CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of **Frederick Peisley**
Hearing dates:	20-24 June 2016
Date of findings:	16 December 2016
Place of findings:	State Coroners Court, Glebe
Findings of:	**Deputy State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Community Treatment Orders Nursing Home Electronic medical record keeping
File number:	2012/389877
Representation:	**Mr A Casselden: Counsel Assisting, instructed by Ms P Ava-Jones, the Crown Solicitor's Office** **Ms J Shepherd: Ritz Nursing Home** **Ms P Robertson: RN David Hehir** **Mr M Lynch: Sydney Local Health District and Nepean Blue Mountains Local Health District** **Ms R Mathur: Dr Creighton-Kelly, Dr Weerakoddy** **Mr S Barnes: Dr Noore**

Findings:	**Identity of deceased**: The deceased person was Frederick Peisley. **Date of death**: He died on 16 December 2012. **Place of death**: He died at Westmead Hospital, Westmead. **Manner of death:** He fell or jumped from a stairwell at the Ritz Nursing Home. **Cause of death:** The medical cause of his death was a blunt force head injury.

Recommendations:	**To the Ministry of Health**: 1. That consideration be given to expanding access to the Cerner eMR system (including the CHOC Program), the CHIME eMR system, and other electronic medical record systems used by NSW Health across Local Health Districts (LHDs) and Specialty Health Networks (SHNs). 2. That consideration be given to including copies of Community Treatment Orders in the summary level information available in the HealtheNet Portal used by NSW Health. 3. That consideration be given to implementing training about Community Treatment Orders for clinicians (RNs and doctors) working on general medical wards, including their purpose and the role of Case Managers. 4. That consideration be given to ensuring trainee psychiatrists receive comprehensive training about Community Treatment Orders, including their legal implications and when they come to an end. **To the Ritz Nursing Home**: 5. That consideration be given to developing policies and implementing staff training with respect to identifying and managing suicidality, depression and psychosis amongst residents. 6. That consideration be given to formally conducting a risk assessment of all internal and external stair cases at The Ritz Nursing Home having regard to the age and complex and varied needs of its residents.

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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 ***Frederick Peisley.***

REASONS FOR DECISION

Introduction

This Inquest concerns the death of Frederick Peisley. Mr Peisley was a resident at The Ritz Nursing Home. The Ritz is an aged-care facility that caters to people with a variety and degree of challenging behaviours.

On 9 December 2012, Mr Peisley had been observed by staff to be balancing at the top of some stairs and then again on the same day to be hanging from the stair railing. On 13 December 2012, Mr Peisley was again found by staff on a number of occasions to be standing near the top of staircases.

At 6:30pm on 13 December 2012, Mr Peisley was observed to be resting in bed. An entry is made on Mr Peisley's absconding chart indicating he was observed in his bedroom at 7pm. According to an Accident/Incident report, carer James Darrough, found Mr Peisley unconscious and bleeding, lying on the ground floor stairs in Wentworth Ward at 7pm. He was still breathing and was transferred by ambulance to hospital.

After an unsuccessful operation to stop bleeding on Mr Peisley's brain at Westmead Hospital, he died on 16 December 2012.

The issues in this Inquest include who had knowledge of the Community Treatment Order that Mr Peisley was on, the adequacy of the care and treatment at The Ritz, and whether Mr Peisley's behaviour on 13 December 2012 should have triggered a transfer to a mental health facility under the Mental Health Act?

I rely on the evidence included in the substantial brief prepared by the Officer in Charge and the evidence from witnesses who appeared at the Inquest. The brief includes the Post Mortem Report of Dr Kendall Bailey, Forensic Pathologist. Numerous medical and nursing staff gave evidence further to their statements. I was assisted by the expert evidence of Dr Sharon Reutens, psychiatrist, who provided a report and gave evidence at the Inquest. Additional documents were tendered including those relevant to policy and procedure.

