STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquiry	**Inquest into the death of N**
Hearing dates:	8 April – 9 April 2015
Date of findings:	02 July 2015
Place of findings:	NSW State Coroner's Court - Glebe
Findings of:	**H. Barry Coroner**
File number:	2012/00120173
Representation:	**Ms R Mathur Counsel Assisting** **Ms J de Castro Lopo, Instructing** **Mr P Rooney, Local Area Health District – Hornsby Ku-ring-gai instructed by A McCarthy of the Crown Solicitor's Office** **Ms K Doust, NSWNMA** **Ms Louise Goodchild, instructed by Mr P Teitzel for Mrs N's daughter and the family of the deceased**
Findings:	**Identity of deceased**: The deceased person was N **Date of death**: died on 16 April 2012 **Place of death**: died at Hornsby Hospital, Hornsby, New South Wales **Manner of death:** Suicide **Cause of death:** Consistent with hanging
Non Publication Order	A Non -Publication order was made pursuant to section 75(2)(b)(i) of the *Coroners Act* NSW 2009 in relation to the identity of the deceased.

Introduction:

Mrs N was a sixty nine year old mother of two who was a dual national holding both Australian and Polish citizenship.

She resided in Hornsby with her daughter Malgorzata who was her only kin residing in Australia.

Mrs N's son resides in Poland.

She was widower, her husband having passed away some 8 years earlier. Until early 2012 Mrs N had by all accounts enjoyed good physical and mental health.

In a statement read to the court on behalf of Mrs N's daughter, the court heard how Mrs N was the most important person in her daughter's life.

It was explained how Mrs N had brought the family to Australia for a better life. She was a resourceful and compassionate woman.

Mrs N was much loved and her daughter grieves for her on a daily basis. She feels a tremendous sense of loss.

On the morning of 9 April, 2012 Mrs N woke her daughter and informed her she had suffered a seizure. This was not the first she had suffered in recent times.

She told her daughter she felt like jumping out of a window.

That morning she was admitted to Hornsby Hospital.

Seven days later, whilst still an inpatient at the hospital, she was found hanging in a hospital storeroom, in the early hours of the morning.

Mrs N left a note which said amongst other things:

"I am incurably ill….last night I was very sick – I cannot last any longer"

The tragedy in this case is that Mrs N's belief as to the incurability of her illness was not a belief based on the medical facts.

The Inquest:

Function under the Coroner's Act

The primary function under s.81(1) of the *Coroner's Act* is to make findings as to:

(a) The identity of the deceased

(b) The date and place of the persons death

(c) The manner and cause of the person's death.

There is no dispute in this case as to identity, place of death or medical cause of the death.

Namely- it is not in issue that N died at some point in time between 5pm on the 15 April 2012 and 12.40am on the 16 April 2012.

She died whilst an inpatient at Hornsby Hospital.

Her death was by hanging- namely death by asphyxiation.

The real question in this inquest concerns the manner of death.

In other words, what were the relevant circumstances that led to Mrs N taking her own life whilst a patient at Hornsby Hospital?

Issues

At the beginning of the inquest Counsel Assisting identified two primary issues that this inquest has explored. All relate to the circumstances of Mrs N's death.

1. **Whether nursing staff and the medical team supervising Mrs N provided an appropriate level of clinical supervision or observation.**
2. **The second issue concerns the making of an order for an Individual Patient Special- IPS and its removal within a period of less than 24 hours**

Background:

In January 2012, Mrs N was admitted to St Vincent's Hospital having suffered a seizure and remained in that hospital from 8 March 2012 until 14 March under the care of a neurologist.

She had been distressed in the days preceding her admission and had not been sleeping well.

At the time she was diagnosed with sub acute encephalopathy and was prescribed Phenytoin.

She was discharged and directed to follow up with her GP and with the Neurologist in three months time

On 9 April 2012 Mrs N was admitted to Hornsby hospital under Neurologist Dr Jenkins.

Upon admission it was recorded that she had been confused and disoriented and told her daughter she "felt like jumping out of the window."

The physical examination showed that she was alert and orientated.
Her mental health examination revealed anxiety and depression.

The most likely diagnosis was a possible CVA or temporal lobe epilepsy and behavioural changes. EEG and MRI tests were repeated to investigate subacute encephalopathy.

