STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Roger Frederick Schnelle
Hearing dates:	23 – 27 October 2023
Date of findings:	16 May 2024
Place of findings:	Local Court, Albury
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – diagnosis of mental health condition – psychotic depression / depression with psychotic features – care and treatment provided during admission at Nolan House including adequacy of risk assessments, observations, and treatment plans – method and nature of self-harm – impact of Nolan House being subject to both NSW and Victorian health oversight, policy, and guidelines – need for implementation of an electronic medical record across Albury Wodonga Health mental health services – need for induction process for locum and visiting staff members – need for implementation of improved risk assessment tools
File number:	2021/00122654
Representation:	Counsel Assisting the Coroner: Mr Jake Harris, instructed by Ms Clara Potocki (Crown Solicitor's Office) Schnelle Family: Jennifer Cowen, instructed by Ms Emily Hart (Maurice Blackburn Lawyers) Albury Wodonga Health and Dr Jessica Liu: Ms Lorna McPhee instructed by Ms Kate Cooch (MinterEllison) Dr Abhijith Krishna Shanbhogue: Ms Jeunesse Chapman, instructed by Ms Kelly Kandelaars (Landers & Rogers)

Findings:	**Identity** The person who died was Roger Frederick Schnelle. **Date of death** Roger died on 30 April 2021. **Place of death** The location of Roger's death was the Intensive Care Unit of Albury Wodonga Health, 201 Borella Road, East Albury. **Cause of death** The cause of Roger's death was head injuries. **Manner of death** Roger's death was as a result of an intentionally self-inflicted act while at significant risk of self-harm and being cared for and detained as an involuntary patient under the *Mental Health Act 2007* (NSW) at Nolan House.

Recommendations:	**To the Chief Executive Officer, Albury Wodonga Health:** 1. That consideration be given to continuing to advocate with NSW Health and the Department of Health, Victoria, for the implementation of an electronic medical record across Albury Wodonga Health mental health services. Such a record should ideally be compatible with systems in both NSW and Victoria, and should include standardised documents for the assessment, formulation and management of risk and patient observations. 2. That consideration be given to a review being undertaken of the Albury Wodonga Health mental health service policy relevant to risk assessment, patient observation and documentation to ensure compatibility with both NSW and Victorian policies. Where those policies are not compatible, draw this to the attention of NSW Health and the Department of Health, Victoria, in accordance with the process described in the AWH Memorandum of Understanding. 3. That consideration be given to implementing Risk Assessment Tools that focus on assessment, formulation, and importantly management of risk and consider risk indicator factors that are associated with an increased suicide or suicidal behaviour, as set out in the expert evidence of Dr Eagle. 4. That consideration be given to ensuring that the induction processes for locum and visiting staff members clearly identify relevant policy and practices in relation to the assessment, formulation and management of risk documentation and patient observations.

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The Coroners Act in section 81(1) requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Roger Frederick Schnelle.

Introduction

1. Mr Roger Frederick Schnelle died on 30 April 2021, while detained as an involuntary patient at Nolan House, a mental health facility operated by Albury Wodonga Health (AWH), where he inflicted harm on himself and could not be revived.

2. Roger had been admitted on 11 April 2021. Over the course of his admission, his mental health deteriorated, and, on 27 April 2021, an application was made to the Mental Health Review Tribunal (MHRT) to commence Electroconvulsive Therapy (ECT).

3. On the morning of 28 April 2021, Roger placed his head between heavy sliding doors, and slammed them shut, sustaining multiple skull fractures and intracranial haemorrhages. He was transferred to the Intensive Care Unit (ICU), but his injuries were deemed non-survivable. Life support was withdrawn two days later.

4. Roger's sudden mental deterioration was a shock to all who knew him. He had been a very successful, family orientated and very high functioning person, until very suddenly things changed. His family took the steps of taking him to hospital to try and protect him. They put him in the safest place he could be, and yet he still could not be protected. It was important to explore how, while he was involuntarily detained and at high risk of harm that he was still able to inflict injury sufficient to end his life.

Function under the Coroners Act

5. The primary function is provided by section 81 of the *Coroners Act 2009* (the Act). It is to make findings as to:

    a. the identity of the deceased;

    b. the date and place of the person's death; and

    c. the manner and cause of the person's death.

6. Pursuant to section 82 of the Act, the Coroner may make recommendations in relation to any matter connected with the death. Recommendations relating to public health and safety are specifically mentioned in the Act as an example of the category of recommendations that might be appropriate.

Nature of the inquest

7. The proceedings are inquisitorial in nature, not adversarial. It was not the function of this inquest to find negligence nor apportion blame. The proceedings are not criminal. In effect the proceedings were to explore the manner and cause of Roger's death in light of the care and treatment provided to him at Nolan House, AWH.

8. The inquest into Roger's death was held over five days, between 23 and 27 October 2023, at Albury. The Court received extensive documentary material into evidence including 4 volumes of material in the form of the brief of evidence which contained witness statements, medical records, and an expert report. The inquest heard from 14 witnesses who were called to give evidence and had the benefit of a view of Nolan House. The inquest also had the benefit of Family statements. Members of Roger's family including his wife, Yvonne Schnelle, provided moving statements to the Court about Roger.

9. Comprehensive closing submissions have been filed by Counsel Assisting and those representing the interested parties in 2023 and 2024.

10. I have considered and assessed all of the material that has been tendered, the oral evidence given by the witnesses, and the written closing submissions.

The Issues

11. The Court heard evidence in these proceedings in relation to the following issues relating to Roger's death:

    1) The statutory findings required under section 81 of the *Coroners Act 2009 (NSW)*.

    2) Was the care and treatment provided to Roger during his admission to Nolan House from 11 April 2021 to 28 April 2021 reasonable, adequate, and appropriate?

    3) Was the diagnosis made for Roger's mental health condition appropriate, and were alternative diagnoses adequately considered?

    4) Was there appropriate assessment and investigation of Roger's physical health, including any referrals?

    5) Were the mental health treatment plans appropriate, and were they implemented adequately?

    6) Was the decision to seek an order for electroconvulsive therapy timely and appropriate?

    7) Were the risk assessments reasonable? In particular:

a. Was information from different clinicians recorded comprehensively and incorporated appropriately into the risk assessments?

b. Was the assessment of risk sufficiently thorough and adequately documented?

c. Did it result in appropriate risk management?

8) Was there an adequate frequency and quality of observation performed by nursing staff? If not, what factors contributed to this?

9) Was there an adequate response to the deterioration in Roger's mental state, from around 22 April 2021?

10) Was the method by which Roger committed self-harm a foreseeable risk, and if so, what steps were available to reduce that risk?

11) Was Roger's death intentionally self-inflicted?

12) Nolan House is based in NSW but is also subject to Victorian health oversight, policy, and guidelines. Did that have any impact on the nature and quality of care provided to Mr Schnelle during his admission?

13) Is it necessary or desirable to make any recommendations in relation to any matter connected with Roger's death?

Background

Reflection on Roger's life

12. This inquest was looking at a very short period of Roger's life, at the stage where he became mentally and suddenly very unwell, which started a few months before his passing, escalating in the weeks and indeed days leading to his death. This was by no means who Roger was in life, nor how he is remembered by family and friends. Roger was a friend and a delight to many people, a big contributor to the local community and importantly to him a pillar of strength and joy to his family.

13. Prior to 2021, Roger had not suffered any major mental health issues. He had a history of some anxiety, although limited to flying or enclosed spaces. He lived a happy, full, and professionally successful life. He was a high-functioning individual. He ran a successful accountancy business and was looking forward to his retirement. He was active in the community, in his children's schools and in the church. He was an incredible family man, family being of number one importance to him, and he loved nothing more than to be with family enjoying their company. He was a committed and devoted partner and a caring and involved father, it was clear from the evidence that his family was everything to him. It was also clear that he was a linchpin, drawing people to him.

14. Fitness was a priority in his life, and he physically looked after himself, maintaining physical fitness as a priority in his life. He had been a talented sportsman and completed three marathons. In later life, he had developed osteoporosis which imposed obvious psychical limitations, but he retained his ability and remained a keen golfer. He also enjoyed music and had a passion for the piano and guitar.

15. His wife, Yvonne described Roger, in her Family statement that she prepared and shared with the Court, as:

> *"intelligent, considerate, and generous in all respects. He was known and respected for his integrity in all that he did. He was naively trustful at times. He generally gave people the benefit of the doubt. He was compassionate and knew how to make people feel better about themselves, especially those that he loved … He liked to give people joy, especially where it concerned music. If we were at a small gathering and there was a keyboard around it was going to be a long and fun night.*"

Onset of physical illness

16. There were limited factual disputes, and in canvassing the evidence and addressing the issues. I have been greatly assisted by the written submissions of Counsel Assisting. The facts are extracted and set out below.

17. On 2 January 2021, Roger suddenly began to suffer symptoms of severe vertigo. He attended a General Practitioner (GP) and received medication and was referred to a physiotherapist. The symptoms appeared to lessen or resolve themselves. However, about a month later they returned, becoming worse. They became debilitating and therefore all consuming, including symptoms such as vertigo, nausea, ringing in his ears (tinnitus), blurred vision, rapid eye movements (nystagmus), sensitivity to light, sound and touch, sleeplessness and lost appetite, and weight loss. He was unable to enjoy the very things he delighted in such as playing guitar or listening to music, which was an integral part of his daily life.

18. Roger attended his regular GP, Dr Peter Crawford who considered that Roger had possibly developed Benign Paroxysmal Positional Vertigo (BPPV), or vestibular neuritis. He was trialled on further medication and referred to an Ear, Nose and Throat (ENT) physician, Dr Gerard Fogarty, although was not able to make an appointment before April.

19. He was also referred for an MRI and a CT brain scan. Roger was not comfortable with having these investigations, due to his claustrophobia. He did not think he would be able to proceed with those investigations unless he was sedated.

20. It is possible that Roger had started to develop symptoms of mental unwellness at this time. Roger's wife, Yvonne Schnelle, noted that, after returning from a trip to Arnhem land, Roger told her he had not slept. The ongoing physical investigations were unable to identify a cause. Dr Kerri Eagle, expert

psychiatrist who provided a report to the Court, opined that at this point Roger: "*displayed a somatic preoccupation that appeared out of keeping with his actual physical condition*".

8 April 2021

21. On 8 April 2021 Dr Crawford ordered a CT scan, however Roger did not feel he could go through with the procedure. It was at this time Roger's situation began to rapidly escalate and he began to equally deteriorate, expressing uncharacteristic feelings of hopelessness. He told Yvonne he could no longer live as he would never get rid of his condition. He spoke about thoughts of running into the traffic. Yvonne reached out to her brother, Dr Brent Waters.

22. It should be noted that Dr Waters is an eminent consultant psychiatrist, formerly Professor of Psychiatry at University of NSW, and Head of the Department of Psychiatry at St Vincent's Hospital. He spoke with Roger. He was very concerned and felt Roger had: "*strong hopeless feelings that he was never going to get better*." He discussed a safety plan with Yvonne. This initially proved to be very helpful, but things then deteriorated further.

23. Although Roger's mood appeared improved a short period, he then became distressed again. Yvonne was understandably terribly concerned and looking for help, and so called the mental health crisis line. A nurse made an appointment at the Brain and Mind Centre, at Mercy Hospital, that afternoon. Although Roger attended, his condition deteriorated again. At 6.47pm, Yvonne made the decision to call 000, realising that she needed to take urgent steps to protect Roger.

24. Paramedics attended, and Roger told them he had: "*considered taking himself to a busy road and jumping in front of a car or bus.*" A form pursuant to section 20 of the *Mental Health Act 2007* (NSW) was prepared. Roger agreed to go voluntarily to the Albury campus of Albury Wodonga Health (Albury Base Hospital).

