CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of SB
Hearing dates:	20 to 24 June 2022; 17 August 2022
Date of Findings:	16 September 2022
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death of involuntary patient, Kaoriki House, clinical documentation, neuropsychiatric assessment, forensic assessment, risk assessment, observation levels, *Mental Health Act 2007*, *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*, medication regime, use of interpreters discharge planning, environmental hazards, structural vulnerability points
File number:	2017/85386
Representation:	Ms M Gerace, Counsel Assisting, instructed by Ms C Potocki (Crown Solicitor's Office) Mr P Aitken for Hunter New England Local Health District, instructed by Hicksons Lawyers Ms K Burke for Dr B Lokuge, instructed by Meridian Lawyers Ms E Elbourne for Dr M Bull, instructed by HWL Ebsworth Lawyers Mr T Hackett for Dr J McDonald, instructed by Avant Law Ms R Mathur for Dr U Babu, instructed by Moray & Agnew Lawyers

Findings: SB died on 18 March 2017 at Wyong Hospital, Hamlyn Terrace NSW 2259.

The cause of Mr SB's death was cardiac arrest following neck compression due to hanging, with vascular dementia, delusional disorder and chronic alcohol dependence being significant conditions contributing to the death.

Mr SB died as a result of actions taken by him with the intention of ending his life. At the time that these actions were taken, Mr SB was detained as an involuntary patient at a mental health facility pursuant to the provisions of the *Mental Health Act 2007*. Mr SB's death was, therefore, intentionally self-inflicted.

Recommendations: *To the Chief Executive, Hunter New England Local Health District:*

I recommend that consideration be given to amending the *Mental Health: Assessment and Management of Mental Health Patients on section 19(b) of the Mental Health and Cognitive Impairment Forensic Provisions Act 2020* Clinical Guideline so that it explicitly instructs staff at declared mental health facilities, upon a patient's presentation to a facility pursuant to a section 19(b) order, to make a referral to Court Liaison Services for the purpose of facilitating provision of information regarding a patient's legal proceedings from court registries.

Non-publication orders: Pursuant to section 75 of the *Coroners Act 2009* publication of any material, including any photograph or pictorial representation, that identifies SB, and any relatives of Mr SB, is prohibited.

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1. Introduction

1.1 On 21 October 2016, Mr SB, an 81 year old gentleman, was arrested and charged in relation to a domestic violence incident involving his wife and the discharge of a firearm which had occurred the previous evening. Mr SB appeared at court the following day and orders were made for him to be taken for a mental health assessment.

1.2 Pursuant to the provisions of relevant mental health legislation, Mr SB was admitted as an involuntary patient at a mental health unit before being transferred to a specialist neuropsychiatric unit on 31 December 2016. Mr SB remained at this second unit until 18 March 2017. On that day, Mr SB's wife and son arrived at the unit so that his son could visit him.

1.3 After being unable to find his father, Mr SB's son approached the nursing unit manager for assistance. After searching a number of common areas, Mr SB was found in a recreation room, suspended from an electrical cord which had been tied around Mr SB's neck at one end, and around a window security screen at the other end. Mr SB showed no signs of life and was lowered to the ground. Emergency medical services were contacted and resuscitation efforts were initiated. Following the arrival of paramedics, Mr SB was transferred to hospital in a critical condition and provided with advanced life support. However, Mr SB's condition did not improve and he was later tragically pronounced life extinct that evening.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 By virtue of his status as an involuntary patient, the State assumed responsibility for Mr SB's care during the course of his admissions. In such circumstances, it is important that an independent and transparent enquiry is conducted as to whether the State discharged its responsibility appropriately. Mr SB was initially an inpatient at the Mental Health Unit for Older People (**MHUOP**) at the Mater Mental Health Centre (**Mater**), before being transferred to Kaoriki House at Morisset Hospital. Both facilities are located within the Hunter New England Local Health District (**HNELHD**). In Mr SB's case, it was also necessary to specifically examine the duration of his admissions, and the circumstances which led to his apparent act of self-harm on 18 March 2017.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a

death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified during a coronial investigation and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

3. Recognition of Mr SB's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr SB was born in Treviso, Italy in 1936. He came from a poor peasant family and was the third son of six children. Mr SB's parents experienced a number of challenges and hardships. In particular, Mr SB's father struggled with alcohol abuse. Mr SB's childhood coincided with World War II and as a result, he was exposed to the violence and brutality of war in his youth.

3.3 At the age of 13, Mr SB was forced to leave a school and contracted into servitude to a family who owned a dairy farm many hours away from his family home. When he was 18, Mr SB was able to leave this arrangement and he pursued a trade in concreting. Mr SB was known to be a smart man and would look for opportunities to earn income.

3.4 In 1958, when Mr SB was 22 years old, he migrated to Australia together with three of his brothers, to pursue work in the Snowy Mountains Scheme and to avoid military service in his home country. Mr SB eventually gained a governmental contract and commenced working on the scheme.

3.5 It was there that he met his future wife, Mrs SB, who had also moved to Australia from Italy. After completing work on the scheme, Mr SB moved to Queensland to cut sugarcane. He later returned to New South Wales and married Mrs SB in 1964. Mr SB and his wife lived in a number of rural properties in Cardiff, Martins Creek, Belmont North and Hilldale. They had three children together.

3.6 Mr SB came to run a successful concreting company before retiring in his fifties. He was a strong believer in the value of hard work and saving money.

3.7 Mr SB's daughter, Ms AC, describes her father as a direct man who was sometimes hard to like. However, with an appreciation of the hardships that Mr SB experienced in his youth and the isolated life that he lived after migrating to Australia, it is evident that Mr SB was a remarkable person.

3.8 Ms AC recalls that although her father was difficult, he is missed and fondly remembered regularly, especially by his grandchildren. They remember Mr SB as an inspirational man who had a wicked sense of humour, who was grumpy and yelled at them in Italian but would do anything for them, and encourage them to pursue their goals and dreams.

3.9 There is no doubt that the sudden and tragic way in which Mr SB was separated from his family is heartbreaking. It is equally evident that his loss continues to be deeply felt by those who loved him the most.

4. Mr SB's personal background

4.1 Mr SB had a history of heavy alcohol consumption for over 40 years. He reportedly drank beer and wine daily, and was known to consume alcohol throughout the day. Mr SB himself reported drinking between five and 10 litres of cask wine per week, and up to 6 stubbies of beer per day.

4.2 In 2010, Mr SB's general practitioner (**GP**) diagnosed Mr SB with alcohol dependency and developed a care plan which included referring Mr SB to a gastroenterologist, Dr Bulipo. This consultation identified that Mr SB had a cyst on his liver, together with chronic liver disease, notably cirrhosis. Mr SB was advised to stop drinking wine, and later reported that he had done so. However, during a further review, it was noted that Mr SB continued to drink both beer and wine. Mr SB was again counselled regarding his alcohol consumption, and he expressed the view that he would be able to quit drinking. However, Mrs SB did not share his optimism.

4.3 On 6 April 2016, Dr Bulipo reviewed Mr SB again. At that time, Mr SB reported that he was still drinking both beer and wine, but claimed that his total volume of alcohol consumption had halved. When reviewed again in June 2016, Mr SB reported that he was still drinking both wine and beer, and that he had no intention of ceasing either.

4.4 A short time later, Mr SB presented to a hospital emergency department following an alcohol-related incident. He was referred to a drug and alcohol clinic at the Mater in Newcastle for review. Mr SB again expressed a reluctance to change his usual pattern of alcohol consumption, but indicated that he may be willing to reduce his volume of consumption in order to mitigate against the risk of alcohol-related falls. Mr SB was offered inpatient admission for detoxification purposes, but declined and indicated that he wanted no further contact from the unit.

4.5 Mrs SB describes her husband as a difficult man to live with, who was known to be either very happy or very cranky. Mr SB was known to make repeated outbursts where he would refer to killing himself, killing Mrs SB and killing "*everybody*". According to Mrs SB, Mr SB was also a very

paranoid man who always had to have everything his own way. During the later stages of his life, Mr SB became decreasingly social, and spent much of his time at home, rarely leaving his property.

4.6 Sometime around June 2016, Mr SB reportedly became extremely paranoid, expressing the belief that unknown persons were attempting to take his property and possessions. In addition, Mr SB also expressed the belief that Mrs SB, who at the time was 70 years old, was having an affair with the partner of their daughter. Family members repeatedly told Mr SB that this was not true. Notwithstanding, Mr SB maintained his belief and repeatedly accused Mrs SB infidelity.

4.7 On 18 September 2016, Mrs SB reported to her GP that Mr SB was showing signs of increased paranoia, and that he had accused the partner of their daughter of having an affair with Mrs SB. In addition, Mrs SB reported that on one occasion during an outburst, Mr SB pulled out the phone line whilst she was on the phone and then took their cat to his room, announcing that they would die together.

5. The events of 21 and 20 October 2016

5.1 On the evening of 20 October 2016, Mrs SB returned home after attending a doctor's appointment in Maitland. Mr SB was noted to be initially behaving normally before he began raising his voice and yelling. Mrs SB went to her bedroom in order to speak to her daughter on the phone.

5.2 Mr SB entered the bedroom carrying a .22 calibre rifle which he used to discharge one round in Mrs SB's direction. The projectile struck, and became lodged in, the wall just above Mrs SB's head. Mrs SB approached Mr SB and, after a brief struggle, she removed the firearm from Mr SB and threw it under a car outside the house. Upon re-entering the house, Mrs SB saw that Mr SB was standing in the kitchen with a knife in his hand and he made a verbal threat towards her. Mrs SB returned to her bedroom and locked the door.

5.3 The following morning, Mrs SB left the house whilst Mr SB was still sleeping. She attended her GP, Dr Salaria, and reported the events of the previous evening. Dr Salaria prepared a mental health schedule pursuant to section 19 of the *Mental Health Act 2007* (**Mental Health Act**). Dr Salaria sent the document to the Mater, together with a patient summary sheet listing Mr SB's mental history and medications. In response to Dr Salaria's report, police officers attended Mr SB's home and arrested him. He was charged with a number of offences relating to the events of 20 October 2016, including discharging a firearm, endangering life, possessing an unregistered firearm and common assault.

5.4 On 22 October 2016, Mr SB appeared at Maitland Local Court while still in custody. An interim apprehended domestic violence order (**ADVO**) was applied for and granted. In addition, orders were made for Mr SB to be taken by police for a mental health assessment pursuant to section 33(1D)(b) of the *Mental Health (Forensic Provisions) Act 1990* (**Forensic Provisions Act**) in force at the time.

6. Admission to Mater Mental Health Centre

6.1 Mr SB was subsequently taken by police to the emergency department at Maitland Hospital. There, he was assessed by the ED registrar (Dr Newell) and a psychiatry registrar (Dr Malchandani). It was documented that Mr SB had attempted to shoot his wife "*driven by delusions of infidelity*" and that he was showing signs of secondary depressive symptoms, suicidal ideation, cognitive impairment with poor short-term memory, disorientation and perseveration. Mr SB was admitted as a mentally ill person, and prescribed thiamine and olanzapine (antipsychotic medication).