The Evidence:

Background

Frederick Peisley (Fred) was an Aboriginal man born on 2 July 1954, along with his twin brother, John Henry Peisley. The boys were raised in the Sydney suburb of Woolloomooloo which at that time was an impoverished area. Fred came from a family of ten; his mother, Fredericka Maryann, his father, Thomas Roy, his three sisters, Letitia, Angelina and Elizabeth and his four brothers, Elvie, Thomas, John (twin) and Christopher. The family also took in a young cousin named John (known as Big John) whom they considered as their brother.

The family moved to Annandale after their Woolloomooloo home was repossessed by the Government to make way for the Eastern Suburbs Railway line.

Fred started a relationship with Julie Black in 1982 and started living together in Randwick in 1983. They married in 1988 and they have a son, Thomas and a daughter, Taylor. Fred also had custody of Tamara, his daughter from a previous relationship and his step-daughter, Tammy also lived with the family.

The family moved to Leichhardt in 1984 and it wasn't long before Fred and Julie welcomed two more relatives into their home, Fred's nephews aged 19 and 21 years.

Fred owned a newspaper delivery business and worked long hours to provide for his large family. According to his family, Fred was a very generous and kind man, always ready to lend a hand to someone in need.

Fred and Julie divorced in October 2001 but remained good friends. Julie moved to Queensland with the children. Fred moved to the Gold Coast a few years later to be closer to his children. In the words of Julie Black, *"Fred loved his family dearly and always strived to make life easier for them."*

The brain injury

It was in Queensland that Fred sustained a brain injury in an assault in 2007. As a result of the injury, Fred developed a schizoaffective disorder, depression and suicidal ideations and had multiple psychiatric hospital admissions. When Fred was released from hospital, his twin brother, John, thought it best that he return to Sydney where they had a bigger network of family and friends.

Prior to his brain injury Fred was described by his niece, Kim Apap, as a *"fit and healthy man*". He had worked in the past as a nightclub operator and personal trainer, and had no known psychiatric history.

The Community Treatment Order

In February 2012 Fred was admitted to the Concord Centre for Mental Health at the Concord Hospital as an involuntary patient following aggressive behaviour at his residence, the Haberfield Presbyterian Aged Care Facility. He was subject to a Community Treatment Order ("CTO") at the time of his admission managed by Croydon Community Mental Health Service.

During his time at Concord Hospital, Mr Peisley was visited regularly by Ms Apap. He was discharged from Concord Hospital on 18 July 2012 under a new CTO to be managed by the Camperdown Community Mental Health Service. The CTO required Fred to accept a monthly intra-muscular injection of the anti-psychotic Paliperidone and to maintain contact with his CTO Case Manager (or delegate) every two weeks.

The CTO obliged Camperdown Community Mental Health Service to provide support, monitoring and education to Fred regarding his mental illness by providing information and advocacy. A copy of the CTO was forwarded by Concord Hospital to Camperdown Community Mental Health Service that same day, but the circumstances of its receipt are unclear. For reasons which emerge below Fred was not managed by the Camperdown Community Mental Health Service.

Annesley House admission

Fred was transferred to a low care residential facility in Leichhardt, Annesley House. On 19 July 2012 Fred was visited by RNs Donna Beeson and Rachel Culican from the Camperdown Acute Care Service, which is part of the Camperdown Community Mental Health Service. At the time of their visit they were unaware that Fred was the subject of a CTO. They did not see him again.

Fred was reviewed at Annesley House by private psychiatrist, Dr Shannon Paisley, on three occasions. He was also attended by GP Dr Zeina Jamal who administered his anti-psychotic medication on 3 August 2012.

On 23 August 2012 Mr Peisley absconded from Annesley House. Ms Apap located her uncle the following day. He had ulcers under his arm and looked unwell. Ms Apap took Mr Peisley to her GP, who advised Mr Peisley should attend a hospital immediately as he was suffering from a septic skin condition.

