CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of GY
Hearing dates:	14 October 2020
Date of findings:	11 November 2020
Place of findings:	Coroner's Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Cause and manner of death – ligature strangulation – suicide – acute mental health unit – observations – access to ligatures
Non-publication and non-access orders:	1. Pursuant to s. 75(1) and (2) of the *Coroners Act 2009,* there be no publication of any matter (including the publication of any photograph or other pictorial representation) that identifies: a. GY; or b. GY's mother. 2. Pursuant to s. 75(4) of the *Coroners Act 2009*, order (1) continues to have effect after the delivery of findings.
File number:	2017/278116

Representation:	Mr Jake Harris, Counsel Assisting, instructed by Ms Taylor Bird of the Crown Solicitor's Office Mr Patrick Rooney, instructed by Ms Kate Hinchcliffe of Makinson d'Apice Lawyers, for Sydney Local Health District
Findings:	**Identity of deceased**: The deceased person was GY. **Date of death**: GY died on 12 September 2017. **Place of death**: GY died in the Missenden Acute Mental Health Unit at Royal Prince Alfred Hospital, Camperdown. **Cause of death:** GY died of ligature strangulation. **Manner of death:** GY died while admitted as an involuntary patient to an acute mental health unit. He tied shoelaces around his neck with the intention to end his life. The death was self-inflicted.

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The Coroner's Act 2009 (NSW) in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of the inquest into the death of GY.

Introduction

1. GY died on 12 September 2017 at the Missenden Acute Mental Health Unit, at the Professor Marie Bashir Centre ("PMBC"), Royal Prince Alfred Hospital ("RPAH"), Camperdown. He was 41 years old (born on 17 October 1975). He had been admitted to that facility on 23 August 2017. He was found in his room at about 5am by nursing staff, with his shoelaces tied around his neck.

2. GY's mother ("Mrs Y") attended the inquest and her love for her son was clear. Mrs Y continues to grieve the loss of her only child and I extend my sincere condolences to Mrs Y.

Nature of an inquest

3. This inquest is a public examination of the circumstances of GY's death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. The holding of an inquest does not itself suggest that any party is guilty of wrongdoing.

4. The primary function of an inquest is to identify the circumstances in which the death occurred.

5. The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) ("the Act"), is to make findings as to the identity of the person who died, the date and place of the person's death, and cause and manner of death. The manner of death refers to the circumstances in which the person died.

6. Pursuant to s. 82 of the Act, a secondary purpose of an inquest is for the Coroner to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the person's death. This involves asking whether anything should or could be done to prevent a death in similar circumstances in the future.

7. During the coronial investigation, sufficient documentary evidence was gathered to answer the questions about GY's identity, the date and place of his death and the

medical cause of his death. The inquest was therefore focused on the manner of GY's death.

The proceedings

8. The inquest into GY's death was held at the Coroner's Court of New South Wales at Lidcombe on 14 October 2020.

9. An issues list was distributed in advance of the inquest, which included the following in relation to the manner of GY's death:

    1. *The adequacy of care provided to GY at RPAH, and in particular:*

        a) *The circumstances in which GY had access to ligatures (shoelaces).*

        b) *The assessment and review of GY during the admission, including for suicide risk.*

        c) *The frequency and manner of nursing observations.*

    2. *Whether any recommendations are necessary or desirable.*

10. GY's family was concerned to understand how GY was able to end his own life whilst in an acute mental health unit at hospital.

11. In preparation of my findings, I have been assisted by the oral submissions of counsel assisting, Jake Harris.

Background

12. Prior to the events that ended with his death, GY lived with his mother, Mrs Y (aged 78 years) in a fifteenth-floor unit in Redfern. His father had died in the mid-1980s of a heart attack. He had no other siblings or children of his own.