The progress notes recorded on that day state that she *"wished she was dead today" but has no plans to take her life. Very emotional.*

It was reported that she was difficult to examine and refused to be seen by an Indian doctor. She did not want to be examined by any doctors, She had already been examined by the Emergency Department

A Mental Health Assessment noted a '*frail woman who appears to be overwhelmed by her circumstances. She is tearful and seems to be afraid of her current illness, which she understands is epilepsy'*

She has thought about jumping off the balcony at home but does not have current thoughts. She reported :'I feel safe here'.

The progress notes indicated that her judgement was impaired and that she should remain in hospital pending a more thorough assessment.

A further note stated *"if she attempts to leave it may be prudent to schedule her given her emotional distress and impaired judgement"*

At 1pm on 9 April EEG testing revealed no abnormality.

At 3.45pm Mrs N indicated she wanted to die and did not want to take any medication or have any tests.

At 8.25pm she again indicated she did not want to have any test and requested to be left alone.

On 10 April a mini mental state examination(MMSE) was conducted resulting in a score of 10 out of 30.This indicated “moderate to severe cognitive impairment” according to the occupational therapist who conducted the test. It was her opinion that Mrs N may require 24 hour supervision and functional test.

At 1.30pm on that day Mrs N was seen by Dr Goriparti, Psychiatric Registrar in the company of an interpreter. She was emotional and tearful and denied psychotic symptoms, suicidal thoughts/plans.

She told Dr Goriparti *“I cannot cope like this. I am sick”*

Her mood was described as depressed. She had poor insight. Dr Goriparti recorded it was *“difficult to diagnose dementia at this stage”* and ordered a review by Dr Farideh Absalam, Consultant Psychiatrist.

The notes show a considered diagnosis of delirium, dementia, depression.

At 2.50pm that day the notes record that Mrs N’s mental health had deteriorated and she was pacing the ward and attempting to leave.

Dr Absalam attempted to see her but Mrs N refused to see Dr Absalam. Dr Absalam obtained a history from Mrs N’s daughter. She recorded her impression in the notes:

Manic episode. Question seizure. Dr Absalam stated *‘A manic episode at this time usually indicates an organic problem’.*

She recorded ***Needs one to one nurse if she remains agitated.***

At 4.35pm the notes reveal the following nursing entry

ADON had been advised that Mrs N ‘requires special’. No special available and will try and organise for tonight. Emergency Medical Unit Registrar aware of same.

At 7.50pm, Mrs N was increasingly agitated and refusing any observations.

On 11 April, 1 : 1 nursing care commenced. At 8.50am Mrs N was moved to ward 1A from the Medical Assessment Unit.

She was reviewed by Dr Jenkins Neurologist. She was commenced on Epilim. The notes suggest ***ongoing psychiatric management.***

At 7.45pm Mrs N was quite distressed and again refused to have an EEG.
At 8.45pm it was noted that Mrs N was pleasant and exhibited no aggressive behaviour.

At 9pm, Mrs N was reviewed by Dr Chan. He noted that Mrs N had been cooperative in the last few hours and he was ***happy to remove IPS- namely the Individual Patient Special of one to one observation.***

On 12 April, Mrs N was noted to be alert and orientated but confused at times. She was upset and crying at the beginning of the shift.

She was seen by Dr Absalam at 1.30pm.

Dr Absalam noted that she was looking sad, and had negative thoughts about herself and the future. She had many bad thoughts in her head but was unable to explore them. She denied suicidal thoughts but wished she could *'go to sleep and never wake up .*' Mrs N was agitated and frightened of the future with poor concentration and memory problems. She did not want to be a burden.

Dr Absalam noted: "*More settled in manic symptoms however more depressive symptoms resurfacing"* The plan was to increase Quetiapine; and Mrs N was commenced on Lexapro, Epilim and Benzodiazepam prn.

At 4.30pm a review by the neurology resident was unremarkable.

On 13 April 2012, the notes record that Mrs N as *upset and teary* at 9.45am

At 2.10pm, she was *alert and orientated but confused at times.*

At 3.50pm, it was recorded that she was to be moved to the psychiatric unit as an inpatient when a bed became available.

On 14 April 2012 during a neurology assessment Mrs N was co-operative and happy to have an EEG.

At 2.15pm, she was verbally aggressive to staff.