6.2 Registered Nurse (**RN**) Keira Boxsell conducted a comprehensive risk assessment which identified a number of risk factors for suicide and violence. It was noted that Mr SB had voiced suicidal thoughts to his wife and that he had threatened to kill her and subsequently discharged a firearm at her. Mr SB reportedly explained the incident as occurring because "*my head just snap*" and "*I just wanted to frighten her*", and that he regretted his actions.

6.3 On mental state examination, themes of hopelessness and worthlessness were observed, and Mr SB identified that he had nothing to live for. Mr SB also described hearing his daughter's partner "*babble*" with Mrs SB, and referred to police wanting to get him. RN Boxsell documented collateral information obtained from Mr SB's family including a history of long-standing paranoia relating to Mrs SB's alleged infidelity, a history of heavy alcohol consumption and associated alcohol-related physical conditions. RN Boxsell noted the possibility of a psychotic illness complicated by organic issues and recommended inpatient admission for further assessment.

6.4 The assessment and plan were discussed with a psychiatrist who was of the view that Mr SB was a mentally ill person who posed a risk to himself and others, and that hospitalisation was considered the least restrictive care that could be provided to him. The documented plan for Mr SB's management included involuntary admission, further assessment as required, the use of an Italian interpreter and to contact police upon discharge.

6.5 Accordingly, on 22 October 2016, Mr SB was transferred to the Mater pursuant to section 80 of the *Mental Health Act 2007* and admitted to the Psychiatric Emergency Care Centre (**PECC**). There he was assessed by a psychiatry registrar (Dr Michael Bull) who documented that Mr SB had been transferred from Maitland Hospital due to "*bed pressure*".

6.6 On review, Dr Bull assessed a medium level of suicide risk and concluded that Mr SB required involuntary admission with no leave. Mr SB remained at the PECC for only a few hours before being transferred to the Mental Health Substance Use Unit.

6.7 On 24 October 2016, a comprehensive assessment of Mr SB was conducted with the assistance of an interpreter. It was documented that Mr SB reported that he "*made a mistake*" and that he "*was drunk*". Two days later, nursing staff noted that Mr SB appeared teary and that he expressed regret and remorse. A social worker documented a plan to engage Mr SB's family to provide support and to liaise with a court liaison officer. Accordingly, on 26 October 2016, a referral was made to the HNELHD Court Liaison Service (**CLS**) requesting assistance regarding Mr SB's court proceedings and details of his ADVO.

6.8 On 28 October 2016, a family meeting was conducted involving a psychiatry registrar and social worker. Collateral information was obtained from Mr SB's family and the treating team discussed with Mr SB's family a diagnosis of delusional disorder, a possible neurocognitive disorder and that there was a statistically higher risk of violence by Mr SB towards his wife.

6.9 On 28 October 2016, Mr SB's treating team also prepared a report outlining his presentation and admission the purpose of an upcoming Mental Health Review Tribunal (**Tribunal**) enquiry. It was noted that Mr SB had delusions of infidelity on admission with possible secondary low mood and impaired cognition. Chronic liver failure due to heavy alcohol use was also noted, with no organic cause for his deterioration having been identified.

6.10 It was also noted that Mr SB remained delusional, teary, remorseful and preoccupied that he had lost his family, and that he expressed a wish to return to live with his wife. A plan was formulated for Mr SB's antipsychotic medication to be increased, to refer Mr SB to the Mental Health and Substance Use team for older people, and to define the extent of any neurocognitive decline.

6.11 On 3 November 2016, a mental health enquiry was conducted by the Tribunal and Mr SB was made subject to an involuntary treatment order until no later than 26 January 2017. Also on 3 November 2016, the Addenbrooke's Cognitive Examination – III (**ACE – III**) was administered to Mr SB with the assistance of an interpreter. The results of the assessment were suggestive of cognitive impairment (with some consideration given to the fact that the testing may have been affected by Mr SB's level of education).

6.12 On 6 November 2016, Mr SB was noted to be quiet on the ward and references were made to him displaying a "*sense of sadness*" at times. On 9 November 2016, Mr SB was visited by his wife and daughter. It was noted that Mr SB continued to mention delusional beliefs regarding his wife.

6.13 On 15 November 2016, a MRI of the brain was performed which reported volume loss, left sphenoid disease and chronic small vessel change. Radiology review indicated that the volume loss in the brain appeared to be more than expected for Mr SB's age, but was not considered to be profound. Nevertheless, arrangements were made to transfer Mr SB to the Mental Health Unit for Older People (**MHUOP**) for further assessment and management.

6.14 On 17 November 2016, Mr SB was assessed with an interpreter and his version of events was documented. Mr SB indicated that his wife was having a relationship with another man, and he denied clinical or biological markers of a mood disorder. Mr SB reported that shooting at his wife was a mistake and that he did not intend to harm her. Mr SB was assessed again with an interpreter on 24 November 2016, and it was noted that he retained his belief that his wife was having an affair. A provisional diagnosis of delusional disorder in the context of alcohol dependence was noted with a potential differential diagnosis of cognitive impairment.

7. Transfer to the Mental Health Unit for Older People

7.1 On 26 November 2016, Mr SB was accepted for transfer to the MHUOP for specialised treatment and follow-up of legal issues under the care of Dr Petra Muir, consultant psychiatrist. Transfer documentation noted the need for an interpreter.

7.2 On 29 November 2016, Mr SB was reviewed by Dr Muir and Dr Emily Bart, a junior medical officer who was able to speak some Italian. It was noted that Mr SB maintained his thinking that his wife had a boyfriend and that Mr SB expressed anger towards her. Mr SB denied getting a knife after the shooting incident and appeared to understand that as he had been charged by the police he was no longer able to visit his wife.

7.3 On 1 December 2016, a Mini-Mental State Exam (**MMSE**) was administered. On 5 December 2016, a social worker contacted CLS to enquire whether neurocognitive testing could be done if Mr SB returned to police custody. Mr SB's treating team considered that an underlying cognitive impairment may have been contributing to Mr SB's presentation.

7.4 On 8 December 2016, a general request form was completed which requested consideration for Mr SB's admission to Kaoriki House for "*neurocognitive testing and diagnostic clarification*". A risk assessment noted a major psychiatric illness but that Mr SB did not have a significant alcohol or drug history. Additional risk factors including disinhibition/impulsive behaviour, isolation, recent significant life events and hopelessness/despair were all noted.

7.5 On 18 December 2016, CLS sent a letter to Maitland Local Court advising that Mr SB was currently an inpatient at the Maitland MHUOP, with his current order due to expire on 26 January 2017. Mr SB's treating team requested that all matters be adjourned until the expiry of the current involuntary treatment order, and noted that it was quite likely that a further extension would be sought regarding this order in January 2017.

7.6 On 9 December 2016, Mr SB expressed the feeling that he was lost in the hospital as he was unable to contact his wife, and that he hoped that death is near. On the same day a Roland Universal Dementia Assessment Scale (**RUDAS**) was administered, with the results suggesting that Mr SB was above the cut-off for dementia. On 15 December 2016, Mr SB reported missing his wife and family and that he would rather die than stay in hospital, and that he wished to be dead so that his family would be free.

7.7 On 20 December 2016, Mr SB expressed his belief to Dr Bart that he would spend the rest of his life in hospital. Progress notes indicated that Mr SB was isolated on the ward, kept mainly to himself and that he did not interact with other patients. Other entries noted Mr SB having difficulty in engaging and that assessment by nursing staff was limited due to Mr SB's language difficulty.

7.8 On 22 December 2016, Mr SB was reviewed by Dr Jedda Schutz, psychogeriatrician, and it was noted that Mr SB expressed frustration with his prolonged hospital admission. In addition, Mr SB stated that he would be better off dead than being in hospital much longer, especially given his separation from his family. Following a lengthy review and assessment with the assistance of an interpreter, Dr Schutz recorded that Mr SB required neuropsychiatry and forensic input as a matter of urgency. Dr Schutz requested a single-photon emission computerised tomography (**SPECT**) cerebral perfusion imaging assessment and recorded her impression that Mr SB was suffering from delusional jealousy, alcohol dependence and queried alcohol-related dementia.

7.9 A plan was formulated recommending that Mr SB be monitored for any decrease in mood, changing features and emergent secondary suicidality. Mr SB continued to repeatedly voice his thoughts that he would rather be dead than be in hospital. However, when asked directly, Mr SB denied any suicidal ideation, intent or plans. Nevertheless, Mr SB's treating team considered that he was at risk of secondary depression due to isolation and frustration with his prolonged mission.

8. Transfer to Kaoriki House

8.1 On 31 December 2016, Mr SB was transferred to Kaoriki House at Morisset Hospital. On arrival, Mr SB was reviewed by Dr Bennett with the assistance of an interpreter over the phone. Dr Bennett assessed Mr SB as suitable for admission to Kaoriki House, a specialised inpatient neuropsychiatry unit.

8.2 On 3 January 2017, a multidisciplinary team (**MDT**) meeting was conducted by Dr Sevagram Umesh Babu, a consultant neuropsychiatrist under whose care Mr SB had been admitted. Mr SB was noted to have a 50 year history of alcohol abuse. A plan was formulated to contact CLS for information regarding Mr SB's court proceedings. It was noted that Mr SB was scheduled for a SPECT scan and it was to be confirmed whether Mr SB had taken pramiprexole (medication used to treat Parkinson's disease) on the day of the incident involving his wife. Mr SB's dose of paliperidone (atypical antipsychotic medication used to treat schizophrenia) was to be reduced (to 6mg and then 3mg) whilst oxazepam (benzodiazepine-class medication used to treat anxiety and alcohol withdrawal) was ceased and escitalopram (antidepressant medication) at 5mg daily was commenced for "*impulsivity*".

8.3 On 9 January 2017, a ward round was conducted with Dr Babu and Dr Schofield. On 13 January 2017, Mr SB was reviewed by Dr Josef McDonald, psychiatry registrar. Mr SB denied a variety of symptoms on review.

8.4 A Tribunal report dated 17 January 2017 noted that Mr SB had a history of significant alcohol abuse resulting in liver cirrhosis and portal hypertension. It was also noted that Mr SB had a 12 month history of jealousy and suspicion towards his wife associated with increased aggression towards her. Mr SB had also expressed a belief that people were entering his house and stealing his belongings. The Tribunal issued an involuntary treatment order to be reviewed on 17 April 2017.

8.5 On 24 January 2017, a ward round was conducted with Dr Bull. It was noted that Mr SB's family "*would like him home*" but that there were "*localities involved - currently for discharge into custody*". By this time, Mr SB was still waiting to have testing done to exclude dementia.

8.6 On 6 February 2017, Mr SB was reviewed by Dr McDonald with an interpreter. Mr SB expressed a wish to return home to live with his wife and reported that he no longer believed that she was having an affair with another person. A SPECT study report dated 10 February 2017 found no convincing evidence of a neurodegenerative disorder.

