).
[118] Exhibit 1: Vol 1, Tab 10, PP110-111 (Q148-152)
[119] Exhibit 1: Vol 1, Tab 10, P110 (Q146-147).
[120] Exhibit 1: Vol 1, Tab 10, PP110-111 (Q148-152)
[121] Exhibit 1: Vol 1, Tab 10, PP106-107 (Q113-121)
[122] Exhibit 1: Vol 1, Tab 10, P115 (Q190)
[123] Exhibit 1: Vol 1, Tab 10, P116 (Q192)

the back...if there's a doctor there, we always get them to review them".[124] There is no note on either night about such an event occurring. Dr Hetman's notes do not suggest such an incident had been reported to him when he performed his assessment on 26 May 2017.

162. The police officer asked RN Watkins whether it was possible that Mr Edwards was deceased for a little while. She said: *"That he could've been. Yeah, but it seems to be funny if he was sitting in the middle of the bed, if he was deceased he, he would've fallen. He wouldn't have been in that position, sitting. Maybe later on when we checked, maybe 6.00, 7.00 it could have been, I don't know. I really don't know that. But that won't show up til autopsy anyway...".*[125] She described again Mr Edwards' position at 7.00 a.m. as: *"Sitting towards the back of the bed, sort of half on the bed, half off, sort of angled towards the door and he looked like he was leaning up against the back, back bit board…the wall"*.[126] She was asked if there was anything next to the bed and she said there was nothing but that he had a chair there but it wasn't beside the bed.

163. The reference to the chair is likely to be the armchair Mr Edwards had moved from the patients' lounge area to his room at some stage of the night of 26-27 May 2017. He may have used it to barricade the door or he may have used it to stand on whilst attempting to locate an anchor point in the ceiling - a ceiling panel had been removed and found in the room the morning he was discovered deceased.

164. The police officer pointed out to RN Watkins that she had covered the hourly rounds but not the 30 minute ones and RN Watkins replied that because Mr Edwards was RN Dudhela's patient she just did the hourly ones to help him.[127]

165. She was asked whether she knew if the checks were getting done in between the hourly ones and she said: *"I have no idea whether Mehul was checking those because we*

[124] Exhibit 1: Vol 1, Tab 10, PP116-117 (Q195-207)
[125] Exhibit 1: Vol 1, Tab 10, P123 (Q223)
[126] Exhibit 1: Vol 1, Tab 10, P124 (Q227)
[127] Exhibit 1: Vol 1, Tab 10, P108 (Q122-131)

were out on the floor. We sat out on the floor from 6 o'clock onwards...we open up the breakfast bar sort of thing so they can come and make coffees and have drinks and everything, we sit out there to supervise them and make sure everything's okay".[128] She did not tell the police that no-one performed half hourly checks.

166. RN Watkins told the NBMLHD investigation panel that she was aware that RN Dudhela had not signed the Observation Chart for the half hourly checks. She says that she asked him if he performed those rounds and when he confirmed that he had and so she signed them for him.

167. That account is untruthful. She would never have asked RN Dudhela if he had performed his half hourly observations as it was common knowledge that no nurse on that shift ever performed them.

168. Though there is no evidence that RN Watkins caused the Fireboard Sheet to be removed from its folder, she had apparently good knowledge of the contents. The NBMLHD investigation panel interviewer advised RN Watkins that the Fireboard Sheet had gone missing and she said: *"I know I signed the fireboard for 4, 5, 6 and I signed the other one for the next day for the 7 a.m. and Phoebe signed the one for 6 but Mahool when I viewed it last, hadn't signed and that was why the police asked me why he hadn't."* I take that to mean that the police had seen the Fireboard Sheet and noticed that two initials had been placed on the document for the entries except for the 4 a.m. and 5 a.m. entries. It is inconsistent that she would have signed the Fireboard Sheet for those times as well as the Observation Chart given the evidence that one nurse would sign the Observation Chart after the other nurse had signed the Fireboard Sheet.

169. The police did **not** ask RN Watkins why RN Dudhela had not signed the Fireboard Sheet – they had asked why he had not signed the Observation Chart for 5.30 a.m. and 6.30 a.m.[129] It would appear that RN Watkins had seen the Fireboard Sheet to know

[128] Exhibit 1: Vol 1, Tab 10, PP108-109 (Q131-134)
[129] Exhibit 1: Volume 1, Tab 10, P109 (Q131-Q138)

that Phoebe Chikuku had signed it at 6.00 a.m. because her signature does not appear on any part of the Observation Chart.

