New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of NL
Hearing dates:	21 to 23 August 2023; 19 December 2023
Date of Findings:	28 March 2025
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, cardiac arrythmia, QT prolongation, hypothyroidism, compliance with thyroxine medication, endocrine management, thyroid function test, endorsement of pathology results, multidisciplinary team meetings, copying and pasting from eMR, observations of mental health inpatients, team model of nursing, *Health Practitioner Regulation National Law (NSW)*
File number:	2019/00124245
Representation:	Ms K Kumar, Counsel Assisting, instructed by Ms A Heritage & Mr P Armstrong, Crown Solicitor's Office Ms K Doust, New South Wales Nurses & Midwives Association, for Mr B Woodruff Ms L McFee for Dr T Cox, instructed by Barry Nilsson Lawyers Mr P Rooney for South Eastern Sydney Local Health District, instructed by Makinson d'Apice Lawyers Mr T Saunders for Dr S Buten, instructed by Meridian Lawyers

Findings made pursuant to section 81(1) *Coroners Act 2009*:	NL died on 20 April 2019 at the Kiloh Centre, Prince of Wales Hospital, Randwick NSW 2031. The cause of NL's death was cardiac arrhythmia secondary to prolongation of the QT interval. NL's recurrent hypothyroidism due to non-compliance with thyroxine, probable hypothyroidism-induced dilated cardiomyopathy, antipsychotic therapy, elevated body mass index, marijuana use and possible sleep apnoea were all contributing factors to prolongation of the QT interval. NL died whilst admitted as an involuntary patient for treatment of his mental and physical health conditions. Management of NL's hypothyroidism and his non-compliance with thyroxine were significant features of his admission. Thyroid function test results available 15 days before NL's death were not reviewed and, consequently, no consideration was given to whether any change in NL's clinical management was warranted. However, there is no evidence that if a review had been performed it would have materially altered the outcome.
Recommendations made pursuant to section 82(1) *Coroners Act 2009*:	See Appendix A.
Non-publication orders:	Pursuant to section 74(1)(b) of the *Coroners Act 2009*, the publication of any matter (including the publication of any photograph or other pictorial representation) that identifies NL is prohibited.

Table of Contents

1. Introduction

1.1 NL had a history of schizoaffective disorder, for which he had been prescribed antipsychotic medication, and hypothyroidism, for which he was required to take thyroxine daily. On 2 October 2018, NL was brought to the Emergency Department at Prince of Wales Hospital (**POWH**) after not having taken his thyroxine for some time. He was diagnosed with severe hypothyroidism and admitted to the intensive care unit (**ICU**).

1.2 After absconding from the ICU, NL was detained as an involuntary patient under the provisions of the *Mental Health Act 2007* and transferred to the Acute Mental Health Inpatient Service at POWH, also known as the Kiloh Centre. Over the next six months, NL was treated for his mental health condition and hypothyroidism.

1.3 On the evening of 19 April 2019, NL went to bed in his room. He was observed by nursing staff overnight at regular intervals and was noted to asleep for most of the night. At around 5:50am on 20 April 2019, NL was checked on and found to be unresponsive and showing no signs of life. Emergency resuscitation efforts were initiated but NL could not be revived and was pronounced deceased at 6:29am.

2. Why was an inquest held?

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

2.2 NL's death was considered reportable because it occurred unexpectedly and the cause and manner of his death were not immediately clear. In addition, at the time of his death NL was an involuntary patient, meaning that he did not exercise agency over his health care and that, instead, the State had assumed this responsibility. An independent examination of the circumstances of that care and NL's death is therefore important to ensure that the State has adequately and appropriately discharged its responsibility. Accordingly, the coronial investigation gathered evidence from a number of health practitioners, POWH and the South Eastern Sydney Local Health District (**SESLHD**), within which POWH is located.

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

3. NL's life

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

3.2 NL was born in 1956 in Moss Vale. He was the youngest of four siblings and considered to be a bright and gifted child. NL attended boarding school where he completed his Higher School Certificate. He attended university but later discontinued his studies to become a journalist. NL worked as a TV news anchor in regional NSW, ran his own sports news publication, and published an article on the front page of The Australian newspaper.

3.3 In 1986, NL moved to Sydney to further his career. In 1987, he met his wife, ML. They later married and their son, OL, was born in 1989. NL later began to show signs of instability and erratic behaviour resulting in the breakdown of his relationship in 1991 and the loss of his employment.

3.4 NL continued to see OL regularly and they enjoyed their time together. After working a series of odd jobs, NL found work again in 1998 working night shifts in a factory. He was later employed as a media officer in a NSW Government department.

3.5 In 2003, NL inherited a sum of money and began, in OL's words, lecturing his son about personal finance. OL describes his father as educating him about "street maths" and giving him a treasure map after countless hours spent researching the information he was imparting to OL.

3.6 During OL's teenage years, NL moved into a Housing Commission unit and was able to find some degree of peaceful living. He had a beloved cat, Tiger, who brought him much joy. He and OL watched their beloved Sydney Swans together and rejoiced at their Premiership wins.

3.7 Following the death of NL's mother in 2009 he and OL continued to meet up every weekend for the same ritual of football games, food and much coffee. OL describes this time together as often the happiest of his life, and the happiest of his father's life.

3.8 In the years that followed, NL's condition gradually deteriorated and he became increasingly dependent on OL to care for him.

3.9 OL describes his father as living with immense purpose and that he was determined to find a way to ensure that OL would have a better life than he possibly could have imagined. With the clever investment of his inheritance and the lectures he gave to OL many years ago, NL fulfilled his purpose. OL says that though NL will never meet his grandchildren they will know his legacy for many years, and that NL can rest in peace knowing that he did make a better life for his son and for posterity.

4. NL's medical history

4.1 During his early 20s, NL had periods of erratic behaviour but continued to work and live independently. He was diagnosed with schizophrenia in his late 20s and was initially treated in Canberra. When he was around 30, NL resumed working in journalism and marketing. However, by his late 30s, NL's mental health had deteriorated to the point where he ceased working and his relationship ended. Thereafter, NL became isolated and dependent on his parents for his care and medical treatment. As a result of his mental health issues, NL held paranoid beliefs that medication and a number of foods were poison. NL was resistant to medical intervention and assessment which adversely impacted his physical health.

4.2 From 2006, NL was admitted to mental health units on several occasions. He presented as thought disordered, agitated, and with misperception and intense delusions. He had a history of chronic non-compliance with antipsychotic medication and, as a result, had previously been managed on a Community Treatment Order (**CTO**). This required medication being given by injection, sometimes with the assistance of New South Wales Police Force officers. NL also had hypothyroidism and was required to take thyroxine daily.

4.3 NL lived alone in the community and received a disability support pension. His son, OL, visited weekly and, together with ML, helped NL with activities of daily living. During 2016, NL was largely compliant with his medication regime and remained well. In May 2017, NL was discharged from his community mental health service into the care of his general practitioner (**GP**), who had been administering his antipsychotic medication injections.

5. Admission to Prince of Wales Hospital

5.1 On 2 October 2018, OL brought NL to the Emergency Department at POWH. NL presented with myxoedema coma (a life-threatening emergency due to untreated hypothyroidism), and was noted to be hypothermic and bradycardic. NL reported that he had not taken his thyroxine medication for some time, and he was diagnosed with severe hypothyroidism.

5.2 On 3 October 2018, NL was admitted to the ICU. His thyroid stimulating hormone (**TSH**) was found to be high at 112.8mlU/L, and his thyroxine free (**TF**) level to be low at less than 3pmol/L. As a result, NL was commenced on intravenous thyroxine therapy.

5.3 On 8 October 2019, a guardianship application was prepared seeking orders for a guardian to be appointed to make medical decisions on behalf of NL, due to his history of non-compliance with his medication regime. The next day, NL was made an involuntary patient pursuant to the provisions of the *Mental Health Act 2007 (NSW)* after he absconded from the ICU. During the course of NL's admission, the Mental Health Review Tribunal held a number of hearings to consider his status as an involuntary patient. OL was also given the power to make decisions relating to his father's medical treatment.

5.4 On 10 October 2018, NL was transferred to the Observation Ward of the Kiloh Centre after his thyroxine levels had significantly improved and his physical health was stable. Upon transfer, it was noted that NL had known schizoaffective disorder and had been subject to previous CTOs, and that he was a mentally ill person with an extensive history of non-compliance with antipsychotic and thyroid medication. NL was found to be suffering a relapse into schizoaffective disorder or delirium due to hypothyroidism because of poor adherence to treatment due to psychotic thinking.

Management of hypothyroidism

5.5 On 25 October 2018, NL was transferred to the General Ward of the Kiloh Centre where he came under the care of Dr Sara Buten, staff specialist psychiatrist. Apart from the period between 22 January 2019 and 1 February 2019, when NL was transferred to the Mental Health Intensive Care Unit (**MHICU**) for more intensive nursing support and treatment regarding compliance with thyroxine, he remained under the care of the psychiatry team at the Kiloh Centre. Dr Tristan Cox commenced working as a psychiatry registrar in February 2019 under Dr Buten.

5.6 During his admission, NL was managed as a mentally ill patient. However, NL was also regularly seen by an endocrinologist until December 2018 and the endocrinology team were regularly consulted, and advised, regarding his thyroid management. As part of this management, regular monitoring of NL's TSH and TF levels occurred as set out in the table below:

DATE	TSH	TF
14 December 2018	29.9 mIU/L (high)	11.2 pmol/L (low)
17 January 2019	40.3 mIU/L (high)	9.0 pmol/L (low)
23 January 2019	26.0 mIU/L (high)	11.7 pmol/L (low)
30 January 2019	32.9 mIU/L (high)	13.7 pmol/L (normal)
6 February 2019	15.5 mIU/L (high)	17.5 pmol/L (normal)
12 February 2019	20.3 mIU/L (high)	12.4 pmol/L (low end of normal)

5.7 On 17 January 2019, NL's thyroxine medication was increased from 250mcg to 300mcg daily following his high TSH results from the same day.

5.8 On 23 January 2019, NL was reviewed by a registrar. Advice was sought from the endocrinology team and it was recommended that NL's thyroxine should continue at its current level with a repeat thyroid function test (**TFT**) to be performed in a week.