13. GY had diagnoses of mild-to-moderate intellectual disability and Autism Spectrum Disorder. He also had a cannabis and alcohol use disorder. He experienced episodes of psychosis, which were thought to be either drug-induced or possibly caused by schizophrenia. Dr Danny Sullivan, who prepared a report for the inquest, notes that the expression of psychotic symptoms may differ or be less clear-cut in individuals with mild-moderate intellectual disability and/or Autism Spectrum Disorder.

14. Because of his condition, GY had poor anger management and tolerance and he could become frustrated and impulsive.

15. The relationship between GY and Mrs Y was strained. He blamed her for his problems, and this led to aggression and thoughts of self-harm. GY often became abusive and aggressive towards Mrs Y. This situation seems to have endured for many years. Despite these difficulties, GY and his mother reportedly refused respite care or supported accommodation for GY.

16. GY was unable to live independently and so Mrs Y was his effective carer. He had limited other support. From 2011, GY received four hours of support per week from a disability support service called Sunnyfield Disability Services, to assist him to participate in the community.

17. He also had a case manager, social worker Debra (Debbie) Denton ("Ms Denton") from Redfern Community Mental Health Team. She had known GY since 1997. She recalls a long history of reported incidents where GY assaulted Mrs Y. She considered it to be unsustainable for GY to continue living with Mrs Y, and was attempting to find alternate accommodation for him.

18. GY's finances were under financial management by the Trustee and Guardian and he received a spending allowance three times a week from his Centrelink payments. Despite this, he continued to obtain cannabis and alcohol, by taking Mrs Y's money.

19. GY's general practitioner, Dr Susana Tjandra, saw him every two to three weeks from May 2014 until September 2017. Dr Tjandra did not observe any evidence of psychosis or pervasive mood disorder. From about 2015, there were efforts to rationalise and reduce GY's psychotropic medication. By the end of 2016, GY was no longer receiving antipsychotic medication.

20. Unfortunately, from early 2017, GY's behaviour escalated. There were numerous contacts with police and admissions to hospital in 2017, comprising 24 police events (14 of them mental health related) and at least 11 presentations to hospital. GY often said he wanted to harm himself or others. Significant events include the following:

    a) In December 2016, Mrs Y reported to Dr Tjandra that GY wanted to jump from a balcony and Dr Tjandra called the Crisis Team.

    b) On 28 March 2017, GY deliberately overdosed on antipsychotic medication olanzapine and was admitted to RPAH.

    c) On 17 April 2017, police attended and GY referred to jumping from a balcony. Mrs Y stated that the day prior GY had taken a chair to the unit's balcony and indicated he would jump.

d) On 5 May 2017, GY was taken to hospital by ambulance after threatening suicide by jumping off his balcony. He was assessed as at medium risk of suicide.

e) On 9 May 2017, GY reported hearing voices, admitted to thoughts of self-harm and attempted to jump off a balcony at his home. He was admitted to RPAH. On 23 May 2017, GY was discharged home with a plan including three monthly follow-up with psychiatrist, Dr Clint Pistilli ("Dr Pistilli").

f) On 29 May 2017, GY was taken by ambulance to hospital following a disagreement with Mrs Y. The ambulance record indicates he threatened suicide, although his risk of suicide or self-harm was identified as low.

g) On 25 July 2017, GY called police to express a delusional belief that he had assaulted Mrs Y. GY was scheduled under the *Mental Health Act* by Dr Tjandra due to concerns he intended to harm Mrs Y and taken to RPAH.

21. While some of these incidents included actual or attempted self-harm, Dr Pistilli, the psychiatrist who treated GY during his admissions in May and August 2017, notes that GY's suicidal thoughts were "*historically brief and observed to resolve following a short period of containment".* GY also sometimes claimed he had assaulted his mother, when in fact he had not. Dr Pistilli notes that there was no record of GY ever self-harming in a hospital, and his risk in hospital was considered low.

22. While it is possible that the escalation of these events during 2017 occurred in the context of psychotic symptoms, Dr Sullivan considered it most likely that GY's problems with emotional self-regulation, anger and impulsive self-harm escalated due to situational stress. This stress was associated with GY living with Mrs Y and a function of his low capacity to manage stress due to his disability.