On 15 April at 7.00am she was pacing around the ward and complained of heart problems and nausea.
20mls Gastrogel were given.

Mrs N was still depressed. When visited by her daughter she did not want to go outside for lunch.

The last recorded note in the progress notes was made at 2.20pm when it was recorded that Mrs N had been co-operative.

At 4.05pm the medical chart recorded that she had been given Gastrogel.

At 5.00pm, the general observation chart was filled out.

It would appear this was the last time Mrs N was seen by staff.

At 8.00pm, it was noted by nursing staff that Mrs N was missing. A search was undertaken by staff and at 8.20pm security was advised.

Police were notified at 8.30pm.

At 12.40am on16 April 2012 Mrs N was found hanging in an equipment storeroom in Ward 1B.

Ward 1B is on the same level as ward 1A and is separated by a set of swinging doors.

A suicide note was later located in Mrs N's toiletry bag.

Was there an appropriate level of supervision?

The Nursing staff

Patricia Butler was acting Nurse Unit Manager (NUM) on ward 1A at the time of Mrs N's admission to that ward on 11 April 2012.

Ward 1A is a 25 bed acute medical/stroke unit with the patients being mostly high care

Ms Butler gave evidence that patients in this ward require a high level of care and management and include patients with complex medical issues as well as mental health patients with a dual diagnosis.

The nurse patient ratio at the time was 1 nurse to every 4 or 5 patients and on a night shift in April 2012 there were 3 nurses on duty including 2 RN.

Since 2012 that ratio has been increased to 4 nurses.

The minimum level of observations in a medical ward such as ward 1A was 3 times in a 24hour period, but this was increased if the patient had been transferred from ICU or in other cases, such as if the patient had a fall.

Ms Butler said there was no specific policy in place for patients with a dual diagnosis such as Mrs N.

In circumstances where patients present with a confused mental state and there may be self- harm issues, patients are located in an area as close as possible to the nurses' station. However, as Ms Butler stressed, if patients have not been scheduled under the *Mental Health Act* then they are free to move about.

Mrs N was in bed 9, within good view of the nursing staff, there being a lot of people in the vicinity of that room for a lot of the time.

Ms Butler first saw Mrs N on 13 April.

Ms Butler was aware that Mrs N had been seen by Dr Absalam and the psychiatric Registrar and had been advised to stay in hospital over the weekend for medical titration.

Ms Jill Phillips had been allocated the care of Mrs N on 14 April. During that shift she noted that Mrs N was alert and general observations were in the normal range.

On 15 April, Ms Phillips was in charge of ward 1A – there being no NUM on duty on the weekend. Mrs N was again her patient and she assumed care of her at 3pm.

At 4.05pm she gave Mrs N 20mls Gastrogel for epigastric pain. She stated Mrs N was co-operative and she does not recall being concerned about her.

That is the last time Ms Phillips recalls seeing Mrs N, although the observation chart shows that she was seen by staff at 5.oopm

Associate Professor Michael Robertson, consultant psychiatrist, was critical of the level of care provided by the nursing staff, stating in his report:

"there appears to have been deficiencies in the level of observation and supervision on the part of the nursing staff"

In his oral evidence Professor Robertson stated that the failing was "at the very least in documentation about increased observations"

Dr Heather Gluyas, Associate Professor of Nursing provided a report concerning the nursing care provided to Mrs N. It was her conclusion that the nursing care provided to Mrs N on the medical ward was "appropriate and of an acceptable standard of care".

Whilst I have concerns about some of the matters on which Dr Gluyas based her opinion, especially in her reading of the clinical notes and her comments on the cognitive process of decision making, which would appear to be an area outside her expertise, I am not in disagreement with the conclusion drawn by Dr Gluyas as to the standard of nursing care.

Notwithstanding Professor Robertson's comments, it is noted that Mrs N was in a medical ward and it is unsurprising that nurses were focussed on medical issues. This is not to say that nursing staff did not observe or note Mrs N's mental state.

During the 4 days prior to her death. A number of nursing staff had noted in the progress notes Mrs N's expressions of sadness and wanting to die.

It is also noted that Mrs N had been seen by a Consultant Psychiatrist and no plan was put in place to suggest increased supervision. Indeed the IPS had been withdrawn after being in place less than 24 hrs. This can only be done by medical staff.

