CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Errol Handog
Hearing dates:	5 October 2017
Date of findings:	21 December 2017
Place of findings:	State Coroner's Court Glebe
Findings of:	**Magistrate Teresa O'Sullivan, A/State Coroner**
Catchwords:	CORONIAL LAW – Suicide Mental Health assessment
File number:	2014/321158
Representation:	Coronial Advocate, Sergeant Durand Welsh Mr Patrick Griffin SC, representing Dr Bhavanishankar Ms Boyd, Crown Solicitor's Office representing Nepean Blue Mountains Health District Mr Saxton representing Dr Shrestha

Findings:	**Identity of deceased**: The deceased person Errol Handog **Date of death**: Errol Handog died between 3:30 p.m. on the 29 October 2014 and 1:00 p.m. on the 30 October 2014 **Place of death**: He died within his bedroom at 14 Kookaburra Crescent, Glenmore Park **Manner of death:** Errol Handog hanged himself with the intention of ending his life **Cause of death:** Hanging
Recommendation:	**To the Ministry of Health** That the Minister of Health NSW consider the implementation of a “take home” document for families/patients that would contain information such as the treatment plan, follow up appointments, medications, emergency telephone numbers and other information relevant to the patient’s ongoing care and support. The document would be intended for patients who are not admitted, but who have undergone a mental health assessment at a Local Health District.

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Errol Handog.

Reasons

Introduction

On 30 October 2014, Errol Handog was discovered by his father in his bedroom with one end of a cord tied around his neck and the other tied to his bed. Sadly, he was not able to be revived. He had been experiencing some mental health problems leading up to the time of his death and been treated by the Nepean Hospital's Nepean Access Mental Health Team in the days leading up to his death. His death was tragic and the loss and pain felt by his family is both significant and ongoing.

The inquest

The following issues were explored during the inquest:

1. What criteria were used in assessing if Errol Handog should have been admitted for hospitalisation and/or further assessment at Nepean Hospital on the 29 October 2014?

2. What advice and treatment did Dr Shrestha and Dr Bhavanishankar provide to Errol Handog and his family on the 28 October and the 29 October 2014?

3. Are there any changes to the assessment and admission process that might improve outcomes at Nepean Hospital in the areas of client suicide risk assessment and suicide prevention?

The coronial brief included statements from Errol Handog's family, a statement of Gilda Palermo (a witness who accompanied Errol to Nepean Hospital on the 29 October 2014), a statement of Senior Constable Hayward (Officer in Charge), a statement of Dr Shrestha, a statement of Dr Bhavanishankar, a report by Dr Smith and a report by Professor Large.

The witnesses called were the following:

- Senior Constable Andrew Hayward, the Officer in charge

- Reynaldo Handog Snr, the father of Errol Handog

- Dr Shrestha, the Psychiatry registrar within the Nepean Access Mental Health Team

- Dr Bhavanishankar, the Psychiatry consultant within the Nepean Access Mental Health Team

- Dr Glen Smith, Consultant clinical and forensic psychiatrist

- Professor Matthew Large, Consultant psychiatrist

Dr Smith and Professor Large were called to give evidence in the capacity of expert witnesses in the field of psychiatry. They gave evidence jointly in a conclave and provided their expert opinions about the care and treatment Errol Handog received at Nepean Hospital on 29 October 2014.

The Evidence

Background:

Errol Handog was born in the Philippines on 24 June 1980, where he lived until 1997 when his family moved to Australia. They initially stayed in St Clair, Sydney, and after living at a number of locations the family settled at 14 Kookaburra Crescent, Glenmore Park, in the year 2000. Errol resided at this location with his father, Reynaldo Snr, his mother, Renilda, and his two brothers, Roy and Reynaldo Jnr.

In 2001, Errol was approved for a job with Australia Post, and worked there in a permanent part-time position until 2010. Citing a lack of promotion, Errol terminated his employment and subsequently received Centre link benefits.