Admission to Albury Wodonga Health

25. Roger was reviewed by Dr Heshmati in the Emergency Department (ED). He reported feeling hopeless and socially isolated. Dr Heshmati spoke with Dr Waters, who helpfully remained invested and involved and who confirmed his view that there was a real risk of self-harm. Roger remained in the ED overnight. A CT brain scan was performed, which was normal. In the morning of 9 April 2021, Roger was reviewed by Dr David Rutherford in the ED. Dr Rutherford is a consultant physician. Dr Rutherford was surprised Roger had not been admitted to the mental health unit. He understood that a mental health admission had been declined, although he was unable to find a clinical entry regarding this. His view was that Roger did not need a medical admission, as his symptoms of vertigo had resolved and were already being investigated in the community.

26. Dr Rutherford was a very experienced consultant in the Albury Wodonga region and arranged to transfer Roger to the Albury Wodonga Private Hospital. He explained that this was to facilitate an MRI, and to obtain an assessment by the neurologist, Dr Ring. He also hoped that Roger would then be admitted to the local private mental health unit, Karinya.

27. Dr Rutherford explained that in the past he had enjoyed very helpful and professional relationships with psychiatrists at Nolan House. He indicated however that this had changed with a change to the model of staffing at Nolan House. Before there had been a range of Visiting Medical Officers (VMO) however a move was made to directly engage medical officers on a permanent engagement model, leading to a number of the long term VMO disengaging from the service. He considered this a disadvantage as previously he had been able to resolve issues about individual admissions because he knew who to call. He explained that it was this change that prompted him to arrange an admission to the private hospital for medical reasons, despite thinking Roger needed a mental health admission.

Admission to Albury Wodonga Private Hospital

28. Roger was then transferred to the private hospital in the afternoon of 9 April 2021. However, on review by an ENT registrar there, Roger became extremely distressed and wanted to leave the hospital. Dr Rutherford attended the private hospital and formed an impression that Roger had features of psychotic depression. He considered it was not safe for Roger to remain at the private hospital, and he scheduled Roger under section 19 of the *Mental Health Act 2007* (NSW). Roger was transferred back to the ED.

Re-admission to Albury Wodonga Health

29. At 10.11pm, Roger was transferred by ambulance back to the ED, where he was detained as an involuntary patient under the *Mental Health Act 2007* (NSW). He was agitated and restless and as a result was given quetiapine. The following morning, 10 April at 10:55am, Roger was reviewed by psychiatrist Dr Iqbal. Roger was expressing suicidal ideas and intent, and he appeared depressed. He was thinking negatively, catastrophising, and viewed himself as being "*weak*". Dr Iqbal's impression was that Roger had depression, secondary to his physical health problems, with a history of anxiety. The plan was to admit Roger to the psychiatric unit, Nolan House, commence sertraline (an antidepressant) and continue quetiapine, and arrange a review by Dr Ring. Roger remained in the ED, with a security guard present, and was transferred to Nolan House the following afternoon, 11 April 2021.

Admission to Nolan House

30. Roger was initially placed in the High Dependency Unit (HDU) at Nolan House and found this traumatic. He was observed to be pacing around the lounge area on the first evening, refusing to engage with staff and telling them he felt unsafe.

31. Roger then came under the care of psychiatrist Dr Abhijith Krishna Shanbhogue (Dr Krishna), and his registrar Dr Jessica Liu, who was at that time about 16 months into her psychiatrist training. They had both commenced locum placement at Nolan House earlier in February 2021.

32. Roger was assessed by nursing staff each day according to the *Risk Monitoring Nurse Observation & Engagement Tool* (Part A). These assessments consistently rated Roger to be at "moderate" risk of self-harm or suicide, resulting in 30-minute observations, which were then recorded on Part B of that tool.

Dr Rutherford speaks to the treating team

33. Dr Rutherford attended Nolan House on 12 April 2021, to advocate for Roger's admission, and to discuss his findings. He spoke with Dr Krishna and Dr Liu. Dr Rutherford stated in evidence that he told Dr Krishna of his concern that Roger had "*psychotic depression".* He also conveyed that he felt Roger was at high risk of self-harm. Dr Krishna accepted that Dr Rutherford said Roger may be suffering from psychotic depression, and that he was concerned about him. He listened to Dr Rutherford and considered his views as part of his diagnosis.

Dr Krishna and Dr Liu review of Roger

34. Dr Krishna and Dr Liu first reviewed Roger later that morning. Roger told them he had suicidal thoughts, but said he didn't think he would have acted on these, because he was "*chicken".* He expressed pessimism, that he was going to be: "*the most intelligent person in the nut farm for the rest of my life".* He said not being able to listen to music or play guitar had affected the quality of his life. He wanted to know and be reassured that his condition could be fixed.

35. Dr Krishna's impression was that Roger had an anxiety disorder, and a secondary depressive disorder. The presence of nihilistic traits were insufficient to warrant a diagnosis by him of psychosis, and he considered were better explained by Roger's "*clear long-standing anxiety*". In contrast to the reports from Dr Rutherford, neither Dr Krishna nor Dr Liu observed any signs of psychosis. Dr Krishna stated that, if he had observed signs of psychosis, it is likely that he would have continued the schedule.

36. It was determined by him that Roger's status should be changed to voluntary. He was moved to a room in the Low Dependency Unit (LDU, or General Patient Unit, GPU), initially to room 15. The plan was to obtain an ENT review, arrange occupational therapy and input from psychology. Quetiapine was continued. Dr Krishna explained that this was used as a sedative and an anxiolytic, because it augmented the effects of the antidepressant, and also because of the reported psychotic symptoms. The team also spoke with Yvonne, who provided a history of Roger's condition.

37. Both Dr Waters and Yvonne visited Roger that evening. Yvonne continued to visit Roger every evening during his admission, and Roger's daughters and

other family members attended during the days. He had a great deal of support from family and friends, constrained of course by COVID limitations a the time.

Dr Waters speaks to the treating team

38. On 13 April 2021, Dr Krishna met with Dr Waters and Dr Liu. Dr Waters' recollection was that they all agreed Roger was severely ill, and that his depression was "*psychotic*", in that he held fixed nihilistic delusions from which he could not be shifted. Dr Waters observed that Roger had been commenced on an antipsychotic medication, quetiapine (albeit not at a dose to achieve that therapeutic effect). Dr Liu, who took a detailed note of the discussion, did not recall the use of the word "*psychotic"*, which she believes she would have considered significant and would therefore have recorded. She accepted taking information from the family was important, although not as important as the observations made by the treating team. It wasn't clear the weight that was given to Dr Waters, for although he was family he was also a renowned psychiatrist able to provide further assistance to the hospital. It was not clear in the evidence that a great deal of weight was placed on his contribution which was surprising.

39. A multidisciplinary team meeting (MDT) that day discussed a plan to refer Roger back to the private hospital for an ENT review, and to organise an MRI under general anaesthetic. An ENT review did occur that day. The MRI brain scan was arranged on 16 April 2021. These did not identify any significant pathology.

Events from 14 to 20 April 2021

40. Dr Liu reviewed Roger alone on 14 April and 16 April 2021. Roger told her that the medication was only giving him relief for an hour and that he was sleepless and feeling overwhelmed. He was not "*panicky"* but still anxious. He said he was on a "*downward spiral"* and saw no way of coming out of it. He expressed boredom and social isolation, and shame about his situation. His medication dose was increased, and continued to be titrated upwards over the next few days.

41. Yvonne noted that Roger was bored. This was upsetting for family to watch and seemed to her to contribute to Roger's distress. She observed that there was little at Nolan House by way of distraction. Roger played table tennis, although the equipment broke. There were jigsaws. Roger also played his guitar, twice. It must be noted that the lack of diversionary activities was impacted by the effect of the COVID-19 pandemic. Allied health and diversionary activities have since returned.

42. Yvonne said Roger felt Nolan House was "*prison-like*" and noted that she had never seen anything like it. The view, conducted during the inquest, noted some of the improvements to the physical environment that have been made since Roger was present there, all which are positive attempts to improve the aesthetics of the ward. Limitations exist given the need to minimise risks to patients and staff. It is clear that there is still room for improvement, simple

things mentioned like more colour and warmth into the rooms through linen and features in the rooms. There are plans to build a new facility over the coming years.

43. On 16 April 2021, Roger was moved to another room (room 4) which was smaller than his first room, and at some distance from the nursing station. Roger told Yvonne the room made him feel claustrophobic and he felt distressed. He remained in that room until the time of his death. The notes record that, over the next few days, Roger frequently asked for medication, to relieve his symptoms or help him sleep. He complained of anxiety and was pessimistic about his recovery. He played his guitar on occasion and watched movies to keep him occupied.

44. On 19 April 2021, Roger was referred to Deborah Newman, a social worker who was part of the HOPE initiative (Hospital Outreach Post-suicidal Engagement). That is a Victorian Department of Health initiative, which provides assertive outreach for a period of up to 3 months post-discharge. Ms Newman saw Roger on a few occasions, and they discussed psychoeducation and relaxation techniques. At this review, he was lying on the bed and was "*full of despair".* He expressed hopeless and helpless themes, and pessimism for his recovery.

45. Dr Liu recalled in evidence that a significant feature of Roger's admission was that, due to the COVID-19 restrictions, he was unable to access leave as he ordinarily would. Leave would usually have been used as a therapeutic tool, to test a patient's progress, and to assist with transition back to the community. The lack of leave was restrictive, appears to have contributed to Roger's levels of boredom and sense of being "*stuck",* and, in Dr Liu's opinion, increased his anxiety. Dr Liu saw that access to leave was a particular advantage that still was possible at the private hospital, in addition to the psychological support and diversionary activities that Roger could access there.

46. The MDT on 20 April 2021 resolved to explore the option of referring Roger back to the private hospital. Dr Krishna and Dr Liu reviewed Roger. Roger said he was bored, and he wanted to go home, but would prefer being in the private hospital than Nolan House. A referral was made to the private hospital's Karinya Clinic that day.

Roger's condition deteriorates

47. On 21 April 2021, there was a deterioration in Roger's condition. He got up at 5am and told nursing staff he was going to kill himself and that the medication was not working. He was reviewed promptly by Dr Liu. He told her he had imagined his life being stuck inside the institution and could not see a way out. Despite his earlier comments, he denied being suicidal. His medication was changed, with diazepam as a regular medication every 2 hours.

48. That evening, Roger told nursing staff he had said "goodbye" to his family.

49. Dr Liu reviewed Roger briefly the next morning. Roger was expressing "*significant nihilistic themes and passive SI* [suicidal ideation]". Dr Liu had a discussion with Dr Krishna, and medication was increased.

50. Ms Newman also saw Roger that day, and she performed a CAMS Suicide Status assessment. That is a self-assessment form. Roger indicated that his suicide risk was "*extremely high risk (will kill self)".* He told Ms Newman: "*I should have committed suicide 2 weeks ago, had I known it would come to this. If I had the choice I would yes, I would definitely do it now*." Ms Newman believes she would have spoken to other staff about this. She believes all staff appreciated Roger was deteriorating and was at high risk of suicide. She completed her notes on returning to her office and sent them to Nolan House by email or fax. Copies are within the Nolan House medical records.

51. In the morning of 23 April 2021, Roger sent Yvonne text messages stating: "*Had panic attack last night. All hope gone … Petrified*".

52. Dr Crawford also visited Roger that day. He saw Roger bouncing a ball in the hallway, in an uncharacteristic manner. Roger told Dr Crawford he did not think he was going to get better. Dr Crawford recalls telling staff he thought Roger was at risk of suicide.