The Apprehended Violence Order

23. On 7 August 2017, GY was trying to paint the ceiling of Mrs Y's unit. When doing this he spilled some paint, which resulted in an argument with Mrs Y. GY became aggressive, pushed his mother into a wall and then followed her into the foyer and the lift. He then pushed her again, causing her to fall and graze her leg. Police attended and arrested GY. He was taken to RPAH for assessment but discharged back to police custody.

24. Police issued a provisional apprehended violence order ("AVO") protecting Mrs Y. The order did not prevent GY from residing at the unit, and he returned there that

day. The AVO was listed at Downing Centre Local Court on 9 August 2017, when orders excluding GY from the property were to be sought.

25. Ms Denton visited GY and his mother that day. GY told her he no longer wanted to live with his mother. He wanted to have his own home and get a girlfriend. Ms Denton contacted Sunnyfield and together they began looking for other accommodation options, although this was difficult due to GY's history.

26. On 8 August 2017, Mrs Y contacted Dr Tjandra to report GY had not taken his medication for a week. Dr Tjandra contacted Ms Denton and referred him to the Drug and Alcohol service.

27. During the evening of 8 August or early on 9 August 2017, GY took an overdose of Mrs Y's diabetes medication. He was taken to St Vincent's hospital for review. Police attended him there and he told them he wanted to kill himself.

28. On 9 August 2017, an interim AVO was granted by the Court.

29. Following discharge from St Vincent's on 10 August 2017, GY moved out of his home and was accommodated at the Haymarket Centre. However, he returned to Mrs Y's unit on 13 August 2017, and police were called. He told police he wanted to hurt Mrs Y and he was taken to Concord Hospital for assessment. He was briefly scheduled and discharged two days later back to the Haymarket Centre. During this admission, he told staff he had thought about jumping off the balcony. There was a plan to recommence Risperidone and increase his support in the community.

30. On 20 August 2017, GY set fire to an old mattress in an alcove next to the Haymarket Centre. Police and the fire service were called. GY told them he wanted to burn the place down and that "*[t]he voices told me to*". Police took him to RPAH, but no beds were available, and he was again admitted on an involuntary basis to Concord Hospital.

Admission to RPAH

31. On 23 August 2017, GY was transferred to the PMBC at RPAH.

32. What follows is a summary of the medical records and statements obtained from treating staff at the PMBC.

33. GY was initially assessed by Dr Sean Booth ("Dr Booth") (resident medical officer) in the Missenden Assessment Unit at PMBC. GY denied thoughts of self-harm or harm to others and said he felt safe at the hospital. The plan was to admit GY to the

Missenden Acute Unit, on level 3 of the PMBC, and place him in room 16. His regular medication (Risperidone and Catapres) was continued.

34. GY was to be checked daily for lighters due to his fire-setting risk.

35. On 24 August 2017, GY was assessed by Dr Justin Ho (psychiatrist) with Dr Booth. GY denied hallucinations or thoughts of self-harm but when questioned he accepted that he lit the mattress because voices told him to. He also admitted smoking three to four cones of cannabis daily. He was placed on a further involuntary schedule. The plan was to refer GY to social work for assistance with accommodation and provide him with nicotine therapy.

36. The next psychiatric review took place on 29 August 2017, when Dr Pistilli reviewed GY for the first time during this admission, with Dr Booth. Dr Pistilli had also seen GY during the May 2017 admission. GY told Dr Pistilli he had set fire to the mattress at the Haymarket Centre because he felt depressed. He denied thoughts of self-harm and was not exhibiting features of acute psychosis or major mood disturbance, although he also told Dr Pistilli he was hearing voices. Dr Pistilli's impression was of a schizophrenia-like illness, exacerbated by cannabis use and non-compliance with medication.