5.9 On 28 February 2019, Dr Saul Bert, psychiatry registrar, discussed NL with the endocrinology team and reported the TSH and TF results from 12 February 2019. Dr Bert was advised that it could take six to eight weeks for the increase in thyroxine on 17 January 2019 to reflect regulatory changes. The endocrinology team suggested that the TFT be repeated in four weeks and that if the thyroxine needed to be changed, it would take another 6 to 8 weeks to reflect any change. If no change to thyroxine was needed, then the TFT was to be repeated every three months for a year and then repeated every six months.

5.10 On 18 March 2019, a complex case review was held with Dr Buten, the multidisciplinary inpatient team (**MDT**), and the community team. It was agreed to organise a family meeting to discuss graduated leave for NL and eventual discharge planning with support from the National Disability Insurance Scheme (**NDIS**), Mission Australia, OL, and a CTO.

5.11 On 21 March 2019, a family meeting was held with OL and NL's former partner. Who expressed concern about the condition of his father's home. OL expressed support for an application for NDIS services to allow his father to live independently or in supported accommodation.

5.12 Following the meeting, NL continued to take daily leave which was dependent on him taking his thyroxine medication. Planning for his discharge also continued and it was agreed that additional support from the NDIS and Mission Australia needed to be pursued.

5.13 On 4 April 2019, Dr Cox ordered another TFT for NL in accordance with advice previously provide by the endocrinology team. On 5 April 2019, the last documented pathology tests were taken for NL. His TSH level was found to be 92.7mIU/L (high) and his TF was 1.6 pmol/L (low). These results suggested that NL had not been taking his thyroxine medication. Dr Cox endorsed the test results.

5.14 On 8 April 2019, a MDT meeting was held in relation to NL. A plan was formulated which included NL being closely monitored for medication compliance, being placed on care level 5 observations (every second hour), his NDIS application to be followed, and a medical officer being advised if NL refused to take his medication.

6. The events of 19 and 20 April 2019

6.1 At around 7:10pm on 19 April 2019, NL was captured on CCTV footage to walk slowly with the aid of two walking sticks into his bedroom. NL was wearing a long sleeved top and pants at the time.

6.2 At around 8:39pm, a registered nurse (**RN**) recorded that NL had gone to bed. Following this, nursing staff checked on NL every hour by opening his door, recording that he was asleep, and that his chest was seen to rise and fall.

6.3 At around 6:10am on 20 April 2019, Enrolled Nurse (**EN**) Joanne Townsend entered NL's room whilst attending to the morning medication round. EN Townsend saw that NL was lying on side and said it was time to wake up to take his thyroxine. NL did not respond. EN Townsend touched NL's shoulder, again with no response, and then felt his face was cold to touch. After moving NL to lie flat, EN Townsend saw that NL's lips were blue and that he showed no signs of life.

6.4 An emergency medical response was called and a resuscitation team from POWH attended a short time later. Resuscitation efforts were initiated but a defibrillation unit indicated that no heart rhythm could be detected and that NL was in asystole. Resuscitation efforts continued until 6:29am when the efforts were ceased and NL was pronounced deceased.

7. The post-mortem examination

7.1 NL was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Rianie Van Vuuren, forensic pathologist, on 29 April 2019. This examination identified the following relevant findings:

(a) a markedly enlarged heart;

(b) moderate coronary atherosclerosis with the left circumflex coronary artery showing approximately 60% stenosis due to atherosclerosis, and the right coronary artery showing approximately 50% stenosis; and

(c) toxicological analysis identified cannabinoids and a low level of alcohol (0.011 g/100mL), all or none of which could be due to post-mortem changes.

7.2 Due to decomposition changes, biochemistry testing could not be performed.

7.3 In the autopsy report dated 25 February 2020, Dr Van Vuuren noted the following:

(a) sudden cardiac death can occur in uncomplicated cardiomegaly;

(b) myxoedema coma can occur on a background of infection, heart failure, stroke or not taking thyroid medication;

(c) a fatal arrhythmia is associated with myxoedema.

7.4 Ultimately, Dr Van Vuuren opined that the cause of NL's death was cardiomegaly.

8. What issues did the inquest examine?

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

(1) What was the cause of NL's death?

(2) Was NL's endocrine and cardiac status and/or medical conditions appropriately managed between 2 October 2018 and 20 April 2019?

(3) What steps were undertaken to ensure that NL was ingesting his thyroxine medication?

(4) Were the observations of NL overnight on 19 April 2019, and on the morning of 20 April 2019, adequate and conducted in accordance with SESLHD and NSW Health policies?

(5) What processes does SESLHD have in place to ensure that the medical needs of inpatient mental health patients are appropriately assessed and met?

8.2 For clarity, some of the issues have been divided into a number of sub-issues.

8.3 As part of the coronial investigation, the following independent experts were instructed to provide reports addressing a number of questions regarding the circumstances of NL's death:

(a) Associate Professor Mark Adams, consultant cardiologist, and Head of the Department of Cardiology at Royal Prince Alfred Hospital; and

(b) Professor John Carter AO, consultant endocrinologist.

8.4 Both experts were asked to address a number of specific questions posed to them covering several different topics arising from the circumstances of NL's death. Each expert prepared a report answering the questions posed.

9. What was the cause of NL's death?

9.1 Associate Professor Adams expressed the view that NL "*almost certainly suffered a sudden cardiac death*" mostly likely due to a cardiac arrythmia. Associate Professor Adams considered that the cause for this arrythmia was most likely multifactorial, including NL's hypothyroidism, obesity and mental health problems, noting the following:

(a) Associate Professor Adams explained that thyroid function and cardiac function are closely related, with changes in the latter caused by both overactive and underactive levels of thyroid hormone. In some cases, hypothyroidism can lead to the development of a dilated cardiomyopathy which is generally reversible with thyroid hormone replacement therapy but may be fatal without treatment. Associate Professor Adams noted that given NL's cardiomegaly "*it is certainly possible that he had hypothyroidism-related dilated cardiomyopathy*", especially given the deterioration in NL's thyroid function in April 2019 and notwithstanding a relatively normal echocardiogram in October 2018 prior to treatment with thyroxine. Associate Professor Adams went on to explain that if NL had an element of cardiomyopathy this would have increased his risk of suffering a fatal arrhythmia.

(b) Associate Professor Adams also noted that hypothyroidism is associated with heart block which can lead to a very slow heart rate and cardiac standstill. However, given that observations taken of NL in the days preceding his death were fairly unremarkable, Associate Professor Adams expressed the view that bradycardia and complete heart block is less likely as a cause of death.

(c) Associate Professor Adams noted that during the early stages of NL's admission in October 2018 evidence was found of QT prolongation (an abnormality in heart muscle electrical repolarisation) which can lead to fatal arrhythmias or deteriorate into ventricular fibrillation. Associate Professor Adams explained that in NL's case, QT prolongation was likely due to his hypothyroidism state, with his TFT in April 2019 demonstrating a high level of TSH (probably due to non-compliance with thyroxine) with levels of thyroxine likely to have been low enough by the time of death for recurrence of QT prolongation. In addition, NL was receiving antipsychotic medication which is known to increase the QT interval. In addition, Professor Adams noted that NL's elevated body mass index, likely obstructive sleep apnoea, and his known use of marijuana are all known to cause QT prolongation.

9.2 Overall, Associate Professor Adams opined that:

> [I]t is most likely that NL suffered a fatal arrhythmia probably secondary to QT prolongation from an accumulation of the effects of recurrent hypothyroidism from non-compliance with thyroxine, probable hypothyroidism induced cardiomyopathy, antipsychotic therapy, marijuana use, obesity, and possible sleep apnoea.

9.3 Professor Carter similarly expressed the view that the most likely cause of NL's death was cardiac arrest secondary to an arrythmia associated with cardiomegaly and chronic hypothyroidism. In evidence, Professor Carter agreed with the views expressed by associate Professor Adams and considered that an arrhythmia was most likely the terminal event. Professor Carter also explained:

So, an irregular heart rate associated with some underlying damage to the heart caused by the relatively longstanding and severe hypothyroidism - underactive thyroid. So, with an underactive thyroid, or longstanding, and of sufficient severity, it is well-known that a cardiomyopathy can develop.

9.4 **Conclusions:** The expert evidence established that the cause of NL's death was cardiac arrhythmia secondary to prolongation of the QT interval. NL's recurrent hypothyroidism due to non-compliance with thyroxine, probable hypothyroidism-induced dilated cardiomyopathy, antipsychotic therapy, elevated body mass index, marijuana use and possible sleep apnoea were all contributing factors to prolongation of the QT interval.

10. Was NL's cardiac status managed appropriately managed from October 2018 to April 2019?

10.1 Associate Professor Adams expressed the view that the management of NL's cardiac state during his admission was reasonable, noting that NL had a normal echocardiogram, there were no real signs of cardiac disease that would have been of concern, and that NL's QT interval appeared to improve rapidly after thyroid hormone therapy was instituted. Overall, Associate Professor Adams opined that there were no cardiac signs that would have suggested further testing or screening during the course of NL's admission.

10.2 **Conclusions:** The expert evidence established that NL's cardiac status was appropriately managed in the period between October 2018 and April 2019. The investigations that were performed did not reveal any concerning issues or provide any indication for further investigations or escalation of care.

11. Were appropriate steps taken in response to NL's TFT results of 5 April 2019?

11.1 One issue of central focus regarding during the inquest regarding NL's endocrine management concerned the pathology results returned on 5 April 2019 which had been ordered the previous day. They are important for two reasons. First, no thyroid function testing was performed between 12 February 2019 and 4 April 2019. This is likely because advice received from the Endocrinology team was that NL's TSH levels could take six to eight weeks to reflect regulatory changes. Second, the 5 April 2019 pathology results represented the last measurement of NL's TSH and TF levels prior to his death, and which suggested that he had not been taking his thyroxine.

Endorsement of the 5 April 2019 pathology results

11.2 In his statement of 24 April 2023, Dr Cox stated the following regarding the 5 April 2019 pathology results:

> On 5 April 2019 NL's thyroid function tests were returned and that I 'endorsed' those results that day. What ordinarily happens is that when results are available for investigations ordered by a particular clinician, a notification is received to indicate they are available. You would then have to click a button to confirm receipt of those results. I do not now have a recollection of receiving NL's 5 April 2019 thyroid function test results or whether I spoke to anybody about these results.