8.7 On 14 February 2017, a documented collateral history regarding Mr SB was obtained from his daughter, Ms AC. She described Mr SB as becoming more paranoid over the preceding 15 years, and that Mr SB's English skills had markedly deteriorated in the previous five years.

8.8 On 21 February 2017, a ward round was conducted with Dr McDonald and Dr Bull. The terms of Mr SB's ADVO were discussed and it was noted that a forensic assessment was to "*start this week*".

8.9 On 28 February 2017, a ward round was conducted with Professor Schofield. It was discussed whether Mr SB was suffering from a delusional disorder or dementia process. It was noted that the current picture was consistent with a delusional state of 15 years, but the possibility of superimposed dementia state could not be excluded. A plan was formulated to await Mr SB's forensic assessment and to repeat the RUDAS.

8.10 On 4 March 2017, nursing staff noted that Mr SB had a low mood and again expressed the belief that he was going to die in hospital and that he "*just wants to be able to talk to his wife*". Mr SB later refused to attend lunch and again repeated that he just wanted to die. In response, Level 2 observations were initiated due to an assessment of increased risk of self-harm. A medical assessment was undertaken by the psychiatry career medical officer (**CMO**), Dr Buddhima Lokuge, with the assistance of a phone interpreter. It was noted that Mr SB had refused to eat or drink and that he stated that he wanted to die having not spoken to his wife for the last few weeks. The treating team noted an impression of adjustment disorder as Mr SB had been unable to interact with his wife, and that the localities regarding contact would be examined in order to determine whether or not contact with Mr SB's wife could be facilitated.

8.11 On 5 March 2017, Mr SB was reviewed by Dr Lokuge without the assistance of an interpreter. Mr SB was noted to be calm and reacting appropriately. It was also noted that Mr SB guaranteed his safety and that he denied any suicidal ideation. A plan was formulated for Mr SB to receive his regular medications, and that he was for general observations with eye contact hourly by nursing staff until he could be reviewed by the treating team the following day. Nursing notes indicated that Mr SB's mood had improved, and that he was eating and drinking.

8.12 On 7 March 2017, Mr SB was reviewed by Dr McDonald with an interpreter. It was noted that Mr SB said that he would refuse to eat so that he would die as a result of being unable to contact his wife. The nursing notes indicate that Mr SB was showing signs of an improved mood.

8.13 On 9 March 2017, Mr SB was similarly noted to have an improved mood. Nursing entries on 10, 12 and 13 March 2017 noted no change in Mr SB's mood and that he was eating and drinking.

8.14 On 13 March 2017, Mr SB requested an interpreter to discuss financial matters. The following day, nursing entries recorded that Mr SB said that he was okay, and that he seemed happy and reactive.

8.15 A ward round the following day, 14 March 2017, noted an ongoing forensic assessment with a need for discharge planning. The treating team called Ms AC and it was noted that Mr SB's discharge preference was back to his farm.

8.16 On 16 March 2017, Mr SB was noted to be awake at all rounds. Nursing notes documented an unchanged mental state, that Mr SB appeared calm and settled, that he had a good appetite and that he was wandering the unit in order to pass the time.

9. The events of 18 March 2017

9.1 On 18 March 2017, it was noted that Mr SB appeared settled and had a good appetite, but was still wandering aimlessly to pass the time and that he appeared to be in a "*holding pattern*". On this day, Mrs SB and Mr MB travelled to Morisset in order to visit Mr SB. However, on arrival, Mrs SB remained in the car as she did not want to contravene the ADVO.

9.2 Upon entering Kaoriki House, Mr MB attempted to locate his father but was unable to do so. Mr MB enlisted the assistance of the nurse unit manager, David Wallace, to look for Mr SB in a number of common areas. Mr SB was eventually found inside a recreation room, suspended from a ligature (an electrical cord) which had been tied around his neck and attached to a security screen. Mr SB showed no signs of life. He was brought to the ground and found to have no cardiac output but still be warm to touch.

9.3 An emergency response was initiated with commencement of resuscitation and contact made with emergency medical services. Paramedics arrived at the scene a short time later and, with the use of a defibrillator and medication, achieved the return of spontaneous circulation and cardiac output. Mr SB was conveyed by ambulance to Wyong Hospital and admitted to the intensive care unit. Investigations revealed a stable fracture through the 2nd cervical vertebra with no evidence of acute intracranial pathology or vascular injury in the neck, together with multiple resuscitation related rib and sternal fractures, bleeding in both chest cavities, mild collapse of the left lung and bilateral lower lung zone consolidation.

9.4 A meeting was held between Mr SB's family members and his treating team and Mr SB's poor prognosis was discussed. A plan was made to continue ventilation and vasopressin management overnight with reassessments the following day for likely hypoxic brain injury. Due to Mr SB's poor clinical condition, it was decided that he was not for resuscitation in the event of cardiac arrest. Despite phylactic measures, Mr SB's condition continued to deteriorate and he was later pronounced life extinct later in the evening on 18 March 2017.

10. What was the cause and manner of Mr SB's death?

10.1 Mr SB was later taken to the Department of Forensic Medicine at Newcastle where a postmortem examination was performed by Dr Leah Clifton, forensic pathologist, on 21 March 2017. A poorly defined, vague discontinuous patterned red ligature abrasion around the neck rising to a point of suspension posteriorly was identified. Dr Clifton noted that this pattern of ligature abrasion is in keeping with those seen in self-inflicted hanging deaths.

10.2 In the autopsy report dated 1 June 2017, Dr Clifton opined that the direct cause of Mr SB's death was cardiac arrest following neck compression due to hanging, with vascular dementia, delusional disorder and chronic alcohol dependence being significant conditions contributing to the death but not relating to the condition causing it.

10.3 Having regard to the circumstances in which Mr SB was found on 18 March 2017 and his previous expressions of suicidal ideation proximate to the time of his death, there is sufficiently clear and

cogent evidence[1] to allow for a conclusion to be reached that Mr SB acted on 18 March 2017 with an intention to end his life.

11. What issues did the inquest examine?

11.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues:

(1) In relation to the admissions to Mater Mental Health Unit at Newcastle and at Kaoriki House at Morisset:

(a) Whether the mental health care and treatment provided to Mr SB was appropriate and timely?

(b) Whether the clinical and diagnostic assessments of Mr SB were appropriate and timely?

(c) Whether there were appropriate and regular assessments of Mr SB's risk of self-harm and if the frequency of observations of Mr SB was appropriate?

(d) Whether there was a delay in forensic assessment of Mr SB for the purpose of section 32 *Mental Health (Forensic Provisions) Act 1990* (now repealed) and if so, why?

(e) Whether there was a delay in assessing whether Mr SB was suffering any neurodegenerative conditions, and if so, why?

(2) The appropriateness of the transfer of Mr SB from the Mater Mental Health Unit at Newcastle to Kaoriki House at Morisset?

(3) Whether there was appropriate discharge planning for Mr SB during his admission at Kaoriki House and if not, factors which contributed to the apparent lack of discharge planning?

(4) Whether interpreters were needed for the proper clinical and diagnostic assessment of Mr SB?

(5) Whether limited availability/use of interpreters caused:

(a) delays in assessment and discharge planning;

(b) incomplete or inaccurate assessments;

(c) less frequent/comprehensive reviews by members of medical and nursing teams than would have applied if an interpreter was not required;

(d) increased isolation in a context where Mr SB was prevented from contacting his wife?

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[1] Briginshaw v Briginshaw 60 GLR 336.

(6) Whether it was appropriate for Mr SB to have remained at a Level 4 observation level between 15 March 2017 and 18 March 2017?

(7) The circumstances in which Mr SB was able to commit suicide as an inpatient of Kaoriki House and the adequacy of assessment of his mental state in the period before his suicide and the physical layout and features of the recreation room at Kaoriki House.

(8) Whether clinical staff had a proper understanding of the effect of the Maitland Local Court's order of 22 October 2016 and the consequent requirements of the *Mental Health (Forensic Provisions) Act 1990* (now repealed)?

11.2 Each of the above issues is discussed in detail below, and it will be convenient to consider some of the issues together and in chronological order.

11.3 In order to assist with consideration of some of the above issues, opinion was sought from the following experts. Each of the experts provided reports which were included in the brief of evidence, and some of the experts also gave evidence during the inquest:

(a) Dr Kerri Eagle, consultant forensic psychiatrist, who was briefed by the Assisting Team; and

(b) Associate Professor Christopher Ryan, consultation-liaison psychiatrist, who was briefed by the legal representatives for Dr Babu.

12. Was appropriate care and treatment provided to Mr SB at the Mater Mental Health Unit?

Clinical and diagnostic assessments

12.1 Whilst admitted to the MHUOP, Mr SB came under the care of Dr Petra Muir, psychogeriatrician. Mr SB was administered the ACE-III, RUDAS and MMSE whist at the MHUOP. Dr Muir gave evidence that there was clear evidence of cognitive impairment for Mr SB but further assessment was required to confirm a diagnosis of probable dementia. Dr Muir also noted that due to Mr SB's lengthy history of alcohol use, a prolonged period of abstinence was required to allow for such an assessment to be conducted. Dr Muir gave evidence that her plan was for Mr SB to remain in hospital for a prolonged, but undetermined, period of time as his trajectory was unclear by the time that Dr Muir went on leave, three weeks after Mr SB's admission.

12.2 However, Dr Muir explained that her plan was to monitor Mr SB "*for long enough until such time as that definitive assessment or more or less definitive assessment could be done*". Dr Muir also gave evidence that her focus was on establishing whether Mr SB had dementia or not. In addition, she felt there was a need for neurocognitive neuropsychological assessment to be undertaken. However, Dr Muir explained that if such an assessment was undertaken prematurely it may lead to an inaccurate diagnosis. That is, time was required to allow Mr SB to recover so that the possibility of any reversible components, such as alcohol abuse, could be considered before any question regarding major neurocognitive assessment was addressed.

12.3 On 23 December 2016, Dr Schutz recorded an entry in Mr SB's progress notes indicating that an advanced trainee in the MHUOP was to liaise with forensic services for the purposes of an

assessment, and that Mr SB would likely also need a neurocognitive assessment "*for meaningful suggestions on management*". Following this, Mr SB was not seen by a medical officer until he was transferred to Kaoriki House.

12.4 Dr Brendan Flynn, the HNELHD Executive Director of Mental Health, gave evidence that due to the number of public holidays and weekends between 23 and 31 December 2016 it would have been unusual for a consultant psychiatrist to be available at a psychiatric facility during this period. Dr Flynn went on to explain that there would have been one registrar available, but who would have been required to cover all of Morriset Hospital, meaning that there was less medical cover generally available during this period.

Understanding of the provisions of the Mental Health (Forensic Provisions) Act 1990

12.5 Dr Muir gave evidence that she was aware that Mr SB had been detained under the Mental Health Act. Due to the risk that Mr SB posed to his wife and potentially to others by virtue of his alleged use of the firearm, Dr Muir considered it was appropriate for Mr SB to remain an involuntary patient.

12.6 Dr Muir went on to note that if she had continued to be involved in Mr SB's care regular reviews would have been conducted to determine whether Mr SB needed to be involuntarily detained on an ongoing basis.

