STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of SS
Hearing dates:	3-5 February 2016
Date of findings:	5 February 2016
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	Coronial Law – care and treatment at Gosford Hospital, communication between primary carer and physicians
File number:	2014/1183345
Representation:	Sgt D Williamson (Advocate Assisting) Mr T Slevin of counsel (Mrs KS) Mr A Saxton (Dr 8 Lachter) Mr E Pike of counsel instructed by Avant Law (Dr I Noor)
Findings:	I f1nd that SS died on 18 June 2014 or 19 June 2014 at Boronia Park NSW by hanging which was intentionally self-inflicted.
Recommendations:	To the NSW Minister for Health: I recommend that a review be conducted of standard mental health admission and discharge forms and checklists to ensure that there is uniformity across all documentation and to ensure that hospital clinicians are provided with appropriate reminders of all mandatory requirements under the *Mental Health Act 2007* in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment To the Chief Executive of the Central Coast Local Health District: I recommend that appropriate training and education systems be implemented in order to ensure that medical officers in mental health facilities are aware of all mandatory requirements of the *Mental Health Act 2007* in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment, and that guidelines be implemented to clearly identify the authorised medical

officer in all cases.

Non publication order: Pursuant to s 75(2) of the Coroners Act 2009 I direct that there be no publication of any material that identifies the deceased person or his family.

Pursuant to s 75(5) of the Coroners Act 2009 I direct that reports of the proceedings and findings may be published as being in the public interest.

IN THE STATE CORONER'S COURT
GLEBE, NSW
SECTION 81 *CORONERS ACT 2009*

REASONS FOR DECISION'

INTRODUCTION

1. This is an inquest into the death of SS.

THE ROLE OF THE CORONER AND THE PURPOSE OF THIS INQUEST

2. The role of a Coroner, as set out in section 81 of the *Coroner's Act 2009,* is to make findings as to:

   (a) the identity of the deceased;
   (b) the date and place of the person's death;
   {c) the physical or medical cause of death; and
   (d) the manner of death, in other words, the circumstances surrounding the death.

3. Pursuant to section 82 of the *Coroners Act* a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

4. In this case, there is no issue as toSS's identity, when and where he died, and the cause and manner of his death.

5. However SS's wife, Mrs S, has raised questions regarding the degree and the appropriateness of contact between herself and the clinical team responsible for SS's care and treatment whilst he was a patient at Gosford Hospital in June 2014. This inquest will consider:

   (a) the nature of the contact between Gosford Hospital and Mrs S;

   (b) whether it was appropriate in all the circumstances;

   (c) whether the asserted lack of contact contributed toSS's death; and

   (d) whether this case warrants the making of any recommendations to potentially improve the care and treatment of patients at Gosford Hospital.

THE LIFE OF SS

6. SS was born on 27 July 1965 to his parents, RS and RS. He was raised in Wingham on the State's mid-north coast and attended primary and high school there. SS was a gifted and intelligent student He often helped out at his parents' nursery and had a great love for the natural sciences and his many hobbies.

[1] These findings have been prepared without the benefit of a transcript of the oral evidence.

7. This passion led SS to the University of Wollongong where he studied engineering. He would later go on to work in the field of information technology. He met his wife, Mrs S, in 1989 at St Barnabas church and they married 2 years later in 1991. SS and Mrs Shad two children who they loved dearly. When Mrs S started her ministry work as a school chaplain, SS worked part· time to help raise their children. He has been described as a very hands.on dad, and a loving husband and father. The family have many fond memories of spending holidays at South west Rocks which was a favourite spot for them to go fishing and enjoy each other's company.

8. SS had a natural charm relating to people and was able to converse with them on a wide range of topics. He was a wonderful companion to Mrs S. He was both well·liked and well-respected by his many friends and work colleagues. There is no doubt that he is greatly missed by family and friends alike.

SS'S MEDICAL HISTORY

9. SS had a long history of recurring depression for over 20 years. He started seeing a counsellor in 2003 and was referred to a psychiatrist the following year. In the middle of 2004, SS was hospitalised at the Sydney Clinic for about two months and underwent his first course of electroconvulsive therapy (ECT).

10. SS's condition improved following his discharge but worsened again in 2007 to 2008. In 2011 SS was re·admitted to the Sydney Clinic and later hospitalised at the Parkview Macquarie Hospital. In late 2011 SS underwent further ECT treatment at the Sydney Clinic and in January 2012 he was admitted to Manly Hospital as an involuntary patient. After his discharge, SS was in contact with the Ryde Community Mental Health Service throughout 2012.

11. SS and Mrs S separated in December 2012 and SS initially went to stay with his parents in Wingham. Over the next two years he alternated between living with his parents and living with Mrs S and was in contact with the local community mental health service in Taree.

12. In February 2014, whilst in Sydney, SS became unwell and voluntarily admitted himself to Ryde Hospital where he stayed for about two weeks. Following his discharge he returned to stay with his family in Wingham.

13. The medical records establish that up to 2014, SS suffered from treatment·resistant depression for several years and he had not responded to a full range of pharmacological, psychological and neurostimulation treatments. He was identified as person who had chronic suicidal ideals and plans.

SS'S ADMISSION TO RYDE HOSPITAL

14. On 26 May 2014, SS called Mrs S and told her that she would not see him again. At about 3:00pm the next day SS went to Mrs S's home unexpectedly, dropped off some property, and left in a hurried manner. Afterwards Mrs S spoke to some of SS's close friends who told her that they had received text messages from SS which suggested that he was going to harm himself. At about 4:30pm Mrs S contacted Ryde Hospital where SS had last been seen in February and March 2014 following a self-harm attempt. Hospital staff advised Mrs S to contact police, which she did, and she reported SS as missing.