11.3 Dr Cox's statement raised immediate questions regarding what endorsement of the test results actually means, and whether any steps in NL's management ought to have been taken upon receipt of the results. Dr Cox was invited to address both of these issues during the course of his evidence. As to the issue of endorsement, Dr Cox gave this evidence:

> So, with taking bloods, they're typically ordered in the afternoon and then placed in a, sort of, collection tray. The blood nurse would come around in the morning, get all the bloods and record them, then usually - so, the next morning, I would then see the results in an inbox on the electronic medical record system. We would then go through those records and endorse it. To endorse it, you'd have to scroll to the bottom to sight all the blood results. In reflection, what I think has happened was that I would've ordered a lot of bloods, which I typically do for blood count and other metabolic bloods and then something like TSH might be typically is towards the bottom, so I think I may have scrolled down, sighted everything else, not noticed those particular bloods and then clicked "endorse" before checking the next patient and the next patient's bloods.

11.4 NL's medical records indicate that in addition to ordering the TFT on 4 April 2019, Dr Cox also ordered a liver function test, full blood count, electrolytes, urea and creatinine. Dr Cox gave evidence that the intention of the system of endorsing pathology results is to ensure that clinicians are reviewing results of tests that they have ordered but there is "*no pressure to do so*". To illustrate this point, Dr Cox gave evidence that if a clinician did not endorse any results upon receipt, they would have "*an inbox filled with various bloods waiting for endorsement*".

11.5 Dr Buten gave evidence that she had no recollection of making any specific enquiry regarding the 5 April 2019 pathology results, and provided the following explanation:

> I know that was a week just before my own leave, which, you know, looking back and generally is a very chaotic time where, you know, you're trying to do as many things as possible. I know there were a lot of other things involved with NL's case that may be - if I can put it, distracted me from such an obvious thing like all the complex psychosocial things, looking at him transitioning out of hospital, increasing the leave, getting the additional supports he needed. Even the complexity of how we would monitor him I remember just took a lot of, a lot of effort and a lot of thought, you know, involving the clinical director in the potential community treatment order and so for that reason, I don't remember specifically checking it.

11.6 Dr Buten accepted that as the consultant under whose care NL was admitted, she had a responsibility to follow-up, or at least enquire about, whether a TFT had been repeated for NL on 4 April 2019 as planned and if so, what the results were. However, Dr Buten sought to explain that this would have occurred in "*an ideal world*", appearing to suggest that, in practical day-to-day terms, as a consultant she had limited time on the ward, was looking after multiple patients, and that NL's case was very complex with the focus of the treating team spread across a number of issues.

11.7 **Conclusions:** Neither Dr Cox nor Dr Buten conducted any follow-up or enquiry to determine whether the repeat TFT which was expected to be performed on 4 April 2019 had actually occurred. Dr Cox and Dr Buten also did not appropriately review NL's TFT results that were available on 5 April 2019. Indeed, the evidence establishes that the test results were simply endorsed by Dr Cox as a matter of course amidst a range of other test results that were available on the same day.

Review of the 5 April 2019 pathology results at a multidisciplinary team meeting

11.8 Separate to the issue of endorsement of the TFT results, a MDT meeting was, relevantly, held on 8 April 2019. Dr Cox gave evidence that as at April 2019 a patient's blood test results would typically be discussed at an MDT meeting. However, during his evidence Dr Cox was unable to provide any explanation as to why no such discussion took place regarding NL's TFT results, particularly when it had been noted during previous MDT meetings that NL's blood tests were to be repeated on 4 April 2019. The detail of these notes are set out below.

11.9 In a progress note entry made by Dr Cox on 14 February 2019 part of the plan recorded was to:

> Liaise with endocrine re meds; for repeat bloods.

11.10 Similarly, the MDT notes made on 22 February 2019 recorded this as part of the plan for NL:

> Chase repeat bloods, then to discuss with [endocrinology].

11.11 The MDT notes for 4 March 2019 records the following as part of the plan for NL:

> <u>Suggested:</u>
> - GP to repeat TFTs in 4 weeks (4/04/2019)
> - If thyroxine change is required at this point to repeat TFTs 6-8 weeks following
> - If no changes required, to repeat TFTs every three months for a year, then every six months following. [original emphasis]

11.12 This entry was repeated identically as part of the plan for NL in the notes for each MDT meeting subsequently conducted on 11 March 2019, 19 March 2019, 21 March 2019, 25 March 2019 and 1 April 2019. Indeed, the entry was also repeated identically in the MDT meeting notes for 8 April 2019 which obviously occurred after the TFT was repeated on 4 April 2019. It is therefore evident that the entry first made in the MDT meeting notes for 4 March 2019 regarding the repeat of NL's TFT on 4 April 2019 was copied and pasted into the notes for subsequent MDT meetings.

11.13 Dr Cox agreed in evidence that at the MDT meeting on 8 April 2019, he would have had the notes from previous MDT meetings opened which referred to the need to repeat NL's TFT on 4 April 2019. Dr Cox gave evidence that these notes "*should've triggered [his] memory*" to raise the 5 April 2019 TFT results for discussion. Notwithstanding, it is evident that no such discussion occurred.

11.14 During his evidence, Dr Cox expressed some views about factors which may have contributed to why it was not recognised at the 8 April 2019 MDT meeting that the TFT results from four days earlier were available. First, Dr Cox explained that during the course of a MDT meeting he, as the registrar scribing notes of the meeting, was the only participant looking at the notes on the screen in front of him. In this regard, Dr Cox considered that it is "*probably more beneficial to be having [sic] a set on [sic] paper list that every member of the MDT could look at and go through*". Second, Dr Cox considered that use of a template during MDT meetings might be of assistance:

> There could be a bit more of a template to follow with MDTs regarding, you know, looking at medications and looking at pathology results and other investigations, x-rays. I think that might help ensure things don't - there is no oversight of issues like this.

11.15 Dr Buten gave evidence consistent with Dr Cox that the medical officer (usually a registrar) taking notes of the MDT would be the only participant able to read the notes in real time. Dr Buten contrasted this situation with her experience in the MHICU where all MDT participants have access to relevant records as plans are being discussed for a patient.

11.16 Dr Buten also gave evidence that, as a general matter, she had no recollection whether during a MDT meeting which she attended there would be any discussion about a plan formulated at a previous MDT meeting. Dr Buten gave evidence that this was due to the "*limited time allocated*" to MDT meetings, which would often run longer than an hour, and because the meetings were "*a little bit too complicated*" with "*too much information*" and "*too ambitious*" having regard to the resources available.

11.17 In NL's specific case, Dr Buten gave evidence that one additional contributing factor may have been that NL was a long-term patient (he had been admitted for more than six months). Dr Buten also explained that the possibility of performing a ward round with NL or bringing him into the MDT meeting could have "*potentially been overlooked*".

11.18 **Conclusions:** It was not recognised at the MDT Meeting on 8 April 2019 that NL's TFT results were available four days earlier. This is despite Dr Cox having available to him the notes from previous MDT meetings which identified that a repeat thyroid function test was to be performed on 4 April 2019. Dr Cox acknowledged that having visibility of such notes ought to have allowed him to recognise that the test results were available. One physical limitation present at the 8 April 2019 MDT

Meeting was that Dr Cox was the only participant who had visibility of these notes meaning that all the meeting participants were not working off a common electronic or paper document.

What steps in NL's management ought to have been taken in response to the 5 April 2019 pathology results?

11.19 The issue of what would, or ought to, have occurred once NL's TFT results became available on 5 April 2019 was explored with several witnesses. Dr Cox gave evidence that if he had viewed the abnormal TFT results on 5 April 2019, he would have contacted Dr Buten, and that if she were unavailable he would have probably called the endocrinology team and reviewed NL to identify any clinical indications or concerns. In addition, Dr Cox said that he would also speak to nursing staff and formulate a plan to administer thyroxine in a different way.

11.20 Dr Sue Mei Lau, staff specialist endocrinologist and (then) Acting Director of the Department of Diabetes and Endocrinology, gave evidence that if she had been notified of the 5 April 2019 TFT results she would have expected the following to occur:

> I think that he would have gotten an ECG, had some observations, which he may have been having regularly anyway. We would - at that stage, we may have had an MDT, yeah, or some sort of more formal discussion I think with endocrinology and depending on his - it's very hard to say because we'd have to really look at how he was clinically, but there may have been the option of bringing him back, you know, to a more acute setting if he was unwell. If he wasn't, there would have to be some more - perhaps more coercive plans as to how to administer that thyroxine in a more immediate fashion or different preparation, like, a T3 preparation, which is not good long-term but, you know, just to bring, bring levels up quickly.

11.21 Dr Lau also gave evidence that the frequency of thyroid function monitoring was related to NL's level of medical acuity (which at that stage was not higher), the trajectory of his tests (which appeared to show that he was "*getting into a rhythm with his thyroid hormone replacement*"), and his discharge planning. Dr Lau gave evidence that if the endocrinology team had known that there was a concern about worsening thyroxine compliance by NL in the context of his most recent test results (from February 2019) it would have been prudent to perform another TFT at a shorter frequency, most likely "*within a week or so*". However, if there were no particular concerns, then Dr Lau considered a four week interval to be reasonable.

11.22 Professor Carter expressed this view about what he would have recommended for NL's management if the 5 April 2019 TFT results had been reported to him:

> Well, it would be to increase the amount of thyroxine that's being ingested to relatively slowly but progressively reduce the TSH to normal. You wouldn't want to do it, you can't do it overnight, but you wouldn't want to do it overnight because that would stimulate the heart and increase the chances of arrhythmias.
> […]
> [C]ertainly somebody who's hypothyroid, and you're rendering them euthyroid trying to get their thyroid hormone levels normal, you'd need to keep an eye on the cardiac situation the heart and then most other things that are associated with hypothyroidism aren't life-threatening but these should all be recorded and reviewed as the treatment progresses.