Understanding of the Local Court proceedings

12.7 Dr Muir gave evidence that she understood that Mr SB was facing charges in relation to discharging a firearm in an unsafe manner and that an ADVO was in place. However, Dr Muir could not recall whether she had seen the ADVO or was aware of its conditions. Dr Muir also gave evidence that she was aware of the CLS and the assistance that it could provide regarding the relevant provisions of the Mental Health Act.

Use of interpreters

12.8 Dr Muir gave evidence that she assessed Mr SB on two occasions: on 29 November 2016 with Dr Bart and a social worker, and on 1 December 2016, again with Dr Bart and a healthcare interpreter. Dr Muir indicated that on the first occasion she found that she could still speak to Mr SB with some English and that Dr Bart's knowledge of Italian was "*quite helpful for some of the more nuanced conversation*".

12.9 **Conclusions:** The care and treatment provided to Mr SB at the Mater was appropriate. A working diagnosis was established and consideration was given to the possibility of cognitive impairment. In this regard, appropriate screening tests were administered to address the possibility of dementia. The treating team recognised the need for Mr SB to be stabilised, in particular in relation to his alcohol dependency, and for investigations to be conducted regarding any organic cause of comity of impairment.

12.10 There was recognition that for diagnostic clarification Mr SB required transfer to a specialist unit with access to a neuropsychiatrist so that a neuropsychological testing could be conducted prior to any forensic assessment. Whilst this process was initiated on 23 December 2016, it was not completed prior to transfer.

12.11 There is no evidence that Mr SB was reviewed by a medical officer after 23 December 2016 prior to his transfer to Kaoriki House. However, the evidence establishes that there was limited medical cover during this period due to the number of public holidays and the likely unavailability of any consultant psychiatrist.

13. Was it appropriate to transfer Mr SB to Kaoriki House?

13.1 Dr Muir explained that the screening tools that were administered during Mr SB's admission to the MHUOP all carried a variety of limitations regarding interpretation of their results. Therefore, Dr Muir referred Mr SB to Kaoriki House to allow for a longer period of admission so that the reversibility of alcohol could be completed prior to any neurocognitive assessment. Dr Muir also explained that it would not have been in Mr SB's best interests to remain at the MHUOP for an extended period of time. She described the MHUOP as "*a very confined, small unit, and the sense of being imprisoned is something many patients describe when they have to stay there for lengthy periods of time*".

13.2 Dr Muir gave evidence as to her clinical decision-making in referring Mr SB to Kaoriki House. She explained that it had functioned as a unit to look after people with a brain injury for several decades and that it had developed expertise in looking after people with chronic alcohol-related brain injury. Therefore, Dr Muir considered it an appropriate unit to review Mr SB, given his history of alcohol-related brain injury, and to conduct an appropriate neurocognitive assessment. Dr Muir also gave evidence that cessation or reduction of psychotic symptoms would seek to be achieved before performing any neurocognitive assessment. In addition, minimising any medication that may be affecting cognition might also be sought, whilst also striking a balance between minimising psychotic symptoms.

13.3 Dr Babu gave similar evidence that, in his opinion, it was appropriate for Mr SB to be transferred to Kaoriki House:

> And when [Mr SB] came in it was very clear that he needed to be here. And basically because of the complex legalities that was evident and the complex family dynamics that was to be unravelled and assessed. As for less [sic], the confusion that he has dementia and it was possibly unlikely that he has dementia and it is more likely due to alcohol. So for this variety of reasons, I felt it was suitable for him to be there.

13.4 Further, Dr Muir gave evidence that the issue of bed pressures was not part of her consideration in requesting Mr SB's transfer to Kaoriki House. Dr Schutz gave similar evidence that any advocacy on her part to support Mr SB's transfer to Kaoriki House was not informed by bed pressures in the MHUOP.

13.5 Both Dr Eagle and Associate Professor Ryan agreed that Mr SB's transfer to Kaoriki House was appropriate for diagnostic clarification and neuropsychological assessment. Whilst Dr Eagle noted that resource and staffing constraints were relevant considerations as to the timing of the transfer occurring on New Year's Eve, this needed to be balanced against the need to progress Mr SB's treatment so that the length of his admission could be minimised, and his recovery optimised.

13.6 One issue associated with the transfer of Mr SB to Kaoriki House was that Mr SB's complete medical file and a discharge summary did not accompany his transfer. Dr Flynn gave evidence that he conducted enquiries with a clinical information manager who indicated that it is usual practice, and that was the practice in 2016, for a patient's entire file to accompany the patient upon their transfer from the Mater to Morisset. As to this issue, Dr Eagle noted that a discharge summary should have accompanied Mr SB to Kaoriki House so that there was sufficient information for the incoming treating team regarding his background and immediate history of treatment "*to ensure continuity of care and effective risk management*". Notwithstanding, Dr Eagle did not identify any specific factor arising from Mr SB's transfer that contributed to his risk of self-harm.

13.7 **Conclusions:** Mr SB's transfer to Kaoriki House was appropriate for the purposes of diagnostic clarification, further investigations and determination of the next steps in his management. Regrettably, Mr SB's complete medical file and a discharge summary were not received at Kaoriki House. The reason for this is unclear as the evidence establishes that it was usual procedure for such documents to accompany a patient's transfer between facilities. However, it does not appear that this information materially affected Mr SB's subsequent management in any adverse way.

14. Were appropriate and timely clinical and diagnostic assessments conducted at Kaoriki House?

14.1 Dr Babu gave evidence that it was his expectation that Mr SB would be reviewed at least once per week and, in addition, as required if there was any change in his mental state. Dr Babu also gave evidence that he thought that he conveyed this expectation to both Dr McDonald and Dr Bull.

14.2 Dr McDonald gave evidence that whilst it would be ideal for patients to be reviewed as frequently as possible, there was no defined parameters as to the frequency of such reviews. Instead, Dr McDonald gave evidence that patients were prioritised based on their clinical need, a matter which was discussed during the MDT meetings. Dr McDonald explained that these MDT meetings took place once a week, usually on Tuesdays. It started in the morning and took "*some hours to get through*". The meetings were attended by a consultant, the advanced trainee (Dr Bull), the nurse manager, a social worker, an occupational therapist and a clinical nursing representative. Dr McDonald also explained that following the MDT meetings he and Dr Bull would divide the clinical tasks to be completed amongst themselves. Dr McDonald acknowledged that in terms of documented reviews, he was the only medical officer who reviewed Mr SB.

14.3 Although Dr Babu said in his statements that he reviewed Mr SB on 3 January 2017, in evidence Dr Babu said that he was unsure whether in fact he did conduct an assessment of Mr SB on this day. Dr Babu agreed that it is generally good practice where a consultant undertakes an assessment of a patient, for that assessment to be clearly documented, which did not occur on this occasion (or any other occasion involving Dr Babu).

14.4 Dr Babu was asked specifically whether he considered there was a need for him to conduct a comprehensive psychiatric assessment of Mr SB upon his transfer to Kaoriki House. Dr Babu indicated:

> I would say that good practice would require me to do that, but my position at that time was based on the work that was set out we would prioritise how we did that assessment. Whether through the other staff and continue to do a psychiatric assessment and - at that time.

14.5 Notwithstanding the above, Dr Babu accepted that at no stage did he complete a comprehensive psychiatric assessment of Mr SB during his admission. In evidence, he also accepted that this did not represent good clinical practice. Dr Bull gave evidence that he also did not undertake a comprehensive psychiatric assessment of Mr SB during his admission.

14.6 Part of the difficulty in assessing whether appropriate and timely assessments were conducted of Mr SB is due to the poor documentation of any such occurrences in the progress notes. Dr Babu agreed that he did not himself make any entry in Mr SB's progress notes, medication charts or any MDT mental health review document. In this regard, Dr Babu also agreed that it was his responsibility to dictate the formulation of a management plan for a patient and to determine what medication would be prescribed to a patient and at what dose. By way of example, Dr Babu acknowledged that in relation to a MDT meeting conducted on 13 March 2017, there was no proper documentation of the meeting attendees, nor documentation of the formulation and medication prescribed to Mr SB. When confronted with the relevant records, Dr Babu acknowledged: "*I certainly agree that's a good practice and I see that it's missing here*".

14.7 Both Dr Eagle and Associate Professor Ryan agreed that if the evidence established that the only psychiatric assessment of Mr SB was performed by Dr McDonald, this would be less than ideal and not indicative of good clinical practice. Both of the experts also agreed that documentation of such an assessment is critical for continuity of care.

14.8 In terms of timeframes for review, Dr Eagle considered that it would be good clinical practice for an involuntary patient detained in a psychiatric facility to be reviewed by a psychiatrist weekly, allowing for this factors such as leave and the availability of resources. Associate Professor Ryan described that, as "*a rule of thumb*" and depending on a patient's circumstances, such a review occurring every "*4 to 6 weeks sounds about right*". Notwithstanding, both experts agreed that an involuntary patient being reviewed approximately weekly by a medical officer would represent good clinical practice.

14.9 Dr Flynn gave evidence that whilst the frequency with which a consultant reviews a patient does vary with the patient's clinical situation, he accepted that the consultant should at least periodically review the patient. Dr Flynn explained:

> [W]e're very aware that Mr SB's already been in hospital since October, and I can only speak for myself which probably informs my expectations as a director, that if I felt comfortable that I understood what was happening with the patient at the start of their admission and that it was evident to me that the clinical team also did that I wouldn't necessarily say I needed to review

them more frequently but I accept that ongoing review, whatever the frequency of it is an expectation.

14.10 Dr Flynn went on to indicate that it would be of concern if Dr Babu did not undertake any assessment of Mr SB during the course of his admission. Further, Dr Flynn also indicated that it would be less than ideal if Dr McDonald conducted all of his assessments of Mr SB without Dr Babu, or a consultant, being present.

14.11 **Conclusions:** It is accepted that Dr Babu was on leave between 16 January 2017 and 7 March 2017, meaning that he was away for seven out of the 11 weeks that's Mr SB was admitted to Kaoriki House. It is also accepted that when not on leave, Dr Babu was physically present at Kaoriki House only one day per week.

14.12 The evidence establishes that during these physical attendances, Dr Babu was largely preoccupied with MDT meetings. The evidence established that no ward round was conducted in the matter, as that phrase is usually understood in other hospital inpatient settings, with consultants reviewing patients admitted under their care. Whilst Dr Babu gave evidence that there may have been brief interactions with patients on the occasions that he was at Kaoriki House, there is no direct evidence that he conducted a comprehensive assessment of Mr SB during the entirety of his admission. The expert evidence establishes that this did not constitute good clinical practice.

14.13 Related to the issue of whether timely clinical and diagnostic assessments of Mr SB were conducted is the paucity of information contained in the progress notes in many instances. As a result, it is difficult to now determine whether any such assessments were performed at a particular point in time, and the outcome of such assessments in terms of diagnostic formulation and clinical decision-making.