Both Ms Butler and Ms Phillips spoke of the increasing number of patients admitted to medical wards with confusion and dementia. Within the limits of the ward environment the Nursing staff when caring for such patients try to keep an eye on these patients.

Essentially, Ms Butler said there is a need to exercise common sense and judgement. Any report by a patient expressing sadness and wanting to die is recorded in the notes and reported to medical staff. That was done in this case.

It may be that the failing was not so much one of supervision but a failure by the nursing staff to recognise the danger signals in relation to Mrs N's presentation.

Without some guidance in relation to the recognition of those risk factors concerning the complexities of dual diagnosis patients it would be unfair to be critical of the nursing staff.

Both Ms Butler and Ms Phillips were impressive witnesses. They both have extensive experience and were realistic about the challenges to be met in a high care medical unit with patients presenting with the full spectrum of illnesses.

Medical Supervision

Mrs N was admitted to a medical ward but it is clear from the clinical notes that there was an increasing concern about her mental state.

A psychiatric examination was conducted by Dr Goriparti, psychiatric Registrar on 10 April. He saw her in the Medical Assessment Unit.

She presented as *very confused, tearful, emotional and labile in her mood. She denied suicidal thoughts and psychotic symptoms.*

Dr Goriparti found her mood to be depressed but found no grounds to take action under the *Mental Health Act.*

He considered the possibility that Mrs N may have been suffering delirium from a seizure but also considered a possible diagnosis of dementia and depression.

On 10 April Dr Absalam, Consultant Psychiatrist attempted to examine Mrs N but she refused to allow the examination. Dr Absalam spoke with Mrs N's daughter. Based on that conversation and the clinical notes Dr Absalam queried a manic episode and/ or possible seizure. She also ordered a one to one nurse if she remained agitated and ordered a review by the psychiatric team.

On 12 April Dr Absalam examined Mrs N. She noted that she was *feeling sad and expressing negative thoughts about herself and the future.*

Mrs N stated she did not want to be *a burden on others"* and complained of *"many bad thoughts in her head".* She denied suicide thoughts but "*wishes to go to sleep and never wake up"*

Dr Absalam noted increased depressive symptoms resurfacing. She made a plan for commencement of Epilim and Seroquel.

It was Dr Absalam's opinion that Mrs N was not a high risk of suicide and her provisional diagnosis was that she was suffering a depressive episode with agitation. She considered transferring Mrs N to a psychiatric ward once her medical condition had resolved.

In his report, Professor Robertson was uncritical of the medical care that Mrs N received.

In his oral evidence however, he spoke about the critical issue concerning Mrs N as being the highly changeable nature of her mental state.

This he described as a red flag in assessing the question of risk surrounding Mrs N.

It highlighted the unpredictability of behaviour and consequentially a higher level of clinical vigilance was required.

In response to the suggestion that Dr Absalam, after seeing Mrs N on 12 April recommended her transfer to a psychiatric unit when a bed became available, but failed to order increased supervision- Professor Robertson replied:

"I would have argued that the level of observations be increased either by a 'special' or 15 minute observations".

Further, in response to the suggestion that there was no psychiatric input after Dr Absalam saw Mrs N on Thursday 12 April, Professor Robertson replied:

"*I would have wanted the patient viewed by a Psychiatric Registrar daily"*

Dr Absalam in her oral evidence stated that Mrs N's mental state was changeable but not **highly** changeable.

She seemed to rely on the fact that Mrs N was possibly suffering delirium and as a consequence was unlikely to plan suicide.

She stated in her oral evidence that she would have expected Mrs N to have been seen by the Psychiatric Registrar on the Friday or if there were concerns about a patient then there was a Psychiatric registrar available on call over the weekend.

At no time did she order a review.

In relation to the Suicide Risk Assessment and Management Protocol prepared by NSW Health and referred to by Dr Robertson, Dr Absalam stated that the protocol was a guide only.

She never believed Mrs N to be a suicide risk and believed any need for increased supervision was properly a matter for the nursing staff in the exercise of their judgement.

I found Dr Absalam's evidence to be largely unresponsive and unhelpful. It is not clear whether this stemmed from a communication issue in the questioning or a failure to grasp the issues raised.

She was not in agreement with Professor Robertson about Mrs N's highly changeable mental state and as such a risk factor in suicide.

She stated that Mrs N was oriented in time and place and lucid. She further stated that Mrs N was religious and had said she would not do any harm to herself.