11.23 In addition, Dr Cox also gave evidence as to the following changes that he has made in his practice as a result of his involvement in NL's care:

> So, before endorsing, I do make sure that I pay particular attention to everything, even stuff will that may be towards the end. I also have a practice now of reviewing bloods at the end of each day. Going through all the different patients in the list and looking at bloods and then using that to not only see if any results are back that there may be concerns about, but also thinking what bloods need to be ordered for the next day and whether it's something like thyroid or lithium that needs - that you might want to check again or if other bloods were slightly elevated or outside of normal ranges to repeat them and then the following clinical day - because blood results don't tend to get back until around some time during the midday - reviewing bloods again the next afternoon and keeping that practice going throughout the week

11.24 **Conclusions:** If appropriate review had been undertaken of NL's TFT results of 5 April 2019 it is most likely that advice regarding his management would have been sought from both Dr Buten (if she had not reviewed the results herself) and the endocrinology team. Depending on NL's clinical state, this would have presented several management options including discussion between the psychiatry and endocrinology teams, formal MDT discussion, transferring NL to a more acute care setting, and considering alternative, possibly coercive, measures for his thyroxine to be administered.

Applicable policy and procedure material

11.25 The NSW Health Policy Directive, *Health Care Records – Documentation and Management* (PD2012_069), which was in force as at April 2019, provides:

> The health care record must document pathology, radiology and other tests ordered, the indication and the result.
> […]
> Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner / approved clinician, with endorsement involving the name, signature, designation of the medical practitioner / approved clinician, and date / time.
> […]
> **Critical/unexpected/abnormal results** should be documented in the patient / client's health care record by the responsible medical practitioner / approved clinician as soon as practicable and any resultant change in care / treatment plans documented. [original emphasis]

11.26 These provisions are repeated in the SESLHD *Documentation in the Health Care Record* (SESLHDPR/326), published March 2019. In addition, it also provides that professional groups should audit entries for their disciplines (such as medical, nursing, allied health), with a minimum of 60 records to be audited annually per ward or medical speciality/stream. Mr Christopher Hay, General Manager of the Mental Health Service at SESLHD, gave evidence that the audit results "*are submitted to the local site Clinical Governance Committee for review and address of any issues of non-compliance or any issues that need to be escalated*". Mr Hay agreed that one area included in such audits is unexpected or abnormal results from pathology testing.

11.27 As at April 2019, medical officers could access and endorse pathology results in three different ways:

(a) From the Inbox Summary in Message Centre;

(b) Via the Endorse Results button on the Toolbar; and

(c) From the Flowsheet.

11.28 When endorsing pathology results from the Inbox Summary or the Endorse Results button, a medical officer is presented with a screen with checkboxes next to each result presented. By default, the boxes are checked. The medical officer is then able to uncheck any box for a result that they do not want to endorse. Conversely, when endorsing pathology results from the Flowsheet, a medical officer is required to follow a two-step process of individually selecting results to be endorsed, and then endorsing the results.

11.29 SESLHD only captures whether a pathology result is endorsed or not, and which medical officer endorse the result. Therefore, it is not possible to determine which of the three methods that Dr Cox used on 5 April 2019 to endorse NL's pathology results.

11.30 The SESLHD Electronic Medical Record (**eMR**) Reference Guide, *Messaging Centre and Endorsing Results*, relevantly provides the following:

> The Results section of the practitioner's in box contains normal and abnormal results awaiting endorsement.
>
> […]
>
> If you are happy to endorse these results, click either OK, or OK and Next. Click Next to bypass these results at this time. Endorsed results will be removed from Message Centre.
>
> All test results that you ordered will display in the Message Centre until you have endorsed them. By clicking the endorse action on these results, you are entering your electronic signature for all results listed. Your action will be saved in the history of the result as you having reviewed each result.
>
> If reviewing results through Flowsheet, each result is to be reviewed. If any are questionable or require more information, click Cancel to return to the Flowsheet where you can drill down to view details on a particular result.

11.31 In November 2020, the functionality to endorse results through Flowsheet was removed. Mr Hay gave evidence that he did not know why this had occurred. Mr Hay also gave evidence that it would be his clinical preference for the checkboxes in the Inbox Summary or via the Endorse Results button to be unchecked by default. This would require a medical officer to manually check the box for each pathology result to be endorsed. However, Mr Hay gave evidence that he did not have the "*in-depth technical knowledge of the purpose and function of [the] checkboxes*".

11.32 The possibility of making changes within the eMR platform so that the checkboxes are not checked by default was explored with Mr Hay. He gave evidence that "*there is a process"* for such changes to be made and that "*a lot of the changes that we do propose take a while to go through so that the [S]tate can afford it within the [e]MR process*".

11.33 **Conclusions:** Dr Cox's electronic endorsement of NL's TFT results of 5 April 2019 did not comply with NSW Health and SESLHD policies and procedures that were applicable at the time. Dr Cox was required to document and review the test results and note any action required. Further, as NL's test results were abnormal, any resultant change in NL's treatment plan was also required to be documented. None of these requirements were complied with.

11.34 The available electronic records do not definitively identify how the test results were endorsed by Dr Cox. However, it is most likely that the test results were presented electronically to Dr Cox with an endorsement box already checked. Other test results for NL were presented in an identical manner. It is therefore most likely that the manner in which the results were presented did not require Dr Cox to review and manually check each result prior to endorsement. Having regard to these matters, and removal of the functionality to endorse through Flowsheet, which presented test results in a converse manner, it is necessary to make the following recommendation. It was submitted on behalf of the SESLHD that there is agreement with the recommendation.

11.35 **Recommendation 1:** I recommend to the Chief Executive, South Eastern Sydney Local Health District, that a request be escalated to the relevant State entity for changes to be made to the eMR to ensure that any test results for a patient are not checked as endorsed by default, and that instead there is functionality requiring a clinician to manually endorse such test results.

Consideration given by South Eastern Sydney Local Health District

11.36 Mr Hay gave evidence that he was surprised about Dr Cox's evidence that there was "*no pressure*" to endorse pathology test results and that it was possible to have an inbox filled with various tests awaiting endorsement. Mr Hay was asked about the process at SESLHD in relation to instructing medical practitioners regarding endorsing results for pathology tests they have ordered:

> It would be between the supervisor and the trainee and would also be part of the multidisciplinary team process to go through that, particularly around test results when it came to physical health but also with regards to medical and psychiatric issues.

11.37 Mr Hay went on to give evidence that it would be his expectation that when endorsing pathology results, individual medical practitioners should:

> [...] abide by what they're trained in and that they actually - what they're regulated to do - and ensure that they actually include that in their clinical processes.

11.38 In the event of any abnormal pathology results, Mr Hay also gave evidence that it would be his expectation that individual medical practitioners should:

> […] escalate that and seek support from their supervisor in escalating that.

11.39 Finally, Mr Hay gave evidence that when documenting any such escalation, it would be his expectation that there should:

> […] be some documentation of receipt and escalation of that concerns that they would have from a clinical, that the patient is medically deteriorating or that there are signs of this possible deterioration. That that should be documented and there should be a plan to, to clearly articulate what the process and steps are to address that issue.

11.40 In May 2019, the SESLHD published the *Clinical Review In Mental Health* Procedure (SESLHDPR/642) (**Clinical Review Procedure**). It provides that inpatient services will conduct regular MDT clinical review meetings to discuss the clinical plan for consumers in the units, and that clinical review occurs at least weekly in acute units and no less than fortnightly in subacute and non-acute units. From a practical standpoint, one of the minimum requirements for clinical review venue is accessibility to eMR and connected to a data projector or large LCD screen, plus video conferencing facility.

11.41 Mr Hay gave evidence agreeing with the functional limitations at MDT meetings described by Dr Cox and Dr Buten, acknowledging that "*it's not satisfactory at this point in time and to meet this requirement we need to do some work*". To that extent, Mr Hay gave further evidence that as at December 2023, there was one room available to be used for MDT meetings that would allow all participants to see a patient's record. However, as this room is shared it is not always available for MDT meetings. However, Mr Hay gave evidence that a purchase order had been approved for the delivery of additional equipment (screens) that would be functional by early 2024.

11.42 Section 4.3 of the Clinical Review Procedure sets out the roles and responsibilities of core participants in the clinical review meeting. Specifically, it provides that the attending medical officer is responsible for the final formulation of the clinical plan, and ensuring all elements of the plan are complete and documented. In addition, the attending medical officer is required to sign off and endorse the completed Clinical Review and Care Plan PowerNotes.

11.43 **Conclusions:** Since April 2019, the SESLHD has made a number of improvements to the clinical review process for mental health inpatients. First, minimum physical functionality requirements for MDT Meetings have been established to ensure that all participants have access to a patient's records and notes of the meeting in progress. Second, clear timeframes have been established for the conduct of clinical reviews. Third, the roles and responsibilities of MDT Meeting participants have also been clearly established to ensure that indicated management plans for patients are formulated and followed.

Application of the Health Practitioner Regulation National Law (NSW)

11.44 Section 151A of the Health Practitioner Regulation National Law (NSW) (**National Law**) National Law is found within Subdivision 8 of Division 3 (which deals with complaints) of Part 8 (which deals with health, performance and conduct). It provides:

> **151A Referral of matters by courts [NSW]**
>
> (1) A court in this jurisdiction before which a person is convicted of an offence, or is made the subject of a criminal finding for a sex or violence offence or a drug related offence, must cause notice of the conviction or criminal finding, and of any penalty imposed on the person, to be given to the Executive Officer of a Council for a health profession if the court has reasonable grounds to believe that the person is or was, at the time the offence was committed, registered in the health profession.
>
> (2) If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession.
>
> (3) If a notice or a transcript of evidence is given to the Executive Officer under this section—
> (a) a complaint is taken to have been made to a Council about the person to whom the notice or transcript relates; and
> (b) the Executive Officer must give written notice of the notice or transcript of evidence to the National Board for the health profession in which the person is or was registered.
>
> (4) The coroner is not the complainant in relation to a complaint taken to have been made under subsection (3) and sections 144D(1), 144E and 144F do not apply to the complaint.