37. In a statement provided for this inquest, Dr Pistilli states:

> "*I felt that [GY] was at moderate risk of further dangerous behaviour in the community, if he were to be discharged without appropriate community supports in place, and also was at high risk of breaching his AVO protecting his mother…*
>
> *He was assessed as a low risk of self-harm or suicide and low risk of aggression to others in a hospital locked ward setting. The basis for this assessment was the current absence of major mental illness symptoms, his restricted access to illicit substances, his supervised compliance with medications, and the absence of historical risky behaviours during multiple previous hospitalisations. In addition, [GY] was known to keep a high profile on the unit, regularly interacting with staff and seeking them out if distressed."*

38. Dr Pistilli felt GY was at moderate risk of dangerous behaviour and in need of a high level of care and support. Dr Pistilli's plan focused on the following:

    a) GY remaining in hospital to undergo further assessment of his functional support needs and exploration of supported accommodation options;

b) exploring funding through the NDIS;

c) arranging occupational therapy assessment and neuropsychological testing;

d) organising a case conference to discuss the way forward; and

e) trialling a change in antipsychotic medication from risperidone to oral Paliperidone, with a view to GY commencing the long-acting injectable form of that medication to ensure better compliance in the community.

39. GY was due to be reviewed by the Mental Health Review Tribunal on 1 September 2017, but he did not attend because he had gastroenteritis. He therefore remained in the Acute Unit until the next review, due on 15 September 2017 (after the date of GY's death).

40. GY was focused on trying to get discharged, telling staff he missed his mother. He lacked insight into the reasons why he could not return home. He was given medication as necessary for his agitation. He was also said to keep a "low profile", which seems to be in contrast to previous admissions.

41. On 4 September, Dr Booth reviewed GY again. It was explained to GY that he would not be discharged until he was well and there was a safe discharge destination.

42. On 7 September 2017, a multi-disciplinary team meeting was held. GY was reduced to observation level 4, which required checks to be made only each mealtime.

43. Dr Pistilli saw GY for the second and final time that afternoon, prior to the case conference. GY appeared calm but did not cooperate with Dr Pistilli's questions. Dr Pistilli planned to next review GY on 12 September 2017, the day of his death.

44. Following this, there was a case conference between Dr Pistilli, Ms Denton and an occupational therapist, and Mrs Y attended with a Greek interpreter. Mrs Y said she no longer felt safe caring for GY. It was felt that GY would need to enter supported accommodation and would need a guardian. Dr Pistilli also said he would consider a change back to Risperidone, as GY was less irritable and disorganised with that drug.

45. On 8 September 2017, GY swallowed two nicotine inhalers. As a result, he was reviewed by a psychiatric registrar, Dr Caitlin White. GY did not offer any reason for swallowing the inhalers, but agreed it was an attempt to harm himself. He denied any further plans to harm himself. Dr White consulted a toxicologist, Dr Christian, and psychiatrist, Dr Russell. GY was placed on 30-minute observations for four hours following this. His vital signs remained normal.

46. Over the next few days, GY continued to keep a low profile on the ward, but he appeared frustrated about his continued presence in hospital.

11 to 12 September 2017

47. On the morning of 11 September 2017, GY was seen by a clinical neuropsychologist, Andrew Jones. The assessment was abandoned due to GY's low effort level.

48. In the evening of 11 September 2017, an altercation was reported to have occurred between GY and another patient. GY told staff the other patient had kicked him in the groin. He was seen by Nurse Geeta Pandey ("Ms Pandey"), who reported this incident to nurse-in-charge Alina Prasai, who advised to keep an eye on him and said she would inform a doctor. However, GY said he did not want to see a doctor. He was given diazepam (as needed). He was initially anxious, but then appeared to settle.