Nepean Hospital admission

Fred was admitted to Nepean Hospital on 24 August 2012 for treatment of multiple abscesses and remained there for over six weeks. During his admission Ms Apap raised concerns on a number of occasions with staff that Mr Peisley wasn't receiving his anti-psychotic medication.

Fred had his first psychiatric review by Dr Weerakkody (RMO) at Nepean on 14 September 2012. In his notes, Dr Weerakkody states that Mr Peisley, "*denied suicidal or homicidal intent"* and had "*no psychotic symptoms".*

On 19 September 2012 Dr Weerakkody noted: "*patient has not taken any anti-psychotic medication since he was in Annesley House…but he currently demonstrates no evidence of psychosis*". He noted that Mr Peisley's presentation was consistent with his brain injury and *"patient does not wish to take anti-psychotics".* Psychiatrist, Dr Noore, also reviewed Mr Peisley that day. He concluded Mr Peisley should be reviewed the following week for psychosis and a definitive decision about the prescription of anti-psychotics would be made then.

On 24 September 2012, Dr Weerakoddy requested and received Mr Peisley's discharge summary from Concord Hospital. The discharge summary refers to Mr Peisley's CTO and ongoing medication needs.

Blue Mountains District Hospital admission

Mr Peisley was discharged to Blue Mountains District Hospital on 11 October 2012 before Dr Noore could assess him again. He remained at Blue Mountains District Hospital while waiting for placement at a suitable nursing home.

On 15 October 2012, Mr Peisley had a mental health review. That review noted Mr Peisley had been discharged from Concord Hospital on Paliperidone and that Ms Apap was concerned he had not had any anti-psychotic medication since his admission to Nepean Hospital. There was no reference to Mr Peisley's CTO in the notes. Plans were made to liaise with a consultant psychiatrist, however it does not appear that this occurred.

On 22 October 2012, it was noted that Mr Peisley should have ongoing mental health review, however this did not happen. Following an Aged Care Assessment Team ("ACAT") assessment determining that Mr Peisley required high level care in a residential aged care facility, he was transferred to The Ritz Nursing Home on 26 October 2012.

The Ritz

There was no suggestion in the medical notes that Mr Peisley was depressed or suicidal during his hospitalisation at either Nepean or Blue Mountains Hospital and neither was there any indication of suicidality in his ACAT assessment.

The Ritz is an aged-care facility that caters to people with a variety and degree of challenging behaviours. The Ritz is a secure facility with a security fence and key pads for access. The ability to leave the home depends on the particular individual and The Ritz's risk assessment. Within the facility, residents can access the gardens and other external areas.

Ms Apap visited Mr Peisley at The Ritz between one and two times a week. She recalls it as a "*reasonably nice"* facility with nice staff. She was concerned, however, due to Mr Peisley's history of absconding, that the stairs were not gated and there was easy access to the elevator and exits.

The Ritz was not aware of Mr Peisley's CTO prior to his admission, however by at least 31 October 2012 they had received a copy of Concord Hospital's discharge summary that refers to the CTO. On that same day, General Practitioner Dr Paul Stephens recommended that Mr Peisley be re-commenced on his anti-psychotic medication. It appears Mr Peisley's first dose of Paliperidone at The Ritz was administered on 1 November 2012.

Psychiatrist, Dr Thiering, first reviewed Mr Peisley on 9 November 2012 and Mr Peisley apparently received another dose of Paliperidone that day. Another dose was administered on 6 December 2012.

According to Dr Thiering, he was never made aware that Mr Peisley was the subject of a CTO, and had he known he would have worked with Mr Peisley's CTO Case Manager.

The Absconding Chart

An "Absconding Chart" was maintained for Mr Peisley throughout his entire time at The Ritz. The first specific record of Mr Peisley attempting to abscond was on 1 November 2012 when he smashed a window. Thereafter, there are a number of instances of Mr Peisley attempting to leave through the locked gates or otherwise indicating a desire to leave. In contrast, on 16 November 2012 the notes reflect that Mr Peisley reported feeling "*good, great, no problems*".