15. Were there appropriate and regular assessments of Mr SB's risk of self-harm?

15.1 Dr McDonald gave evidence that risk assessment was discussed during the MDT meetings, and a level of observation for Mr SB was decided upon. This was documented on a whiteboard in the nurses' station and also on the nursing handover sheet. Dr McDonald also gave evidence that if something was observed on the ward which gave rise to reconsideration of a patient's risk assessment, then the level of observations could be altered by a medical officer, meaning a consultant.

15.2 Dr McDonald gave evidence that he was not aware of any requirement for any medical officer to undertake a risk assessment of patients on a daily basis. Dr McDonald explained that there was not a medical officer on site each day for that to occur.

15.3 Examination of the progress notes reveals that risk assessments were conducted at periodic intervals. For example, on 4 March 2017, a nursing entry recorded expressions of distress felt by Mr SB which resulted in the following entry: "*Risk to self increased to medium*". As a result, observations for Mr SB were increased. Similarly on 7 March 2017, Dr McDonald recorded an entry noting that Mr SB had denied any intent or plan regarding self-harm. A nursing entry made later on the same day noted that Mr SB's "*risk to self/others remains low*".

15.4 One matter of particular relevance concerned the events of 4 and 5 March 2017. Dr Lokuge was the medical officer at Kaoriki House during this weekend. He was often rostered to provide weekend cover, and had previously done so at Kaoriki House. Dr Lokuge reviewed Mr SB at around 12:30pm on 5 March 2017and conducted a MMSE. An interpreter was not present but Dr Lokuge gave evidence that he felt confident that Mr SB was able to understand what he was asking and that he was able to understand what Mr SB was saying "*in terms of making the medical decision that I was asked to make*".

15.5 Dr Lokuge went on to explain that if he had any concerns that language impacted on his ability to conduct a thorough medical examination, he would organise for an interpreter to be present. Dr Lokuge gave evidence that his review was focused around assessment of risk and whether it had increased or decreased in view of the observations made of Mr SB the previous day, when he refused to eat and indicated that he wanted to die.

15.6 Dr Lokuge gave evidence that he saw his role as supporting the treating team regarding Mr SB's management and therefore what he was doing was returning Mr SB to the level of observations that the treating team had determined prior to him voicing thoughts of suicidal ideation. That is, in Dr Lokuge's mind, returning Mr SB to Level 3/4 observations meaning half hourly observations when Mr SB was awake, and hourly observations when he was asleep. However, Mr SB had in fact been placed on Level 2 observations the previous day. In addition, Dr Lokuge acknowledged in evidence that there was a degree of ambiguity regarding his entry in the progress notes. Instead of documenting Level 3/4 observations, Dr Lokuge instead noted: "*RN eye contact hourly till review by team tomorrow*".

15.7 Dr Lokuge gave evidence that in doing so it was his expectation that the treating team would arrive on Monday and that if there was any delay then nursing staff or the nurse unit manager "*would then look at alternatives*", meaning that the treating team would be contacted to review or assess Mr SB if there was concern about any risk to him.

15.8 However, Dr McDonald did not come to review Mr SB until Tuesday, 7 March 2017 when Mr SB expressed a change of attitude, indicating that he would not stop eating because he wanted to contest the ADVO. Dr McDonald viewed this as a positive development and left the review feeling more hopeful for Mr SB. However, Dr McDonald acknowledged that in hindsight and with the benefit of five years' experience, including working as a staff specialist in mental health for older persons, he would have been "*more concerned*" with the events over the weekend of 4 and 5 March 2017. Dr McDonald did not alter Mr SB's observation level and did not undertake any further review of Mr SB after 7 March 2017.

15.9 On 15 March 2017, a nursing entry in the progress notes recorded the following: "*Silvio said that he wishes to be divorced from his wife and to divide the assets half and half. Dr McDonald informed of same. To be discussed further via interpreter*". Dr McDonald gave evidence that he could not recall the specifics of any such conversation but acknowledged that it may have occurred. Dr McDonald was asked about his interpretation of this matter, in light of Mr SB's indication on 4 and 5 March 2017 that he was going to stop eating and wanted to die because he could not contact his wife. Dr McDonald explained:

> I think at the time when I brought this to the MDT, it was seen as he was making future plans and that was seen as positive. I think with the benefit of hindsight and the experience that I have now, it probably would have raised my suspicions or I should say raise my concerns.

15.10 Dr McDonald gave evidence that in hindsight it would have been ideal to arrange a review earlier than 13 March 2017.

15.11 Both Dr Eagle and Associate Professor Ryan agreed that, as a general principle, medical officers need to give consideration to the issue of risk for an inpatient in a psychiatric facility on a periodic basis. Further, both experts agreed that any determination of such a risk, and any underlying rationale, ought to be documented.

15.12 Associate Professor Ryan expressed the following view with respect to the utility of risk assessments and observation levels as predictors of risk:

> There is no evidence, in fact it’s clear, that repeated risk assessments for an individual with respect to suicide or serious self-harm on a ward can provide any useful information about the care of that person. So, even if the policy says you should do it, you would be foolish to do it. It will actually mislead you.

15.13 In this regard, Associate Professor Ryan considered that if any NSW Policy required a clinician to undertake such an assessment it should be ignored. Notwithstanding, Associate Professor Ryan expressed agreement with having levels of observations for a patient, but not for the purpose of keeping a patient safe. Instead, Associate Professor Ryan explained that there may be many other reasons to have observation levels, depending on the complexity of an individual patient, including to monitor a patient who may be prone to absconding, or to accommodate patients who may have a preference to be checked on from time to time.

15.14 Dr Eagle expressed agreement with Associate Professor Ryan that likelihood statements such as whether a person is a low, medium or high risk of self-harm, are unhelpful, unreliable and can be misleading. Dr Eagle explained that the broader international community on risk assessment has moved away significantly from such likelihood statements and instead there is support for formulation of risk for the purpose of developing risk management strategies. Dr Eagle went on to express this view:

> Mr SB was detained involuntarily on the basis of a risk assessment, so I think it's very difficult to then say that you shouldn't be doing a risk assessment, that's why he was in hospital against his will. So if you're going to take away somebody's freedom on the basis of a risk assessment, I think you're obligated to continue evaluating that risk, whether it's a risk of harm to others or to himself.

15.15 Despite the differences of opinion expressed above, both Dr Eagle and Associate Professor Ryan agreed that the events of 4 and 5 March 2017 indicated a need for care and more interaction from the medical officers involved in Mr SB’s care. Further, both experts agreed that Mr SB should have been reviewed in the period between 7 March 2017 and 18 March 2017, when in fact no review occurred.

15.16 It should be noted that since March 2017, HNELHD has issued an updated policy in relation to mental health engagement and observation. This policy provides for a risk assessment tool to be completed by clinical staff in relation to observation levels for a patient. Dr Flynn gave evidence that at least two audits have been conducted in relation to the use of this tool at Kaoriki house (as part of a service wide audits more generally) which has produced results that Dr Flynn considered to be satisfactory.

15.17 **Conclusions:** The available evidence indicates that risk assessments were conducted of Mr SB at periodic intervals and his level of observation was determined commensurate with the level of risk. By virtue of the fact that Mr SB had been involuntarily detained on the basis of an assessment of the risk he posed to others, in particular his wife, there was an obligation on the clinicians involved in his care to evaluate the nature of that risk on an ongoing basis. Indeed, the relevant mental health engagement and observation policy in force in 2017, and currently, provides for such assessments to be undertaken.

15.18 In this context there was a missed opportunity to review Mr SB in the period between 7 and 18 March 2017 following the events of 4 and 5 March 2017. Dr McDonald's evidence establishes that, viewed retrospectively, Mr SB's shift in attitude between 4 and 7 March 2017 represented a matter of concern. The expert evidence further establishes that this ought to have prompted greater interaction from the medical officers involved in Mr SB's care.

15.19 However, it is not now possible to determine whether this interaction would have identified the unintended reduction in Mr SB's observation level from 4 March 2017, or whether such interaction would have materially altered the course of events on 18 March 2017.

16. Was it appropriate for Mr SB to have remained at a Level 4 observation between 15 and 18 March 2017?

16.1 On 4 March 2017, Mr SB was placed on Level 2 observations (every 15 minutes) in consultation with the after-hours Nurse Unit Manager, which was later endorsed the following clinical review on the same day. As noted above, following his review on 5 March 2017, Dr Lokuge noted that Mr SB was to be observed hourly by eye contact by nursing staff until reviewed by the treating team the following day, although his intention was to return Mr SB to his original observation levels. Instead, for reasons which are not clear, it appears from nursing handover notes that Mr SB was placed on Level 3/4 observations (meaning that he was to be observed half hourly during the morning and afternoon nursing shifts and hourly during the evening shift) between 5 March 2017 and 15 March 2017.

16.2 Dr Eagle opined that the progress notes do not disclose any clinical review or indication to support the change in Mr SB's observation level from 2 to 3/4. Equally, Dr Eagle opined that there did not appear to be any clinical basis to reduce Mr SB's observation level from 3/4 to 4 for the period between 15 and 18 March 2017. In this regard, Dr Eagle noted that, with the benefit of hindsight, Mr SB's reference on 13 March 2017 to divorcing his wife and dividing his assets, together with his disrupted sleep between 15 and 17 March 2017, may have indicated a deterioration in his mood that ideally warranted clinical assessment.

16.3 **Conclusions:** The available evidence does not disclose any clinical indication for Mr SB's observation level to have been changed for the period between 15 and 18 March 2017. Indeed, the evidence instead suggests that a clinical assessment ought to have been considered in view of Mr SB's further shift in attitude (following his earlier statements that he refused to eat and wanted to die) and his disrupted sleep. It was therefore not appropriate for Mr SB to have remained at a Level 4 observation level during this period. However, it is again not possible to determine whether any reversion to Mr SB's intended observation level or clinical assessment would have materially altered the events of 18 March 2017.

17. Understanding of Mr SB's Local Court proceedings

17.1 On 9 January 2017, Dr McDonald contacted CLS to clarify what offences Mr SB had been charged with and his next court attendance date. Dr McDonald gave evidence that he could not recall whether at this time he was aware that there was an ADVO in place, nor recall when precisely he became aware of this fact.

17.2 Dr McDonald also gave evidence that he could not recall whether at this time he had access to Mr SB's records from the MHUOP. Dr McDonald gave evidence that it became apparent from a number of the MDT meetings that Mr SB was unhappy that he was unable to contact his wife, and that he was distressed by this fact. Following discussion of this issue, a decision was made by the treating team that Mr SB could not contact his wife. Dr McDonald gave evidence that he also recalled discussions regarding whether Mr SB's wife was able to contact him. However, Dr McDonald was unable to recall the ultimate decision that was made regarding this issue.

17.3 Dr McDonald acknowledged that following the weekend of 4 and 5 March 2017 it would have been important for Mr SB to understand his legal situation given that the lack of contact with his wife was a stressor for him. Dr McDonald gave evidence that at the time the treating team was trying to clarify his legal circumstances and that, with hindsight, it seemed "*quite important*".