49. At approximately 9.20pm, Ms Pandey went to check on GY. He was in his room with the window shade closed and was wearing only a T-shirt. Ms Pandey told GY not to close the window shade and asked if she could examine him. She did so but could not see any visible injury. He denied having been assaulted. He then got into bed and the nurse wished him good night. Ms Pandey made a note about this incident and also believes she gave a handover about it to the oncoming shift. Ms Pandey recalls that at the end of her shift, during her handover to the night staff she requested that GY be monitored in case he complained of any pain.

50. At 9.30pm, nurses Luseane Taumalolo ("Ms Taumalolo"), Vincent Evbuomwan ("Mr Evbuomwan") and Tom Hiddleston ("Mr Hiddleston") commenced duty in the Acute Unit. Ms Taumalolo was the nurse-in-charge.

51. Those nurses each provided a statement for this inquest in 2017, and Ms Taumalolo and Mr Evbuomwan provided supplementary statements in 2020.

52. During the night of 11 to 12 September 2017, GY was monitored on observation level 3. At that time, observation level 3 required hourly observations. No decision appears to have been recorded to that effect; it may have been the care level for all patients in the Acute Unit overnight. This is expanded upon below.

53. At the time of these events, a single observation chart was used for all patients in the unit, requiring a nurse to initial against a patient's name to confirm observations had been performed.

54. That observation chart records that checks were made for GY every hour between 10pm and 5am.

55. There was a window in the door to Room 16 which had an internal shade or blind, controlled from the inside, which gave it a frosted appearance. In 2017, patients were generally encouraged to leave the blind up to allow nurses to observe them without disturbing them.

56. The three nurses recorded observations of GY as follows:

    a. Mr Evbuomwan recorded observations at 10pm, 12am, 1am and 2am. Mr Evbuomwan stated that on each occasion the window blind was up, GY appeared asleep and Mr Evbuomwan could see the rise and fall of GY's chest. In 2017 he had about 20 years' experience as a nurse. According to Mr Evbuomwan, his usual practice at the time was to take the observation chart or a list of names as he performed observations, and sign it as he observed each patient. He would "*generally observe the patient through the window at door of the patient's room to see if the patient was breathing (chest rising up and down)*".

    b. Ms Taumalolo recorded observations at 3am and 4am. Her usual practice was to perform observations and then return to the nurses' station to record them. While she does not now specifically remember checking GY at 3am, as is recorded, she recalls checking him at 4am. At that time, the window blind was still up and she observed GY lying on his bed. She could see his chest rising and falling.

    c. Mr Hiddleston also says he made observations of GY, at 1.30am and 3.30am, again observing GY to be asleep in bed on each occasion. However, the observation chart only records him making one observation at 11pm.

GY's death

57. At about 5am on 12 September 2017, Mr Evbuomwan attended GY's room. He looked through the window and saw GY lying on the floor. He entered the room, saw GY lying on his left side facing the bed and covered in faeces. GY was not responsive. The nurse activated his duress alarm and sought help from Ms Taumalolo, who at 5.08am called the Clinical Emergency Response System ("CERS") arrest team.

58. Nurse Zamora attended and commenced CPR. It was realised that GY had a ligature around his neck, which was cut by Mr Hiddleston. The CERS team arrived and took over resuscitation. Tragically, GY could not be revived, and CPR was ceased at 5.48am.

59. Police attended the hospital at about 7am. They located a pair of Converse shoes in GY's room which had the laces removed. Police formed the view that the ligature had initially been tied to the side of the bed to effect a hanging, but had somehow become loose prior to the arrival of Mr Evbuomwan.

60. Following GY's death, Mr Evbuomwan continued to complete the observation chart, indicating that he had checked GY at 6am and 7am. The form was subsequently amended to record that GY had been found deceased at about 5am. When asked about this recently, Mr Evbuomwan was not able to explain why he completed the form, but speculates he may have done so by accident when completing it for other patients; he notes that it was a very chaotic morning.

Autopsy

61. A limited autopsy, by way of external examination only, was performed by Dr Jennifer Pokorny on 14 September 2017. The direct cause of death was recorded as ligature strangulation. Toxicology showed non-toxic levels of benzodiazepines.