53. Dr Krishna and Dr Liu reviewed Roger on 23 April. Roger continued to express pessimistic, nihilistic thoughts. He said:

> *"I'm no good at all, the drugs did not do their job for me and [I] have no expectation for the rest of my life except to be institutionalised and held down in a facility for people not able to be cured… I should have killed myself 2/52 ago, you have failed me, got me into a position where I have nothing to looked forward to, living in purgatory between death & hell…"*

54. The treating team believed Roger was deteriorating, although they felt this was in part a response to his current setting. They did not consider changing the observation levels at that stage. They also did not document any explicit recommendations for Roger's management over the weekend – for example, what might indicate his risk was increasing, and how to respond.

55. Yvonne was at the review and was told that Roger would benefit from long term therapy, and that it was important to establish a routine for psychoeducation about the process of recovery. Yvonne reportedly said she was: "*certain he will not attempt suicide, but has been asking if other people can kill him*." Roger's Sertraline was increased, and the plan remained to transfer Roger to the private hospital.

Weekend of 24 to 25 April 2021

56. Roger's condition deteriorated significantly over the weekend of 24 to 25 April 2021. The notes show that he told staff he was unable to stop his panic attacks. He declined medication, saying it would not help, and for a period he refused to have fluids. He became concerned he was unable to pass urine. He became

hostile towards staff and refused to speak to Yvonne on the phone. At some stage, he also arranged to sell all his shares.

Roger's text messages and emails to Yvonne

57. Roger communicated with Yvonne regularly throughout this time. Yvonne was very proactive and ensured that what she was being told was being provided to the team looking after his care.

58. On Sunday, 25 April 2021, Roger sent Yvonne some concerning text messages, saying: "*Heading to hdu* / *Lost interest in life completely / Sorry*". At 3.42pm, Roger sent Yvonne the following email:

> *"My lost interest in living has nothing to do with my enduring love for you but simply being unable to cope with my health issues. I had no idea that the scenario for not going through suicide was being kept alive in terror. … Unfortunately I am obviously the most anxious person I know and totally unable to cope with any unknown adversity. … the best very best scenario is that my heart gives up quickly or my brain explodes. It is going to be awful. I don't think you should visit or even see how bad it is*."

59. Understandably, Yvonne was extremely concerned, contacting EEN Akalya Stone and RN Megan Duncan, the Nurse in Charge. At 5.46pm, she sent a copy of the texts and emails to RN Duncan. Yvonne also believes she had sent RN Duncan an email at 4.17pm, which also forwarded a copy of the above email from Roger, and included this text:

> "*Hi This is the text Roger sent me today. He has told me that he has sold all his shares. I can't see where the money is so therefore when he actually sold them. It may come through tomorrow .Please take care that he doesn't harm himself. He has contemplated running head first into a wall. He hasn't because he realises he would probably just end up with a major head or spinal injury that would debilitate him but not kill him. I get the feeling he will only do something that would definitely kill him. His anxiety is increasing exponentially."*

60. Yvonne was unable to locate a copy of this email initially, but produced it during the inquest. However, it was unclear on the evidence at the inquest whether the email was ever received by RN Duncan. RN Duncan only recalled receiving a blank email attaching the text messages and email, and that was located within the medical records. The email timed at 4.17pm does not appear in the medical records.

61. On the evidence it was clear that most of the content of the 4.17pm email was known to staff. EEN Stone recalled that Roger had been expressing a passive death wish, to run into a brick wall and kill himself. Roger was asking to be transferred to the HDU, and EEN Stone recalled it was because he wanted to "*feel safe"*. EEN Stone recalls being told Roger had sold all his shares and had sent Yvonne the concerning messages. She made a progress note recording

those details. Her note also records that she had discussed Roger's presentation with the "*NIC*" (Nurse in Charge, RN Duncan).

62. EEN Stone says that, around lunchtime, she spoke with a doctor, whom she believes was Dr Krishna, about Roger's request to move to the HDU. She says Dr Krishna asked: "*how is he going to kill himself, run into a brick wall?"* Dr Krishna does not recall this discussion, although accepts he was on call that day. He denies he would have said those words, because they were extremely insensitive, and says if the conversation occurred EEN Stone either misheard or misunderstood him.

63. EEN Stone had completed a "*Risk Monitoring Nurse Observation & Engagement Tool"* that morning, indicating that Roger was at "moderate" risk of self-harm and suicide. That form was not modified, despite the information supplied by Yvonne about Roger selling his shares and sending the messages noted above.

64. RN Duncan and EEN Stone each stated that, in hindsight, they thought Roger's risk observation level should have been increased to "high". This would have had the result that Roger would have been observed every 15 minutes, and consideration may also have been given to moving him to the HDU. They were unable to explain why they did not give consideration to raising the observation level or seeking a further review by the treating team. They expressed regret for not doing so.

65. I agree with Counsel Assisting that those concessions were appropriate. The events of the weekend ought to have resulted in a reconsideration of Roger's risk, and an increase in his observation level, if not a move to the HDU. This also ought to have led to a review by the treating team, albeit the team did review Roger the following morning. However, the nurses did take other appropriate action because they felt "*uneasy*" about Roger's presentation, they decided to keep an eye on him, as a "*tag team*", ensuring that one or other of them kept Roger under observation during the rest of the shift. While this action was not recorded, they were worried about him, and changed practice as a result, which as submitted reflected an appropriate, patient-focused response.

66. Yvonne came into the hospital and spent the evening with Roger. At one stage, he asked her to hold a pillow over his face. She did not advise staff of this at the time.

The treating team's review on 26 April 2021

67. On Monday 26 April 2021, Dr Krishna and Dr Liu reviewed Roger. They became aware of the events over the weekend. Roger told them:

> *"I'm ready to go, the drugs don't work … I'm going to live forever because I'm fit, I want to die now … states he's tearful & wishes to go, I need to die now, because my time is finished … the only thing you could do for me is to give me a lethal injection …"*

68. Dr Krishna formed the view that Roger's presentation was "*leaning towards psychosis*". He determined to admit Roger as an involuntary patient, cancel the referral to the private hospital, commence an antipsychotic medication (risperidone) and commence work-up for Electroconvulsive Therapy (ECT). It seems that ECT was first suggested by RN Duncan.

69. A decision was not made to transfer Roger to the High Dependency Unit (HDU). Dr Krishna explained his rationale in evidence. He understood that Roger saw the HDU as a form of "*punishment*". His experience of the HDU had been traumatic. Dr Krishna thought Roger may have been seeking to test his belief that he was not going to recover, and his desire to be transferred to the HDU reflected his "*fear of impending doom*". Roger's requests did not reflect a concern about risk, but were playing into his own fears. If Dr Krishna had acceded to Roger's request, he believed it may have affirmed those fears, and caused him to deteriorate further. Dr Krishna felt the decision he had to make was a complex and difficult one.

70. Dr Krishna did believe that Roger's risk had increased. Roger's suicidal ideation had gone from passive to active and the plan implemented was to manage that risk including the commencement of an antipsychotic and a move to ECT. Yet the plan did not address other risk mitigation strategies, such as an increase in observation levels, to be undertaken while the treatment took effect.

71. Dr Liu believed that Roger's risk had increased, to between "medium" and "high" risk, but felt he could be managed under "medium" observations. No record was made of this, and Dr Liu accepted it would have been helpful for her to have done so.

72. Similarly, Dr Krishna stated that, in hindsight, an increase to a "high" level of observation, or the use of a 1:1 special, may have been appropriate at this stage. He regretted not doing so.

73. Roger had his last session with Ms Newman that day, which he ended early as he was feeling groggy. She recalls that, at the end of their session, Roger walked up to a brick wall in the courtyard and put his head against the wall. She did not record or report this at the time, although she did not think it was a clear expression of self-harm, and it appeared to be with the benefit of hindsight that his actions took on a different meaning.

74. That evening, Roger continued to express nihilistic thoughts and was asking staff to kill him. He said he wanted to hit himself over the head with objects. As a result, his room was cleared of large objects, including his laptop.

Dr Krishna speaks to Dr Waters

75. On 27 April 2021, Dr Krishna phoned Dr Waters. He explained the plan to proceed with ECT. Dr Waters understood that Dr Krishna believed that Roger was at *"high risk of self-harm"* and could no longer wait for the medication to work. Dr Waters understood that Roger did not want to be transferred to the HDU, because it made him feel claustrophobic. He understood that Roger

would be put somewhere safe. They did not discuss observation levels, although Dr Waters had assumed given what was occurring that the observation level would be very high.

The ECT application

76. A second opinion about ECT was obtained, as is required pursuant to the Act, from a psychiatrist Dr Harsh Chalana. Dr Chalana's notes record that Roger did not want to consider ECT and declined to talk about it. He asked if the doctor had a gun to shoot him, although denied plans to end his life. Dr Chalana's impression was that Roger had severe anxiety disorder and major depression. He thought he was a "*high suicide risk*", and at risk of a decline in his mental state if he stopped eating or drinking. Dr Chalana recommended that ECT should commence and discussed this with Dr Krishna. Neither doctor could recall the content of that discussion.

77. Dr Chalana did not make any recommendation about Roger's placement. He notes, in a statement, that Roger was being nursed under "*high care*" in a closed unit with 1:1 nursing. That was not correct, as Roger remained in the LDU, under 30-minute observations. It may be that the location or circumstances of Dr Chalana's assessment led him to believe that Roger was at a higher level of care than he was. It should be noted that Dr Chalana was performing a role under the *Mental Health Act 2007* (NSW), to in effect consider ECT as an option, as opposed to treating Roger.

78. Dr Liu had attempted to engage Roger on the issue of ECT, but he did not want to discuss it. She did not consider his refusal as an indication of risk. She completed a report for the MHRT. She recorded the diagnosis as "*agitated depression"* and sought a 6-week order to facilitate 12 sessions of ECT.

79. A MDT meeting noted Roger's deterioration over the previous week, that involuntary ECT was being considered, and that longer-term case management would be required. Ms Newman attended the meeting. She understood that the team felt Roger was at high risk of suicide.

80. At 5pm, Roger was given notice of the application for ECT. A hearing before the MHRT was booked the following day at 3pm, with a plan to commence treatment on 30 April 2021.

81. It should be noted that Roger was clear that he did not want ECT.

Roger attempts to choke himself on a banana

82. Yvonne visited Roger for the final time at 8pm that evening. It was clear to her that he wasn't in a good state, and it appeared that he didn't want to speak to her. He told her he had tried to choke himself on a banana, and showed her a banana, which was intact but mushy. She understood that he had tried to insert the banana with its skin on down his throat.

83. Yvonne says she reported this incident to RN Daniel O'Shanesy, who was at the nurses' station. She said she showed him and another nurse the banana and then threw it away in the kitchen bin.

84. RN O'Shanesy gave evidence to the inquest. He had been a nurse for 23 years. He worked as an agency nurse. He had only worked at Nolan House twice. RN O'Shanesy was adamant in his evidence that he was not told about the banana incident. He believes if he had been told, he would have considered this to be a risk of self-harm and would have taken the banana to the team leader, and would also have made a note about it. He pointed out that it was unusual and therefore would have been memorable.

85. RN O'Shanesy did have some recollection about the events. He recalled that Roger was anxious about his bladder. He recalled Roger demanded admission to the HDU. He recalled spending time with Roger for a period, until eventually Roger allowed himself to be taken back to his room. He also recalled having a conversation with Yvonne, as he walked her out of the unit, where she told him about the circumstances of her engagement at the top of the Eiffel tower. He was touched that Yvonne shared this memory with him.

86. The nurse-in-charge that evening, RN Tiby Thankachan, did not recall being made aware of the banana incident, and did not recall any issue being escalated to him. Nothing was documented about it in the notes, which would have been his usual practice.

87. The observation tool completed by RN O'Shanesy that night records that Roger was asleep from 10.30pm to 7am. However, at 1.43am, Roger sent Yvonne a text, asking her for Beconase spray for his allergies. This may be explained by the staff attempting to be as unobtrusive in their observations as possible during the night particularly.