17.4 On 4 March 2017, it appears that an email was sent by RN Matthew Hale regarding Mr SB's mental state and review on the afternoon of that day. The email recommended the following:

> Our staff call Court liaison to clarify if Silvio has ever attended the court for the purpose of AVO, is the interim order (the only paperwork we have) still legal?
> [Dr McDonald] to sit down with Silvio and interpreter on Monday afternoon to clarify the situation.
> Silvio states that if he can talk to his wife once per week he will be happy. [Dr McDonald] to clarify why he wrote in the notes for Silvio to have no contact with family, has he read the interim notice and presumed it is legal?

17.5 Dr McDonald had no recollection of seeing this email or of having any conversation with RN Wallace or any other member of the nursing staff.

17.6 John Wills, a clinical nurse consultant employed in CLS, gave evidence that CLS did not in 2017, and does not currently, routinely request details of the charges that a patient is facing. Instead, Mr Wills gave evidence that he relies on a patient's legal representatives to provide him with relevant paperwork, such as charge and police facts sheets. This material is usually provided when a patient

returns to court, for example pursuant to section 19(b) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.

17.7 Mr Wills explained the process in this way:

> Usually, the hospital lets us know that they're sending somebody back and therefore I try and track down who the appropriate lawyer will be for the particular Court matter it's listed in which is difficult because I service 11 Courts in the Lower Hunter and the rostering of various Courts is not always managed centrally through Newcastle, it's managed from Sydney.

17.8 Mr Wills gave evidence that upon Mr SB being referred to CLS in October 2016, it was not routine practice obtain a copy of his charges and the facts sheet. Mr Wills explained: "*Not a routine practice, no, and that is often driven by the fact that the Courts say it's none of your business*". Mr Wills also indicated that in his experience there had been previous occasions where this information had been requested from police and not provided.

17.9 Mr Wills gave evidence that he could not recall receiving a copy of the interim ADVO made on 17 November 2017 by Maitland Court in relation to Mr SB. In addition, Mr Wills also said that he could not recall receiving a response to a request sent to Maitland Court on 20 February 2017 for a copy of the ADVO. Mr Wills gave evidence that this is still an issue that CLS experiences currently:

> The matter is that it depends on who you come across in terms of your communications with the Court, which registrar from the Court will you contact and how cooperative they will be.

17.10 Both Dr Eagle and Associate Professor Ryan agreed that a lack of clear understanding regarding the terms of Mr SB's ADVO and his legal position some 10 weeks following his initial presentation did not assist the treating team. Both experts also agreed on the deleterious impact that this would have on Mr SB's care. Dr Eagle explained it in this way:

> I think ideally patients benefit from being given clear expectations about what's going to happen, hope, so instilling some hope in the patient in terms of, you know, discharge plans, timeframes. Certainly they were very important. I think uncertainty potentially increases distress in these situations of indeterminate detention, in my experience. Secondly, I think that supportive psychological therapy or counselling can sometimes assist, particularly when a person is experiencing a number of grievances and losses, which Mr SB certainly seemed to be. He'd lost his wife, he'd lost his freedom, he was also experiencing potentially a psychotic relapse, he was facing criminal charges. So, certainly it might've only been from a supportive perspective, but I think counselling can play a role in reducing distress in these circumstances.

17.11 In evidence, Mr Wills drew attention to the HNELHD Mental Health: Assessment and Management of Mental Health Patients on section 19(b) of the Mental Health and Cognitive Impairment Forensic Provisions Act 2020 Clinical Guideline (**Section 19(b) Guideline**). Drafting of this guideline commenced in 2010 and was finally issued in May 2022. The Section 19(b) Guideline provides that staff at a declared mental health facility where a patient has been taken for assessment ought to obtain copies of relevant court papers from the persons accompanying the patient to the facility, whether it be, for example, police officers or Corrective Services New South Wales (**CSNSW**) staff. Mr Wills gave evidence that it is intended that information and training in relation to the Section

19(b) Guideline will be provided to relevant staff at declared mental health facilities over the next six months but planning for this has not yet commenced due to staff resourcing considerations.

17.12 Mr Wills also gave evidence that in his view Courts should provide information regarding a patient's court proceedings at the time that a section 19(b) order is made, and that police should be forthcoming with this information and present it to staff upon a patient's arrival at a declared mental health facility.

17.13 The Section 19(b) Guideline provides for a number of matters regarding the presentation of a patient to a declared mental health facility. It relevantly notes:

> As is standard practice for clinical staff with all presentations via Police or Corrective Services to a DMHF, the following questions should be asked:
> …
> Is there an AVO in force or an interim AVO planned? (Request a copy)
> Request all facts sheet for current alleged offending
>
> **If the Police cannot provide this information, ask them to check their systems and notify the facility. It is unlikely Corrective Services will have all this information.** [original emphasis]

17.14 It is evident that the above provisions draw attention to the need for staff receiving a patient pursuant to a section 19(b) order to request relevant information regarding a patient's court process from police. However, Mr Wills agreed with counsel for the HNELHD that it would be helpful to modify the Section 19(b) Guideline to also instruct declared mental health facilities to contact CLS so that it can direct enquiries to relevant court registries to obtain court process material. Dr Flynn gave evidence in support of such an arrangement given that the CLS has specifically been established as the interface between courts and declared mental health facilities.

17.15 The Section 19(b) Guideline also includes a number of new aspects, relevantly:

(a) that a mental health assessment should be comprehensive and collaborative where possible (per the relevant HNELHD guideline);

(b) that if a person is assessed as not requiring further treatment in hospital but would benefit from ongoing care in the community, appropriate discharge planning and transfer of care should occur;

(c) when a patient is transferred between mental health units, clinical handover must include that the patient was admitted following presentation pursuant to a section 19(b) order; and

(d) for patients at the Mater, Morisset Hospital and Maitland Mental Health Unit, the CLS should be notified (both in writing and verbally) at the time of transfer.

17.16 In addition, Dr Flynn gave evidence that some resources would be directed towards CLS to effectively backfill Mr Wills' position. This would effectively allow for the intended training in relation to the Section 19(b) Guideline to be conducted by Mr Wills.

17.17 **Conclusions:** From the time of Mr SB's admission to the Mater, and continuing through to his transfer to Kaoriki House, it is plain that the treating teams managing his care did not have a clear understanding of the nature of his court proceedings. Despite requests being made by CLS for copies of the relevant paperwork, particularly in relation to the ADVO, this material was not forthcoming.

17.18 The resultant effect was that Mr SB's treating team at Kaoriki House did not fully appreciate the conditions of Mr SB's ADVO. This left the question of whether Mr SB could contact his wife, and whether his wife could contact him, unresolved. This in turn caused considerable distress to Mr SB and likely contributed to his shifting attitude in the period between 4 and 7 March 2017 described above. The overall effect was that the treating team could not provide Mr SB with clear expectations as to steps in his management and eventual discharge, and the likely timeframes involved.

17.19 Since 2017 the HNELHD has issued a guideline which is aimed, in part, to facilitating provision of a patient's court paperwork at the time that the patient first presents to a declared mental health facility pursuant to a section 19(b) order. There is clear recognition that it is of assistance to treating teams to have such information available at the time of a patient's admission. The evidence establishes that if such paperwork does not accompany a patient at the time of their presentation to a declared mental health facility then CLS is best placed to attempt to facilitate provision of such paperwork from court registries. Having regard to these matters, it is necessary to make the following recommendation.

17.20 **Recommendation:** I recommend that the Chief Executive, Hunter New England Local Health District give consideration to amending the *Mental Health: Assessment and Management of Mental Health Patients on section 19(b) of the Mental Health and Cognitive Impairment Forensic Provisions Act 2020* Clinical Guideline so that it explicitly instructs staff at declared mental health facilities, upon a patient's presentation to a facility pursuant to a section 19(b) order, to make a referral to Court Liaison Services for the purpose of facilitating provision of information regarding a patient's legal proceedings from court registries.

18. Assessment of any neurodegenerative condition

18.1 Dr Babu gave evidence as to his understanding of the nature of Mr SB's long-term admission:

(a) First, a diagnostic understanding was required regarding the possible causes of his delusional disorder: alcohol, medication or cognitive decline;

(b) Second, a period of observation was required to determine whether Mr SB could return to court and that in this regard the court was interested in a forensic assessment;

(c) Third, there was an ongoing obligation on clinicians to assess whether Mr SB continued to require involuntary admission, and that the ultimate decision as to whether Mr SB could be discharged rested with Dr Babu.

18.2 In evidence, Dr Babu was asked whether a neurocognitive assessment for Mr SB could have been conducted the week after 10 January 2017 if both a neuropsychologist and interpreter were available, noting that oxazepam had been ceased for Mr SB, his dose of paliperidone had been reduced and he was abstinent from alcohol for about 10 weeks. Dr Babu gave evidence that this timeframe would not be ideal and that a timeframe of mid to late February instead "*would have been helpful*". Dr Babu explained his reasoning in this regard:

> It was just to see that he doesn't have the psychotic symptoms appear, but also the longer that we are abstinent from alcohol, we get a better base line. Because what he had was very subtle and there was a complication of his education and alcohol use, so to get much more clarity I would think that either required a further four to six weeks. And that is something that the neuropsychologist would also be able to tell, I think, there was some discussion.

18.3 Dr Babu gave evidence that upon his return from leave, he was surprised that by 10 March 2017 no neurocognitive testing had been performed for Mr SB. He explained:

> [W]e were trying to get that looked into but I, when I came in, there was this issue of his acute declaration that had occurred and we were more focussed on that day on that. But I did look at that he's having a forensic assessment ongoing and that would help us and getting the neurocognitive assessment done closer to discharge, once we have an idea where he's going.

18.4 Dr Flynn gave evidence that as at 2017 there was a neuropsychologist attached to Kaoriki House in a part-time position of up to 4 days per week. However, this position was shared between Kaoriki House and another outpatient service at Waratah.

18.5 Notwithstanding, Dr Flynn gave evidence that it was "*unclear*" to him why neuropsychological testing was not conducted at Kaoriki House. In this regard, Dr Flynn accepted that from the time that the prospect of neuropsychological assessment was first raised on 9 December 2016 until Mr SB's death 99 days later such an assessment had still not occurred. Dr Flynn agreed that this represented a long period of time particularly for a patient who was involuntarily detained.

18.6 Dr Eagle recognised that it can take weeks for neuropsychological testing to be organised and that there is a need to ensure that a patient's cognitive capacity is optimised if possible. However, she considered that "*ten weeks seems to be too long to be waiting when someone's being detained on that basis*".

18.7 Associate Professor Ryan agreed that such a period is "*a long time*" but recognised that "*it can take a long time for a lot of the things that might have been interfering with neuropsychiatric function to resolve*". Initially, Associate Professor Ryan considered that the period seems like a long time "*but it didn't seem unreasonably long*".

18.8 Dr Eagle considered that neurocognitive testing was necessary to exclude dementia but noted that Mr SB had been observed and the treating team felt that any cognitive impairment, if present, was very mild and that the team had not formed the view that he had dementia. However, she considered it reasonable from a forensic psychiatry perspective to obtain an understanding of what the diagnostic impression of Mr SB was, but noted that "*there would have been an ongoing process of diagnostic clarification in the community in the matter what*".