Issues explored at the inquest

62. I will now consider the issues identified in the list of issues as circulated prior to the inquest.

Issue 1: The adequacy of care provided at RPAH

63. The first issue concerns the adequacy of the care and treatment provided to GY during his admission to RPAH from 23 August 2017 to 12 September 2017.

64. During the coronial investigation, medical records from RPAH (and other hospitals) and statements of doctors and nurses involved in GY's care at RPAH were obtained. Policy documents from NSW Health and Sydney Local Health District ("LHD") that were in place in the Acute Unit at the time of GY's death and subsequently also formed part of the brief of evidence.

65. Dr Andrew McDonald is the Director of Clinical Services, Mental Health at the Sydney LHD and has been in that role since August 2012. Dr McDonald was not directly involved in GY's care at RPAH in August to September 2017. Dr McDonald provided

a statement in this inquest in relation to changes made to LHD policies and procedures following GY's death. Dr McDonald also gave oral evidence during the inquest.

66. Dr McDonald also conveyed the Sydney LHD's condolences for the loss of GY and expressed that he was sorry for what happened to GY whilst under the service's care.

67. An expert opinion was provided by consultant forensic psychiatrist, Dr Danny Sullivan. Dr Sullivan is the Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health (Forensicare) and is an Honorary Senior Fellow at the University of Melbourne and Adjunct Research Fellow at Swinburne University. Dr Sullivan reviewed relevant records and statements in providing his expert report dated 25 July 2020. Dr Sullivan also gave oral evidence at the inquest.

Issue 1(a) Access to ligatures (shoelaces)

68. Firstly, I turn to the issue of GY's access to ligatures.

69. Senior Constable Jeremy Greentree agreed with investigating police officer Detective Senior Constable Adam Royds that it is likely the shoelaces that formed the ligature were from the shoes owned by GY located in his room.

70. The inquest heard evidence from Dr Sullivan that the removal of items such as shoes with shoelaces should be limited to circumstances in which an individual has a significantly elevated risk of suicide, and that should occur for the minimum amount of time necessary. Dr Sullivan emphasised that such restrictions can impact a person's quality of life and be considered humiliating and demeaning.

71. At the time of GY's death, the Sydney LHD Mental Health Service Policy Directive, "Searching Consumers and Their Property Policy" was in force. That policy outlined the actions staff should take if an individual was suspected of being in possession of a weapon, or in possession of (or using) alcohol or other drugs. The policy did not expressly refer to removal of ligatures.

72. It was Dr McDonald's evidence that in 2017 it was the practice of staff in the Missenden Acute Unit to conduct a safety assessment of patients including for removal of potential ligatures.

73. The policy was subsequently replaced with an updated version in May 2019. The current policy provides that:

> "*Personal items, particularly those that could be potentially used in a harmful way, should be locked away for safekeeping and returned to the patient on discharge…*
>
> "*If a consumer is assessed as at risk of suicide the following items listed, but not limited to, should be removed; dressing gown cords,* ***shoelaces****, headbands and belts*" [emphasis added]

74. According to Dr McDonald, this change in policy came about partly in response to GY's death.

75. While there is evidence that a personal search was performed on 20 August 2017, there was no evidence that a safety assessment was performed during GY's admission to PMBC, in the manner described by Dr McDonald. However, on balance I am not critical of the fact GY's shoelaces were not removed, upon admission to the PMBC or at any later stage. There was no indication during the admission that GY was at an acute risk of suicide, to warrant his shoelaces being removed, and there had been no prior indication that he might use a ligature to harm himself. Staff should be guided by an assessment of the patient's risk in removing such items.

76. The amendment of Sydney LHD policy, which now specifically directs staff to remove shoelaces and other ligatures if a consumer is assessed as being at risk of suicide, is clearly an improvement. As that policy change has been made, I do not consider it to be necessary or desirable to make any further recommendation on that issue.