The events of 28 April 2021

88. RN Matilda Star-Hossack commenced duty at 6:45am on 28 April 2021. She was a graduate nurse who had commenced at Nolan House in January that year, her first qualified role. She believed 28 April was her first interaction with Roger.

89. On commencing work that day, she had a handover with other nursing staff, including RN O'Shanesy. She did not recall being told about the banana incident, and only learnt about it after reading Yvonne's statement in these proceedings.

90. At about 7.20am, after the handover was completed, RN Star-Hossack went to see Roger. Roger was lying in bed in his day clothes. He said he had not slept well. He appeared angry, in particular about the prospect of ECT, and he said: "*I can't believe she* [Yvonne] *is making me do this"*. RN Star-Hossack tried to encourage Roger to come outside, but he rolled over. She spent a few minutes

with him, then left, saying she would bring his breakfast when it came. She had no concern about suicide risk at that time.

91. At about 7.30am, RN Star-Hossack came out to perform observations on Roger. As she was leaving the office, she saw him in the courtyard. He was pacing slowly and appeared to be okay. She made an entry about this.

92. About 8 minutes later, she heard a female patient scream for help.

93. Roger's self-harm was not observed by any staff member, although another patient was present. Roger reportedly placed his head in between the large sliding doors to the courtyard, and slammed the doors shut. He then fell backwards, striking the back of his head on concrete.

94. RN Star-Hossack and other nursing staff went to help Roger. He had an obvious head injury. A MET call was activated, and other staff attended.

95. After Roger's self-harm, RN Star-Hossack completed the *Risk Monitoring Nurse Observation & Engagement Tool* (Part A), recording that Roger was at "moderate" risk of self-harm and suicide. She explained in evidence that she did so to ensure the paperwork was in order before it was sent to the ICU. She was then a graduate nurse, who was endeavouring to fulfill her obligations at a highly pressured time. I accept that she was a very new nurse and that immediately after the incident there was understandable confusing arising as staff were called to assist, patients had to be cared for and others would have been in a state of shock. I accept that after the event she went back to complete the paperwork so it could be sent to ICU.

96. I accept the submissions that none of the other *Risk Monitoring Nurse Observation & Engagement Tool* Part As had an increased risk rating, despite Roger's deterioration from 21 April 2021 and over the weekend of 24 to 25 April 2021. His risk rating should have been escalated. He remained rated as a "moderate" risk throughout even given that there had been three significant events over that period:

    1) the messages Roger sent to Yvonne on 25 April 2021, including a threat to run into a brick wall;

    2) the threat to hit himself with heavy objects on 26 April 2021; and

    3) the attempt to choke himself on a banana on 27 April 2021.

Roger's transfer to the ICU

97. Roger was transferred to ICU and placed on a ventilator. It was discovered he had sustained multiple skull fractures and a massive subarachnoid haemorrhage. He was reviewed over the following days, but his condition did not improve. It was determined that his injuries were non-survivable.

98. At 10.23am on 30 April 2021, ventilation was withdrawn. Roger was pronounced deceased at 10.46am.

Autopsy

99. A post-mortem examination was performed on 6 May 2021 by Dr Bernard I'Ons. He found the cause of death to be "*head injuries*", noting multiple skull fractures and subarachnoid haemorrhage.

Evaluation of Evidence

Evidence of prior self-harm attempt

100. One piece of evidence that was not agreed was whether or not staff were informed that Roger attempted to harm himself with a banana.

101. Counsel Assisting submitted that Yvonne's evidence should be accepted because Roger told her he had attempted to choke himself, and she then showed the banana to RN O'Shanesy and another staff member. Her evidence has been consistent on this point, and she raised it at an early stage, at a family meeting on 29 April 2021 contemporaneously.

102. RN O'Shanesy was an experienced nurse, who did maintain memory of nursing Roger, and did recall some facts specifically of matters that occurred while Roger was in his care, and of conversations that he had with Yvonne. He was adamant that he did not hear of the banana.

103. Yvonne's recollection was very detailed, and the incident had shocked her. She was in the habit of giving nursing staff all information that she thought relevant. Yvonne also recalled taking the banana from him and showing the banana to staff. Her recollection was clear as was her description of her reaction to finding this out and removing the banana from Roger. I accept that it occurred as she set out, and that she did inform staff. It is possible that nursing staff did not understand or properly register the significant nature of what was being said. It was clear that all staff had Roger's interests at the forefront of their minds, and if the significance of the self-harm attempt had been appreciated, I agree that it is likely some action would have been taken. This was, however, important information that was being provided by a family member, and information that should have been escalated to the treating team.

104. The first note made about the banana incident was after Roger's death, when Yvonne mentioned it during the family meeting. The treating team were not made aware of it prior to Roger's death. The incident itself may have provided the treating team with another piece of evidence supporting the significant deterioration in Roger's mental state.

Diagnosis and care of Roger

105. The focus of the inquest related to diagnosis and treatment at Nolan House. Dr Rutherford who saw Roger in the early stages observed signs of psychosis and reported this to Dr Krishna. Dr Waters formed the view that the diagnosis was likely psychotic depression he also expressed that view, Dr Krishna considered those views, however together with Dr Lui formed a different diagnosis at the time they reviewed Roger.

106. After the initial assessment by Dr Krishna, the decision was made to change Roger's status from involuntary patient to voluntary, as a result of his diagnosis then being determined as anxiety disorder and secondary depressive disorder. Dr Krishna felt the presence of nihilistic traits were insufficient to warrant a diagnosis of psychosis at that time and was instead better explained by Roger's clear long-standing anxiety. He said he would have maintained the schedule had he observed any signs of psychosis. Later when Roger's symptoms increased, he readjusted his findings to make him an involuntary patient. He then made arrangements for Roger to be reviewed in order to seek an order for the administration of ECT which he considered at that point to be the most suitable treatment to assist Roger and treat his mental illness.

107. On the evidence there was also an available differential diagnosis of psychosis, particularly in hindsight given what is now known about the course of Roger's illness. Dr Rutherford and Dr Waters considered psychosis at the time of Roger's initial presentation. Dr Eagle noted that, as Roger's admission progressed, it became more apparent that he was experiencing psychotic symptoms, including somatic delusions. However, she noted that these symptoms may not have been of delusional intensity, certainly initially.

108. Dr Krishna and Dr Liu were clear in their evidence that they did not elicit any psychotic symptoms from Roger at the time of their initial reviews. Dr Krishna felt that Roger's nihilism was better explained by his anxiety. It was only at the review on 26 April 2021 that Dr Krishna felt that Roger's symptoms were "*leaning towards psychosis"*.

109. It was submitted that there was a missed opportunity by the treating medical team to fully appreciate the nuances of the information provided by Dr Rutherford, Dr Waters, and Yvonne and to record an illness involving psychosis as a differential diagnosis from early in Roger's admission to Nolan House, based upon the possibly delusional extent of Roger's unjustified nihilistic beliefs, in comparison with his normal presentation. In support of this submission, it was noted that Dr Eagle stated that at the time of the initial assessments by Dr Krishna and Dr Liu, a differential diagnosis of depression with psychotic features could not be excluded and needed to be considered because it could potentially influence his treatment and his risk.

110. Dr Krishna did consider the possibility of psychosis initially and from 12 April 2021 he prescribed Roger quetiapine, one of the purposes of that prescription being its anti-psychotic effect. Dr Krishna did consider the

differential diagnosis of psychotic depression, however, concluded that Roger's presentation at the time of review was not consistent with a psychotic illness.

111. I accept that Dr Krishna did consider the differential diagnosis, but that he was not satisfied on his review of Roger that he could make that diagnosis initially. I accept the expert view of Dr Eagle that although he should have considered it, it was open to him to form a different initial diagnosis.

112. Dr Krishna considered the observations of Dr Rutherford. Roger presented differently at different times throughout his admission. Roger was a highly intelligent man, and he was being internally tormented by what was occurring to him. The emotional pain suffered by Roger was very clear on the evidence. It was also clear that his mood, demeanour, and presentation fluctuated somewhat. Dr Krishna had an obligation as a psychiatrist to make his own assessment of Roger as he presented. It is not unusual as noted by Dr Eagle that patients change in presentation.

113. Dr Waters was an extraordinary resource available to the treating team. He is a consultant psychiatrist, was formally a professor of psychiatry at UNSW and was previously the head of the department of psychiatry at St Vincent's Hospital, Sydney. I accept that he raised his thoughts on diagnosis with the team, even though they were not captured in notes accurately. I also note that he was not playing a part as a treating doctor, but as a family member. He noted that Dr Lui may have been recording the conversation on that basis, rather than recording as she might the views of a psychiatrist. He travelled to Albury to assist Roger. He was left with the understanding that the two doctors were in agreement with him, that Roger was suffering with an agitated and probably psychotic depression. He had the insight of a doctor and a close family member. He noted that there were significant changes in his nature, and the things he was expressing. He said ordinarily Roger was a person who would understate things. He also had a careful optimism, and so what he was exhibiting was extremely out of character.

114. Dr Waters painted a very clear picture of Roger's symptoms when he said the following:

> *"But hopelessness – hopelessness to the extent that Roger was expressing it and to the extent that it was so different from his normal attitude. This is a guy who was really involved in philanthropic work and was able to be optimistic and positive and create optimistic and positive opportunities for people……*
>
> *…….I think that one could fall into a trap of really not understanding (a) how dogmatic he was about it and (b) how different that was from his normal …. frame of mind."*

115. He went on to explain the Roger's thoughts were beyond unreasonable, they were irrational, and how he became completely focused and fixated on how hopeless things were. Dr Waters was a very valuable resource, he was able to not only bring his experience to assist, but he was able to describe how

significant the changes were in Roger. It did seem that he was a resource that could have been relied upon to a greater extent. It also seemed that his opinion should have been expected to carry significant weight, and I am not satisfied that a great deal of weight was placed on his observations, prior knowledge of Roger, ability to identify the significant of the changes in Roger, and finally his ability to proffer a diagnosis as a psychiatrist.

116. Further, the family was generally of the view that Yvonne was best placed to speak to changes in Roger. It is too common that family do not feel heard in cases of mental health. Dr Eagle reinforced that family play a very essential part in diagnosis and treatment. Yvonne was in the best position to note signs of deterioration and their intensity in the person that she knew best, and the inquest highlights the importance of treating teams listening to family and using that information to inform diagnosis and treatment.

117. The inquest was greatly assisted by an independent review of Roger's case, by Dr Eagle. Her evidence both in report and oral evidence explored the nature of the diagnosis and treatment, being cautious of the ability to make such comments and opinions with the benefit of hindsight. Dr Eagle also was respectful and conscious of the fact that there must be a range of diagnosis and treatment plans, and that those dealing with Roger were best placed to make a thorough assessment. She highlighted that it is not an exact science, and that the most important thing in psychiatry is that the treating doctor considers all of the reasonable differential diagnoses or explanations for a person's behaviour to ensure that all treatment considerations and risk considerations are taken into account.

118. Dr Krishna considered that Roger had anxiety, with a secondary diagnosis of depressive disorder. Dr Eagle was not critical of that diagnosis. She opined:

> *"Overall, I am of the view that the diagnostic formulation of Mr Schnelle's presentation was reasonable and appropriate on the information available."*

119. In making those observations Dr Eagle considered that it was open to Dr Krishna to make the diagnosis that he did, and although others were also open to him, I cannot find that this was not available to him at the time.

Physical symptom elimination

120. This was not the focus of significant evidence during the inquest. Roger was investigated for his symptoms of vertigo in the community. A referral to an ENT specialist did not proceed, due to the waiting time for a review and the need to first undergo diagnostic testing, including an MRI.

121. Once Roger was admitted to hospital, he was referred promptly to obtain a CT scan, an MRI, and a review by a neurologist, although his deterioration in mental health meant this did not occur. He was also reviewed by an ENT registrar.