On 28 October 2014, around noon, Errol Handog requested his father drive him to Nepean Hospital. On the advice of general practitioner, Dr Chua, Errol wished to present to the Access Mental Health team. There was no formal letter of referral and a copy of Dr Chua's notes was not provided to clinical staff at the hospital.

Reynaldo Handog Snr delivered Errol to Nepean Hospital, where Errol was seen by the mental health clinical nurse specialist at 5:45 p.m. The Nepean Hospital medical records state that Errol had presented seeking help for his anxiety on advice of his GP.

Errol did not disclose any prior mental health diagnosis or significant medical history upon presentation. He did, however, report having previously seen a psychologist. He was not known to have been taking any prescription medications as at 28 October 2014, although notes made during Errol's presentation the following day indicate he may have been taking Zoloft approximately 5 years ago.

After the initial presentation at Nepean Hospital on 28 October 2014, Errol's brother Roy and his nephew Jayden collected him from the hospital that same evening.

On 29 October 2014 Errol left his home at 7:00 a.m. to attend the FCF church in Minchinbury. Around 8:30 a.m., the church custodian called Reynaldo Handog Snr to inform him that Errol had left. Reynaldo Snr understood that Errol had an

appointment at Breakthrough Recruitment Agency, and assumed he had left to attend.

Errol attended the Breakthrough Recruitment Agency in Penrith at approximately 8:30 a.m. where he met with agency employee Gilda Palermo. Errol's behaviour caused Gilda to have concerns about Errol's wellbeing, and she subsequently transported him to Nepean Hospital for a mental health assessment.

He was subsequently referred to Dr Shrestha, the psychiatry registrar in the Nepean Access Mental Health Team.

Dr Shrestha determined that Errol showed symptoms consistent with a generalized anxiety disorder. Errol was demanding hospital admission, seeking solitude and time out from his family for at least a couple of days. He threatened suicide if he was sent home from the hospital. Dr Shrestha noted that Errol did not have a past history of suicide or self-harming attempts and acknowledged that he had a supportive family. Dr Shrestha conducted a mental state examination and amongst other things noted the following:

- Errol was co-operative, engaged well, but was anxious
- His speech was normal
- His mood was distressed and had reactive affect
- There was no evidence of formal thought disorder
- He was preoccupied with his anxiety symptoms and demanded hospital admission seeking solitude
- He expressed suicidal ideation if discharged from hospital but he had no active plan or intent
- He denied any delusions or perceptual disturbance
- He was orientated to time, place and person and his insight was partial regarding his mental state and judgement was fair

Dr Shrestha's notes do not indicate he was aware of any substance abuse issues. The notes taken by the mental health nurse during his initial assessment record that Errol specifically denied substance abuse.

Dr Shrestha prescribed him quetiapine 25 mg orally as a single dose to calm his anxiety symptoms and planned to review him in an hour and observe his mental state.

Around 1:30 p.m. Dr Shrestha reviewed Errol again and states that he presented much better compared to his previous presentation. Errol reported feeling much calmer and denied active suicidal/self-harming or suicidal thoughts.

Dr Shrestha then called Reynaldo Handog Snr, who informed Dr Shrestha that he would attend Nepean hospital in person. Dr Shrestha then discussed Errol Handog's presentation with Dr Bhavanishankar, psychiatry consultant in Nepean Access Mental Health.

In the presence of Dr Shrestha, Dr Bhavanishankar reviewed Errol at around 2:30 p.m. Dr Bhavanishankar suggested commencing Errol on three medications: the anti-depressant sertraline; temazepam for his insomnia; and quetiapine to use if needed for severe anxiety. A follow-up appointment was booked with Dr Bhavanishankar for 31 October 2014.

Errol's father, Reynaldo Snr, arrived during the assessment and met with Dr Shrestha and Dr Bhavanishankar to discuss Errol's situation. Errol subsequently left the hospital in the company of his father. They returned home to their residence in Glenmore Park.

Around 3:30 p.m. Renilda Handog gave Errol some food and drink before he slept. Errol then locked his door and his family believed that he was sleeping.