11.45 On 23 August 2023 it was indicated to Counsel for Dr Cox that the evidence given by Dr Cox on 22 August 2023 raised for consideration whether section 151A of the National Law was enlivened. Counsel Assisting and Counsel for Dr Cox have both provided helpful submissions regarding this issue.

11.46 However, it seems that the timing of when this issue was first raised with Counsel for Dr Cox is an important consideration. It obviously occurred after Dr Cox had given evidence and after the list of issues which the inquest proposed to examine had already been distributed to the parties. Relevantly, as has been noted above, the list of issues did not expressly identify the operation, or potential operation, of section 151A of the National Law as a discrete issue for the inquest to examine.

11.47 Had this occurred then Dr Cox may have sought the protection afforded by section 61 of the Act or sought that additional evidence, including expert evidence be included in the brief of evidence to be tendered at inquest. Such additional evidence, if adduced, may have been relevant to the threshold reasonable grounds question posed by section 151A. Importantly, this inquest commenced prior to findings being delivered in the *Inquest into the death of Adam Fitzpatrick* [2023] NSWCorC 80 (31 October 2023), in which the operation of section 151A was considered in detail.

11.48 **Conclusions:** The timing of when the potential operation of section 151A of the National Law was first raised with Counsel for Dr Cox was largely influenced by Dr Cox's evidence a day earlier. Dr Cox has also been afforded an opportunity to, through his Counsel, advance submissions regarding the application of section 151A. However, it seems that there may be a risk that it would be procedurally unfair to Dr Cox to determine the potential operation of section 151A without Dr Cox having the opportunity to consider, and possibly follow, at least either of the two courses described above. In the circumstances particular to this inquest, it is not proposed to make any determination regarding the potential operation of section 151A of the National Law.

12. Copying and pasting within a patient's medical records

12.1 As set out above, the MDT meeting records for NL disclosed multiple instances where sections of the management plan were copied from an initial record entry and pasted verbatim in subsequent record entries. The evidence also disclosed other instance where such copying and pasting occurred.

12.2 During a MDT meeting on 18 February 2019, under the heading "*Current issues and plan going forward*", Dr Cox recorded this entry:

> taking thyroxine, worsening compliance again noted

12.3 The same entry was recorded for the MDT meeting notes on 4 March 2019, 11 March 2019, 19 March 2019, 25 March 2019, 1 April 2019, 8 April 2019. When asked what the practice was in April 2019 and whether the section headed "Current issues and plan going forward" would be updated at each MDT meeting, Dr Cox gave this evidence:

> Typically. So, my usual practice at that time would be copying the previous MDT and then updating things as appropriate.

12.4 Dr Cox accepted in evidence that despite this, the MDT meeting records did not reflect any updating of the current issues and management plan for NL. Dr Cox later gave this evidence about his practice:

> I think the fact that it's repeated shows that I was copy pasting that phrase or that section and not - and it's not a true reflection of things worsening. That's a failing on my end, I should've not say [sic] "worsening" each week, it should've just been, "Concerns with thyroid adherence", or, "Medication adherence".

12.5 Dr Lau recognised the difficulties associated with such a practice when asked whether the reference to "*worsening compliance*" suggested that a more timely repeat of NL's TFT would be warranted. She gave this evidence:

> I'd really have to look at the other MDT notes as well. I know that with MDT notes, a lot of things are cut and pasted and so when it says, "Worsening", does this mean within the last month or two or three or since discharge from ICU?

12.6 Dr Bert similarly recognised the difficulties in this way:

> As to the best of our knowledge as well, we would try and make sure he was compliant and though some of the notes are a little bit, you know, unclear, especially with the copy pasting, you know, as to the compliance, non-compliance and there is some incongruency in that, but, you know, as far as I understood, yeah, we did to the best of our ability try liaise […]

Applicable policy and procedure material

12.7 The SESLHD Procedure, *eMR – Copy and Pasting within Electronic Documentation* (SESLHDPR/605) (**Copy and Pasting Procedure**), which was in force in April 2019, set out the responsibilities of clinicians in maintaining records and, in particular, clinical information systems:

> **Clinicians are responsible for:**
>
> - As a general principle, avoiding or not copying and pasting information within clinical information systems, including ensuring the correct patient and encounter.
> - As the author of a clinical document, the clinician is the person responsible for ensuring all information is accurate and appropriate
> - When a clinician feels it is necessary to copy and paste clinical information, they should do so with caution understanding potential risks, how to identify them if they occur and how to correct them. [original emphasis]

12.8 In addition, the Copy and Pasting Procedure also provides:

> **Avoid use of Copy and Paste functionality where possible**
>
> Copy and pasting can produce unintended consequences and risks. Clinicians or anyone using copy and paste in clinical information systems should be aware of such risks. These include:
>
> - Information from one patient being copied and pasted into another patient record
> - Inaccurate, or non-current, information being pasted
> - Information pasted is not relevant to the current visit
> - Sensitive information is pasted into new documents inappropriately
> - Information copied is not identified as copied text and original author may not be referenced
> - Inappropriate information is sent on external correspondence
> - Medico-legal issues associated with above. [original emphasis]

12.9 On 17 February 2020, the Clinical Director of the Eastern Suburbs Mental Health Service sent a memorandum to all clinical staff in these terms:

> **Purpose**
>
> To ensure that all consumers who are admitted to the [Eastern Suburbs Mental Health Service] who have any tests such as pathology, imaging or ECGs have their results review [sic] by an appropriate Medical Officer within a reasonable timeframe and documented. Copying and pasting of information is discouraged where possible to ensure that a consumer's record is current and accurately reflects their current health and well-being. [original emphasis]

12.10 Anglela Karooz, the former SESLHD General Manager of Mental Health stated that on 15 September 2020, a random audit was conducted of eMR files across three SESLHD mental health service sites which found no evidence of copying and pasting without clinician amendment. Further, Ms Karooz noted that the eMR mental health training for all new staff now includes specific mention of the risks associated with copying and pasting in eMR , and details that staff should "*NEVER*" copy and paste.

12.11 Ms Karooz also stated that SESLHD Mental Health Service has raised the copying and pasting functionality in eMR "*as a State-wide risk issue*" at the Health Records Committee, a combined

committee for SESLHD and Illawarra Shoalhaven Local Health District. Ms Karooz noted that in a future eMR upgrade there will be functionality changes to the system that will enable identification of copying and pasting incidents. However, it was noted that no written confirmation or timeline for this information had been detailed as at January 2021.

12.12 Mr Hay gave evidence that as at December 2023, there was still no update in the eMR to reduce capacity of copying and pasting, and that it was not an issue that was before any committee for consideration. Mr Hay indicated that whilst the SESLHD could continue to lobby the State to change the build in relation to a range of different eMR functions, the consistent feedback received by the SESLHD is that it "*has not been on the top of the priority list of the build change*".

12.13 In addition, Ms Karooz stated in January 2021 that a request had been made for the Copy and Pasting Procedure to be updated to "*include a warning, at the beginning of the procedure, of the dangers associated with copy and pasting information in eMR*".

12.14 Mr Hay gave evidence that as at December 2023 there was no progress with this issue and that it is not under active consideration. Mr Hay explained further:

> I think the difficulty from my, and I expect from SESLHD's perspective, is that there is consistent feedback that the build to change this is not on the agenda, and therefore we have to, rather than change the build, we need to continue to inform staff as we have done in regard to providing warnings around copying and pasting, as we have done in our policy documents subsequent to that.

12.15 **Conclusions:** Between February 2019 and April 2019, certain portions of the MDT Meeting notes regarding NL were copied and pasted verbatim into subsequent MDT Meeting notes. This was done without amendment based on clinical information available, and NL's clinical presentation, at the time of each MDT Meeting. This had the effect of transposing clinical information that was inaccurate and not current, obscuring the availability of NL's pathology results, and preventing a proper interpretation of NL's clinical course in order to inform his management. These instances of copying and pasting were all contrary to the SESLHD procedure applicable at the time which sought to mitigate against a number of risks, some of which were realised in NL's case.

12.16 Given this realisation, the importance of the Copy and Pasting Procedure containing a warning of the kind described by Ms Karooz carries great significance. It is therefore necessary to make the following recommendation. It was submitted on behalf of the SESLHD that there is agreement with the recommendation.

12.17 **Recommendation 2:** I recommend to the Chief Executive, South Eastern Sydney Local Health District, that previous requests for the *eMR – Copy and Pasting within Electronic Documentation* (SESLHDPR/605) to be amended to include a warning of the dangers associated with copying and pasting information in the eMR be followed up until such amendments have been effected.

13. Were appropriate steps taken to ensure NL ingested his prescribed thyroxine?

13.1 Due to NL's history of non-compliance with his thyroxine, his treating team employed different strategies in an attempt to ensure that it was taken.

Concealment

13.2 The medical records indicate that on 24 October 2018 there was a discussion between NL's treating team and his son regarding the concealment of medication. This was proposed in accordance with orders made by the Guardianship Division of the NCAT in granting coercive powers. It was agreed between the team and NL's son that thyroxine, but not antipsychotic medication, could be concealed in NL's food. The records also show two instances of concealment on 1 December 2018 and 4 December 2018.

13.3 There is no evidence that such concealment occurred in 2019. EN Joanne Townsend worked in the Kiloh Centre in April 2019 and cared for NL. She gave evidence that she had no recollection of any discussion regarding concealing NL's thyroxine because of non-compliance and explained:

> We give medications to patients and they know what they're putting in their body.

13.4 EN Townsend also gave evidence that on occasions she administered thyroxine to NL and ensured that he swallowed it with some water. She said that ensuring compliance was "*a bit easier*" because the thyroxine tablets were "*tiny*", and that she could not recall ever having difficulties ensuring that he swallowed his medication. In contrast, Professor Carter gave evidence that the very small size of the thyroxine tablets made it easier for a patient to pretend to swallow it and instead keep it inside their mouth.

13.5 Professor Carter gave evidence that NL's blood test results from January and February 2019 provided objective data which indicated that NL was taking his thyroxine medication. Further, Professor Carter gave evidence that as this period was only three weeks after his thyroxine dose was increased to 300 mcg, he would expect that NL's blood test results would continue to improve by 28 February 2019.