The question of delirium was not an issue at this point and the suggestion by Dr Absalam that the risk of suicide was limited because of delirium could not have been in play. There is nothing in the notes to suggest that Mrs N was presenting in a delirious state at this time.

What is clear is that Dr Absalam was sufficiently concerned to recommend Mrs N's transfer to the psychiatric unit.

This was never documented by Dr Absalam but in her oral evidence she states she spoke with the medical team about this move.

In addition, the clinical notes of 13 April record a note by a social worker that Mrs N was to be transferred to the psychiatric unit when a bed became available.

The question therefore is what was to happen before that transfer could take effect?

Dr Absalam, in her oral evidence stated she assumed that Mrs N would be seen by the Psychiatric Registrar. This could only have happened on Friday 13 April as no Psychiatric Registrar was on duty over the weekend.

Dr Absalam maintained that any concerns about Mrs N's presentation could have been raised with a Psychiatric Registrar on call by the nursing staff.

There is no question that had Mrs N been in a psychiatric unit she would have been reviewed under the Suicide Risk Assessment Protocol and would have been subject to increased supervision.

Professor Robertson is clear in his evidence.

He would have wanted Mrs N viewed by a Psychiatric registrar daily until her transfer to the Mental Health Unit. 15 minute observations would have been a reasonable standard of care.

Dr Absalam made no such plan nor any direction to the medical staff and nursing staff.

This lack of ongoing supervision was criticized by Professor Robertson in his oral evidence.

In my view the responsibility for ensuring appropriate supervision must rest with Dr Absalam.

It is of concern that Dr Absalam was content to make assumptions about medical supervision and to rely on nursing staff observations without taking the care and responsibility to document a plan for ongoing supervision during those crucial days.

It would appear that this was an abrogation of care by Dr Absalam.

The implementation and removal of the Individual Patient Special

Dr Absalam, on 10 April, noted in the progress notes that Mrs N would need one on one nursing care if she remained agitated.

According to the clinical notes that one on one care was put in place at 14.25pm on 11 April.

Dr Chan reviewed Mrs N at 9pm on 11 April. At that time Dr Chan was a Medical Registrar at Hornsby Hospital.

He was asked to review the need for ongoing one on one care. He does not know who made that request.

In his oral evidence it is clear that Dr Chan believed that the question of the continuation of one to one care was largely a staffing question.

He only reviewed Mrs N because he was asked to review the IPS.

He cannot now recall why he decided to stop the IPS, but on reviewing the clinical notes he assumes it was because Mrs N's agitation had decreased and she had become more settled.

He expected that his decision to remove the IPS would be reviewed the next day.

Dr Chan acknowledged he had no knowledge of policy governing the initiation or cessation of an IPS.

Further, his evidence tended to suggest that he did not fully appreciate the significance of an IPS, his focus being on the needs of the staff as opposed to those of the patient.

Policy in place at the time prepared by North Sydney Central Coast Local Health District mandated that:

Only a treating Doctor must terminate the IPS and document the reason in the patient's medical record

A review of the continuing need for an IPS needed to be ongoing and ***documented at least once each shift on the IPS form.***

Dr Chan was unaware of any such form. There was no such document contained within Mrs N's clinical notes.

Ms Butler acknowledged that this is a common oversight.

She also acknowledged that even when an IPS is ordered it may not be immediately implemented, depending on availability of staff.

She was aware of the policy concerning the IPS and agreed that notations should be made every shift.

In Mrs N's case it is abundantly clear that there was a failure to adhere to the policy on a number of points:

- *There was failure to document clearly the commencement of the IPS*
- *A failure to document its cessation*
- *A failure to review daily the ongoing need for an IPS*
- *Failure to document the standard form concerning the implementation of the IPS.*

Professor Robertson, in his oral evidence stated the IPS should not have been removed and should have remained in place until Mrs N's transfer to the Mental Health Unit.

He acknowledged the difficulty in sometimes sourcing a special nurse but his evidence is clear:

I would have argued that the level of observation be increased either by a special or 15 minute observations

Conclusion

This inquest has exposed two main failings in the care of Mrs N.

- The failure of any care giver, in particular, Dr Absalam, to identify Mrs N's highly changeable mental state as a critical issue with respect to self- harm.
- The failure to ensure adequate supervision either in the form of an IPS or at the very least increased observation of Mrs N.