122. None of the investigations revealed any underlying pathology. It is possible that the severity and enduring nature of Roger's symptoms were related to his mental condition.

123. It was submitted that while the MRI scan, which was a referral from the ENT registrar, was an appropriate investigation, it was also incumbent on the ENT service to promptly review the report of the scan and then report back to the psychiatric team regarding their conclusions. The Family indicated that this did not eventuate in the 12 days between the scan and Roger's self-harm incident. The Family further indicated that, while Dr Liu believed her team attempted to follow up ENT in relation to the scan results and further investigations or assessments required, nothing eventuated. The Family also noted that a plan was made for Roger to be assessed by neurologist, Dr Ring, however, this never eventuated, although they acknowledged the difficulty in securing a neurology review while he was a public inpatient.

124. The failure to conclude the investigations for organic causes was nominated as a missed opportunity as clarification that there was no organic cause would have allowed the medical team to more readily appreciate any somatic and/or delusional aspect to the symptoms. The Family noted that Roger's physical symptoms continued throughout his admission, however, in evidence, Dr Liu stated that before Roger's reported physical symptoms could be considered somatic or delusions, organic causes needed to be ruled out. However, the Family noted that organic causes were never fully ruled out because the planned investigations and review remained incomplete.

125. The overall evidence supported that physical causes were on the minds of the treating team, and required elimination. Processes were followed and there were delays as a result of Roger's fears and availability of specialists.

126. It is clear from the evidence that the treating team were satisfied very quickly that this was psychiatric in origin. Dr Rutherford quickly formed that view from his initial assessment, however, took immediate steps to ensure any physical causes were eliminated. Equally, the treating team at Nolan House continued those examinations to eliminate other health issues. Dr Eagle was not critical of this component of the care, and I accept that these investigations were appropriate.

Mental health treatment and plan while in Nolan House

127. Dr Eagle was not critical of any aspects of the treatment plans including the plan to commence an antidepressant, provide medication for anxiety and sleep, admit Roger to the inpatient unit, review him regularly, and defer psychological interventions until his mental state had improved. Dr Eagle was also not critical of the change to involuntary status. In Dr Eagle's view, the plan to proceed to ECT was also appropriate. Dr Eagle noted that ECT is a recognised evidence-based treatment for depression and is considered safe. Efforts were made to schedule ECT quickly, and an application was made to the MHRT on the day after the treating team's determined that he was deteriorating.

128. Dr Waters also expressed the view that the move to ECT was an appropriate strategy, and that ECT can be a dramatically successful intervention with patients like Roger. He noted that by the time they made the decision to move to ECT they had to change course and do it quickly. Dr Waters understood that while this was the course that would be taken, and HDU was not where Roger would be placed that he would be provided with a situation outside the HDU that might replicate a similar level of constant supervision. He noted they did not discuss this, but he had assumed that would occur.

129. It was submitted that while the plan to commence ECT was appropriate, the mental health treatment plans were inadequate and/or improperly implemented because of:

a) the inadequate focus on risk assessment and inadequate management plan for risk, particularly over the final few days of treatment;

b) the lack of adequate psycho-social aspects of care, including the lack of activities available within the unit, the absence of allied health staff as physiotherapy, psychology, dietician and occupational therapy and the unsuitably grim environment within Nolan House. Roger received a therapeutic benefit from the few sessions he had with Ms Newman.

c) the missed opportunities to:

(i) record and consider a differential diagnosis of psychotic depression early in the admission; and

(ii) respond to the deterioration identified by 23 April 2021 and record a management plan for the coming weekend and/or escalate care;

d) the failure to medically review Roger and/or escalate his care from 24 to 25 April 2021; and

e) the breakdowns in communication and failures to escalate care on 26 and 27 April 2021.

130. The course of events can be summarised as follows once he was admitted. Roger was initially involuntarily detained, however, when later assessed he was kept as a voluntary patient. This is in keeping with obligations in accordance with the *Mental Health Act 2007* (NSW) to always determine treatment in the least restrictive way possible, and fundamentally this founding principle of the *Mental Health Act 2007* (NSW). There are also very good reasons in the treatment of a patient as to why least restrictive care can be essential, this is often in the best interests of the patient. Roger then deteriorated and it was determined to treat him again as an involuntary patient. It was recognised that the best course of treatment was ECT, and he was not agreeable to this. As a result, the procedure was followed to allow authorisation of this treatment without his consent. Dr Waters even gave the opinion that the progression to ECT was quite rapid.

131. On that basis I agree that the treatment regime of medication, involuntary detention and move to ECT was appropriate. I should also reflect that this is no means an exact science, but rather a fluid moving situation with Roger's very complex, sudden, and unexpected presentation.

132. The concerns relating to the absence of programs and psychosocial care was evident, and in part that was explicable due to the restrictions public health faced specifically due to COVID. There was also lamenting by the doctors that whereas private hospitals had moved to release programs which was a very important component to treatment they could not offer it to Roger given the restrictions. This hampered the ability to treat Roger as they would have liked. This was notable, particularly in this case, where the environment was recognised as being generally detrimental to Roger and part of his fixation was on the hopelessness of possibly never recovering and getting away from that setting.

133. The remainder of the issues raised are best addressed in relation to the process of risk assessment, and the diagnosis and treatment flowing from that part of the treatment.

Risk Assessment

134. Dr Waters said that in his view the decision to administer ECT was quite quick, but nonetheless appropriate. However, he had assumed that while waiting for ECT to occur there would be a high level of supervision, if not in HDU something similar. He had no discussions with Dr Krishna about this, rather he had assumed this would occur. Dr Waters raised that it is still the case that even patients with the benefit of 1:1 supervision still can manage to self-harm. However, it remains important to therefore risk manage, knowing that even that cannot be a guarantee of safety.

135. Dr Eagle's evidence on the process of risk assessment as a general proposition was very powerful.

136. Dr Eagle explained that risk levels are important to determine, to then decide how to intervene and manage that risk. She also noted that levels of care are not necessarily or only linked to risk levels. Sometimes higher care levels are required because of the needs of the patient, and not necessarily the risk they present. She also noted that the categorisation of risk is merely that, it tells the level of concern for the person, but does not inform how to manage that risk, and that is a critical step. In other words, the risk tool is meaningless without a corresponding action plan. Management of risk is the essential step.

137. Dr Eagle also highlighted that the communication process is the way to ensure that all members of the multidisciplinary team have the same understanding of the patient's needs.

138. Dr Eagle considered steps that have been since taken by the hospital, and agreed with Dr McArdle's recommendations to ensure checks and balances to ensure that the team is regularly communicating and updating risk

assessments. Dr Eagle also commented in her evidence that there had been a comprehensive review of the needs of the unit, steps had been taken to improve the level of staffing, to improve the clinical governance process and to review the clinical guidelines for responding to clinical deterioration and for managing risk. A number of checks and balances were noted to have been introduced to ensure adequate communication and understanding between different members of the team.

139. Dr Eagle described the process of risk assessment as being the assessment, formulation, and management of risk. The *Risk Monitoring Nurse Observation & Engagement Tool (Part A)* provides a "tick-box" method for rating risk, resulting in an automatic determination of the observation level. Dr Eagle noted that risk assessment approaches have moved away from this type of risk prediction over the last decade. The preferred approach is the formulation of risk by the members of a multidisciplinary team, to inform tailored risk-management approaches. She noted that this type of tool does have a role, in communicating the level of concern. However, it does not adequately communicate the ways to manage an individual's risk. This should be recorded by the multidisciplinary team in the progress notes.

140. Dr Eagle discussed a more effective communication mechanism, and a more fluid assessment tool to allow a logical, caring, and thoughtful health professional to provide a reasoned position on risk, rather than being confined to ticking a number of boxes, which leaves little room for actual observation.

141. In Dr Eagle's view, the assessment of Roger's risk, and the formulation of a plan to manage that risk, was not appropriate. There was, in her view, a lack of coordination by the multi-disciplinary team, a lack of documentation, and inconsistent communication about it between the different disciplines. She considered it would have been reasonable, in light of Roger's deterioration, to increase the frequency of observation, identify and document specific signs of increased risk, and consider transfer to the HDU. I accept her opinion which is supported by the evidence.

142. It was clear that nursing staff were noticing changes in Roger's behaviour and were becoming increasingly concerned for his wellbeing. One nurse modified their observations to keep a much closer watch on him. There was a missed opportunity of factoring in Roger's attempt at harm with a banana. There was a shift in Roger's behaviour with Yvonne who had become increasingly worried and the tone of his communication with her was very troubling.

143. This issue raised a number of areas of consideration. There was a divide between the nurses and the doctors, a lack of ease of communication tools as between them, a problem with considering a number of fixed options only, as opposed to consideration of a gradient of possibilities. An example of this was the prescription of observations. Roger was a listed as a medium risk, which equated to 30 minute observations, high risk would have resulted in 15 minute observations, or admission to HDU.

144. The nurses could upgrade the rate of observations, but could not downgrade the observation frequency. To do so would require the risk to be correlated to an outcome on the tick box risk assessment. This seems unusual given the changeability of a patient, Roger being a very good example of this. The nurses had a heightened concern for him and so on an ad hoc basis decided to keep a closer eye on him, which was appropriate. However, the problem with such an ad hoc system is that it is not recorded in a way that can be adopted by new teams or indeed appreciated by the treating team. This is by no way a criticism of the nurses who acted sensibly to upgrade observations. However, it seemed that unless there was a mechanism to escalate and communicate that Roger now posed a different and higher risk rating, there were limited means for them to communicate concerns in a meaningful way with the treating medical team.

145. Counsel Assisting submitted that Dr Krishna provided considered reasons as to why he did not transfer Roger to the HDU, and that for the reasons that he gave, it may be accepted that this decision was justifiable. Dr Krishna was taking into consideration the fact that Roger raised his self-referral in effect to move to HDU, and at the same time dealing with a person determined to be mentally ill, in which he was required to make a psychiatric diagnostic determination about the need for the level of care that he required.

146. It should also be noted, as raised in submissions for the Family, that Roger was initially placed in the HDU at Nolan House and found this traumatic.

147. Dr Krishna also reflected on the concerns about placing Roger back in HDU and the complexities that come with being kept in a highly sterile environment and being watched at all times. He was concerned that this would have played into Roger's fear of impending doom. It was, as Dr Krishna observed, a complex and difficult decision. However, having made the decision to keep Roger in the LDU, I agree that it would have been appropriate for Dr Krishna to consider what further risk mitigation strategies could have been employed, while the antipsychotic medication began to take effect and prior to commencing ECT.

148. There was evidence that Dr Krishna accepted at the time his risk had increased, as did Dr Liu, but notes were not made of this determination.

149. This aspect of planning was missing from the treating team's documentation on 26 and 27 April 2021. In particular, as Dr Krishna accepted in hindsight, Roger could have been placed on a higher observation level, or given a 1:1 nurse special assignment, while remaining in the LDU. It is not known what consequence this might have had, in terms of the tragic events that resulted in Roger's death, but the failure to consider it, or to address other risk mitigation strategies, was a missed opportunity, and it resulted in an inadequate level of care. It also speaks to considerations of matters outside the usual "tick box" approach. This may have had implication on staffing, but that does not mean that it should not be attempted in appropriate cases.

150. On 21 April 2021 there was a deterioration in Roger's condition. At 5am he got up and told nursing staff that he was going to kill himself and the medication was not working. He was reviewed by Dr Liu and repeated that he imagined being stuck inside the institution for his life and could not see a way out, but denied being suicidal. His medication was changed. Later that evening he said goodbye to his family.

151. The next day Dr Liu reviewed him and noted that he was expressing significant nihilistic themes and passive suicidal ideation, and after discussion with Dr Krishna his medication was increased.