Withholding of leave

13.6 Although NL's gate leave was conditional on his compliance with taking his medications, there is no evidence that this entitlement was revoked due to non-compliance. Whilst Dr Cox gave evidence that part of the plan for NL was that leave would be cancelled if there was non-compliance with his thyroxine medication, Dr Cox gave evidence that he had no recollection of advising that NL's leave should be withheld as a response to being told that he had not been compliant with his thyroxine medication.

13.7 For example, at an MDT meeting on 11 March 2019, it was determined that NL could have up to 4 hours unescorted leave per day subject to compliance with his medication. Dr Cox described the issue in this way:

> There's an ongoing balance, I guess, with balancing autonomy and freedom and coercive powers. I would be speculating, but I'm sure there would be an attempt to try to work with any patient and try to build a therapeutic relationship whereas if leave was halted altogether, that may have resulted in things becoming more difficult and unpleasant for NL as well.

13.8 Dr Buten was also asked whether NL's leave would have been cancelled in the event of non-compliance, and gave this evidence:

> I do believe there would have been implications, so, yes, either leave - we would've, we would've discussed it as an MDT, we would've potentially, you know, sought additional advice, like as I did previously from the clinical director to come up with if needed a more restrictive approach to get him to take it. It was a balance of the risks and the benefit.

Consideration given by the endocrinology team

13.9 Professor Carter emphasised that it is difficult to optimise thyroid hormone replacement therapy for patients like NL who are extremely non-compliant with thyroxine medication associated with psychotic illness. Notwithstanding, Professor Carter considered that, overall, the endocrinology team's management of NL was reasonable, whilst noting that at no stage did NL's TSH levels return to normal despite the prescription of increased doses of thyroxine tablets.

13.10 In this context, Professor Carter considered that a different form of treatment could have been trialled in an attempt to normalise NL's TSH and other thyroid hormone levels. Professor Carter considered this could have been achieved by changing NL's dosing regimen so that larger doses of thyroxine were given twice per week, rather than giving smaller doses more frequently. However, Professor Carter noted that there is no guarantee that this would have altered the eventual outcome for NL.

13.11 Dr Lau was asked whether, given NL's history of non-compliance, any consideration was given to reducing the frequency of his medication but at a higher dose. Dr Lau gave evidence that this was "*not an uncommon scenario with certain groups of patients*" and that had been discussed at departmental case meetings. Dr Lau explained the outcome of those discussions in this way:

> I think that twice a week dosing is good for people who are willing to take it and just need to be watched or need to be reminded. However, for NL, I don't think it was always clear as to when he was able to take the tablets or not. There was a mention in one of the entries of perhaps sequestering the tablets in his gums. I understand that there - from the notes anyway, that measures had to be sometimes taken to hide the thyroxine in his food or his, his soda water. So, it's difficult to predict just exactly when he's going to have the dose. So, in our opinion, it would be better to have multiple chances per week of a dose, which is already more than, you know, more than what he would normally require if he was taking it regularly to give him as many chances as possible to take his thyroxine, rather than one or two times a week. If he had missed those doses, that means that's it. No thyroxine for the week. So, we figured that this was the safest way or safer way, yeah.

13.12 Dr Lau was also asked about the possibility of concealing medication in order to increase the chance of ingestion. Dr Lau gave evidence that it was her understanding that concealment had been

employed, and that if only two doses were administered per week at a higher dose, this would have made concealment more difficult (as 1000mcg of thyroxine tastes bitter).

13.13 In addition, Dr Lau explained that if for some reason NL did not take those doses, then there were only two opportunities during the week for him to receive thyroxine. Dr Lau gave evidence that the endocrinology team "*felt it would make more sense to have more frequent dosing of thyroxine*" and that "*this is a much safer way than having two opportunities per week*".

13.14 During his evidence, Professor Carter was asked about Dr Lau's reason and gave this evidence:

> [M]edical society doesn't have the resources for someone to come every day to just make sure somebody is taking a tablet, but if you can compromise - and this is a compromise - twice a week, you could try that. But I don't criticise the doctors. I'm pleased to hear that they considered it and discussed it, but that is a well-recognised way of handling this problem, because the half-life of thyroxine is seven days, which means that if somebody stops taking their thyroxine, it's going to take quite a long time for the thyroxine to get out of the system.
>
> Whereas if a drug had a half-life of 12 hours, within a couple of days, certainly three days, it's out of the system and there could be major medical problems, but much less so with a long half-life tablet like thyroxine. And that's why you can do it. You could do it twice a week because of the long half-life.

Alternative strategies

13.15 Dr Lau was also asked whether consideration was given to the utility of intramuscular injections if there was a risk that NL would not take his thyroxine medication (whether concealed or not). Dr Lau began by explaining that "*utility and availability are very different things*", and that availability needed to be balanced against how acute NL's thyroid under replacement issues were. Dr Lau also explained that NL's TFT results in the period leading up to April 2019 showed gradual improvement, that his TSH "*had come down quite a lot*" and he was "*stable and achieving good T3 levels*". In this context, Dr Lau gave evidence that "*to start someone on intramuscular thyroxine would be a very big call at that stage*".

13.16 Dr Lau gave evidence that whilst thyroxine can be given intramuscularly, it was not on the NSW Medicines Formulary and that she herself had no experience of giving thyroxine in this way to a patient. Dr Lau also gave evidence that whilst NL's TSH "*was not perfect*", it was "*realistically satisfactory for us and safe enough*". Therefore, at that level, Dr Lau explained:

> [W]e would not have considered the more extreme choice of trying to source out or apply even for permission in Australia to have intramuscular thyroxine, notwithstanding, you know, the very large cost and bear in mind that this is still - would still be a coercive process.

13.17 Professor Carter similarly gave evidence that whilst he himself had experience with intramuscular thyroxine for patients on two occasions in the 1970s, it is generally not available, and the use of intramuscular thyroxine is not a feasible option in Australia.

13.18 Mr Hay confirmed that there is no thyroxine injection registered on the Australian Register of Therapeutic Goods, and therefore it is unlikely that there would be any thyroxine injection on the formulary in any Local Health District. An application would need to be made to the Therapeutic Goods Administration to access an unapproved good. In addition, the cost of an intravenous preparation is significantly higher compared with oral options. For example a 200mcg ampoule is approximately almost 1000 times more than the cost of two 100mg tablets.

13.19 **Conclusions:** NL's treating team employed different strategies to overcome his history of non-compliance with his thyroxine medication. It appears that different clinical staff experienced different degrees of success. Concealment of thyroxine was used for a brief period of time. Whilst consideration was given to withholding leave entitlements for non-compliance it does not appear that this was ever enforced as the potential counter-therapeutic implications were appropriately recognised and evaluated. An alternative strategy in the form of intramuscular injection was not readily available or even feasible.

13.20 The long half-life of thyroxine raised the possibility of fewer increased doses of thyroxine rather than more frequent smaller doses. The endocrinology team considered this strategy and exercised appropriate clinical judgment in determining that fewer dosing opportunities may have compromised NL's patient safety.

13.21 Counsel Assisting submitted that there was a failure by the Kiloh Centre nursing staff to ensure that NL took his thyroxine. Professor Carter expressed the view that despite prescribing NL increased doses of thyroxine at no stage did his TSH levels return to normal during his admission. It was submitted that a recommendation therefore ought to be made to the SESLHD to provide refresher training to nursing staff in inpatient mental health units regarding the importance of ensuring that patients take their prescribed medication. Counsel for the SESLHD submitted against such a recommendation being made.

13.22 Whilst the evidence establishes that no normal level was ever achieved from NL's thyroid function tests, there is no clear evidence that this was due to a misunderstanding on the part of nursing staff involved in his care as to the importance of NL taking his thyroxine. Rather, the issue was due to challenges associated with the actual taking of the thyroxine in circumstances where its importance was recognised. As has been described above, alternative strategies to achieve thyroxine compliance were considered or not available. Therefore, it is neither necessary or desirable for a recommendation to be made.

14. Were the observations taken of NL on 19 and 20 April 2019 adequate?

14.1 RN Ben Woodruff was working the night shift in the General Ward of the Kiloh Centre on 19 April 2019. He commenced his shift at 9:00pm and was due to finish at 7:30am on 20 April 2019. RN Woodruff was allocated seven patients for his shift. Although NL was not one of his allocated patients, RN Woodruff was aware that NL was on Care Level 5 observations meaning that he was to be observed every two hours during the day. However, during a night shift Care Level 5 patients are observed every hour.

14.2 NL's room was located on the ground floor of the Kiloh Centre. It contained a window which opened onto a courtyard. The window opened approximately 50 centimetres. A metal insect screen was attached to the window frame.

14.3 RN Woodruff took observations of NL when his allocated nurse (RN Jie Liu) was on a break. These observations were taken at 10:00pm, 11:00pm, 12:00am, 4:00am, 5:00am and 6:00am. RN Woodruff gave evidence that each observation was performed by shining a torch at NL's face very briefly, and then using the torch to observe the movement of NL's chest. RN Woodruff gave evidence that he did this whilst standing at the door to NL's room for anywhere between 10 to 30 seconds. RN Woodruff also gave evidence that the window in NL's room was open and that he noted a breeze coming through as he opened the door.

14.4 RN Woodruff gave evidence that NL was wearing "*a large, woolly jumper that was quite - quite a large, loose fitting jumper*", and that he would not describe the wool fabric as being thick. RN Woodruff also gave evidence that when he initially observed NL between 10:00pm and 12:00am on 19 April 2019, NL was lying on his left hand side. However, during observations made between 4:00am and 6:00am on 20 April 2019, it was noted that NL had moved and was lying on his right hand side.

14.5 RN Woodruff made entries in NL's Observation Chart Level 5 at 4:00am and 5:00am on 20 April 2019. Both entries record the following: "*In bed, eyes closed, breathing noted*".