18.9 Later in his evidence Associate Professor Ryan concurred that it would be preferable to perform neuropsychological testing before obtaining the forensic assessment and expressed agreement with the general sentiment expressed by Dr Eagle that both of these processes simply took too long.

18.10 **Conclusions:** Consideration of a neurocognitive assessment for Mr SB was first raised on 9 December 2016. It was appropriate for any forensic assessment to be deferred until a neurocognitive assessment had been completed. However, although a neuropsychiatrist was attached to Kaoriki House, a neurocognitive assessment had still not been completed by the time of Dr Babu's return from leave on 10 March 2017, which exceeded Dr Babu's expected timeframe for completion. Indeed, no neurocognitive assessment for Mr SB was ever completed.

18.11 Even accepting that some period of time was required for Mr SB to establish a baseline before a neurocognitive assessment commenced, a period of 10 weeks to allow for the commencement of such an assessment is considered to be unreasonably lengthy. This is particularly so having regard to the opinion expressed by Dr Eagle that Mr SB's treating team considered that any cognitive impairment that he had was very mild and the team had not reached the view that Mr SB did in fact have dementia.

18.12 Ultimately, the available evidence does not disclose any clear reason why, despite apparent availability of resources, a neurocognitive assessment was not completed for Mr SB at Kaoriki House. Further, the apparent lack of progress in this regard did not prompt any member of Mr SB's treating team to interrogate the reason for the delay, attempt to progress the assessment or give reconsideration to whether such an assessment or to have been pursued

19. Referral for forensic assessment

19.1 Dr Babu gave evidence that there was a need to look at Mr SB's risk profile from a longitudinal perspective and in relation to a number of other factors namely mental illness, substance abuse and cognitive impairment. Dr Babu expected that the forensic assessment would assist the treating team to manage the risks of mental illness, substance use and cognitive issues upon Mr SB's return to the community or to his family.

19.2 Mr Wills gave evidence that on 9 January 2017, he discussed Mr SB with Dr McDonald who at the time was requesting a forensic review. Mr Wills communicated with Dr McVie, the senior forensic psychiatrist, who indicated that at that time she would not entertain seeing Mr SB until a formal assessment of dementia had been obtained. According to Mr Wills, "*there was little merit in her opinion in seeing to a forensic review given that we hadn't formally established that there was an organic condition going on such as dementia*".

19.3 Dr McDonald gave evidence that by the time that he prepared a letter for the purposes of the Tribunal's review of Mr SB, he had contacted the forensic psychiatry advanced trainee by phone and provided a clinical handover verbally. Dr McDonald gave evidence that it was his understanding that the forensic psychiatry assessment would not take place until the possibility of

dementia for Mr SB had been ruled out. Dr McDonald also gave evidence that due to his relatively junior status at the time, whatever clinical steps were being made to exclude dementia were determined by others and not by him.

19.4 Dr McDonald explained that at the relevant time, interpreting a SPECT would have been well beyond his experience. Instead, Dr McDonald gave evidence that it would have been a matter for either Dr Babu or Professor Schofield to review. Dr McDonald recalled there being a discussion regarding the SPECT scan but said that he was unclear as to its relevance regarding a possible diagnosis of dementia.

19.5 According to the progress notes, it appears that the forensic assessment commenced on 3 March 2017, when Dr McDonald introduced Dr Christina Matthews, the forensic psychiatry advanced trainee, to Mr SB. Dr Flynn gave evidence that from his enquiries he established that no clinical notes were made regarding the commencement of any forensic assessment for Mr SB.

19.6 Neither Dr Eagle nor Associate Professor Ryan took issue with the fact that Mr SB was not sent for a forensic assessment during his 10 week admission at the Mater. However, Dr Eagle drew a distinction regarding the timeliness of such a forensic assessment once Mr SB was transferred to Kaoriki house. She explained that whilst Mr SB was at the Mater he was still being actively treated for his psychosis, but that this appeared to have stabilised by the time of his transfer. Further, once Mr SB was at Kaoriki House, Dr Eagle expressed the view that little appeared to have been done to advance the goal of obtaining a neurocognitive assessment, which was one of the primary goals of his transfer, and obtaining a forensic assessment, which had been flagged early in Mr SB's admission.

19.7 In this regard, Dr Eagle agreed that it was reasonable to obtain Mr SB's best baseline before neurocognitive assessment was conducted. However, Dr Eagle explained that this factor needed to be weighed up against other factors such as the fact that Mr SB was distressed, and consideration being given as to whether such an assessment could be done in a less restrictive environment.

19.8 Ultimately, Dr Eagle considered these to be matters of degree and clinical judgement. Associate Professor Ryan similarly agreed that progression of both the neurocognitive and forensic assessments required evolving clinical judgement and recognition of the potential need to revise any management plan.

19.9 Both Dr Eagle and Associate Professor Ryan recognised the challenges in psychiatrists obtaining an understanding regarding a patient's legal processes, such as the precise meaning of orders like an ADVO, and precisely what occurs should a patient be discharged from a mental health facility. Associate Professor Ryan described this as this "*a failing of the system*" and that "*the extent that the ignorance among psychiatrists, including myself, about this interaction [is between the legal and psychiatric systems) is so great and there is no obvious source that psychiatrist can go too easily*".

19.10 Nevertheless, Dr Eagle considered it to be unreasonable for a patient to be detained solely on the basis of waiting for forensic input that could otherwise be provided if it were available. She noted that there is a state-wide community forensic mental health service that will provide risk

assessments and forensic input in relation to high-risk civil patients, and that the HNELHD has its own the forensic services that can provide such input.

19.11 Dr Eagle considered that it was reasonable for forensic input to be sought for Mr SB for the purpose of obtaining information about risk management strategies that may have been helpful in the community following his discharge. Dr Eagle considered that such a forensic assessment would have been "*relatively straightforward*" and that if she had performed the assessment her advice would probably have been that Mr SB be treated with an antipsychotic medication, so that any delusion regarding his wife's infidelity was attenuated, and that he be discharged in the interim to a placement where he would not have contact with his wife. That said, Dr Eagle went on to explain:

> [B]ut I do think it was relatively clear from a general psychiatric perspective that the risk was related to being discharged back in circumstances where he would have contact with his wife. I think that there were risk management strategies that could have been devised by general psychiatrists that would have been able to manage that risk in the community, at least until a forensic assessment was able to be sought for instance.

19.12 Associate Professor Ryan agreed that a forensic assessment would have been useful for the purposes of discharge planning, and deferred to the opinion expressed by Dr Eagle in relation to the nature of such an assessment.

19.13 **Conclusions:** Initially, it was reasonable to await the outcome of a neurocognitive assessment, and determination of whether Mr SB had a diagnosis of dementia or not, before a forensic assessment was commenced. However, it is unclear why the forensic assessment was not progressed once Mr SB had been transferred to Kaoriki House. It is equally unclear why a little appears to have been done by Mr SB's treating team to progress such an assessment. Certainly, the paucity of documentation regarding the commencement of the forensic assessment process does little to assist in this regard.

19.14 Given Mr SB's status as an involuntary patient, the more time that passed without a forensic assessment being completed ought to have prompted consideration as to whether such an assessment could be conducted in the community, with appropriate risk management strategies in place. The evidence indicates that no consideration was given to such an alternative pathway, or to other available services which may have been utilised to provide such an assessment.

20. Use of an interpreter

20.1 Dr McDonald gave evidence that he had a number of interactions with Mr SB on the ward, mostly without the assistance of an interpreter. Dr McDonald also gave evidence that he would not have felt confident performing a psychiatric assessment without the assistance of an interpreter due to Mr SB's limited English.

20.2 The evidence indicates that the first time that Mr SB was assessed at Kaoriki House by a medical officer with the assistance of an interpreter was on 13 January 2017. When asked whether he considered this to be less than ideal, Dr Babu said, "*certainly that sounds not really a good practice, less than, much less than ideal*". Dr Babu went on to express his suspicion that Mr SB

might have been seen earlier by Dr McDonald. However, Dr McDonald's evidence is that the first time he assessed Mr SB in relation to his mental health (and not in relation to an attendance for any physical ailments) with the assistance of an interpreter was on 13 January 2017.

20.3 Both Dr Eagle and Associate Professor Ryan described having generally experienced few difficulties associated with obtaining an interpreter over the phone. Rather, the difficulty arises in arranging for the attendance of an interpreter in person, which is considered to be more ideal in a clinical setting. Dr Eagle noted that in her experience, which is what Mr SB's treating team attempted to do, was to organise for an interpreter in advance to be regularly available at a designated time and day.

20.4 **Conclusions:** Any comprehensive psychiatric assessment of Mr SB was dependent upon the assistance of an interpreter. Mr SB's treating team appropriately made arrangements for an interpreter to be available at designated times. Notwithstanding, the evidence indicates that the first time that Mr SB was assessed at Kaoriki House by a medical officer, with the assistance of an interpreter, was almost two weeks after his transfer. This did not represent good clinical practice.

21. Medication

21.1 One additional issue considered during the course of the inquest concerned Mr SB's medication regime. During a MDT meeting on 3 January 2017, a plan was formulated to reduce paliperidone, cease oxazepam and to start escitalopram 5 mg for impulsivity. However, Mr SB's medication charts indicated that escitalopram was not charted for him.

21.2 Having reviewed the handwriting on the medication charts following the MDT meeting on 3 January 2017, Dr McDonald acknowledged that it was most likely that he updated the charts. Dr McDonald acknowledged that escitalopram was not charted for Mr SB and gave evidence that he could not recall any specific discussion regarding escitalopram during the MDT meeting itself.

21.3 However, Dr McDonald expressed the view that he did not consider it likely that he would have overlooked charting escitalopram as he explained he would tend to use the MDT meeting and any documentation from it to guide and Mr SB's management. Notwithstanding, Dr McDonald could offer no explanation as to why escitalopram was not charted. By way of explanation, Dr McDonald noted:

> I think this is where the arrangement of two registrars did become complicated in regards as to who was to take responsibility. What I can recall from the MDT's is that myself and Dr Bull, we would delegate the clinical tasks amongst ourselves. So with the question of asking me am I solely responsible, I just don't recall who that task was attributed to.

21.4 Dr Babu agreed that escitalopram was not charted for Mr SB following the 3 January 2017 MDT meeting. Dr Babu gave evidence that he had no recollection of ever changing his mind or reversing his decision to chart escitalopram for Mr SB. Dr Babu also gave evidence that during each MDT meeting a patient's medication chart would be read out. Despite this occurring, it is evident that during the next MDT meeting on 10 January 2017, the failure to chart escitalopram for Mr SB was not identified.

21.5 Despite Dr Babu's intention to reduce Mr SB's dose of paliperidone to 3 milligrams, and to maintain this dose throughout his admission, it was actually ceased on 14 February 2017 whilst Dr Babu was on leave. Upon Dr Babu's return, this cessation was not identified during the MDT meetings that he attended on 7 and 14 March 2017. Dr Babu agreed that if there was a rationale for the cessation of paliperidone it should have been documented, and that absent any such rationale it should have been continued.