152. One critical piece of evidence came from Ms Newman from that same day. Ms Newman was the person who was observed to have built very good rapport with Roger. She gave excellent evidence, had taken exceptional notes and was deeply affected by the outcome for Roger. She completed a CAMS Suicide Status assessment, which is a self-assessment form. Roger indicated that his suicide risk was "extremely high risk (will kill self)" and told Ms Newman: "*I should have committed suicide 2 weeks ago, had I known it would come to this. If I had the choice I would yes, I would definitely do it now*". Ms Newman believed she raised this with other staff, and she had formed the view that all staff appreciated that Roger was deteriorating was at high risk of suicide. She completed her notes after returning to her office and sent them to Nolan House. Copies were within the Nolan House medical records.

153. On 23 April 2021 Roger sent messages to Yvonne indicating that: "*All hope gone… Petrified*". Dr Crawford also visited him that day, saw him bouncing a ball in an uncharacteristic manner. It should be noted that this evidence was very important. Dr Crawford was his GP and his friend. He was making a concerning observation about someone he had known medically for a long time. He passed onto staff that he thought Roger was at risk of suicide. Further review that day with Dr Krishna and Dr Lui confirmed very pessimistic nihilistic thoughts.

154. It was clear to the treating team that Roger was deteriorating, and accepted that part of this deterioration was a reaction to the setting that he was in. However, the observation levels were not changed. Nor were any explicit recommendations for his management noted for the weekend.

155. He continued to deteriorate over the weekend. On the Sunday night a very bleak email and text message read together could have been interpretated as him saying goodbye.

156. Yvonne was concerned and contacted EEN Stone and RN Duncan. She sent a copy of the texts and emails to RN Duncan. One of her emails indicated this:

> "*Hi. This is the text Roger sent me today. He has told me that he has sold all his shares. I can't see where the money is so therefore when he actually sold them. It may come through tomorrow. Please take care that he doesn't harm himself. He has contemplated running head first into a*

wall He hasn't because he realises he would probably just end up with a major head or spinal injury that would debilitate him but not kill him I get the feeling he will only do something that would definitely kill him. His anxiety is increasing exponentially."

157. This was a very apt description of the deterioration that Roger was experiencing. This email does not appear within the medical records and RN Duncan can only recall receiving a blank email attaching the text messages. However, it appears the content of the email was known to staff. It was known that he had raised the possibility of running into a brick wall, and suggesting that he had sold shares. EEN Stone recalls these matters. These were also found within her notes. As a result, his phone was taken for his personal protection.

158. It was following this succession of events that Roger asked to be moved to HDU, and that was passed on by EEN Stone to Dr Krishna.

159. On 26 April 2021 Roger told the doctors that he was ready to go. At this point Dr Krishna formed the view that Roger was leaning towards psychosis. He had his last session with Ms Newman, and he ended that early, as he was feeling groggy. Following this, during the evening he continued to express nihilistic thoughts and asked staff to kill him. He said he wanted to hit himself over the head with objects, and as a result his room was cleared of large objects including his laptop as a precaution.

160. On 27 April 2021, Dr Krishna spoke with Dr Waters and explained his decision to proceed with ECT. Dr Waters believed that Roger was at a high risk of self-harm and that there could be no more waiting for the medication to work. They did not discuss observation levels, but Dr Waters assumed they were high at that point. Dr Chalana also assumed that he was in high care nursing at that time. It was that night that Roger told Yvonne about the Banana incident. The next day was 28 April 2021.

161. Repeating these events highlights the now obvious progressive worsening of Roger's symptoms. On one hand this could be considered with the benefit of hindsight, however, this was all knowledge available to the hospital and indeed the treating team if it had been usefully collected, collated, and kept for review.

162. The weight of the evidence supports that Roger was deteriorating significantly since 21 April 2021, yet his observation level remained the same. Certainly, from 26 April 2021 it is recognised by Dr Krishna that Roger has deteriorated, and the decision to progress to ECT was made, but Roger's level of risk was not changed, nor was the level of nursing increased in response.

163. As previously mentioned, the rapport that Ms Newman had with Roger was obvious. As a social worker her material was kept on the hospital records, however, it appears it carried limited weight, and indeed no one appeared to have any regard to her detailed reports, which provided a great deal of insight

to Roger and his condition. Again, this lack of communication detracted from the teams' ability to perform its role as well as it might.

164. Ms Newman said that she was absolutely concerned for Roger. However, she knew he was in the specialist unit, being treated by a medical team. She believed everyone knew how unwell he was, and she knew he was where he needed to be, and that he was being cared for in hospital in an environment where people were aware of his mental state. She was not there to provide medical treatment, but she was another excellent resource. She spent time with Roger, she undoubtably provided some comfort to him, she listened to him and reassured him, and as a result he spoke with her and shared how he was feeling with her. Ms Newman described Roger as becoming tormented by his thoughts, and that he was in absolute despair, she tried to do some mindfulness with him but she said: "*he was unable to do that. His mind was just too full*." Her detailed notes ought to have been considered in developing an appropriate risk assessment.

165. Equally the nursing staff were extremely concerned. Roger was wanting to be admitted to HDU. He was distressed about his bladder. He had sent very concerning messages to Yvonne. He started to suggest he would hit himself in the head with objects. He became very agitated. His legs were continuously shaking so vigorously at times the bed was moving. He struggled to come out of his room, to even have a shower. He did not want ECT and yet was aware of a decision to provide that treatment, nonetheless. The evidence from the nursing staff, particularly RN Duncan and EEN Stone were caring and concerned staff. They felt his risk was increasing, and therefore it is important to analyse why the risk assessment did not amount to a reflection of that increase in risk.

166. Dr Eagle was not in a position to comment on precisely what level of observations, or other risk management strategies, would have been appropriate in Roger's case. To fairly do so, in her view, would require an understanding of the individual, staffing, and environmental factors existing at Nolan House at the time (numbers of patients, activities, staffing levels and duties, the layout of the unit, etc.). She described the desirable course of action as follows:

> *"Specific risk management strategies could have been communicated in the clinical progress notes and to the broader MDT, such as increasing observation levels, monitoring for specific signs of deterioration and/or increasing concern, placement closer to the nursing station or in the HDU, and psychosocial strategies to reduce distress."*

167. Dr Eagle also noted that risk assessment is a shared responsibility throughout the team, no one individual member of the team can be present and evaluating risk at all times. Importantly she noted risk is dynamic. It changes and so the whole team needs to be able to assess and manage risk. Ultimately however the psychiatrist determines the clinical needs and treatment of the patient as the clinical lead of the multidisciplinary team, and that includes the responsibility for management of the patient's risk.

168. For those reasons, Counsel Assisting submitted that the risk assessment process was not adequate, and it did not result in an adequate level of care. AWH submitted that Counsel Assisting's submissions were persuasive.

169. The Family's submissions agreed, and noted, in particular, the criticisms raised by Dr Eagle regarding the outmoded method of the risk assessment tool used in the AWH Policies. The Family also submitted that there were various failures and factors that contributed to an inadequate risk assessment. This was said to result in staff being reluctant to change risk assessments or escalate care when they considered it necessary. It was submitted that training for all staff in the Unit would be valuable to ensure that all staff are not only aware of legislative requirements and policies, but also to ensure that the requirements and policies become appropriately embedded in daily clinical practice. In turn, this would assist to create a culture whereby staff feel they will be recognised and supported when they do communicate concerns or escalate care.

170. Dr Krishna acknowledged that he had a significant role to play in ensuring the adequacy of risks assessments and acknowledged that the risk assessment process adopted in caring for Roger was inadequate. With the benefit of hindsight Dr Krishna acknowledged that:

a) the risk assessments were a multidisciplinary team responsibility, in which he had a significant role;

b) he should have documented the frequency of nursing observations with his first psychiatric review of Roger and with each subsequent review;

c) it would have been helpful to record potential signs of deterioration for nursing staff to be aware of, prior to the weekend of 24 April 2021 to 25 April 2021; and

d) the plan made for ECT on 26 April 2021 may have contributed to Roger's suicidal thinking.

171. This is an area of system improvement. It was recognised in evidence by doctors that nurses who spend the time with patients are in the best position to notice and report on changes. It is also clear that without the need to necessarily escalate matters, nursing staff would benefit from the ability to note concerns for the attention of the treating doctors. Equally, nurses would be assisted to note the doctors view of risk.

172. One of the results of a more productive and effective risk assessment would be an alteration to the observations and in particular frequency of those being made. Dr Eagle opined that the approach to the determination of observation levels, the lack of MDT involvement in determining the nature and frequency of observations, and the communication in the record, was not adequate to manage Roger's risk.

173. Yvonne also expressed doubt during her evidence that observations were performed as they had been recorded. She did not observe staff making observations during the time when she was visiting Roger.

174. I am satisfied by the evidence that the staff were committed to making observations, but the practice is one where they are moving through the unit making observations in a practical way, not always documenting it as they progressed, depending on demands. Again. it is important to reflect that this is a very unique ward, with many issues and concerns occurring constantly throughout any shift.

175. Counsel Assisting submitted that the observation forms, contained in the brief of evidence that was tendered, show that observations were recorded every 30 minutes throughout Roger's admission. They record only a very brief description of the nature of observation. However, they are completed in a similar manner by many different nursing staff. It is also clear that the records do not record the totality of observations that were made. In particular, EEN Stone and RN Duncan gave evidence of the almost continuous observations they made of Roger on 25 April 2021, while the records for that day continue to show 30-minute intervals.

176. Counsel Assisting submitted that the primary issue with these observations was not their quality or the documentation, but their frequency, following Roger's deterioration. As has been discussed above, more frequent observations may have been a risk management strategy that could have been employed to address Roger's increased risk of suicide.

177. AWH submitted that Counsel Assisting's submissions were persuasive and respectfully adopted, although, emphasised that identification of acute suicide risk and clinical treatment is extraordinarily difficult to predict. This is accepted. Constant observations of Roger may have enabled the staff member observing to become aware of the position Roger was placing himself in to effect self-harm, but this is by no means certain. Nonetheless it is clear on the evidence that it is a step that should have been taken to mitigate the risk faced.

178. Dr Krishna agreed with Counsel Assisting's submission that more frequent observations of Roger was a risk management strategy available to address Roger's increased risk of suicide. With the benefit of hindsight, Dr Krishna acknowledged:

a) he could have made recommendations regarding Roger's observation levels on 26 April 2021; and

b) it may have been beneficial to consider and/or increase Roger's nursing observation levels from 26 April 2021.

179. The evidence on this issue again traverses the above issues, but makes a very clear point regarding the inadequacy of the system. On all accounts Roger was deteriorating, and yet it appeared that those treating him and nursing him did not feel the ability to take any steps unless they were quite rigidly taken,

such as escalating the level of care, rather than having a document that was a working discussion in effect of how Roger was presenting. The evidence of the nursing staff was powerful when they indicated that as a result of their concern, they raised observation levels to keep him in sight at all times. This information ought to have been recorded in a place that communicated this level of concern to the treating team. In simple terms the power of the very fact that the nursing staff had that concern speaks volumes when being enunciated by these important health professionals.

180. Dr Krishna respectfully acknowledged Counsel Assisting's submissions that Roger's care and treatment during his admission was not adequate however noted the following relevant considerations:

a) Dr Krishna was considering the finely balanced question as to whether the benefits of moving Roger to the HDU outweighed the risks of retraumatising him and causing further harm and increased risk to his health. There was a real risk that transfer to the HDU may have resulted in Roger deteriorating and resorting to self-harm sooner;

b) with the benefit of hindsight, an increase in observation levels may have been appropriate;

c) the documented self-harm attempt on 27 April 2021 should have immediately prompted a change in observation level to a 1:1 special and/or transfer to the HDU. Dr Krishna did not become aware of that attempted self-harm event until after Roger's death; and

d) Roger's highly unusual method of self-harm was not foreseeable and sadly even if higher observation levels were in place, the outcome would be no different. This logic applies even if the transfer to HDU had been implemented.