15. At about 11:OOpm later that night police found SS along a bushwalking track in Boronia Park reserve that forms part of the Great North Walk. SS had apparently consumed a large amount of alcohol and was unconscious. When police woke him SS told police that he was going to kill

himself with a knife. The attending police officers noted that there was a knife stuck in a nearby tree.

16. Police arranged for SS to be taken by ambulance to Ryde Hospital where he was assessed, found to be a mentally ill person by the psychiatry registrar, and admitted as an involuntary patient. Upon admission SS nominated Mrs S as his primary carer in accordance with section 72 of the *Mental Health Act 2007* (the Act).[2] Ryde Hospital records reveal that SS told hospital staff that he had been Jiving with his parents in Newcastle for the previous 6 weeks. SS repeated to hospital staff that he was distressed and wanted to end his life by stabbing himself.

SS'S ADMISSION TO GOSFORD HOSPITAL

17. SS was later transferred to the Mental Health Unit at Gosford Hospital on 28 May 2014 as an outMofMarea patient due to limited bed availability at Ryde Hospital. Records show that SS continued to express suicidal thoughts and that he told the staff that he planned to kill himself when discharged.

18. On 30 May 2014 Dr Bruce Lachter, consultant psychiatrist at Gosford Hospital, first saw SS and found him to be a mentally disordered person under the Act. Dr Lachter diagnosed SS as having an adjustment disorder with depressed mood, dysthymia with borderline and histrionic personality traits.[3] SS was kept as an involuntary patient and transferred to the acute ward.

19. At about 2:25pm on 1 June 2014, during regular 30 minute observations, a nurse walked into SS's room and noticed him hide an object down the side of his chair. The object was found to be a sheet that had been plaited into a rope and a bent hospital cutlery knife that had apparently been taken from an earlier meal. When questioned about the plaited sheet, SS expressed thoughts of selfMharm and asked to be allowed to use it. As a result, he was immediately moved to the open ward and later transferred to the High Dependency Unit (HDU).

20. The progress notes record nothing remarkable on 2 June 2014 and that SS had been pleasant and engaging well in conversation.

21. Dr Lachter next reviewed SS on 3 June 2014. The progress notes record that SS appeared settled all day and was experiencing nil voice issues. Dr lachter observed that SS was "not actively suicidal" and that he was "not able/willing to elaborate on the event that led him transferring [to the High Dependency Unit] from open ward" (sic).[4] Under Dr lachter's instruction, SS was made a voluntary patient and returned to the open ward. Dr lachter also ceased SS's prescription for lithium and approved unaccompanied leave twice daily for one hour. SS returned to the open ward at about 2:50pm later that day.

22. Following his return, SS approached the nursing station in a state of distress at about 6:25pm. SS was initially unable to verbalise what was troubling him and so nursing staff spoke to SS in his room a short time later. At that time SS began by saying, "If I tell you **I** will go back there" and went on to tell the nursing staff that he had earlier tied his socks together, hung them over his ensuite door, placed a noose around his neck and stepped *off* a chair. SS said that as a result of this he passed out and woke up on the floor with a headache. He told the nurse that he put the socks in a brown paper bag in his room, where they were later found. SS was subsequently reviewed by the psychiatric registrar and returned to the HDU.

• **I** note that s 72 of the Act has since been amended to refer to "designated", as opposed to "primary", carer.

[3] Exhibit 2, paragraph 16.

[4] Exhibit 1, tab 13.

23. The records note that SS continued to express thoughts of self-harm on 4 June 2014, both to nursing staff and to a friend he called on the phone. His mood was noted to be low.

24. Dr Lachter, together with a social worker, reviewed SS again on 6 June 2014. Dr Lachter formed the view that the appropriate plan for SS was to encourage his agency and recovery with practical and psychological support.[5] Accordingly, SS signed a form for voluntary admission pursuant to section 5(1) of the Act and was moved back to the open ward at about 1:OOpm. Prior to his move the progress notes record that SS appeared to be settled in mood with nil evidence of agitation. Dr Lachter noted that the "overall picture remains of significant personality contributions to this current crisis: histrionic and borderline personality traits predominate", and approved two hours unaccompanied leave twice daily, with SS to continue with his medication on parnate only.[6]

25. Between 6 June 2014 and 10 June 2014, it appears that the progress notes record a general improvement in SS's well-being. It was noted that SS utilised unaccompanied leave several times without incident and that he engaged well with other patients in the common area. The notes do also record that SS was sometimes teary during interaction with nursing staff and that on 9 June 2014 he admitted to ongoing suicidal ideation, but that he had nil suicidal ideation the following morning. The notes also record that on 9 June ·2014 SS expressed his appreciation of unaccompan"1ed leave.

26. On 10 June 2014 SS was reviewed by Dr Lachter and Dr lrfan Noor, psychiatry registrar. SS told the doctors that he was feeling anxious about where he would Jive in the future but expressed a desire to return to Sydney. SS also said that he wanted to be discharged as soon as possible but that he needed to speak to a social worker first. An offer was made to SS to be discharged that day but he indicated that he wanted to be discharged the following day (11 June 2014) so that he could "sort out a few things".[7]

27. According to the progress notes SS was found to be cooperative, engaging, with nil delusions and nil psychosis. A discharge plan was prepared for SS to be discharged the following day, if he was ready. The plan involved SS continuing with his medication for 7 days and for the Gosford Acute Care Team (ACT) to follow up if SS remained on the Central Coast. If SS decided to leave the Central Coast he would be referred to an appropriate Community Mental Health service in the area where he would be living.

28. The notes record that Mrs S was to visit SS in the ward on 10 June 2014 and her mobile number was recorded. In evidence, Mrs S explained that she had previously told SS that she would visit him if she could, but could not guarantee it. Due to several urgent work issues which required Mrs S's involvement, she was unfortunately unable to visit SS before his discharge.