On 30 October 2014, Renilda rang Reynaldo Snr asking if Errol was awake. Around 1:00 p.m. Reynaldo Snr knocked on Errol's door but received no response. He located the key to the room and gained access. Blood was spattered over the floor of the room and Errol was face down on the floor with his neck tied to the bed post using a plastic cord for hanging clothes.

The blood was later determined to come from a number of non-lethal wounds believed to be self-inflicted.

Crime Scene Investigator Parker attended from the Forensic Services Group. There was no evidence suggesting the hanging was with the assistance of another party or that there were suspicious circumstances.

Located within Errol's room was a book titled "What works for anxiety disorders." Also located in Errol's room were the previously mentioned medications prescribed by Dr Bhavanishankar. The medications appeared unused.

Post Mortem and Toxicology:

The post-mortem examination revealed a vertical stab wound on the left side of Errol's mid-abdomen, as well as superficial cuts and puncture marks to the body, and a stab wound and puncture mark to the right foot. The stab wounds, cuts and punctures are not believed to have contributed to the cause of death, which the pathologist, Dr Szentmariay, found to be hanging.

Cannabinoids, benzodiazepines (diazepam and nordiazepam) and quetiapine were located at non-toxic blood levels.

The issues

1. What criteria were used in assessing if Errol Handog should have been admitted for hospitalisation and/or further assessment at Nepean Hospital on the 29 October 2014?

Evidence of Dr Shrestha and Dr Bhavanishankar

Both Dr Shrestha and Dr Bhavanishankar gave oral evidence in addition to statements contained within the brief of evidence. They both gave evidence about what criteria they used in assessing whether Errol Handog required admission, as well as the advice and treatment they provided. They also gave evidence concerning the practical realities of the admission process.

Dr Shrestha and Dr Bhavanishankar both gave evidence concerning the facilities at Nepean Hospital. The short stay accommodation the hospital affords to patients requiring hospitalisation and/or further mental health assessment is a bed in the Psychiatric Emergency Care Centre (PECC) unit. The PECC unit provides six beds, with the stay length varying between 24 to 72 hrs. Longer stay admissions are managed through the Acute Inpatient Unit, but Dr Shrestha indicated in his evidence that someone with Errol's history would not usually be immediately admitted to the Acute Inpatient Unit.

Dr Bhavanishankar stated, and records to this effect were tendered, that no beds were available in the PECC on 29 October 2014. An alternative to immediate admission into the PECC is an admission via the Emergency Department. This would involve waiting in an Emergency Department bed until a PECC bed became available.

In oral evidence, Dr Bhavanishankar re-iterated concerns expressed in his statement that an admission through the Emergency Department could prove stressful for a patient with Errol's symptoms. He was also concerned that Errol's condition might worsen being amongst "quite ill" patients.

In addition to the lack of bed availability, an admission to the PECC requires a physical examination via the Emergency Department. The physical examination can exclude certain physical causes of mental disturbance and the patient's general health (including the patient's associated ability to tolerate certain medications) can also be assessed. As such, any admission to the PECC, regardless of whether a bed was available, would have required Errol going through the Emergency Department, an environment Bhavanishankar believed might be detrimental.

Dr Bhavanishankar stated that there was a balance to be made between risk and benefit when determining if a hospital stay was warranted.

With that as an underlying consideration, in assessing Errol's suitability for admission, Dr Bhavanishankar used the following criteria:

- Errol did not have a long history of social phobia or anxiety
- He denied substance abuse.
- He denied having an active suicide plan or suicidal intent
- He was agreeable to follow up with the mental health team
- He had a supportive family who had agreed to monitor him
- He didn't appear thought disordered or disorganised

Neither Dr Shrestha nor Dr Bhavanishankar had a good recollection of the advice given to Reynaldo Handog Snr and Errol Handog at the conclusion of the consultation on the 29 October 2014. Dr Bhavanishankar, the more senior of the two medical practitioners, gave evidence that normal practice is to encourage the family to give the medications and observe if there is anything they are concerned about. Dr Bhavanishankar provided Errol with prescriptions for Zoloft, temazepam and quetiapine. In his evidence, Reynaldo Handog Snr recalled the provision of medications, but disagreed with the proposal that there had been any discussion with him about monitoring Errol once he left the hospital or that the details of any safety plan or similar were made known to him.