On 9 December 2012 the notes state that Mr Peisley attempted to leave The Ritz, was behaving erratically, and asking staff to break his leg. At 6:00pm he was found balancing on the top step of the stairs in Kanimbla ward and refused to move or hold the hand rail for approximately 15 minutes. At 6:30pm he was found hanging over a stair railing in the Kanimbla corridor. He received doses of diazepam and haloperidol at 7pm to manage his agitation and was moved to a room on the ground floor.

The fatal incident

Over the next few days, Mr Peisley appears to have been quite settled. Apart from some agitation, no suicidal ideation or erratic behaviour is reported in his progress notes. On the morning of 13 December 2012, Mr Peisley's notes indicate he made "multiple" attempts to jump off the fire escape. Mr Peisley remained on an absconding chart on this day and, at the 3pm handover, staff were told that Mr Peisley was on suicide watch.

At about 6pm, Mr Peisley was seen by General Practitioner, Dr Creighton-Kelly, due to his suicidal ideation. This was the first time Dr Creighton-Kelly had seen Mr

Peisley. Dr Creighton-Kelly determined that the best course of action was to increase his haloperidol to try and reduce his impulsivity. Dr Creighton-Kelly did not believe it would be appropriate to schedule Mr Peisley under the Mental Health act.

At 6:30pm Mr Peisley was observed to be resting in bed. An entry is made on Mr Peisley's absconding chart indicating he was observed in his bedroom at 7pm.
According to an Accident/Incident report, carer, James Darrough, found Mr Peisley at 7pm unconscious and bleeding, lying on the ground floor stairs in Wentworth Ward. He was still breathing and was transferred by ambulance to Westmead Hospital.

After an unsuccessful operation to stop bleeding on Mr Peisley's brain at Westmead Hospital, he passed away on 16 December 2012.

Conclusions

The Community Treatment Order

There was compelling evidence that the Concord Centre for Mental Health sent RN David Hehir at Camperdown Community Mental Health Service a fax including the Community Treatment Order (CTO) made by the Mental Health Review tribunal on 18 July 2012.[1] There was no acknowledgement sent back to Concord that Camperdown Community Health Centre received the fax. It was unfortunate that Mr Hehir did not make a note about the CTO in Fred's file after the MHRT hearing in which he appeared via telephone. To his great credit, Mr Hehir was candid and frank about this oversight. There are some systemic issues that have arisen in this case about the recording and sharing of important information such as notification that a patient is on a CTO. Because there was no document recording the existence of Fred's CTO in the Camperdown Community Mental Health Service file RN Beeson and RN Culican were unaware that Fred was the subject of a current CTO when they visited him at Annesley House on 19 July 2012.

Nepean Hospital

Fred was admitted to Nepean Hospital suffering from a septic skin condition. He was in a medical ward and mostly quiet apart from when his dressings were being changed. Fred was being treated by Dr Weerakoddy who was a junior RMO with only eight and a half months experience in psychiatry and no formal psychiatry training program. He relied on Dr Noore for supervision. Dr Weerakoddy reviewed Fred 5 times over the 6 week admission and Dr Noor reviewed Fred once. Expert psychiatrist, Dr Reutens, was not critical of Dr Weerakoddy given his lack of experience. In her opinion he did the best he could.[2] She did, however, comment

[1] Brief of evidence, Vol 5, Tab 46
[2] Evidence given at Inquest on 24/6/16

that she would have expected more direct supervision from Dr Noore and he should have reviewed Fred weekly himself.[3]

Dr Weerakoddy read the Concord Hospital Discharge Notes and was aware of the CTO. To his credit he took steps to contact psychiatrist, Dr Paisley. Dr Reutens was of the opinion that there should have been a phone call made to the CTO Case Manager at the Camperdown Community Health Centre to obtain a collateral history.