SS'S DISCHARGE FROM HOSPITAL

29. The final nursing entry at 5:55am on 11 June 2014 prior to SS's discharge noted that SS was settled in bed and appeared to be asleep at the start of shift, and remained the same on all rounds. Dr Noor later reviewed SS as a follow up to the discharge plan prepared by Dr Lachter the previous day. SS was subsequently discharged and left the ward at 12:25pm that day.

30. An addition to the progress notes made at 1:00pm on 11 June 2014 notes "message left [for] Primary Carer re d/c".[8]

---

[5] Exhibit 2, paragraph 30.
[5] Exhibit 1, tab 13.
[7] 1bid.
[6] 1bid.

31. The discharge summary records that SS expressed a desire to stay in a hotel in Gosford temporarily before making a decision about whether to live permanently on the Central Coast or move back to Sydney. It was noted that SS was to give the Community Mental Health Team details of his GP once he decided where he would be living.

32. The summary also notes that SS's mental state examination at the time of discharge was that there was no evidence of elevated or depressed mood, no formal thought disorder, no delusions or paranoia, and that he denied any suicidal or homicidal ideas. It was also noted that at the time of discharge SS was a low risk of suicide and self-harm. The summary recorded Mrs S as a contact person, noting her mobile and landline numbers, and her address in Hunters Hill.

33. As part of the post-discharge follow up it was noted that:

    - SS was to be referred to the Gosford ACT;
    - he was to continue with his prescribed medication;
    - a Safety Plan was discussed with him; and
    - he was given contact numbers for appropriate mental health services.

WHAT HAPPENED AFTER SS WAS DISCHARGED?

34. The next progress note on 12 June 2014 records that a nurse attempted to contact Mrs S at about 1:OOpm, there was no answer, and a message was left. There was a subsequent call to SS's father who provided SS's mobile number. A call was made to SS who advised that he was staying at the Gosford Hotel and denied any thoughts of self-harm. An appointment was made to see SS in person the following day.

35. SS attended the appointment on the afternoon of 13 June 2014 where it was noted that his affect was anxious but his mood OK. SS denied any current suicidal ideation. SS indicated that he had no family or friends on the Central Coast but wanted to stay in Gosford for a week alone before deciding where to live. A follow up appointment was made for 18 June 2014 but on 17 June 2014 SS called at about 10:20am and asked that the appo"1ntment be rescheduled to 19 June 2014 at 9:00am.

36. SS did not attend this second appointment and when staff from the ACT tried to call him his phone was switched off. At about midday on the same day, the ACT staff received information from the Gosford Mental Health Unit that a day earlier (on 18 June 2014) SS had called a patient in the unit and said that he was going to commit suicide. The patient subsequently advised nursing staff who in turn contacted police and passed on SS's mobile number. The ACT team then called SS's mobile number, which was switched off, and also called the Gosford Hotel and were advised SS was not there but had not yet checked out.

37. The ACT made two further calls to SS's mobile, one at about 1:OOpm and the second at about 4:30pm, both of which were not answered and messages were left.

38. At about the same time as the third call to Stephen, the ACT called Mrs S's mobile but received a message indicating the service had been disconnected. They also called Mrs S's landline number which rang out without answer.

39. In response to the notification from Gosford Mental Health Unit on 18 June 2014, at about 8:40pm police went to the Gosford Hotel to look for Stephen, but could not find him. Senior Constable Creswick called SS on his mobile number. SS answered and Senior Constable

Creswick asked if the police could see him, explaining that there were people concerned for his welfare. SS told Senior Constable Creswick that he was busy and asked him to call back. When Senior Constable Creswick later called SS he asked how he was. SS replied, "I'm OK. I'm down but I'm alright".

40. Senior Constable Creswick told SS that the police had received a call about him possibly hurting himself and wanted to make sure that he would not SS assured police, "No I'm not going to do anything".[9] Senior Constable Creswick asked SS if the police could speak to him person. SS refused to do so, told police that he was 200km away, refused to tell police where he was and hung up. Senior Constable Creswick tried to call SS back but the call was diverted to voicemail.

WHERE WAS SS FOUND?

41. At about 11:45am on 19 June 2014, Andrew Robinson was walking along the bushwalking track in Boronia Park reserve with his wife, Prem, and their son. At a location about 10 minutes from the start of the track, Mr and Mrs Robinson saw SS leaning against a tree with a rope tied around his neck and attached to another tree.

42. Mr and Mrs Robinson immediately alerted the police. After police and ambulance officers arrived on the scene, SS was examined, found to have no signs of life, and taken away from the scene.

43. Dr Rebecca Irvine, forensic pathologist, performed an autopsy in 20 June 2014. In her report of 11 July 2014 Dr Irvine concluded that the dkect cause of SS's death was hanging.

WHAT CONTACT WAS THERE BETWEEN GOSFORD HOSPITAL AND MRS S?

44. At the time of SS's admission there were three consultant psychiatrists at Gosford Hospital, one of whom was Dr Lachter. He was a part-time Visiting Medical Officer who only worked Tuesdays and Fridays. Therefore, during SS's admission Dr Lachter was only present at the hospital on 3 June 2014, 6 June 2014, and 10 June 2014.

45. The hospital clinical notes indicate that at 12:30pm on 30 May 2014, a message was left for Mrs S by Dr Sandra de Silva, registrar, requesting a call back. Dr de Silva did not give evidence at the inquest. Mrs S said that she had no recollection of receiving a message on this day.

46. A further nursing entry on the same day at 8:30pm records that several phone calls were made to family and friends. It is not clear from the record who made the calls, to whom they were made, and whether the calls were answered.