181. Reflecting on the evidence of Dr Krishna, it was readily apparent that Dr Krishna tried to act at all times in the best interests of Roger. He was caring in his approach, and this came across in his evidence. Expert and other evidence highlighted deficiencies in his care as has been discussed. Importantly Dr Krishna recognised many areas of improvement, and assisted the inquest through being candid, reflective and responsive to ideas for improvement and change. It should be acknowledged that risk of self harm is a difficult assessment to make. Dr Krishna was new to Nolan House a place that was still in the process of significant change and improvement in relation to its systems and staffing arrangements, and he was working within the confines of the existing system at a time, when it has been acknowledged that some changes were still necessary. Dr Lui equally brought a caring approach to Roger, and as the junior doctor played a role that was guided in the large part by the ultimate decision maker Dr Krishna.

The method of self-harm

182. Counsel Assisting submitted that it was foreseeable that Roger might try to harm himself, but that the method he might use was less clear. He had threatened to run into a brick wall or to use heavy objects to hit his head. These threats had been recorded in the notes.

183. Counsel Assisting submitted that steps could have been taken to mitigate Roger's *general* risk of self-harm, and that these have been considered as addressed above. However, the *specific* risk that Roger would use heavy sliding doors to harm himself was not reasonably foreseeable. In particular, this is because none of the witnesses who were asked had encountered or heard of a person committing self-harm using that method. This was accepted by all interested parties.

184. However, the Family's submissions were that it was highly foreseeable by 27 April 2021 that Roger may seriously harm himself, including in an unusual or ingenious way, given the threats and attempts he had already disclosed. The Family further submitted that steps should have been taken to mitigate his general risk of self-harm. I agree with those submissions. Indeed, all parties accept this position.

185. It was raised that if Roger had decided to take that course, even if being watched, it would not necessarily have been prevented by increased nursing or observations. Dr Waters gave evidence that he had never encountered that method of self-harm. Although self-harm risk reduction in Roger's case may have been achieved by a combination of interventions, this does not mean that the risk of self-harm would have been negated and Roger's tragic outcome would have been prevented.

186. Dr Krishna submitted that whilst it is open for the Coroner to find that steps could have been taken to mitigate the risk of self-harm to Roger, the word "could" is a low bar. The proper approach is to consider the specific risk and ultimate act of self-harm, which was unusual and was not reasonably foreseeable, and in that context ask whether steps "should" have been taken.

187. AWH have acted to change the structure of the doors. It is the case that this was a distressingly novel action that Roger chose to harm himself. Even Roger in his proper state could not have foreseen the outcome. The act was a quick one, using what was there, in a moment.

188. The real question is, would a change in his protection through increasing observations, communication of the details of the same, providing 1:1 care or failing that moving him to HDU, have reduced the risk.

189. As was highlighted in the evidence, Roger found himself in a place that was most likely the place able to keep him safe while he was in this state of mind. To be determined to be a mentally ill person and to be involuntarily detained by definition means that the most vulnerable and at-risk patients end

up in these mental health wards. Again, by definition many such patients are at some risk of self-harm, in circumstances where mood and stability is fluctuating.

190. Roger's family wanted him kept safe, and he was not able to be kept safe. It must be accepted that from time to time even in these safe spaces people successfully harm themselves. That was part of the evidence in this inquest, and I accept that.

191. However, Roger's family sought that he has the best chance possible afforded to him, the best protection available to him, and the evidence particularly the expert evidence provides that alternate steps, being greater supervision and attention, would have provided him a greater chance, and lowered the risk to him. The ultimate outcome could not be predicted, but there were opportunities missed to provide him with greater security and protection.

The nature of self harm

192. The evidence must be extremely clear and cogent in relation to intention. The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the Briginshaw standard (*Briginshaw v Briginshaw* 60 GLR 336).

193. Although Roger's actions were not witnessed by a staff member, the evidence establishes, on balance, how he caused his injuries. The evidence also establishes to the required standard that Roger deliberately inflicted his injuries. Given the method he used, taken with the statements he had made over the weekend to Yvonne, as well as other statements about harming himself, and in keeping with the submissions of all parties, a finding can be made that Roger intended to end his life.

The impact of Nolan House being subject to both NSW and Victorian health oversight, policy, and guidelines

194. The unique border position of Nolan House raised other areas of consideration, and in particular the complication of NSW and Victorian policies and applicability of both.

195. Dr Elizabeth McArdle, Consultant Psychiatrist, was able to assist and give evidence on the position of policy and process in Nolan House. She indicated that the policy that has been adopted by AWH and is applicable to Nolan House seeks to consolidate policy from NSW and Victoria. AWH strives to adhere to the most robust policy between the two jurisdictions. This approach is consistent with the Memorandum of Understanding (MOU) under which AWH operates. The MOU identifies a process where policy is in conflict.

196. Counsel Assisting observed the unique challenges regarding its policy, given its geographical location, and the reality that staff members working at AWH may have experience of it from different jurisdictions. This also places a greater administrative burden on AWH, in trying to develop its own policies to

be compatible with both jurisdictions. Differences can be identified between the relevant policy applicable to nursing observation and engagement in Victoria and NSW. As was noted in the evidence, the AWH policy in place in 2021 provided that only a Senior Nurse in Charge could increase observation / engagement frequency, whereas the NSW policy provides that any nurse can do this at any time. However, Dr McArdle explained that this was not the way the policy applied in practice, where any staff member could increase observation frequency; this was supported by the evidence of the staff members themselves. An amendment was made to the policy to reflect this during the Inquest.

197. Counsel Assisting submitted that there are other differences as follows:

- The Victorian system has 4 levels of observation, whereas the NSW system has 5; AWH adopts the Victorian approach in its policy.

- The NSW policy provides that the Nursing Unit Manager must randomly review throughout a shift that observation levels are being undertaken and documented as prescribed.

- The NSW policy also provides that observations forms must allow the nurse to document the actual time the observation took place, and must clearly document the consumer's mental state, current risks and concerns (both subjective and objective), interactions with staff and others, and be reflective of the targeted rationale for observation. These matters do not appear to feature in the AWH policy.

198. Counsel Assisting submitted that the evidence does not clearly establish how, if at all, these differences in policy approach might have impacted on the care provided to Roger. As noted, the principal issue was the failure to consider an increase in observation frequency, or to adopt other risk management strategies, once his deterioration became clear. However, given the differences identified, it would be desirable for AWH to revisit the policy in relation to risk assessment, observation, and documentation in the mental health service, to ensure compatibility with NSW and Victorian policies which provides the basis for a recommendation that it is proposed I make.

199. The Family submitted that the failure of AWH to implement and follow the NSW Policy, which was mandatory for Nolan House to follow given its location in NSW, did impact upon the nature and quality of Roger's care. The Family submitted that had AWH followed the NSW policies and conducted risk assessments, engagement, and observations as set out within that policy, then Roger's high risk would have been appropriately recognised by all and his risk of self-harm actively managed. The Family submitted that both medical and nursing staff conceded that they also failed to comply with the AWH policies that were in place. Even under the policies in place at the time, they ought to have escalated Roger's risk assessment and taken appropriate interventions including increasing observations.

200. The complicating feature of the cross-border challenges did play a part in the management of Roger. The provisions in the NSW policy allowing a nurse to document the actual time the observation took place, clearly document the consumer's mental state, current risks and concerns (both subjective and objective), interactions with staff and others, and be reflective of the targeted rationale for observation would have provided a better guide to the risk Roger presented, and is more in keeping with the expert opinion of Dr Eagle.

201. The evidence itself also supports this, the nursing staff, RN Duncan, EEN Stone and RN Star-Hossack, were compassionate and caring, and were doing their best within the confines of their roles to care for Roger. Better tools to allow them with ease to converse equally with doctors would have enabled their concerns to carry through to other shifts and to the treating team.

Submissions on proposed Recommendations

202. Mr William Appleby, Chief Executive Office, AWH provided a statement and gave oral evidence at the Inquest, and proposed three recommendations for consideration, in relation to psychiatry training to address workforce issues in rural and remote areas, the standardisation of risk assessment and observation tools between NSW and Victoria, and adopting a single EMR strategy. Counsel Assisting submitted that the proposed recommendations were addressed to entities which were not interested parties to the Inquest, and for reasons of procedural fairness it would not be appropriate to make these without first affording them an opportunity to be heard. I agree. However, Mr Appleby should be commended for raising these matters, and it is promising that he was willing to engage so positively in the process.

203. Counsel Assisting, however, has submitted that the following areas for recommendations are proposed.

Inadequate documentation

204. Counsel Assisting submitted that this was a significant focus and feature of the Inquest. Dr Eagle highlighted the lack of documentation which formulated a risk management plan. Dr Liu noted that composing long handwritten progress notes was not her usual practice, and that she found typing progress notes better. Dr McArdle also acknowledged the disadvantages of using a handwritten record.

205. The inquest was told that staff at Nolan House continue to use handwritten progress notes, as they had at the time of Roger's death in 2021.

206. Counsel Assisting submitted that this seems to be a consequence of AWH being an inter-government initiative between Victoria and NSW. However:

a) Relevant NSW policy provides that NSW Health organisations must ensure that all mental health services use available electronic medical

record systems for the documentation of clinical practice and care. This is required in all service settings and for all service types.

b) The *Royal Commission into Victoria's Mental Health System* similarly made recommendations that the Victorian Government develop, fund, and implement modern infrastructure for Information and Communications Technology, including a new statewide electronic Mental Health and Wellbeing Record.

207. In the above context, Counsel Assisting submitted that adopting an electronic medical record across AWH (and in particular the mental health service) should be strongly supported.

208. Mr Appleby expressed a preference that any electronic medical record should be compatible with physical health systems used at AWH, and also that NSW and Victorian systems were compatible with each other, given the likely need to refer to both within AWH.

Staff induction

209. Counsel Assisting submitted that both Dr Liu and Dr Krishna stated that, when they commenced at Nolan House, they did not recall undertaking any form of induction. As a result, they were not specifically aware of the AWH policies relating to risk assessment, observation levels, or local practices regarding the documentation.

210. Dr Krishna and Dr Liu both had locum roles at Nolan House, and had only commenced there in February 2021. Their presence at Nolan House was a consequence of the staffing changes described by Dr McArdle, whereby the desire to move to a staff specialist model resulted in a loss of long term VMOs, and reliance on a locum workforce, while permanent members of staff were recruited. Roger's admission coincided with this difficult period of transition.

211. Since the time of these events, the staffing appears to have stabilised, with the recruitment of a senior psychiatrist and other permanent staff members. This seems to have resulted in an improvement in patient care. However, there is still a need to draw on locum staff members and VMOs, and for this reason, it would be desirable to ensure that new staff members are properly inducted into the AWH system, in particular where AWH has "bespoke" policies and practices which may be unfamiliar to new staff.

Compatibility of AWH policy with NSW and Victorian policy

212. I have already referred to Counsel Assisting's submission on this topic above under the heading "The impact of Nolan House being subject to both NSW and Victorian health oversight, policy, and oversight".

Proposed recommendations

213. Counsel Assisting proposed that I make the following recommendations:

> To the Chief Executive Officer, Albury Wodonga Health
>
> 1. Continue to advocate with NSW Health and the Department of Health, Victoria, for the implementation of an electronic medical record across Albury Wodonga Health mental health services. Such a record should ideally be compatible with systems in both NSW and Victoria, and should include standardised documents for the assessment, formulation and management of risk and patient observations.
>
> 2. Review Albury Wodonga Health mental health service policy relevant to risk assessment, patient observation, and documentation, to ensure compatibility with both NSW and Victorian policies. Where those policies are not compatible, draw this to the attention of NSW Health and the Department of Health, Victoria, in accordance with the process described in the AWH Memorandum of Understanding.
>
> 3. Ensure that induction processes for locum and visiting staff members clearly identify relevant policy and practices in relation to the assessment, formulation and management of risk documentation and patient observations.