Neither Dr Weerakoddy, nor Dr Noore were of the opinion that Fred was displaying symptoms of psychosis. Rather, their evidence to the Inquest suggests a provisional diagnosis of delirium was made. This provisional diagnosis is not noted in the medical notes and nor were any investigations undertaken to try and ascertain what was causing it.

Dr Reutens was of the opinion that delirium was one possibility for a person with a history of psychosis but it was lower down on the list of possibilities. She was of the view that if delirium was suspected then it would have been important to investigate what might be causing it. Her practice would have been to check for any infection, obtain a full blood test, a urine test and chest X-Ray to see if anything acute may be happening.

Given the delirium diagnosis, a decision was made by Dr Weerakoddy in consultation with his supervisor, Dr Noore, not to follow the CTO medication regime which included a monthly injection of 100mg of the antipsychotic, Paliperidone. Dr Reutens was of the view that it was a big risk to stop Fred's depot injection and again stressed how important it was to go back to the CTO Case Manager to obtain a full history.[4]

I agree with Dr Reutens that Dr Weerakoddy did the best he could in the circumstances. I also agree with her opinion that Dr Noore should have reviewed Fred more regularly, particularly given Dr Weerakoddy's lack of experience in psychiatry. I am also of the view that contact should have been made with Fred's CTO Case Manager once Dr Weerakoddy and Dr Noore became aware that Fred was the subject of a CTO and before stopping his depot injection.

The Ritz

On 11 October 2012, Fred was discharged to the Blue Mountains District Hospital to wait for a placement in a nursing home. On 26 October 2012, Fred was placed at The Ritz. The Ritz was one of the few facilities that could take a person with Fred's complex needs and history and it was the only facility in the Blue Mountains and close to Kim Apap. I consider the Ritz was an appropriate facility to house Mr Peisley.

The Ritz was not aware that Fred was on a CTO prior to his admission. This is a systems failure that needs some attention. The Ritz became aware of the CTO on or

[3] Evidence given at Inquest on 24/6/16
[4] Evidence given at Inquest on 24/6/16

about 26 October 2012 and the monthly depot injections were recommenced. These injections were administered on 1 November 2012 and then again on 9 November 2012 and 6 December 2012.

Overall, Dr Reutens considered the care given to Fred at The Ritz was commendable and, from a psychiatric perspective, Fred was cared for adequately, noting that The Ritz is not a psychiatric unit.

- **9 December 2012**

On 9 December 2012, the medical notes record Fred was acting erratically and "asking staff to break his legs". Fred was twice found by AIN Beth Whiteley at the top of the internal staircase on the Kanimbla Ward. The internal staircase runs from the Wentworth wing on the ground floor up to the Kanimbla Ward. On the first occasion, at about 6pm, Fred was balancing on the midsection of his feet at the top of the staircase. It took about 10 minutes for Ms Whiteley to coax him off the staircase. About half an hour later, Fred was again found at the top of the staircase. Fred was hanging over the top rail in a way Ms Whiteley considered dangerous. She was able to immediately redirect Fred back to his room.[5]

The medical notes refer to "suicidal ideation" in the context of Fred's behaviour at the stairs, but Ms Whiteley said she did not know what Fred's intentions were.[6]

Ms Whiteley completed two incident reports about these interactions and reported her observations to the RN in charge. A decision was made that Fred, who was already on an hourly observation schedule, should continue to be monitored. He received PRN medications Diazepam and Haloperidol at about 7pm and was settled and resting thereafter.

Notably, by 9 December 2012 Fred's anti-psychotic medication regime of depot injections had been reinstated and, in addition, he was regularly receiving other medications to settle his agitation. The incidents on the stairs followed Fred talking about sex and God on 3 and 6 December 2012; a sign Fred could have been experiencing hallucinations and psychosis.