47. Mrs S states that after SS was admitted to Gosford Hospital she (and SS's parents) called the hospital on 4 June 2014 in an attempt to speak to the consultant psychiatrist in order to discuss SS's health, but was told that there was no one available to speak to.[10] It appears that this call was prompted by the incident a day earlier and SS's return to the HDU. Mrs S was told by hospital staff to call back, which she did, but was never able to speak to Dr Lachter (or any other consultant psychiatrist).[11] Mrs S said in evidence that she recalled calling on 6 June 2014 and was told that Dr Lachter was at the hospital but not available. There is no record of this call in the clinical notes.

[9] Exhibit 1, tab 2.
[10] Exhibit 1, tab 9.
[11] Second statement of Mrs KS, paragraph 25.

48. According to hospital records, Mrs S called the hospital on the morning of 5 June 2014 at about 9:40am to enquire when SS would be discharged, expressed her hope that SS would be discharged the following day {6 June 2014), and asked to be contacted as soon as possible on her mobile number before discharge.[12] In evidence, Mrs S agreed that she called, asked when SS would be discharged, and asked to be called before he was discharged. However, she said that she did not believe that she expressed her hope that SS would be discharged on 6 June 2014 as she did not feel that he was well enough.[13]

49. The hospital records also note that at 10:15am Mrs S called a second time, along with SS's father, and both expressed their concern for his welfare. The entry notes "reassurance given to both parties regarding SS's care whilst he is an inpatient".[14] Exactly what form this "reassurance" took is unclear on the available evidence. I sought to clarify this with Mrs S. Her best recollection is that the nurse she spoke to said that she could be reassured of the care that SS was receiving.

50. The inquest did not receive evidence from the nurse or nurses who made the progress note entries on 5 June 2014. Therefore, it is not possible to resolve the difference in accounts concerning the 9:40am call, nor identify the exact content of the call at 10:15am. In relation to the former, it might have been the case that Mrs S's query regarding the timing of SS's discharge was misunderstood to be an expression of her desire that SS be discharged the following day. In relation to the latter, it seems that Mrs S was content with whatever it was that was told to her by nursing staff.

51. An examination of the hospital records does not reveal any contact between any consultant psychiatrist *or* psychiatry registrar and Mrs S or SS's parents at this time. In his statement Dr Lachter said that following his review of Stephen, either on 3 *or* 6 June 2014, he wanted to call Mrs S in SS's presence, but SS did not give his permission for this to occur.[15] In evidence, Dr Lachter explained that SS's refusal was prompted by a note that he (Dr Lachter) was given by nursing staff asking that he call Mrs Sand clarified that this actually occurred on 6 June 2014.

52. There is no reference in the clinical notes of this request being received from Mrs S on 6 June 2014, although the note may have referred to Mrs S's call the previous day. Dr Lachter went on to explain that ordinarily it was his practice to call family members '1n the presence of a patient and that although the HDU did not have a speakerphone, one was available a short distance away. However, Dr Lachter clarified that SS said that he did not want Mrs S to be called at all.

53. Dr Lachter acknowledges that he did not document SS's refusal of permission[16] and explained in evidence that it would ordinarily be his usual practice to do so. When asked why he did not follow his usual practice, Dr Lachter reasoned that he may have been carrying some of SS's stated position against Mrs Sand therefore kept her out of his notes.

54. Mrs S also states that she spoke to SS on the phone at some stage during his admission and he told her that he attempted suicide.[17] There is no documentary evidence as to when this phone call took place but presumably it was after the incident on 3 June 2014. Mrs S states that she could not confirm this incident with the hospital. There is no evidence in the hospital records of any communication between Mrs S and hospital staff regarding this incident.

---

[12] Exhibit 1, tab 13.
[13] ,Second statement of Mrs KS paragraph 26.
[14] Exhibit 1, tab 13.
[15] Exhibit 2, paragraph 23.
[15] Ibid, paragraph 24.
[7] Supra, paragraph 24.

55. Finally, there is an additional nursing entry at 1:00pm on 11 June 2014 which indicates that a message was left for Mrs S regarding SS's discharge. The content of the message is not known but in any event Mrs S said that she was unaware of this message being left. However she did say that she called Dr Noor at about 4:30pm on the same day who advised her that SS had been discharged. Dr Noor confirmed that this call took place although it is not documented in the records.

56. For completeness, it should be noted that a nursing entry on 12 June 2014 records that at 1:OOpm on that day a call was made to Mrs S, who did not answer, and a message was left. A subsequent call was then made to SS's father who gave the nurse SS's mobile number.

57. In summary:

    (a) there were documented attempts by nursing staff to call Mrs Son 30 May 2014 and 11 June 2014 with messages left, but Mrs S has no recollection of receiving them;

    (b) there were a number of further calls made by nursing staff on 30 May 2014 but it is unclear whether Mrs S was a recipient of any of the calls;

    {c) there were two documented calls between Mrs Sand nursing staff, both on 5 June 2014;

    (d) Dr Noor called Mrs S following SS's discharge but this call is not documented.

58. According to Hospital records, Mrs S's landline and mobile numbers were both kept on file. For the most part, the documented calls make no reference to which number was called. The only reference in the hospital records as to which of Mrs S's phone services was called comes from the ACT entry on 19 June 2014 which records that a call was made to Mrs Sat around 4:30pm, first to her mobile number (which was recorded as being disconnected) and then to her landline (which was recorded as ringing out).

59. On Mrs S's evidence she did not receive any of the messages left by hospital staff, most importantly the calls on 30 May 2014, 11 June 2014 and 12 June 2014. In evidence Mrs S said that her mobile service was never disconnected in June 2014 and that her landline number had a voicemail service, although sometimes it did not work.