Issue 1(b): Assessment and review during admission, including for suicide risk

77. Dr Sullivan carefully reviewed the documentary evidence and concluded that there were no clinical signs to indicate that GY was at increased risk of suicide at any time during the hospital admission which ought to have raised alarm with those treating him. This is so despite the circumstances in which GY was admitted to hospital. While that conclusion appears surprising, it is consistent with Dr Pistilli's opinion, that GY had never self-harmed in hospital and that his risk in hospital was considered low.

78. Dr Sullivan did not consider that medication was associated with GY's apparent suicide. Dr Sullivan considered that the use of Risperidone for GY was justifiable and that Dr Pistilli's commencement of a trial of Paliperidone was an appropriate prescription choice.

79. Further, Dr Sullivan considered that the standard of care provided to GY after the reported altercation between GY and another patient was "good". Dr Sullivan opined

that there is no evidence that distress from that incident was causally associated with GY harming himself and it is impossible on the material to draw a link between the incident and GY harming himself.

Issue 1(c): Frequency and manner of nursing observations

80. GY's observation level was only documented on one occasion in the available medical records following the multidisciplinary team meeting on 7 September 2017 (recording Observation level 4). Dr Sullivan did not consider that to be of any consequence, as it was clear that nursing staff understood the level of observations that GY was on.

81. GY was generally on level 4 observations, which required observations to be performed at least every mealtime. Dr Sullivan considered that observation level to be appropriate for GY. On the night of 11 to 12 September 2017, GY was on level 3 observations which required observations to be performed every hour. Dr McDonald gave oral evidence that as a minimum requirement, all patients within the acute ward were on hourly observations overnight.

82. Dr McDonald was in his current role in 2017. Dr McDonald stated that he was confident that in 2017 in the Acute Unit, nursing observations were performed in compliance with the applicable policy. Based on his review of the material, Dr McDonald considered that GY had been observed in accordance with relevant policy.

83. During oral evidence, Dr McDonald agreed that the recording of observation levels in documentation regarding GY could have been improved. However, Dr McDonald explained that in accordance with the process in place as at 2017, GY's level of observation may have been recorded and changes documented on a "Journey Board" (an electronic whiteboard in the nurses' station containing electronic medical record information, with paper copies at handover). Although that record was not available to the inquest, Dr McDonald was confident that information regarding the observation level would have been recorded on the Journey Board.

84. Dr Sullivan emphasised in oral evidence that observations are intrusive and their frequency should be commensurate with assessed risk. There needs to be a balancing act that takes into account the intrusiveness of observations and the necessity of performing observations to determine a patient's welfare (or in particular, that a patient is alive). The intrusive nature of observations can impact the treating team's rapport with patients, the patient's willingness to engage and the patient's mental health.

85. It was not necessary for the inquest to hear from any of the nurses in oral evidence. Instead, two nurses provided supplementary statements to clarify the manner in which they undertook observations. In summary, they each say they observed GY through the window, saw him to be asleep in his bed, with his chest risking and falling. They then initialled against GY's name in the "Observation Level 3 Form" to confirm they had performed the observations as the times indicated. On the basis of that evidence, I am satisfied that the nursing staff performed observations as recorded prior to GY's death.

86. The "Observation Level 3 Form" also includes initialled entries in relation to GY for 6am and 7am, after the time when GY was discovered deceased. This might suggest that the form was initialled in relation to all patients at the same time, or that it is not as reliable a record as it might otherwise appear. However, Nurse Evbuomwan, who completed those entries, says by way of explanation that it was a "very chaotic" morning after GY's death was discovered, and that those entries may have been completed by accident. I accept that is likely to be correct.

87. The policy in relation to observations has also been amended since GY's death.

88. In July 2017, approximately six weeks prior to GY's death, NSW Health introduced a new Policy Directive in relation to observation levels in mental health inpatient units, "*Engagement and Observation in Mental Health Inpatient Units PD2017_025"*. That Policy Directive was implemented by the Sydney LHD in June 2018 through the introduction of the Sydney LHD Mental Health Services Policy Compliance Procedure, "*Engagement and Observation in Mental Health Inpatient Units*".