Dr Bhavanishankar arranged follow up by the mental health team for the following day and a further appointment with himself for 31 October 2014. However, the only piece of written documentation provided to Reynaldo Handog Snr was a card with an emergency number on one side and the appointment details on the other side.

When Dr Bhavanishankar was asked in evidence whether it would have caused him concern at the time of the assessment if he'd known that Errol would be allowed to enter a bedroom and lock the door once he was in the father's care, Dr Bhavanishankar answered, "That would be a worry. Locking the door would be an alarm."

Further to this, Dr Bhavanishankar was asked by his legal counsel, Mr Griffin SC, whether he had had an expectation that Errol's family would monitor him when he was at home?

Dr Bhavanishankar answered: "Absolutely...We expected they would keep a close eye on him and call if they are concerned about his behaviour."

Further to this, Mr Griffin SC said: "It is fair to say that you didn't expect that he would be permitted to be behind a locked door for 20 hrs or so."

Dr Bhavanishankar answered: "That's right. It's quite alarming to me that he was left on his own without even knocking on the door."

Dr Bhavanishankar agreed with the proposition that written documentation handed to the family at the time of consultation might be of "significant help" for the family. He indicated that there was a lot of information for family members to take in.

Evidence of Dr Smith and Professor Large

Two expert witnesses in the field of psychiatry, Professor Large and Dr Smith, provided reports and gave evidence on the question of Errol Handog's care and treatment at Nepean Hospital on 28 and 29 of October 2014.
At the outset they agreed on several points.

They both agreed that Errol's diagnosis on 29 October 2014 was unclear and that there were a range of differing diagnoses. They also agreed that cannabis withdrawal and cannabis intoxication were possible conditions affecting Errol. They agreed there was an exacerbation of anxiety and that the cause of that was unclear. They also agreed that the reasons for the suicide were unclear. They agreed it was possible cannabis played little role in the suicide. It should be noted that regarding cannabis use, Professor Large interjected that he did feel the long history of cannabis use disclosed in GP records made it more likely cannabis played a role.

The main point of disagreement, however, was whether community management was appropriate. Professor Large maintained that it was appropriate. Dr Smith maintained that it wasn't appropriate.

Dr Smith stated that in his opinion Errol Handog should have been admitted to afford further opportunity for his diagnosis to be clarified. In oral evidence he summarised the factors in support of admission:

- Errol Handog's diagnosis was unclear
- He had displayed suicidal ideation on two consecutive days
- His attendance at hospital was a re-presentation
- Specific methods of suicide were noted
- He was severely agitated
- He was requesting admission
- He was reluctant to go home

Dr Smith said: "Without a clear understanding of what is happening, it is very difficult to have confidence in an assessment of suicide risk [and] confidence in an assessment of how to manage that."

He stated it was critical to obtain further information and further observation.

This opinion was countered by Professor Large on several grounds. Professor Large stated that he did not think it impossible to obtain certainty about the diagnosis in the community. He also stated that many people make suicidal threats and that it was not rare to discharge people who were making such threats. Regarding Errol's requests for admission, Professor Large stated that Errol didn't really know what he wanted. "Hospitals are not places of solace," was Professor Large's succinct description of the hospital environment.

In Professor Large's opinion it would have been reasonable to admit Errol, but also it would have been reasonable to not admit him. Professor Large believed that Dr Shrestha and Dr Bhavanishankar were "hamstrung" by their lack of knowledge about Errol's cannabis use. The cannabis use would have made it likely there was a psychotic element to Errol's presentation. Both Professor Large and Dr Smith believed that there was probably some other disorder underlying the anxiety.