214. The Family submitted that further to the above, with regards to the implementation of an EMR system for the mental health service of AWH, that the recommendation proposed by Counsel Assisting requires AWH to continue to advocate for an EMR system. The Family submitted that it is appropriate for a more robust recommendation to be made in circumstances where a clear need for an EMR system has been identified by AWH itself, NSW Policy mandates EMR systems within mental health units and AWH has already been advocating to Government for funding for such a system, without success. The Family proposed that the following wording be used for a recommendation that captures the needs for the implementation of EMR:

> That the Victorian and NSW Governments provide appropriate funding to AWH to enable it to implement an EMR system within its mental health units, as mandated under the NSW Mental Health Clinical Documentation Policy and as recommended by Recommendation 62 of the Royal Commission into Victoria's Mental Health System.

215. The Family proposed that I make the following recommendations in relation to Policies:

> a) That AWH takes appropriate steps to ensure that it is abiding by all NSW Policies as required under the Memorandum of Understanding, including by:

i. replacing the NEBMHS-Risk Management Inpatient Care Policy with the NSW Policy Engagement and Observation in Mental Health Inpatient Unit;

ii. implementing Risk Monitoring, Nurse Observation and Engagement Tools A and B that align with the above NSW policy and focus on assessment, formulation, and management of risk and consider risk indicator factors that are associated with an increased suicide or suicidal behaviour, as stated by Dr Eagle;

iii. ensuring compliance with the NSW Mental Health Clinical Documentation Guidelines (the **Guidelines**) including:

iv. developing appropriate documentation tools that comply with the NSW Guidelines;

v. developing a role for a Case Manager/Care Co-ordinator as described in the NSW Guidelines;

vi. recruiting further staff to fulfill the requirements for a multidisciplinary team under the NSW Policy.

b) That AWH continue to work to develop and then implement effective tools for:

1) handovers between nursing staff;

2) easily and clearly documenting in the medical record the prevailing risk assessment status.

216. The Family also proposed that the following wording be used for a recommendation that captures the need for both induction and training:

a. That AWH:

1. ensure that induction processes for locum and permanent staff members take place which clearly identify relevant legislative requirements, policies and practices, including those in relation to the assessment, formulation and management of risk, documentation, patient engagement and observations and escalation of care; and

2. undertake ongoing training to ensure all medical, nursing and allied health staff in Nolan House are familiar with the requirements and purposes of the applicable legislative requirements, policies and practices including those in relation to the assessment, formulation and management of risk, documentation, patient engagement and observations and escalation of care, and that all staff are encouraged and

supported to utilise those requirements, policies and practices and be compliant with them.

217. The Family also identified a number of further improvements that they would like to see made to Nolan House which are set out in Annexure A of their written Submissions. There were 21 improvements proffered (which I will not repeat) pertaining to Policy, Procedures and Education; and the Nolan House Environment. The Family acknowledged that while some of these may not be appropriate for the Coroner to include as formal recommendations as they were not the subject of formal evidence at the inquest, the Family has requested that the proposed improvements be provided to AWH for its consideration.

218. Counsel Assisting submitted that a proposed recommendation must relate to "any matter connected with the death". This requires a connection to be established between the death and the matter that is the subject of the recommendation; however, the clause is framed broadly, and it does not require a "direct" connection. The Coroner must form the view that the proposed recommendation is either necessary or desirable. While the inclusion of "desirable" broadens the discretion beyond recommendations which are strictly "necessary", the term also connotes an assessment of the benefits or disadvantages of the proposal. This may include considerations of the practicability or utility of achieving the recommendation, and the consequences of putting a recommendation into effect. The power to make a recommendation in relation to a person or body also likely imports a requirement to afford procedural fairness to that person or body, at least insofar as the recommendation may impact on their interests, including their reputation.

219. Counsel Assisting submitted with regards to the alternative proposed recommendation regarding the implementation of the EMR that it would be inappropriate to make a recommendation to either the Victorian or New South Wales governments, without first affording procedural fairness. They ought to be given notice of any proposed recommendation and an opportunity to be heard against it. However, as an alternative, if an issue worthy of consideration is identified in the written findings, then a copy of the findings could instead be provided to each government's Health department for further consideration. A similar proposal is made by the Family regarding Mr Appleby's proposed recommendations. I agree with this approach, and note that this has occurred.

220. With regards to the Family's proposed recommendations regarding AWH policies and induction of staff and the list of potential improvements identified and set out in Annexure A of their written Submissions, Counsel Assisting submitted that whilst these are borne out of a desire to improve the care provided to patients, and their experience at Nolan House, there would, however, be debate about the extent to which the topics identified in these proposals meet the description of a "matter connected with the death", and also whether it has in fact been demonstrated that they are all necessary or desirable.

221. AWH submitted that it has consistently provided all information relevant to the issues before the Court and has openly embraced the need for

continuous improvement of its health service, patient safety, and clinical governance. AWH submitted that it adopts the recommendations proposed by Counsel Assisting without reservation, and confirmed that:

1) A review of the AWH policy relevant to risk assessment, patient observation and documentation to ensure compatibility with Victorian and New South Wales policies is in progress;

2) An induction documentation is in draft form;

3) No delay is anticipated regarding the introduction of AWH policy changes and induction; and

4) Processes consistent with the proposed recommendations; and

5) AWH has been provided with a copy of the Family's Submissions and Annexure A for consideration.

222. Dr Krishna submitted that Counsel Assisting's proposed recommendations are reasonable and appropriate and should be adopted by the Coroner.

223. The evidence supports the making of the recommendations as set out by Counsel Assisting. I have also added a recommendation, which was proposed by the Family, to those recommendations, and thank them for their thoughtful contribution in that regard.

224. With regards to the Family's list of further improvements, they should be provided to AWH for consideration as requested.

Submissions on the statutory findings required under section 81 of the Coroners Act 2009 (NSW)

225. The Family agreed with Counsel Assisting's submissions regarding the manner and cause of death (section 81(1)(c)), it was submitted that the findings ought be to the effect that Roger's death was due to a "head injury, which was self-inflicted by Roger with an intention to end his life, in circumstances where there had been cumulative failures by AWH staff to appropriately assess, record, communicate and respond to Roger's high self-harm risk while he was an involuntary patient in Nolan House."

226. Counsel Assisting submitted in response, that the phrase "manner and cause" is to be given "*a broad construction so as to enable the coroner to consider by what means and in what circumstances the death occurred*". Subsection 81(3) prohibits a Coroner from indicating or in any way suggesting that an offence has been committed by any person.

227. Counsel Assisting also submitted that provided the findings as to the manner of death are supported by the evidence, there is no other limit in the Act as to the way in which the circumstances of death may be described.

228. Counsel Assisting submitted that the disadvantage of a finding which incorporates a narrative about failures of care of this nature is that it applies a gloss to those issues, without context or precision, and it unfairly identifies "AWH staff" as a homogenous group. Counsel Assisting submitted that a better approach may be to record the proximate circumstances and context of Roger's death, and to record elsewhere the detailed findings as to any failures of care.

229. I am satisfied that the cause of death is appropriately recorded as found by the senior forensic pathologist, and as such this will be recorded. The cause of death was head injuries.

230. In relation to manner, in my view it is sufficient and appropriate in the discharge of my statutory function pursuant to the Act to find that Roger's death was as a result of an intentionally self-inflicted act while at significant risk of self-harm and being cared for and detained as an involuntary patient under the *Mental Health Act 2007* (NSW) at Nolan House.

Conclusion

231. Roger's case represents a case of sudden onset of mental illness, in a person not afflicted by any substance misuse disorder, previous mental health diagnosis or admission, nor any prior attempts of self-harm. His illness was ferocious and sudden, leaving those who tried to help him scrambling to find a way to save him. This was a terrifying story of what can happen to any person, unexpectedly.

232. His family wanted to know he could be kept safe. The end result is that perhaps given the devastating nature of his illness he could not be. However, he deserved the best chance that he could be given, to buy time to attempt to find a treatment that worked. His family and friends united to bring attention to Roger's experience, and assisted this inquest to identify where improvements could be made. This cannot alleviate their feelings of loss and grief, however their preparedness to explore these issues has identified matters that can be changed, and in turn will make it better for others in the future.

Additional submissions

233. Subsequent submissions were received by the Family in response to the submissions filed on behalf of Dr Krishna. Submissions in response were also received on behalf of Dr Krishna in response. These submissions were taken into account, however, in essence the matters raised have been addressed throughout these findings.

Findings required by section 81(1)

234. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

235. The person who died was Roger Frederick Schnelle.

Date of death

236. Roger died on 30 April 2021.

Place of death

237. The location of Roger's death was the Intensive Care Unit of Albury Wodonga Health, 201 Borella Road East Albury NSW 2640.

Cause of death

238. The cause of Roger's death was head injuries.

Manner of death

239. Roger's death was as a result of an intentionally self-inflicted act while at significant risk of self-harm and being cared for and detained as an involuntary patient under the *Mental Health Act 2007* (NSW) at Nolan House.

Recommendations

240. Pursuant to section 82 of the Act, Coroners may make recommendations connected with a death.

241. For the reasons stated above, I am of the view that the evidence supports that the recommendations as outlined below are appropriate to be made in relation to Roger's death.

242. To the Chief Executive Officer, Albury Wodonga Health

1. That consideration be given to continuing to advocate with NSW Health and the Department of Health, Victoria, for the implementation of an electronic medical record across Albury Wodonga Health mental health services . Such a record should ideally be compatible with systems in both NSW and Victoria, and should include standardised documents for the assessment, formulation and management of risk and patient observations.

2. That consideration be given to a review being undertaken of the Albury Wodonga Health mental health service policy relevant to risk assessment, patient observation and documentation to ensure compatibility with both NSW and Victorian policies. Where those policies are not compatible, draw this to the attention of NSW Health and the Department of Health, Victoria, in accordance with the process described in the AWH Memorandum of Understanding.

3. That consideration be given to implementing Risk Assessment Tools that focus on assessment, formulation, and importantly management of risk and consider risk indicator factors that are associated with an increased suicide or suicidal behaviour, as set out in the expert evidence of Dr Eagle.

4. That consideration be given to ensuring that the induction processes for locum and visiting staff members clearly identify relevant policy and practices in relation to the assessment, formulation and management of risk documentation and patient observations.

Acknowledgements and concluding remarks

243. The first recognition needs to go to the family of Roger, who participated in the investigation and proceedings. The family provided the inquest with necessary insight into the life of Roger and evidence. Their voices were heard by those who provided care and treatment to Roger. I acknowledge the profound loss, continuing anguish, and heartbreak that Roger's family and friends are grappling with as a result of his very tragic passing. I offer my sincere and respectful condolences for their difficult loss.

244. Gratitude is extended to the Officer in Charge, Detective Senior Constable Andrew Jones. I thank him for his role in the police investigation and for compiling initial brief of evidence.

245. The legal representatives for the interested parties are recognised for their helpful and sensitive approach to the proceedings.

246. Mr Harris and Ms Potocki as the team assisting prepared and presented a thorough and carefully analysed inquest to ensure the exploration of extremely important issues to promote improvement and change. I extend my thanks.

It is fitting to the end with words shared by Yvonne at the end of the evidence in the inquest:

> "*Roger's death deeply effected so many people Not just me, his children, his siblings but his broader family, friends and even acquaintances. Roger's support, knowledge and compassion was always available to anyone that needed it. He went out of his way to help and mentor his children, his brothers and sisters, his nieces and nephews, and his*

cousins. This extended beyond his family, to his friends and clients as well. He has had an enormous positive impact on the lives of so many."

I close this inquest.

Magistrate Erin Kennedy

Deputy State Coroner, NSW State Coroner's Court, Lidcombe

16 May 2024