60. The reason for the calls not being received by Mrs S cannot be adequately explained on the available evidence. However, it appears to me that there may be two possibilities: firstly, Mrs S acknowledged that her landline voicemail service did not always work; secondly, the Nomination of Primary Carer form signed on 28 May 2014 records Mrs S's mobile number as 0434 196 874, whereas the Discharge Summary (at page 3) records her mobile number to be 0434 196 876. The slight, but obviously important, difference in the last digit of the mobile numbers recorded in the respective records may have been at the root of the issue.

WHAT WERE THE LEGISLATIVE REQUIREMENTS UNDER THE MENTAL HEALTH ACT 2007?

61. During the course of the inquest it became apparent that consideration of certain sections of the *Mental Health Act 2007* (the Act) was central to a number of issues. I note that the Act was amended in August 2015. At the time of inquest there did not appear to be any difference in the provisions discussed below between 2014 and 2016, other than the term "primary carer" being replaced with the term "designated carer", and the introduction of a new term, "principal care provider", pursuant to section 72A All references made in these findings to the Act are references to the Act in force as at June 2014.

62. Part 1 of Chapter 4 of the Act sets out a number of legislative principles in relation to the care and treatment of people with a mental illness or mental disorder. Relevantly, section 68 of the Act provides:

> 68 Principles for care and treatment
>
> It ·ls the intention of Parflamentthat the following principles are, as far as practicable, to be given effect to with respect to the care and treatment of people with a mental illness or mental disorder
>
> (a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,
>
> {b) people with a mental illness or mental disorder should be provided wilh timely and high quality treatment and care in accordance with professionally accepted standards,
>
> {c) the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,
>
> (d) the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others,
>
> (e) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment allernatives and the effects of treatment,
>
> (f) any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances,
>
> (g) the age-related, gender-related, religious, cultural, language and other special needs of people with a mental illness or mental disorder should be recognised,
>
> (h) every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care,
>
> (i) people with a mental illness or mental disorder should be informed of their legal rights and olher entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand,
>
> (j) the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect.

63. Application of section 68 is clearly a delicate balancing exercise. Applying the section to the particular issues of SS's case it is clear that Dr Lachter needed to be conscious of the need to treat and care for SS in the !east restrictive environment and interfere with his right to privacy as minimally as necessary, whilst also giving effect to the rights of Mrs S to be kept informed of SS's care and treatment.

64. Section 78 of the Act provided:

> 78 Notifications to primary carer of events affecting patients or detained persons
>
> (1) An authorised medical officer of a mental health facility must take all reasonably practicable steps to notify the primary carer of a patient or person detained in the facility if any of the following events occurs:
>
> (a) the patient or person is absent from the facility without permission or fails to return at the end of a period of leave,
>
> (b) it is proposed to transfer the patient or person, or the patient or person is transferred, to another mental health facility or other facility,

(c) the patient or person is discharged from the mental health facility,

(d) the patient or person is re-classified as a voluntary patient,

(e) it is proposed to apply to the Tribunal for an ECT inquiry under Part 2 or to ascertain whether the patient or person is capable of giving informed consent to electroconvulsive therapy,

(f) a surgical operation is performed on the patient or person under Part 3,

(g) it is proposed to apply to the Director-General or the Tribunal for consent to a surgical operation or special medical treatment under Part 3.

(2) The authorised medical officer must give the notice as soon as practicable after becoming aware that the event has occurred.

(3) In the case of a proposed transfer, the notice must be given before the relevant order or arrangement is made. except in an emergency.

65. SS was initially admitted to Ryde, and then Gosford, Hospital as an involuntary patient. However there were two occasions when his status changed from involuntary to voluntary patient. Both occasions occurred following SS's review by Dr Lachter.

66. The first occasion was on 3 June 2014 at about 2:50pm, and the second was on 6 June 2014. On each occasion SS signed admission forms as a voluntary patient pursuant to section 5(1) of the Act. He was therefore a person to whom section 78(1)(d) of the Act applied. Use of the word "must" in section 78 meant that there was a mandatory requirement that all reasonable practicable steps be taken to notify Mrs S of SS's re-classifications. Regrettably, this was not done on either occasion.

67. It is convenient at this point to consider the meaning of "authorised medical officer". Section 4 of the Act defines **authorised medical officer of a mental health facility** to mean:

(a) the medical superintendent of the mental health facility; or
(b) a medical officer, nominated by the medical superintendent for the purposes of this Act, attached to the mental health facility concerned.

68. In evidence Dr Lachter said that, as at June 2014, Dr Sandip Anand was the medical superintendent at Gosford Hospital. Dr Lachter went on to say that, given that he was primarily responsible for SS's care, he implicitly understood that he was the relevant medical officer nominated by Dr Anand. If Dr Lachter's understanding was correct, it follows that the responsibility of adhering to the mandatory requirements of section 78 rested with him.

69. In evidence Dr Lachter said that during the time of SS's admission he was not aware of the requirements of section 78. He explained that he only became aware of the provision following a conversation with Dr Anand. Dr Lachter specifically said that he only became aware of this requirement in conversation, and not because of any changes made to hospital policy. However, Dr Lachter's understanding of section 78 appeared to be somewhat deficient in the sense that he referred to the provisions as being a recommendation of what to implement in practice, rather than a mandatory requirement.

70. Section 79 of the Act provides:

> 79 Discharge and other planning
>
> (1) An authorised medical officer of a mental health facility must take all reasonably practicable steps to ensure that a patient or person detained in the facility, and the primary carer of the patient or person, are consulted in relation to planning the patient's or person's discharge and any subsequent treatment or other action considered in relation to the patient or person.
>
> (2) In planning the discharge of any such patient or person, and any subsequent treatment or other action considered in relation to the patient or person, the authorised medical officer must take all reasonably practicable steps to consult with agencies involved in providing relevant services to the patient or person, any primary carer of the patient or person and any dependent children or other dependants of the patient or person.
>
> (3) An authorised medical officer of a mental health facility must take all reasonably practicable steps to provide any such patient or person who is discharged from the facility, and the patient's or person's primary carer. with appropriate information as to follow-up care.