89. Dr McDonald in his oral evidence explained that the most fundamental change in the policy is a change in emphasis, to focus on engaging with patients through an active process of observation, rather than a passive one. Under the revised policy, staff are also required to record the specific time at which they observed the patient, the patient's location and the activity the patient was engaged in. The observation forms have been revised to reflect those changes.

90. There was evidence that there has been extensive training in the Sydney LHD in relation to the new policy, including training of all Missenden Acute Unit staff. Also, two spot check audits were completed in August 2018; the first indicated a compliance rate of 100% for Missenden Acute Unit and the second indicated compliance rate of 95% for that unit. Dr McDonald gave evidence that the audits were

no longer centrally managed and are currently implemented by local Nursing Unit Managers.

91. Dr Sullivan opined that the amendment to the observations policy has been a clear improvement which is more easily understood, has a clearly prescribed rationale and clear parameters and restraints. Dr Sullivan commented that it is commendable that there are now standardised policies regarding observations in all institutions in New South Wales, which allows consistent application of policy state-wide. This is important when agency staff move between institutions. Further, Dr Sullivan opined that the policy changes reflect the balancing act he described, between ensuring patient welfare and recognising the intrusiveness of observations.

92. It is of concern that GY died by hanging on an acute mental health ward, where he had been admitted due to concerns about his mental health, and at a time when he was subject to regular nursing observations. Mrs Y found this aspect of her son's death to be the most difficult to understand.

93. On the basis of all the evidence, I find that GY was appropriately assessed for suicide risk, and that the level of observations he was placed on was appropriate for the level of risk. I find that the nursing staff performed the observations they recorded. Tragically, GY was able to hang himself at some point after the last observation was performed at 4am.

Issue 2: Whether any recommendations are necessary or desirable

94. As I have noted, some improvements have already been implemented at Sydney LHD. The policy in relation to access to ligatures has been amended following GY's death to specifically refer to removal of shoelaces. The observation policy has been significantly improved, in line with the NSW Policy Directive.

95. A number of other recommendations were tentatively proposed in this matter, although Counsel Assisting ultimately submitted that it was not necessary or desirable to make any recommendation in relation to GY's death. I agree with that submission.

96. In particular, Dr Sullivan did not support a proposal for CCTV to be installed in patient bedrooms at the PMBC. While it may superficially appear to provide a better method to monitor patients, in order to be effective it would need to cover areas including toilets, which would be intrusive and go against patient privacy. In any event, individuals could obscure cameras or move to areas not captured on camera in order

to self-harm. Dr Sullivan opined that the monitoring of CCTV is not a better substitute for staff using clinical skills to interact with patients and developing trusting relationships to prevent self-harm where possible.

Findings required by s. 81(1) of the *Coroners Act 2009*

97. Having considered the documentary evidence and the oral evidence heard at the inquest, I make the following findings:

Identity of deceased

The deceased person was GY.

Date of death

GY died on 12 September 2017.

Place of death

GY died in the Missenden Acute Mental Health Unit at Royal Prince Alfred Hospital, Camperdown.

Cause of death

GY died of ligature strangulation.

Manner of death

GY died while admitted as an involuntary patient to an acute mental health unit. He tied shoelaces around his neck with the intention to end his life. The death was self-inflicted.

Concluding remarks

98. Mrs Y attended the inquest and I could see how much sadness and distress she continues to feel over the loss of her son, whom she loved dearly. I would like to sincerely thank Mrs Y for her participation in this inquest. I hope it has provided her with some answers about what happened to her son. I express my deepest condolences for her loss.

99. I close this inquest.

Magistrate Teresa O'Sullivan

State Coroner

Coroner's Court of NSW

Lidcombe

Date: 11 November 2020