Dr Reutens[7] characterised Fred's behaviours at the stairs on 9 December as "suicidal". Dr Reutens considers that, at this stage, Fred should have undergone a medical assessment so that scheduling under the *Mental Health Act 2007* could be considered. I agree with Dr Reutens. Overwhelmingly, I find that at least on 9 December there should have been escalation to contact a GP or psychiatrist or the Blue Mountains Community Mental Health Team. To her credit, The Director of Nursing at The Ritz, Joy Egan, acknowledged that Fred's care should have been escalated to a GP by 9 December and the failure to do so was a departure from policy.

[5] Evidence given at Inquest 22/06/16 and brief of evidence, Vol 1, Tab 13.
[6] Brief of evidence, Vol 3, Tab 41, page 262.
[7] Evidence given at Inquest on 24/06/16.

- **13 December 2012**

By 13 December 2012, Fred had been moved to a bedroom on the ground floor as a consequence of his behaviour on 9 December. On that day, AIN Kim Warrington observed Fred on external fire escape stairs but was able to redirect him back to his room. Approximately 40 minutes later, Ms Warrington found Fred standing at the top of the external staircase that joins the Jamieson and Blaxland wards. Ms Warrington had some concerns about this incident and reported it to the RN in charge.

AIN Belinda Tunbridge contacted GP Dr Creighton-Kelly about Fred's behaviour and it was agreed he would attend The Ritz to assess Fred later that day. By contacting a GP, I accept The Ritz followed procedure on 13 December 2012.

In the meantime The Ritz staff were asked to closely monitor Fred. AIN James Darrough reports checking on Fred every 10 to 15 minutes, together with another AIN, from the beginning of his shift at 3pm, however the observation chart (called an "absconding chart") was only updated hourly. In the absence of entries every 10 – 15 minutes on the absconding chart, I cannot be satisfied that Fred was receiving close monitoring on 13 December. In her evidence, Ms Egan accepted that hourly monitoring, as was recorded on the absconding chart, was a departure from the concept of close monitoring.[8]

Mr Darrough thought Fred appeared more depressed than usual and he was very quiet.[9]

Dr Creighton-Kelly attended The Ritz at about 6pm to assess Fred. He recalls he was asked to attend The Ritz because Fred was loitering around staircases and staff had concerns it could indicate he had suicidal ideas.[10] His contemporaneous notes record that Dr Creighton-Kelly was asked to see Fred

"DUE TO SUICIDAL IDEATION TODAY THREATENING TO JUMP FROM 1ST FLOOR STAIRS OVER W/E".

Dr Creighton-Kelly had not met Fred before. Fred was lying calmly in his bed. He did not present to Dr Creighton-Kelly as depressed and was not showing any signs of pain, stress or discomfort. Although, the doctor acknowledged that signs of depression can sometimes be masked by the symptoms of other conditions.[11] As part of his assessment Dr Creighton-Kelly asked Fred if he was having thoughts of self-harm at that time, to which he believes Fred answered "no".

After examining Fred, Dr Creighton-Kelly reviewed his medication chart[12] and the clinical notes of his regular GP, Dr Stephens, and his psychiatrist, Dr Thiering. Dr Creighton-Kelly was not provided with Fred's progress notes completed by nursing staff. Nor did he receive copies of any incident reports pertaining to Fred. Dr

[8] Evidence given at Inquest 23/06/16.
[9] Evidence given at Inquest 22/06/16
[10] Evidence given at Inquest 23/06/16.
[11] Evidence given at Inquest 23/06/16.
[12] The totality of Dr Creighton-Kelly's evidence suggests that he did not see all Fred's medication charts.