71. Section 4 of the Act defines **patient** to mean:

> "a person who is admitted to a mental health facility in accordance with this Act and who is in the facility following the person's admission, and includes a person so admitted while absent from the facility either with or without leave of absence".

72. Therefore it would appear that, again by virtue of his voluntary admission on 6 June 2014 pursuant to section 5(1) of the Act, SS was a patient to whom section 79 applied at the time of his discharge.

73. This would in turn mean that, pursuant to sections 79(1) and (3) of the Act, there was a mandatory requirement that all reasonable practicable steps be taken to consult Mrs S (as the primary carer) in relation to planning SS's discharge, subsequent treatment, or other action, and to provide her with appropriate information as to his follow-up care.

74. As at June 2014, clause 43 of the *Mental Health Regulation 2013* (the Regulation) provided:

> 43 Information as to follow-up care after discharge
>
> Without limiting section 79 of the Act. the appropriate information as to the availability of follow-up care includes:
>
> (a) a description of patient support groups and community care groups operating in the vicinity of the mental health facility, including a description of the services provided by the groups, and the method of contacting each group, and
>
> (b) a description of any out-patient or other services available at the mental health facility that are available to the patient, and
>
> (c) a description of the purpose and method of obtaining community treatment orders, and
>
> (d) a description of such other similar follow-up services as may be available in the vicinijy of the mental health facility.

75. In evidence Dr Lachter agreed that at the time of his discharge, SS was a patient within the meaning of section 4 of the Act. Dr Lachter indicated that whilst he was aware of the requirements of section 79 as they pertained to involuntary patients, he was not aware that section 79 applied equally to voluntary patients.

76. During the course of the inquest much reference was made to the additional nursing entry made at 1:OOpm on 11 June 2014 which noted that a message had been left with Mrs S regarding SS's discharge. As noted already Mrs S says that she never received the message. The content of the

message is unknown. It would seem that even if the message amounted to notificaflon being given to Mrs S that SS had been discharged this did not comply with section 78(1) which required that Mrs S be consulted in relation to planning SS's discharge, subsequent treatment, or other action.

77. After SS's discharge, Mrs S called the hospital and spoke to Dr Noor. On the evidence of Dr Noor and Mrs S the content of that conversation is unclear. As noted already, the conversation was not documented in any of the hospital records. Given the paucity of evidence it is not possible to conclude whether or not the conversation satisfied the requirements of section 78(3) of the Act or clause 44 of the Regulation.

EXPERT EVIDENCE

78. The inquest received expert reports, and heard oral evidence, from two consultant psychiatrists, Dr Bradley Ng and Dr Jonathan Phillips AM.

79. In his report Dr Ng opined:

> "Once Mr S was off the Mental Health Act and it was decided that no further in-patient treatment was going to be offered, it certainly may have been appropriate for him to be discharged as soon as possible. However, it was preferable that his family or next-of-kin still be involved, irrespective of MrS being of voluntary or involuntary status".

80. Dr Phillips reached a similar conclusion in his report, with certain qualifications:

> "I accept that it is always important to involve family members and carers in the treatment of a patient, as far as this is sensible ar"ld ethical. family members and carers carmake a valuable contribution to the clinical history, can add to and be involved in clinical decisior"l-making in the course of treatment, and be involved ir"l the process of discharge and care post-discharge. However, involvement of family and carers can prove ethically difficult in any situation where the patient does not conser"lt to their involvement. Additionally, involvement of family and carers can become difficult or even problematic where there is a setting of conflict withir"l the family system".

81. Dr Ng's reference to family involvement in the discharge process being preferable mirrored the understanding of Dr Lachter in this regard. Similarly, Dr Lachter reached the conclusion that this preferable course was not to be followed in SS's case because of the qualifications referred to by Dr Phillips, namely SS's refusal to give Dr Lachter permission to contact Mrs S, and the derogatory statements made by SS about her.

82. However, as is made clear by section 79 of the Act, the need for Mrs S (as the primary caregiver) to be consulted in relation to SS's discharge and subsequent treatment was mandatory, not preferable.

83. Dr Ng eventually concluded:

> "In summary, it is my opinion that Mr S's release from the hospital was r ot appropriate and timely, because his primary carer and family were not involved in the discharge plar"lning process".

84. In response to a question inviting comment on the views expressed by Dr Ng, Dr Phillips concluded:

> "...with respect, J find myself ur able to agree with Dr Ng's view that Dr Lachter failed in his duty of care to MrS by not ensuring the involvement of patient's [sic] ex-wife in his treatmer t. Simply, it becomes very difficult and potentially treatment negative to try ar"ld force family contact in a situation where a [patient] will r"l0t conser"lt".

85. At the time of his report Dr Ng had not been provided with a copy of Dr Lachter's statement (which had only been prepared shortly before the inquest) and was therefore not aware that SS

had refused to give Dr Lachter permission to contact Mrs S. Dr Ng was provided with copies of Dr Lachter's statement and Dr Phillips report before he gave evidence.

86. With the benefit of reading both these documents Dr Ng said that the stance expressed in his original report remained the same but it was slightly tempered. Dr Ng acknowledged that a voluntary patient had a clear right to choose that there be no contact between the patient's physician and the patient's primary carer. However, Dr Ng opined that a reasonable standard of care would dictate asking a patient on separate occasions for permission for some type of family involvement, other than the nominated primary carer.

87. Or Philips agreed with Dr Ng in this regard, explaining that if he were to be critical of Dr Lachter it would be on the basis that Dr Lachter could have been more assertive with SS and perhaps suggested a family member to contact other than Mrs S. However, Dr Phillips acknowledged that this would occur in an ideal situation and that his comments should be approached with a degree of caution given the time constraints placed on Dr Lachter and the need to care for multiple patients.