170. It is difficult to reconcile RN Watkins' evidence that she signed the Fireboard Sheet at 5.00 a.m. and 6.00 a.m. given that she signed the Observation Chart and the nurses' version is that the second nurse would sign the Fireboard Sheet so one would not have expected RN Watkins to sign both.

RN Watkins unlikely belief that Mr Edwards was Sleeping

171. RN Hickson who discovered Mr Edwards said it was obvious that Mr Edwards was hanging from a significant height; the length of the ligature was as long as the length of his head to his neck. His feet were barely touching the bed.

172. Even if RN Hickson is incorrect about how far off the bed Mr Edwards was, the description of the lower third of Mr Edwards' legs being on the bed is inconsistent with RN's Watkin's description that Mr Edwards was sitting on the bed with his feet on the floor at 5.00 a.m.

173. RN Bloom's support of RN Watkins' observations have been likely influenced by RN Watson suggesting that Mr Edwards was asleep and asking RN Bloom to make the same observation through the broken slats of the blind on the door's window.

174. Both Mr Dawson and Ms Haider submit that Mr Hickson's evidence that Mr Edwards was obviously hanging deceased would not be accepted over RN Bloom and RN Watkins' observations. I have dealt with that in the body of these reasons but to make it more apparent, RN Watkins was aware prior to inculpating RN Bloom that Mr Edwards was deceased. For reasons earlier articulated I think it is likely that all overnight shift nurses were aware.

Failures and Referrals

175. The overnight shift nurses' failure to make the required Level 3 Observations obviously contributed to Mr Edwards' death. However, this case goes far beyond nurses not carrying out 30 minute checks to ensure the safety of a patient. This case raises flagrant breach of a basic nursing tenet – being caring particularly to a vulnerable, unwell and distressed patient.

176. I think it most likely that prior to taking his life Mr Edwards was demonstrably in a highly distressed state which the nurses would likely have witnessed. I cannot exclude the real possibility that those circumstances included the nurses deliberately failing to provide Mr Edwards with medication and/or an urgent medical review.

177. The lack of transparency and truth about what had really happened on the ACMHU is as appalling as the fact that a patient, detained for his protection, suffered such a failure of nursing care that he took his own life.

178. The nurses are all complicit in falsely conveying that they engaged in carrying out their duties under the Level 3 Observation policy and protocol. Not a single nurse has displayed diligence, accuracy, attendance, or truthfulness. The evidence establishes that one of the nurses has removed or caused the removal of the Fireboard Sheet in an attempt to hinder the investigation into Mr Edwards' death.

179. Ms Haider submits that the policy in relation to the Fireboard Sheet and its use caused ambiguity about the requirement of Nurses to carry out observations separate to the hourly patient location check. She submits that this caused confusion to the nurses because the actions were similar to Level 4 observations. I reject that submission; Level 4 observations require hourly observations to assess a patient's wellbeing and behaviour. A Fireboard round merely identifies where the patient is. The nurses deliberately ignored their duty to perform observations of their patients at 30 minute intervals.

180. The nurses failed to perform nursing duties on a patient/nurse allocation. There was no confusion; it was a deliberate non-performance of requirements. Beaver Hudson, the Nurse Manager of the NBMLHD, said that he identified that the practice went beyond

the nurses on the ACMHU. If that is so, it is difficult to see how those in management were not aware of it so that they could address it. Perhaps that is the confusion – the nurses knew that was the culture and so thought it was an accepted practice by both their colleagues as well as those who were responsible for management.

181. Ms Haider submitted that not all of what RN Watkins had to say would be found to be untruthful. RN Watkins has obfuscated the truth on so many aspects; I think the appraisal of her versions is evident in the body of these reasons. RN Brown's interview with the NBMLHD investigation panel and her statement that she had no knowledge of any issue with Mr Edwards is simply unbelievable and I do not find any comfort in what she has to say.

182. Mr Dawson submits that I would find that the statements provided by the nurses are of substance. He points out that the nurses did not have to provide a statement and they did so voluntarily. Their statements were provided 6 months or more after they had been requested and each statement merely conformed to what they had disclosed in their interviews with the NBMLHD investigation panel. It is sadly not possible to say that the nurses have been forthcoming with the investigation into Mr Edwards' death. They seem motivated by self-protection over concern for a patient who has died.