Professor Robertson stated that the clinical notes reveal that Mrs N's clinical presentation was properly investigated but the failure was in recognising that her highly changeable mental state was a major vulnerability for suicide or self- harm.

He stressed that a minor improvement in mood over a 12 hour shift did not indicate a true improvement when read with the history contained in the clinical notes.

In the 7 days of her admission Mrs N's mood was variously described as anxious, agitated, thoughts of sadness and hopelessness; these descriptions indicating a highly changeable mood, sometimes within the same day.

Secondly, the level of supervision was manifestly inadequate.

This may be attributed to a number of factors:

- Mrs N was in a medical ward and initially at least the main focus was on Mrs N's medical needs. Those medical investigations were adequately pursued and as a medical patient in a medical ward she was receiving the required supervision of three times per day.

- There was no titration of supervision. Supervision was either one on one or every eight hours. Such a gap emphasises the dilemma faced by staff especially in high level care wards such as Ward 1A.

What is highlighted is the variation of care and supervision provided to a patient with a psychiatric diagnosis in a medical ward to that of a mental health unit.

Understandably emphasis in a medical ward is placed on medical issues, but there is currently no procedure in place to ensure that persons with a possible psychiatric diagnosis are managed in a medical unit with the same level of care as that afforded in a mental health unit.

Professor Robertson estimates 1 in 3 to 1 in 4 patients he treats fall within the category of dual diagnosis patients.

Ms Butler and Ms Phillips both described the increasing number of patients admitted to a medical ward who present with symptoms of a confused mental state; psychiatric issues and the many elderly patients with a dual diagnosis.

As Professor Robertson states in his report:

The tragedy in this case emphasises the need for a more cohesive management of medically ill patients with psychiatric presentation, such as that seen in Europe and North America where speciality units deemed "medical psychiatric units " staffed by different medical disciplines, with a more integrated model of care exist.

To date there is only one such unit in Sydney, the Neuropsychiatric Institute at the Prince of Wales Hospital.

NSW Health has prepared a policy document titled Suicide Risk Assessment and Management Protocols in the General Hospital Ward. Whilst that document does not at this stage envisage the setting up of more speciality units as described by Professor Robertson, it goes part way to recognising and addressing this growing problem.

That document provides information and procedure for a preliminary suicide risk assessment for patients admitted to a general ward as well as a suicide risk assessment guide and management protocols.

According to Mr Frank Bazik, General Manager Northern Beaches Health Service/ Hornsby Ku-ring-gai Health Service it is now proposed that in service training take place in relation to this issue at Hornsby Hospital.

I have considered carefully the policy documents supplied by NSW Health relevant to this inquest.

I have also seen a document from NSW Health signed by Mr P Carter , Director, Mental Health and Drug and Alcohol Office dated 15 June 2015.
He states that in a general hospital setting, essentially:

- *It is the role of Consultation Liaison Psychiatry to conduct the specialised, comprehensive assessment and review the patient.*

- *It is expected that the consultation psychiatry assessment would also include attention to current and future risk and establish a management plan that includes ongoing assessment /treatment as well as guidance for continued management within an inpatient setting. This would include guidance provided to the general ward's nursing staff regarding management strategies, including any special observation, care and safety measures that may have been required*.

This is a welcome acknowledgement as it is clear from this matter that there was no guidance and planning offered by the Consultant Psychiatrist who saw Mrs N to the staff in the general ward who were caring for Mrs N.

In addition, Mr Carter states that in the previous term of Government funding for an extra 315 Clinical Nurse Educators or Clinical Nurse Specialists was committed .Another 140 positions have been committed for the years 2015 to 2019. It is expected that these positions will meet the various needs as identified by Local Health Districts.

A new suicide prevention training package for the non – mental health workforce in Local Health Districts is currently being developed and expected to be available during 2015 – 2016.

Given these NSW Health initiatives and Hornsby Hospital's intention to ensure training concerning suicide risk assessment and management protocols, I find that recommendations in this area are presently unnecessary.

Findings

The identity of the deceased

The deceased person was N

Date of Death

16 April 2012

Place of Death

Hornsby Hospital, Hornsby, New South Wales.

Cause of Death

Consistent with hanging

Manner of Death

Suicide

I close this inquest

H.Barry

Coroner
Glebe