Creighton-Kelly spoke with nursing staff about Fred's recent behaviours and was given the impression that it was the impulsiveness of his medical condition that needed controlling. In his oral evidence, Dr Creighton-Kelly could not recall specifically who had informed him that Fred's possible suicidal behaviours had been present for "some time, at least a week"[13], but he thought he had principally gleaned that information from Fred himself.[14]

Dr Creighton-Kelly came to a provisional diagnosis that Fred was suffering from a cognitive deficit secondary to a brain injury sustained some years before and possibly alcohol abuse. He decided that the best course of action was to increase his Haloperidol to try and reduce Fred's impulsivity[15]. Based on his examination, he did not believe it was appropriate to put Fred under a *Mental Health Act* schedule.

Tragically, at about 7pm that evening, Fred was found at the bottom of the internal stairs of the ground floor of Wentworth wing unconscious with a head injury. Fred was conveyed to hospital but did not survive his injuries.

I consider there were some failings by The Ritz in the clinical picture staff presented to Dr Creighton-Kelly about Fred on 13 December 2012. As noted above, Dr Creighton-Kelly did not receive Fred's progress notes. Nor was he otherwise informed by staff of Fred's erratic behaviours four days earlier asking staff to break his leg. It appears from his contemporaneous notes and evidence to the Inquest that Dr Creighton-Kelly had some knowledge of Fred's suicidal behaviours, but his oral testimony suggests the information received from staff about those behaviours lacked specificity. For example, Dr Creighton-Kelly told the Inquest he had not been told Fred was seen to be hanging from the top stair rail in the Kanimbla Ward on 9 December. Nor was he told that Fred had been administered 5mgs of Haloperidol that day because of his behaviours, nor about his Haloperidol regime more generally. Dr Creighton-Kelly said he had not been told Fred had made "multiple" attempts to jump off the fire escape on the morning of 13 December 2012, as per the progress notes.[16]

I accept the evidence of Dr Creighton-Kelly that if he was informed of an accurate and complete history by staff he would have considered Fred at acute risk of suicide on 13 December and would have arranged for Fred to be transferred to a mental health facility for assessment. I further note Fred's psychiatrist at The Ritz Dr Thiering and the independent expert psychiatrist Dr Reutens support Dr Creighton-Kelly's evidence on this point. I am therefore not critical of Dr Creighton-Kelly's provisional diagnosis in the circumstances.

There is some tension in the evidence regarding Fred's prescribed amount of Haloperidol. Dr Creighton-Kelly thought on 13 December he was "increasing" Fred's Haloperidol to receiving a regular 1mg of Haloperidol 3 times per day. In fact, it appears as at that date Fred was already prescribed 2.5mg of Haloperidol 3 times per day plus up to another 20mg of Haloperidol, in 5mg doses, per day PRN (as

[13] Brief of Evidence, Vol 1, Tab 10.
[14] Evidence given at Inquest 23/06/16

[16] Evidence given at Inquest 23/06/16.

needed). Therefore, Dr Creighton-Kelly's order would have represented a decrease in Fred's Haloperidol. Dr Creighton-Kelly told the Inquest he did not remember seeing the PRN medication chart[17] at his consultation on 13 December and was not told Fred had been prescribed a regular 2.5mg dose due to his agitation. However, I find that any confusion in Fred's medication regime is inconsequential noting that, according to the medication charts, on 13 December 2012 Fred received his three 2.5mg doses of Haloperidol.

There was oral evidence from Mr Darrough that he had observed Fred standing at the top of the external staircase near his upstairs bedroom prior to his transfer to a room downstairs on at least three occasions. Mr Darrough said he was concerned about Fred's intentions and reported these incidents to a Registered Nurse or other supervisor, but was told he did not need to complete incident reports as "there'd been enough reports filled in".[18] To my mind, the incidents observed by Mr Darrough represent an escalation in Fred's risk-taking behaviours that is not clearly documented on Fred's file whether in incident reports or Fred's progress notes. Without clear documentation, the remaining nursing staff may not have had a complete picture of Fred's behaviours and, as a consequence, Dr Creighton-Kelly's assessment of him on 13 December was further frustrated.