14.6 In a retrospective note completed at 11:57pm on 20 April 2019, RN Woodruff recorded the following:

> Upon first checks completed by RN Woodruff at 22:00 patient was observed lying in bed on left side , dressed in a thin jumper, trousers and pair of trainers , room smelt of urine as per handover indicating Patient had refused to shower after urinating on his trousers. Patient's window and curtains were open, Patient' s bed and Patient's head positioned under window. Weather was a wet, cold evening with a breeze coming through the Patient's bedroom when door was opened. Patient known to keep window open throughout the day and night at Patient's request to allow for ventilation. Upon all observational checks, movement of the chest area observed by all nursing staff who completed observation. Right arm noted to be down by Patient's right side during initial observations completed by RN Woodruff between 22:00 - 00:00. During observations between 04:00 - 06:00 completed by RN Woodruff, Patient's right arm now observed to be above Patient's head however eyes appeared closed when observed from Patient's doorway and movement of the Patient's jumper specifically the chest area was noted during these checks. Window

and curtains to bedroom remained open during these checks and although breeze noted to be coming through bedroom this did not raise an initial concern to further approach Patient and secure window.

14.7 Later during his evidence, RN Woodruff's attention was drawn to the fact that after NL was found unresponsive, lividity was observed in NL's left side. RN Woodruff conceded, in retrospect, that it would be inaccurate to describe NL as lying on his right hand side, as recorded in his retrospective notes. Instead, RN Woodruff gave evidence that NL was lying on his left side with his arm above his head. He also gave evidence that, in retrospect, it "*would appear to be the case*" that at certain points during his observations of NL he was not in fact breathing but that the jumper was being moved by the breeze through the window. When asked how likely it would be for a breeze to be able to move a woollen jumper so as to mimic the rise and fall of a person's chest, RN Woodruff gave this evidence:

> Considering the - the size of - of NL and the size of the jumper, with the conditions outside - again, the observations that were performed at the time was to - the - the practice was to observe movement of the chest, understanding that the observations do stipulate the respiration rate. It would be the noted movement of the chest that would be the focus of performing the observations at that time.

14.8 RN Woodruff gave evidence that he was confident that he undertook an observation of NL at 6:00am on 20 April 2019. When asked what he based this on, RN Woodruff gave evidence that it is not his practice to document an observation unless it has actually occurred. RN Woodruff also gave evidence that he could not recall whether he took NL's Observation Chart with him on each occasion that he took the observations. Alternatively, he gave evidence that when he returned to the nurse's station he would document the observations there.

14.9 In evidence, RN Woodruff was asked about each observation being recorded on the Observation Chart exactly on the hour. RN Woodruff gave evidence that it would be common practice to document observations on the hour "*with the expectation that it would run a minute either side, or up to five minutes either side of that particular time*".

14.10 RN Liu made a progress note entry at 5:53am on 20 April 2019 which recorded the following:

> Same presentation remain [sic].
> Nicholas was observed to be in bed asleep via most of the night routine checks.
> He current [sic] remain in bed resting with nil raise other concerns ator.

14.11 RN Liu gave evidence that as the RN allocated to NL this progress note entry represented her obligation to ensure that an entry was made for NL at the end of her shift. RN Liu also gave evidence that she did not think she undertook any actual observation of NL after 3:00am on 20 April 2019.

14.12 Dr Thea Morris was a senior intensive care registrar at POWH who attended as part of the emergency team on the morning of 20 April 2019. Dr Morris stated that on arrival to NL's room at 6:16am, the Kiloh staff advised that "*NL was last seen at 0500 hours*". Dr Morris also stated:

> As the attempted resuscitation continued and we gathered more information, it was apparent to me and the other medical officers attending the emergency that this situation was unlikely to result in return of spontaneous circulation. The factors that led us believe this were that this was an unwitnessed cardiac arrest and by the time of commencement of resuscitation, NL was already cool and stiff. Thus we felt he had likely been in cardiac arrest for an hour or more.

14.13 In evidence, Associate Professor Adams expressed the following opinion about the length of time that NL was likely to have been in cardiac arrest:

> [T]he fact that he is in asystole is consistent with [NL being deceased for a matter of hours rather than minutes] as well is that often - often the arrythmia that causes death, for instance, say, a ventricular fibrillation or ventricular tachycardia, won't stay like that for very long, will, in fact, degenerate into asystole as well. So, from a cardiac perspective, looking just at his cardiac rhythm, I'd say that he'd been in cardiac arrest for at least 15 or 20 minutes […]

14.14 A report from the Bureau of Meteorology established that the wind speed for Sydney during the evening of 19 April 2015 was between approximately 0km/hour to 12km/hour but was mostly between 5km/hour and 12km/hour.

14.15 **Conclusions:** It is most likely that NL was already in cardiac arrest by at least 6:00am, and possibly even earlier at 5:00am, on 20 April 2019 when the last two observations of him were documented. Associate Professor Adams and Dr Morris both expressed the view that the finding of NL in asystole and the evidence of rigor mortis and NL being cool to touch upon discovery suggests an extended period of cardiac arrest.

14.16 RN Woodruff's ready concession regarding the inaccuracy of his documenting on which side NL was lying in bed raises some doubt about whether any observations were performed at 5:00am or 6:00am on 20 April 2019. RN Liu's progress note entry at 5:53am was not based on any actual observation of NL performed after 3:00am but rather represented an entry made at the end of shift as the RN allocated to NL. The physical layout of NL's room, the meteorological evidence and RN Woodruff's evidence all establish the possibility of a breeze blowing through the window in NL's room on 20 April 2019. However, it is most likely that such a breeze (if present) could not have moved the jumper that NL was wearing so as to mimic the rise and fall of his chest. The weight of NL's jumper and RN Woodruff's unresponsive answer to the very question posed to him in evidence as to this likelihood supports this conclusion.

Applicable policy and procedure material

14.17 The NSW Health Policy Directive, *Engagement and Observation in Mental Health Inpatient Units* (PD2017_025) (**Observation Policy Directive**), provides that for Observation Levels 1 to 5:

> During all periods where a consumer is asleep, the nursing staff must be able to view the consumers respiratory rate, activity during sleep/night hours (eg. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.

14.18 The SESLHD Procedure, *Engagement and Observation in Mental Health Inpatient Units* (SESLHDPR/615) (**Observation Procedure**), similarly provides that part of the responsibilities of nurses is to:

> Not disturb patients sleeping at night but to view the patient's respiratory rate and effort of breathing, activity during sleep/night hours (eg. awake, asleep, laying on side, snoring etc) noting this in the medical record.
> Document observations contemporaneously in the medical record in line with the documentation requirements listed within the procedure.

14.19 Similarly, the NSW Health *Mental Health Nursing Observation Chart Level 5* includes a column titled:

> **Behaviour/Aspect/Remarks and MO Review and Outcome**
> (eg. PRN, incidents, engagement & activities undertaken and outcome of same, respiration rate and activity during sleep) [original emphasis]

14.20 Mr Hay gave evidence that as at April 2019, the Observation Policy Directive did not require nurses to count a patient breaths per minute and then record that in the Observation Chart. However, on 3 September 2020, a decision was made by the SESLHD Mental Health Service Document Development and Control Committee (**DDCC**) that a patient's respiration rate must be recorded overnight in all mental health units within the SESLHD. The Minutes from the relevant DDCC Meeting provide:

> Respiratory rates, observation of, and recording of
> Respiratory rates within SESLHDPR/615 Engagement and Observation in Mental Health Inpatient Units. It has been determined that overnight respiration rates are to be recorded as per the education provided which details that a respiration rate (number) must be recorded in the appropriate area of the Engagement and Observation form.
>
> Action
> SESLHDPR/615 requires update to clarify that the overnight Respiration Rate is to be recorded as a count/number as per the Engagement and Observation Policy education. Memo clarifying the count requirement to be sent from Clinical Nurse Manager.
> Memo to also detail audit required to confirm the process is being complied with.

14.21 On 7 September 2020, the SESLHD Clinical Nurse Manager sent a memo to Mental Health Service Directors, Clinical Operations Managers, and the Chair of the Mental Health Clinical Governance Committee requesting that the recipients ensure that the determination made at the 3 September 2020 DDCC Meeting, and the planned update to Observation Procedure, be implemented in all Mental Health Units during night shifts, to demonstrate appropriate implementation.

14.22 The Observation Procedure was, as at January 2021, being updated to specify that a patient's respirations must be counted/documented at the time of each observation. Further, education in relation to engagement and observation procedures is conducted within site-based education sessions, and is also part of the orientation process for new mental health staff members.

14.23 In 2020, 2021 and 2022, monthly audits were performed in relation to compliance with the Observation Policy Directive. The audits demonstrated 97%, 95% and 99% compliance respectively.

14.24 **Conclusions:** It is most likely that NL was not exhibiting signs of any actual respiration at 5:00am and 6:00am on 20 April 2019. It is also most likely that external environmental conditions did not depict any movement which could have been interpreted as respirations by NL. It therefore follows that sufficient observations, in accordance with the applicable Policy Directive and Procedure, were not performed to determine whether NL was exhibiting actual respirations and effort of breathing.

The experience of nurses at the Kiloh Centre

14.25 Mr Hay gave evidence that across SESLHD sites, clinical nurse educators are employed to provide in-service education program to nurses and allied health staff regarding engagement and observation procedures. Similar education is provided to casual and agency staff members prior to commencing their shift.

14.26 A number of nurses working at the Kiloh Centre were asked about the changes made to policy and procedure material described above:

(a) EN Townsend gave evidence that since April 2019, she is not aware of any changes being made to the manner in which observations made overnight are recorded, and that she had not undergone any further training in relation to observations of patients overnight.

(b) RN Pingping Li similarly gave evidence that she could not recall any changes to policies or procedures made since April 2019 regarding how observations of mental health patients are to be conducted. RN Li also gave evidence that she could not recall being provided with any additional training regarding the requirements of observations of mental health patients.

(c) RN Woodruff gave evidence that prior to commencing as a casual nurse in 2016 he was not provided with any specific training regarding the taking of observations of mental health patients. Rather, RN Woodruff gave evidence that it was "*more self-taught more often than not when it comes to specific policies and procedures*". RN Woodruff gave evidence that he could not recall seeing the Observation Procedure prior to 19 April 2019.

He also gave evidence that in around October 2020, he became aware of procedural amendments which required nurses to record a patient's actual respiratory rate, and that observation sheets had been amended to allow for the respirations to be recorded, and that window panels had been placed in patients' room doors to allow for a clear view of patients.