In expressing his opinion about why admission was preferable, Dr Smith referred to the NSW Health policy directive *Framework for Suicide Risk Assessment and Management for NSW Health staff (2004)*. In particular, he referred to "assessment confidence". He put it as follows:

> If you have low assessment confidence you might be more vigilant in managing the person given your gaps, accepting that you may not be able to assess accurately the nature of the risk.

Professor Large countered by stating that uncertainty would not necessarily have been resolved with a hospital stay. He listed several actions that Dr Shrestha and Dr Bhavanishankar had taken to mitigate the risk of community treatment.

- Acute care contact was scheduled for the following day
- An appointment with Dr Bhavanishankar was made for two days' time
- There was family support
- They provided treatment (sertraline; temazepam and quetiapine).

Professor Large also agreed with Dr Bhavanishankar's opinion that anxious patients do poorly in hospitals and emergency departments. He also stated that given the limitations of hospital bed numbers, preference had to be given to involuntary patients.

While the inquest examined the circumstances of Errol's presentation for admission, it was never the view of any of the medical professionals that an admission would have prevented his suicide. Nor was there any suggestion of a causal link between the decision not to admit Errol and his suicide. Within his report within the brief of evidence, Dr Smith states:

> Hospital admission would have allowed for observation, diagnosis and subsequent treatment according to the provisional diagnosis. Whether this would have altered the tragic outcome in Mr Handog's case is speculative.

While Dr SMITH did not agree with Dr Bhavanishankar's decision not to admit Errol Handog on the 29 October 2014, he also stated that it was common for psychiatrists to have differing views about appropriate treatment. There was no suggestion Dr Shrestha or Dr Bhavanishankar had not complied with policy or performed in a manner that was manifestly inadequate or lacking in a duty of care.

The criteria Dr Bhavanishankar used in assessing Errol Handog's case were outlined in his evidence and are described earlier within these findings. Of note is that he was not aware of Errol Handog's cannabis use at the time he conducted the assessment. Cannabinoids were detected in Errol Handog's toxicology results. Dr Smith and Professor Large both expressed the opinion that cannabis withdrawal or intoxication could have affected Errol. Conversely, they also both agreed that the cannabis may have played little role, but it remains the case that a potential factor influencing Errol Handog's mental state was not disclosed to Dr Bhavanishankar.

Dr Bhavanishankar, therefore, was lacking correct information when he made his assessment. Professor Large expressed the view in his report that there were links between cannabis use and psychosis, and in particular between early psychosis and self-stabbing. Professor Large stated that it was possible that Errol Handog had an acute psychosis associated with cannabis use on the day of his death. The precise extent to which knowledge of cannabis use might have influenced Dr Bhavanishankar's assessment cannot be known, nor can it be stated with confidence the role cannabis played, if any, in Errol's suicide.

This lack of information complicated Dr Bhavanishankar's ability to accurately assess and/or diagnose Errol. Errol's diagnosis was unclear on 29 October 2014.

Dr Smith expressed the view that it would have been better clinical judgement for Dr Bhavanishankar to have admitted Errol Handog given Errol's incomplete diagnosis. While Dr Smith did not agree with Dr Bhavanishankar's decision, I do not find on the totality of the evidence that it was inappropriate for Dr Bhavanishankar not to admit Errol to Nepean Hospital.

Dr Smith and Professor Large agree that identifying those patients who will attempt suicide is one of the most difficult clinical assessments within psychiatry, and the NSW Health Policy Directive: *Clinical Care of People Who May be Suicidal (PD2016_007)* states that clinical judgement of mental health professionals is central to the assessment and management of a person at risk of suicide. There is no one-size-fits-all prescription, and each situation requires a difficult judgement call on the

part of the assessing doctor. Dr Bhavanishankar's decision was informed by criteria that included Errol having a supportive family, agreeing to follow-up from the Mental Health Team and Errol denying suicidal intent or having an active suicide plan. Errol had also denied substance abuse.

Dr Smith's opinion as to the appropriateness of Dr Bhavanishankar's clinical judgement was also balanced by Professor Large's opinion that the decision to manage Errol Handog in his home was "entirely normal and very understandable".