88. Both Dr Ng and Dr Phillips acknowledged that SS's case was a difficult one. Both also acknowledged that the competing legislative requirements of the Act, on the one hand, and the need to respect a patient's wishes and observe the boundaries of confidentiality, on the other hand, created a challenging clinical dilemma for Dr Lachter. Finally, both Dr Ng and Dr Phillips referred to the fact that in their views the law is unable to anticipate every clinical scenario, and gave an example (of a person with a psychotic disorder and a highly disturbed primary carer) where strict compliance with legislative requirements may be highly detrimental to the care of a patient.

CONCLUSIONS

89. Dr Lachter did not contact, or attempt to contact, Mrs S at any point during SS's stay at Gosford HospitaL This was acknowledged by Dr lachter both in his statement[18] and in evidence. The first time that Dr lachter spoke to Mrs S was after SS's death. Although Dr Lachter's notes of the conversation are undated, in evidence he said he believed it occurred on the day that SS was found, after being told about this fact by Dr Noor.

90. Applying the provisions of the Act to SS's admission it is clear that there was a requirement to notify Mrs S of SS's re-admission as a voluntary patient on 3 June 2014 and 6 June 2104. This was not done. The reason was due to Dr lachter's unfamiliarity with the requirements of section 78 (as he acknowledged in evidence) and not SS's refusal to give permission for him to contact Mrs S. The absence of permission is a moot point in relation to the 3 June 2014 admission in any event because the evidence establishes that SS's refusal was expressed on 6 June 2014.

91. As noted above, section 79 of the Act imposed a number of further mandatory requirements. conclude that section 79(1) was not complied with because although the message left for Mrs S at about 1:OOpm on 11 June 2014 after SS's discharge may have amounted to notification, it did not amount to consultation in relation to planning SS's discharge. The language of section 79 makes it clear that the required consultation with a primary carer was to take place before a patient's discharge.

92. However, SS's discharge was attended by a number of complicating issues. Firstly, in evidence Dr lachter indicated that he only understood consultation with a primary carer prior to discharge to be a preferable course of action, not a mandatory one. Whilst it is accepted that Dr lachter

,Exhibil2, paragraph 57.

recognised generally the potential therapeutic benefit of following such a course, he decided against doing so in SS's case due to a number of factors, namely:

(a) absence of permission from Stephen;
(b) derogatory comments made by SS about Mrs S (describing her as "controlling and rigid");
(c) Mrs S being an "ex-wife"[19] toSS due to their separation in 2012; and
(d) SS's expression of suicidal ideation in the context of perceived rejection by another woman named Michelle who he had known since child.

93. On behalf of Mrs S, it was submitted that the conclusion reached by Dr Lachter about there being an acrimonious relationship between SS and Mrs S was an incorrect one. It is not appropriate for me to make any finding on this issue as it exceeds the limitations of the coronia! jurisdiction and because the issue was never put, as a matter of fairness, to Dr Lachter in evidence, nor were Dr Ng or Dr Phillips invited to comment on it. In any event, this issue was only a secondary consideration in Dr Lachter's reasoning, the primary consideration being the absence of SS's consent.

94. Secondly, Dr Lachter was confronted with a difficult ethical dilemma. As he explained, and as Dr Ng and Dr Phillips agreed, had he failed to comply with SS's wishes there may have potentially been therapeutically harmful, and adverse legal, implications.

95. Thirdly, it appears that the possibility of consulting with Mrs S was raised on 10 June 2014 when Dr Lachter and Dr Noor discussed the possibility of being discharged with Stephen. This is apparent from the reference in Dr Noor's notes which record that Mrs S was to visit SS on 10 June 2014. Dr Noor explained in evidence that he was expecting to discuss SS's discharge with Mrs S during the visit. However, the visit did not take place and therefore the opportunity was not taken. It should be noted that Dr Noor returned from leave on 10 June 2014 and that was the first occasion that he met Stephen. This recent involvement at the end of SS's admission may explain the absence of any follow-up on 11 June 2014.

96. On balance, **I** find that the lack of communication between Mrs S and Gosford Hospital was the result of a number of factors: lack of awareness regarding the mandatory requirements of relevant provisions of the Act, ambiguity regarding who was an authorised medical officer for the purposes of the Act, and SS's refusal to allow Dr Lachter to contact Mrs S.

97. Although there was non-compliance with mandatory provisions of the Act, **I** do not think the deficiency in communication between Gosford Hospital and Mrs S was inappropriate. Instead, it was the product of a lack of understanding concerning legislative requirements and SS's refusal to give consent. Even very experienced physicians such as Dr Ng and Dr Phillips acknowledged the difficult situation that Dr Lachter faced, and neither was able to definitively answer questions posed to them in how to deal with such a situation.

98. The ultimate view taken by both experts was that Dr Lachter could have consulted with his professional colleagues about the issue, and that it may have been possible for Dr Lachter to explore the possibility of a family member, other than Mrs S, being involved in planning SS's discharge. However, both experts acknowledged that these possibilities should have occurred in an ideal situation and were not without their own potential complications. Accordingly I cannot conclude that the deficiency in communication was inappropriate.

[19] I acknowledge that the reference to Mrs S being an "ex-wife' was incorrect, both factually and legally. SS and Mrs S separated in 2012 but did not divorce. Indeed, the evidence is that SS returned and stayed at the marital home on many occasions following the separation. I have taken the references in the hospital records and in the evidence to Mrs S being an 'ex-wife" to be a reference to the separation and an assumption of SS's perception of it. **I** am confident that no disrespect was intended by the use of that term.

SHOULD ANY RECOMMENDATIONS BE MADE?