183. The conduct of the nurses invites only one course to prevent any patient being under their care- and that is a referral to the Health Care Complaints Commission which I have no hesitation in making – in relation to all 5 overnight nurses: RN Emma Brown, RN Jill Watkins, RN Mehul Dudhela, RN Phoebe Chikuku and RN Florence Egbufor. I decline to refer RN Emma Bloom to the Commission due to her age, inexperience and non-involvement in the death of Mr Edwards.

184. I am satisfied that she was influenced by RN Watkins in both suggestion and compliance with RN Watkins' assertion that Mr Edwards was asleep at 7.00 a.m. when he was obviously deceased. I am of the view that each of the overnight nurses must have known that he had died during their shift and that his death would be discovered by a morning shift nurse.

Changes Made by NBMLHD

185. I have heard evidence from Mr Hudson that the Hospital has introduced an Observation and Engagement Policy which is aimed at ensuring staff provide better nursing care. A duty operation manager system is now in place to affect "spot checks" so that random audits are conducted which instils some confidence that an event such as this might not happen again.

186. Mr Lynch submits that the operations and clinical practice changes now implemented by NBMLHD are such that nurses are properly engaged in patient care. He submits that the new Team Leader and the random checks by the duty operations manager ensure compliance.

187. Mr Lynch submits that the installation of CCTV cameras on a mental health ward is a vexed issued as they may be counterproductive for patients in psychiatric units who are sensitive to being under scrutiny and it may not add their therapeutic progress. He says that the Black Dog Institute is considering safe, non-disruptive sleep monitors to avoid nurses having to conduct rounds with torches and disturbing patients' sleep.

188. Counsel assisting suggests that a system such as the Team Leader keeping a Day Book to record the names of the nurses to whom a patient is allocated should be kept. Mr Lynch wasn't sure how that would fit in with the electronic record keeping process.

189. The NBMLHD have engaged in an audit of the processes by which their nursing staff are required to account for the discharge of their duties. I have received that evidence and I need not go into detail about it. Though it is of a high standard, I am still not satisfied that it properly ensures that a similar situation will not occur. The culture by which the nurses were able to engage in a longstanding practice of not carrying out observations as required or being in a position to withhold or not acquire approval for extra medication that a patient needs, or just failing to provide basic nursing care is so

serious that the mandate to protect the safety of vulnerable patients calls for the implementation of CCTV cameras.

190. As noted above, Mr Lynch on behalf of the NBMLHD opposes a recommendation requiring the Hospital installing such a system in the ACMHU and he suggests that research indicates that cameras can be counterproductive to a patient's recovery. If there is any such counterproductive effect, it is better than an outcome such as that which occurred in this case. Other mental health units have CCTV cameras showing the corridors, loungerooms and nurses stations. I can see no good reason, in light of this case, why the NBMLHD should resist the installation of such a system.

191. Improvements to non-disruptive sleep monitoring would be a welcome innovation for both patients and nursing staff but that is really not the issue in this case. As earlier articulated I don't accept that Mr Edwards was woken at 4 a.m. night by RN Watkins' torchlight.

192. What remains is that a vulnerable patients detained under the Mental Health Act should never be exposed to poor nursing practices and whilst all the procedural changes are an excellent improvement the fact remains, that only CCTV cameras, even if they are called surveillance, can ensure that the environment in which such patients are detained are safe.

Recommendations

193. I recommend that the Nepean Blue Mountains Health Local District install and use Closed Circuit Television cameras throughout the public areas and at the nursing station window in the Acute Mental Health Unit of the Nepean Hospital.

194. I recommend that the Nepean Blue Mountains Health Local District implement a system whereby the allocation of patients to a nurse on each shift is recorded under a system that allows identification of such at any one time to improve quality staff performance monitoring and appraisal.

The findings:

Identity: Harold Edwards (a pseudonym)(Identity suppressed)

Date: 27 May 2017

Place: Acute Mental Health Ward, Nepean Hospital, Kingswood, NSW

Cause: Hanging

Manner: **Suicide**

Referral

I refer the Registered Nurses Brown, Watkins, Dudhela, Egbufor, Chikiku to the Health Complaints Commission to consider their Registration of Nursing Status

This inquest is now closed.

Magistrate E Truscott
Deputy State Coroner
29 November 2019