(d) RN Liu gave evidence that SESLHD did not provide her with any training regarding the undertaking of observations prior to her commencement as an agency nurse. Instead, this training was provided by external sources. She gave evidence that she could not recall receiving any instructions from SESLHD regarding the policies or procedures which required nurses to take observations of mental health patients. She also gave evidence that she was not aware of there being any change in staff practices regarding the recording of a patient's respiratory rate

on an observation chart between April 2019 and when she finished working at the Kiloh centre sometime in 2020.

14.27 RN Woodruff gave evidence that as at April 2019, it was not the responsibility of a nurse allocated to a patient to conduct every observation required of that patient during a shift. Instead, the allocated nurse (as determined by the Nurse-in-Charge) was responsible for making an entry in the eMR for a patient after reviewing the observation charts and discussing any concerns with the other nurses who performed those observations.

14.28 In evidence, RN Woodruff agreed with the description that during night shifts in April 2019, a team model of nursing was adopted so that observations of all patients would be shared by the nurses on duty. He gave evidence that as at August 2023, such a practice was still in effect during the night shifts at the Kiloh Centre. He confirmed that it was not the practice as at August 2023 for a nurse to be allocated a set number of patients, with the nurse being entirely responsible for managing the patients' care overnight, including the taking of observations.

14.29 However, Mr Hay gave evidence that it was his understanding and expectation that registered nurses are allocated to a patient on an electronic patient journey board, and that it is the nurse's responsibility to both perform and document any observations. Where an observation cannot be performed, it is the nurse's responsibility to delegate that task to another team member in conjunction with the nurse in charge during the particular shift.

14.30 **Conclusions:** Since April 2019, improvements have been made to the relevant procedure to strengthen the process by which observations are taken of mental health inpatients to ensure that the observations accurately reflect an inpatient's clinical state. The requirement for nurses to now count and document on an observation chart a patient's actual respirations provides reassurance of patient safety at the time of the observation.

14.31 The inquest identified conflicting evidence as to whether a team model of nursing existed during night shifts at the Kiloh Centre as at August 2023. RN Woodruff's evidence suggested that observations of patients are shared amongst the nurses on shift whilst Mr Hay's evidence suggested that it is a nurse's responsibility to perform and document observations for patients allocated to them, or delegate such responsibility to another nurse.

14.32 It was submitted by Counsel Assisting that a recommendation ought to be made to the SESLHD that it ensures that each inpatient has an allocated nurse who is responsible for the totality of that inpatient's care. In opposition, it was submitted by Counsel for the SESLHD that existing procedures within the Kiloh Centre and resourcing limitations mean that staffing numbers and patient-to-nurse ratios are fluid and determined on a shift-by-shift basis depending on patient load.

14.33 Much of the submissions advanced by Counsel for the SESLHD was not in evidence at the inquest. Further, the evidence of RN Woodruff and Mr Hay highlighted a divergence in the evidence between a clinician on the ground and an executive level manager. These two matters suggest that further investigation and consideration ought to be given to the issue outside the context of an inquest. It is therefore desirable to make the following recommendation.

14.34 **Recommendation 3:** I recommend to the Chief Executive, South Eastern Sydney Local Health District, that consideration be given to reviewing the nursing model of care which exists in the Kiloh Centre to determine whether staffing numbers, patient-to-nurse ratios, and allocation of clinical responsibilities to nursing staff are sufficient to meet patient loads and ensure patient safety.

15. Processes to ensure medical needs of mental health inpatients are met

15.1 The evidence established that NL was managed under the psychiatry team with consultation sought from subspecialty teams as medical issues were identified. During the course of his admission, NL received input from the intensive care, cardiology and the endocrinology teams.

15.2 Dr Lau gave evidence regarding responsibility for follow-up of a patient:

> So, we have well over a thousand consults per year in the hospital, just in the hospital. That's not including our own inpatients or outpatients, so we are not able to follow all those patients in the same way we would if they were our own admitted patients. And we rely on the treating team who have the primary responsibility to let us know when they are concerned about a test, and we try and make it clear in our notes regarding this.

15.3 Professor Carter gave evidence that:

> [P]sychiatric units generally speaking, are extremely competent in managing psychiatric problems, but their training is so strongly orientated towards psychiatry, and not to general medicine, their postgraduate training, that they are very quick to consult regarding other medical problems, as a general statement.

15.4 Professor Carter also acknowledged that the condition that NL presented with (myxoedema precoma) was uncommon and that, as a matter of interest, the endocrine team may have been keen to follow-up. However, Professor Carter was not critical of this model of care provided that there was clear communication between the psychiatry and endocrine teams regarding when further consultation with the endocrinology team might be indicated. The records demonstrate that regular communication between the psychiatry and endocrine teams during NL's admission in the period up to February 2019.

15.5 Professor Carter was also asked whether a member of the endocrine team ought to participate in a multidisciplinary team meeting for a patient such as NL. He gave this evidence:

> Well, I mean, it may not be practically feasible because of the workloads, but certainly there's a place for the endocrine team to be involved in a multidisciplinary meeting, but I wouldn't think they'd need to be involved in every meeting, because by far the majority of meetings would be concentrating on the progress from the psychiatric point of view.

15.6 Professor Carter went on to express the view that it would be "*absolutely vital*" for the endocrinology team to be involved once NL's management reach the point where discharge was being considered.

15.7 The NSW Health Policy Directive *Physical Health Care Within Mental Health Services* (PD2017_033) provides direction to mental health services in improving the provision of physical health care to consumers. Provision and access to such physical health care is recognised as the responsibility of the mental health service.

15.8 In order to implement the NSW Health Guideline *Physical Health Care For People Living With Mental Health Issues* (GL2021_006), the SESLHD employed one full-time equivalent physical health Clinical

Nurse Consultant and three full-time equivalent physical health Clinical Nurse Educators in January 2021. Further, in December 2021, SESLHD Mental Health Services published a *Physical Health Guideline Hospital Gap Analysis Report* which identified a number of focus areas for SESLHD including achieving minimum standards for physical health screening, integrating physical and mental health plans, including physical health information in discharge summaries from mental health services, and ensuring a variety of referral pathways, resources and programs that are suitable to meet the needs of all specific populations. In addition, the report identified a number of implementation requirements :

- Assign responsibility, personnel and resources to implement the principles and procedures in mental health service settings.
- Local policies and procedures developed and disseminated to support services to understand and meet the requirements of the Guidelines and Policy.
- Develop and implement a strategy to establish or build on local partnerships with GPs, Primary Health Networks, Community Managed Organisations and other health providers,
- Undertake a review of current staff skills, identify gaps in knowledge and factor these into future training plans.
- Identify, develop and implement strategies to address at risk populations.

15.9 **Conclusions:** The consultation-liaison model of care which exists within the Kiloh Centre provides for appropriate services and treatment for mental health inpatients. Where an inpatient has a physical health condition associated with their mental health condition, appropriate advice and consultations are sought from other specialist teams. The SESLHD has increased staffing resources to ensure that its mental health services fulfil their responsibility to provide access to physical health care for inpatients. In NL's case consultation from the endocrinology team was sought when indicated, and there was regular communication between the psychiatry and endocrinology team up to February 2019.

16. Findings

16.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Karen Kumar, Counsel Assisting, and her instructing solicitors, Ms Ashliegh Heritage and Mr Paul Armstrong from the Crown Solicitor's Office. I am most appreciative of the assistance that they have provided throughout all stages of the coronial process, their thoroughness and diligence, and the sensitivity and empathy that they have shown, particularly in their communication and interactions with NL's family.

16.2 I also thank Senior Constable Ross Nichols for his role in the investigation and compiling the initial brief of evidence.

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

Identity

The person who died was NL.

Date of death

NL died on 20 April 2019.

Place of death

NL died at the Kiloh Centre, Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of NL's death was cardiac arrhythmia secondary to prolongation of the QT interval. NL's recurrent hypothyroidism due to non-compliance with thyroxine, probable hypothyroidism-induced dilated cardiomyopathy, antipsychotic therapy, elevated body mass index, marijuana use and possible sleep apnoea were all contributing factors to prolongation of the QT interval.

Manner of death

NL died whilst admitted as an involuntary patient for treatment of his mental and physical health conditions. Management of NL's hypothyroidism and his non-compliance with thyroxine were significant features of his admission. Thyroid function test results available 15 days before NL's death were not reviewed and, consequently, no consideration was given to whether any change in NL's clinical management was warranted. However, there is no evidence that if a review had been performed it would have materially altered the outcome.

16.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to NL's son, OL; his ex-wife, ML; his sister, Jane, and NL's other family members and loved ones, for their loss.

16.5 As OL said in his statement at the conclusion of the evidence in the inquest, NL would have wanted to end with this quote from Shakespeare's *Hamlet,* delivered during a soliloquy in the film, *Withnail and I*, which NL and his son loved. It is a fitting reflection on the human condition, capturing how we humans are wonderful and impressive creations, yet fragile and temporary.

> What a piece of work is a man, how noble in reason, how infinite in faculty, in form and moving how express and admirable, in action how like an angel, in apprehension how like a god! The beauty of the world! The paragon of animals! And yet, to me, what is this quintessence of dust? Man delights not me, no, nor woman neither, though by your smiling you seem to say so.

16.6 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
28 March 2025
Coroner's Court of New South Wales

Inquest into the death of NL
2019/00124245

Appendix A

Recommendations made pursuant to section 82(1) Coroners Act 2009

To the Chief Executive, South Eastern Sydney Local Health District:

1. I recommend that a request be escalated to the relevant State entity for changes to be made to the eMR to ensure that any test results for a patient are not checked as endorsed by default, and that instead there is functionality requiring a clinician to manually endorse such test results.

2. I recommend that previous requests for the eMR – Copy and Pasting within Electronic Documentation (SESLHDPR/605) to be amended to include a warning of the dangers associated with copying and pasting information in the eMR be followed up until such amendments have been effected.

3. I recommend that consideration be given to reviewing the nursing model of care which exists in the Kiloh Centre to determine whether staffing numbers, patient-to-nurse ratios, and allocation of clinical responsibilities to nursing staff are sufficient to meet patient loads and ensure patient safety.

Magistrate Derek Lee
Deputy State Coroner
28 March 2025
Coroner's Court of New South Wales