99. In his report Dr Ng opined that even if Mrs S or SS's family had been involved in his discharge planning, "this may not have altered the eventual outcome" and that "there was a strong likelihood that the outcome would have been the same".[20] Dr Phillips reached the same conclusion when he said that it was improbable that the lack of involvement of Mrs S or family members in SS's care "made any material contribution to his death". Dr Phillips went on to conclude that SS would have ultimately had to manage without Mrs S and that it was his belief that SS would "have remained at high risk for suicide in the longer term".[21] Both Dr Ng and Dr Phillips adhered to their opinions in oral evidence.

100. Given these conclusions I am unable to find that the deficiency in communication between Gosford Hospital and Mrs S contributed toSS's death.

101. Section 82 of the *Coroners* Act *2009* provides that a coroner may make such recommendations as the coroner considers necessary or desirable to make in relation to any matter connected with the death with which an inquest is concerned.

102. Given that the lack of communication in this case was due not only to the ethical dilemma posed by SS's refusal to give consent, but also due to the lack of awareness and ambiguity on the part of clinicians in relation to legislative requirements (and that this issue was connected with SS's death), I consider it desirable to make recommendations to address this issue. Given the agreement amongst all the clinicians in this case as to the therapeutic benefit of having primary carers and family involved in a patient's treatment and discharge, in my view, it is not difficult to envisage a potential situation where failure to have such involvement may result in harmful, even fatal, consequences for a patient.

103. I am reinforced in coming to the conclusion that the making of recommendations is desirable by the fact that Dr Lachter said that the only reason he became aware of the requirements of section 78 was via informal discussion with his superior, Dr Anand, and not through any formal education or training program. Further, as Dr Ng and Dr Phillips pointed out, awareness of the mandatory legislative requirements required upon SS's discharge may have provided greater compulsion for Dr Lachter to explore the possibility of finding a family member, other than Mrs S, to involve in the discharge process.

104. Examination of the medical records completed during SS's admission has highlighted a number of inconsistences. For example, the *Mental Health Transfer/Discharge Checklist,* which was completed on 11 June 2014 when SS was discharged, contains the reference: "Notify Primary Carer/Person Responsible of Discharge". As noted already, mere notification does not accord with the requirement of section 79 of the Act for a primary carer to be consulted in planning the discharge of a patient.

105. The *Nomination of Primary Carer* form, signed by SS on 28 May 2014 contains, on the reverse side, extracts from sections 71 and 72 of the Act which provide for the definition, and nomination, of a primary carer. Further, the *Transfer Between Declared Mental Health Facilities of Involuntary Patient or Other Person Detained Form,* completed on 28 May 2014, contains a box which an authorised medical officer is required to tick to verify that section 78 of the Act has been complied with.

---

[2] Exhibit 1, tab 12.
[21] Exhibit 4.

106. In contrast there is an absence of such reminders, and an absence of extracts of relevant legislation being included, on other standard forms. For example, there is no extract or reminder in the *Discharge Checklist* or *Discharge Summary* completed on 11 June 2014 of the mandatory requirements of section 79. Similarly, the *Personal Application for Voluntary Admission to a Declared Mental Health Facility* forms, which SS signed on 3 June 2014 and 6 June 2014, also do not contain any reminders or extracts of section 78(1)(d) of the Act.

107. Counsel for Mrs S submitted that it would also be desirable to make recommendations in relation to the establishment of a voluntary next of kin register. I note that such a recommendation was previously made on 18 December 2014 by his Honour, State Coroner Barnes in the *Inquest into the death of JX*. That matter concerned a situation where a person had expressed an intention to self-harm, could not be located by police, and the person's family were not notified until about 10 hours later, by which time the person had already intentionally caused his own death.

108. This submission was grounded on the fact that when police were notified on 18 June 2014 about SS's intention to self-harm, Mrs S was not contacted. However, on the available evidence no attempt was made to contact anybody who knew SS because the report of self-harm made to police had come from a third party (the patient at Gosford Hospital that SS spoke to) and SS did not himself make any threat of self-harm when police spoke to him.[22]

109. Notwithstanding, on 17 August 2015, in response to the State Coroner's recommendation in *JX,* the Minister for Justice advised the Attorney General that the New South Wales Police Force had considered the feasibility of developing a voluntary next of kin register. The conclusion reached was that the development of such a register was not feasible due to existing links between the Police Force database and other comprehensive government databases, and the fact that a separate register could mislead efforts to locate persons suspected of being missing or deceased.

110. Given the above, and particularly due to the conclusion reached that the creation of a separate register may produce adverse outcomes, **I** am not of the view that it would be desirable to repeat the recommendation that has previously been made.

111. I therefore make the following recommendations:

To the NSW Minister for Health:

I recommend that a review be conducted of standard mental health admission and discharge forms and checklists to ensure that there is uniformity across all documentation and to ensure that hospital clinicians are provided with appropriate reminders of all mandatory requirements under the *Mental Health Act 2007* in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment.

To the Chief Executive of the Central Coast Local Health District:

I recommend that appropriate training and education systems be implemented in order to ensure that medical officers in mental health facilities are aware of all mandatory requirements of the *Mental Health Act 2007* in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment, and that guidelines be implemented to clearly identify the authorised medical officer in all cases.

[22] Exhibit 1, tab 7.

FINDINGS

112. I now turn to the findings that I am required to make pursuant to section 81 of the *Coroners Act 2009.*

The identity of the deceased
The person who died was SS.

Date of death
SS died on 18 June 2014 or 19 June 2014.

Place of death
SS died in Boronia Park, NSW.

Cause of death
SS died from hanging.

Manner of death
SS intentionally caused his own death.

I close this inquest.

Magistrate D e Lee
Deputy State Coroner
NSW State Coroner's Court, Glebe
5 February 2016