21.6 Dr Babu gave evidence that his rationale in reducing Mr SB's dose of paliperidone was to identify whether it had any impact on Mr SB's cognitive function prior to any neurocognitive assessment. Dr Eagle considered that such an approach would be dependent on Mr SB's discharge plan. In other words, if the plan was to discharge Mr SB on antipsychotic treatment, which would have been indicated in his case, then "*you would do the neuropsychological testing on the treatment that you plan to discharge the patient on*". Relevantly, Dr Eagle noted that the prescription of 3mg paliperidone was a relatively low dose and that "*if anything it may well have optimised his cognitive function rather than cause any impairment or artefact in it*".

21.7 Associate Professor Ryan expressed some uncertainty as to whether this was indeed the plan for Mr SB:

> I don't know that that wasn't necessarily the plan in which case I think, and against judgement, it's about how much time everything is going to take, it'd be better for him to be off it. He's described it as calming, that could be a synonym for sedating, which could mean something is [affecting] his cognition.

21.8 Both Dr Eagle and Associate Professor Ryan agreed that the failure to chart escitalopram and the cessation of paliperidone without a clear, documented rationale did not represent ideal clinical practice. Further, both experts agreed that if Mr SB's medication regime was being reviewed at each MDT meeting, then these prescribing errors ought to have been recognised.

21.9 **Conclusions:** It is evident that there were certain deficiencies associated with Mr SB's medication regime at Kaoriki House. Contrary to Dr Babu's intentions and instructions, escitalopram was not charted for Mr SB, and paliperidone was ceased with no clear, documented rationale. Despite the apparent review of Mr SB's medication regime at each MDT meeting, these errors were, for reasons unknown, not identified. Overall, the administration errors, and the failure to identify them prior to Mr SB's death, did not constitute good clinical practice.

21.10 In addition, the absence of good, clear documentation does not assist in understanding the rationale behind certain decisions made regarding Mr SB's medication regime. For example, in the absence of contemporaneous documentation, it is unclear whether reduction and continuation of paliperidone was critical to either completion of neuropsychological assessment or discharge planning for Mr SB.

22. Discharge planning

22.1 Dr McDonald gave evidence that between 31 December 2016 and 7 March 2017, he could not recall a discussion at any MDT meeting regarding a specific timeframe for the duration of Mr SB's

admission. Rather, Dr McDonald explained, the discussions focused on assessment of Mr SB's risk from a forensic point of view and determining an appropriate discharge destination. Further, Dr McDonald gave evidence that as at 14 March 2017, his understanding was that the only matter that the treating team was waiting on, prior to any decision regarding discharge and an appropriate discharge destination, was the forensic assessment report.

22.2 Dr Babu gave evidence that the forensic assessment was relevant to the issue of discharge planning. Further, Dr Babu indicated that the lack of understanding by the treating team regarding Mr SB's legal circumstances made this planning more challenging. This also made it difficult to identify where, or to whom, Mr SB would be discharged and to identify appropriate community referrals should he be released from a hospital setting.

22.3 Apart from the forensic assessment, Dr Babu gave evidence that having clarity as to how Mr SB's legal matters could have been accelerated would have been of assistance.

22.4 Dr Eagle considered that Mr SB appeared to have a delusional disorder, characterised by a persistent delusion of infidelity involving his wife, and a severe alcohol use disorder, which was in remission in the controlled environment of an inpatient setting. Dr Eagle also considered that Mr SB may have had a major neurocognitive disorder secondary to severe alcohol dependence, or the complications of severe alcohol dependence and/or vascular dementia. Finally, Dr Eagle considered that Mr SB may have had a depressive disorder, but that any accurate clinical assessment was likely hampered by language, personality characteristics, age and potential cultural barriers.

22.5 Associate Professor Ryan considered that it was "*distinctly possible*" that Mr SB had a delusional disorder but that this over simplifies the possible diagnoses (such as paraphrenia, alcohol induced psychosis, early cognitive impairment or medication side effects) that may have accounted for his delusions of infidelity. In addition, Associate Professor Ryan considered that whilst Mr SB may have had dementia it is more likely that his cognitive impairment would have been better characterised as mild neurocognitive disorder or minimal cognitive impairment. Finally, Associate Professor Ryan expressed the view that, on balance, Mr SB did not have a major depression at the time of his death, and that it is more likely that he had an adjustment disorder.

22.6 Both Dr Eagle and Associate Professor Ryan agreed that the greatest risk for Mr SB in terms of discharge planning was recommencing consumption of alcohol and delusional thoughts regarding his wife's alleged infidelity. Dr Eagle considered that if on discharge, Mr SB was to be placed in custody or released on conditions that he not approach his wife, that any neurocognitive assessment could have been performed in the community. Associate Professor Ryan expressed some reservations with such a scenario:

> I mean it was just a question of whether [Mr SB] was going to be discharged before he'd had as much work up as he possibly could because if he got discharged then he may or may not be held in custody or be released, and if he were released he'd be bailed in circumstances where he wouldn't - where he'd be prohibited from approaching his wife, but I'm not necessarily going to be reassured that's going to be helpful. I might be more reassured that a way for it could be found if he was assessed as much as possible. Obviously though there's got to be some limit to that, it's a matter of judgment.

22.7 Both experts were invited to consider the circumstances of Mr SB's admission in the sense that he was being provided with no treatment for alcohol abuse, other than abstinence, and that antipsychotic medication was provided for a period of time in relation to possible delusional disorder. Associate Professor Ryan opined that he considered it reasonable to detain Mr SB for further diagnostic clarification despite the fact that his alcohol abuse was not going to be actively treated, that any delusion and associated risk was in relation to his wife, and any impressions of cognitive impairment were mild. However, Associate Professor Ryan went on to indicate that "*because if it were me, I would sort of want that [diagnostic clarification] but I would be really trying to speed this up*".

22.8 Dr Eagle expressed the view that it was reasonable to obtain a neuropsychological assessment, but given Mr SB's distress and that he was not on any active treatment, such an assessment could have occurred in a less restrictive environment. Dr Eagle went on to explain:

> I don't disagree that a neuropsychological assessment should've been done but I think it should've been available earlier in the admission so that he then could've been discharged back into the community and further a diagnostic assessment could've taken place with the benefit of a community team, the family's input and the medicolegal process would also have been progressed.

22.9 Both Dr Eagle and Associate Professor Ryan agreed that the duration of Mr SB's admission, and the need for appropriate discharge planning, required consideration of an appropriate place for him to be discharged, and whether it would be considered safe. Such planning necessarily required consideration of complicating factors such as the absence of any kind of longitudinal history, potential neurocognitive impairment by virtue simply of Mr SB's age and the extent to which Mr SB's alcohol abuse contributed to either his possible delusional disorder and/or neurocognitive impairment. Ultimately, when asked whether part of the "*prolongation*" of the process of determining where Mr SB could be discharged and what would be considered safe, Dr Eagle opined:

> I'm not really sure what happened in the five months, apart from him getting a bit better, that enabled them to come up with this plan. Or what prevented them from coming up with this plan three months earlier, because no neurocognitive testing had been done, the forensic assessment still hadn't been provided, but they still managed to come up with what actually looks like a perfectly appropriate and safe plan, with the collaboration of the family. So having regard to that, I think that's sort of the crux of the issue really. I agree with everything else you've said, but I think that's the crux. Like what changed that enabled them to come up with that plan at that point? Because none of the things that they said they were trying to do had actually been done at this point.

22.10 **Conclusions:** The expert evidence established that discharge planning for Mr SB ought to have commenced from the first day of his admission. As has been stated a number of times already, much of the treating teams' apparent focus was on obtaining a neurocognitive assessment for diagnostic application, followed by a forensic assessment to assist with Mr SB's management together with discharge planning and, in particular, is discharge destination.

22.11 However, as Mr SB's admission progressed there is no evidence that any reconsideration was given to how discharge planning might be progressed without the availability of a neuro psychiatric assessment and forensic assessment. The opinion expressed by Dr Eagle suggests that appropriate and safe discharge planning could have been finalised in a timelier manner to allow for the assessments that were considered important to be conducted in a less restrictive environment.

23. Steps taken to address the layout and physical features of the recreation room at Kaoriki House

23.1 Following Mr SB's death, the physical features and potential environmental hazards of the recreation room were examined and the machine and electrical cord used by Mr SB were removed. In addition, Dr Flynn gave evidence that the most recent version of a policy compliance procedure in relation to a mental health facility safety checklist, issued in March 2021, provides that a facility checklist audit is to be completed at least annually which identifies risk vulnerability points, including hanging points. Service managers are then required to review any recommendations made regarding action plans for improvement and determine the feasibility of implement things such recommendations. When recommendations are not able to be implemented, they are escalated to a mental health clinical quality and patient care committee.

23.2 In addition, Dr Flynn gave evidence that Morisset Hospital has very aged infrastructure and its buildings are not easily modifiable. As a result, Dr Flynn explained that there are inherent problems with the use of older structures as inpatient mental health units, which is an issue not confined to the HNELHD. Dr Flynn gave further evidence that early discussions are occurring involving NSW Health regarding proposals to relocate clinical services at Morisset and "*ideally… we would have the consumers who are at Kaoriki at the moment in the more modern facilities and soon as we could*".

23.3 **Conclusions:** Appropriate steps have been taken by the HNELHD to immediately remove the physical means by which Mr SB was able to inflict his own death, and to implement a policy framework that allows for regular audits of environmental hazards and physical features at Kaoriki House (as well as other facilities within the HNELHD) that may pose a risk to patient safety. Further, the evidence establishes that appropriate consideration is being given to the suitability of existing, older structures being used as mental health facilities.

24. Findings

24.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Maria Gerace, Counsel Assisting, and her instructing solicitor, Ms Clara Potocki from the Crown Solicitor's Office. The Assisting Team has provided tremendous assistance during the conduct of the coronial investigation and throughout the course of the inquest. I am extremely grateful for their dedication and meticulousness, and for the sensitivity and empathy that they have shown during all stages of the coronial process.

24.2 I also thank Detective Senior Constable Jonathan Newton, the police officer-in-charge, for his role in the coronial investigation and for compiling the initial brief of evidence.

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

Identity
The person who died was Mr SB.

Date of death
Mr SB died on 18 March 2017.

Place of death
Mr SB died at Wyong Hospital, Hamlyn Terrace NSW 2259.

Cause of death
The cause of Mr SB's death was cardiac arrest following neck compression due to hanging, with vascular dementia, delusional disorder and chronic alcohol dependence being significant conditions contributing to the death.

Manner of death
Mr SB died as a result of actions taken by him with the intention of ending his life. At the time that these actions were taken, Mr SB was detained as an involuntary patient at a mental health facility pursuant to the provisions of the *Mental Health Act 2007*. Mr SB's death was, therefore, intentionally self-inflicted.

24.4 On behalf of the Coroners Court of New South Wales and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences to Mrs IB, Ms AC, Mr MB, and the other members of Mr SB's family for their most painful and sad loss.

24.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
16 September 2022
Coroners Court of New South Wales