On the evidence, the treatment and medications provided by Dr Bhavanishankar are not in dispute and are outlined earlier in these findings. There was no controversy over the specifics of the treatment and medication other than a difference of opinion between Dr Smith and Professor Large over the appropriateness of Errol being managed in the community rather than admitted to hospital on 29 October 2014.

2. What advice and treatment did Dr Shrestha and Dr Bhavanishankar provide to Errol Handog and his family on the 28 October and the 29 October 2014?

As for the advice provided by Dr Shrestha and Dr Bhavanishankar to Reynaldo Handog Snr and Errol Handog, it is not possible for me to satisfactorily determine what conversation took place between the parties on 29 October 2014. None of the witnesses present had a good recollection of the interaction and there is minimal written documentation.

What is clear, however, is that there were crucial shortfalls in communication between the family and the medical/clinical staff. In particular, the scenario that eventuated, with Errol returning home and locking himself in his room, was a scenario that Dr Bhavanishankar had not envisaged occurring. These shortfalls in communication are relevant also to the third issue the inquest explored.

3. Are there any changes to the assessment and admission process that might improve outcomes at Nepean Hospital in the areas of client suicide risk assessment and suicide prevention?

Clearly the discussion on 29 October 2014 between Dr Bhavanishankar and Dr Shrestha and Reynaldo Handog Snr took place in circumstances that were extremely stressful for Reynaldo Handog Snr. In those circumstances, adequately retaining the content of a verbal conversation would have been difficult and

Reynaldo Handog Snr did not have the benefit of a written information sheet or similar that he could have referred to upon his return home.

Dr Bhavanishankar readily acknowledged that improvements could be made in how information relating to caring for a mental health patient in the community could be better communicated to the patient and their family members. Specifically, a “take home” document for patients and family members was supported by Dr Bhavanishankar. Dr Smith and Professor Large also expressed positive opinions in relation to a “take home” document for patients/family members.

Recommendations

Under s.82(1) of the Coroners Act 2009 (NSW), a coroner may make such recommendations as are considered necessary or desirable to make in relation to any matter connected with the death with which this inquest is concerned. By and large, recommendations have a protective purpose, their aim being to prevent the occurrence of similar deaths in the future. I consider that it is desirable to make recommendations in this case concerning the provision of a “take home” document for families/patients that would be similar to a discharge summary but would be for patients who are not admitted.

I am pleased to say that the legal representatives for the Nepean Blue Mountains Local Health District sought and received instructions from the Ministry of Health regarding the benefit of such a recommendation. I understand that the Ministry supports the use of such a document as being helpful to families and patients and that the Director of Clinical and Regulatory Services, Mental Health Branch of the Ministry of Health considers that such a document should be developed by each Local Health District rather than a state wide pro forma.

Findings required by s81(1)

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

The identity of the deceased

The deceased person was Errol Handog

Date of death

Errol Handog died between 3:30 p.m. on the 29 October 2014 and 1:00 p.m. on the 30 October 2014

Place of death

He died within his bedroom at 14 Kookaburra Crescent, Glenmore Park

Cause of death

Hanging

Manner of death

Errol Handog hanged himself with the intention of ending his life

S82 Recommendations

I recommend that the Minister of Health NSW consider the implementation of a “take home” document for families/patients that would contain information such as the treatment plan, follow up appointments, medications, emergency telephone numbers and other information relevant to the patient’s ongoing care and support. The document would be intended for patients who are not admitted, but who have undergone a mental health assessment at a Local Health District.

I would like to thank Sergeant Durand Welsh for his excellent assistance. I would also thank the officer in charge, Senior Constable Andrew Hayward for his investigation and preparation of the brief. .

Finally, I offer my condolences to Errol Handog’s family. I thank them for their participation in this inquest. They loved and cared for Errol very much and his loss to them is immense.

I close this inquest.

T. O’Sullivan
A/ State Coroner

Date 21 December 2017