- **Improvements**

Director of Nursing at The Ritz, Joy Egan gave evidence[19] to the Inquest regarding improvements made at The Ritz following their internal investigation into Fred's death as follows:

a) The Ritz has introduced a "close observation chart" that is used to monitor a resident's mood as well as location at set times. This is in addition to their other charts.
b) A wall has been built to prevent people falling over the top railing of the internal staircase.
c) The Ritz's pre-admission form has been amended so that information about CTOs can be included.
d) The Ritz has introduced an 8-week trial for residents that are referred from a hospital. If a resident displays behaviours during the trial period that The Ritz cannot manage, or information is received that was not disclosed on admission, The Ritz has the ability to move that resident to a more appropriate facility.

Ms Egan said the internal stairs could not be closed off because they are fire stairs. Furthermore, residents are encouraged to be up and about and have freedom of movement in their home. She acknowledged there is also an elevator that the residents can use between floors.[20]

[17] Brief of Evidence Vol 3, Tab 41, page 149.
[18] Evidence given at Inquest 22/06/16.
[19] Evidence given at Inquest 23/06/16 and Brief of Evidence, Vol 4, Tab 44.
[20] Evidence given at Inquest 23/06/16.

As for the external stairs, Ms Egan said consideration could be given to installing alarms on the access doors to those stairs.[21]

Manner of death

The Inquest heard evidence from Mr Darrough that he thought Fred could have been depressed. However, on this point, I accept the evidence of Dr Creighton-Kelly, Dr Thiering and Dr Reutens who all agreed that it would not have been obvious that Fred was depressed because his other behaviours, including aggressive behaviours and religiosity, would have masked it.

Mr Darrough thought Fred's behaviours at the top of the staircases were indicative of suicidal ideas.[22] Some of the progress notes written by other staff also record that Fred was displaying suicidal ideation. However, based on the evidence before me, I cannot conclude that Fred intended to take his own life on 13 December 2012. I consider it just as probable that Fred's death was the result of misadventure, noting the agreement between Dr Thiering, Dr Creighton-Kelly and Dr Reutens that Fred's pre-existing brain injury meant he was more prone to poor judgment and risk-taking behaviours.

I would like to thank the officer in charge, my counsel assisting, Mr Casselden and Ms Ava -Jones from the Crown Solicitor's Office for their excellent assistance.

Finally, I offer my sincere condolences to Fred's family who spoke so highly of him. I thank them for their participation in this inquest and I hope that some of their questions have been answered.

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 Frederick Peisley

Date of death

He died on 16 December 2012

Place of death

He died at Westmead Hospital, Westmead.

Cause of death

The medical cause of his death was a blunt force head injury.

[21] Evidence given at Inquest 23/06/16.
[22] Evidence given at Inquest 22/06/16.

Manner of death

He fell or jumped from the first floor, Kanimbla Ward at the Ritz Nursing Home.

Recommendations

To the Ministry of Health:

1. That consideration be given to expanding access to the Cerner eMR system (including the CHOC Program), the CHIME eMR system, and other electronic medical record systems used by NSW Health across Local Health Districts (LHDs) and Specialty Health Networks (SHNs).

2. That consideration be given to including copies of Community Treatment Orders in the summary level information available in the HealtheNet Portal used by NSW Health.

3. That consideration be given to implementing training about Community Treatment Orders for clinicians (RNs and doctors) working on general medical wards, including their purpose and the role of Case Managers.

4. That consideration be given to ensuring trainee psychiatrists receive comprehensive training about Community Treatment Orders, including their legal implications and when they come to an end.

To the Ritz Nursing Home:

5. That consideration be given to developing policies and implementing staff training with respect to identifying and managing suicidality, depression and psychosis amongst residents.

6. That consideration be given to formally conducting a risk assessment of all internal and external stair cases at The Ritz Nursing Home having regard to the age and complex and varied needs of its residents.

I close this Inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner

Date: 16 December 2016