STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Hugh David LISLE
Hearing dates:	10 to 14 February 2014
Date of findings:	8 May 2014
Place of findings:	Glebe, NSW
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	CORONIAL LAW – Mental health patients; clinical supervision; CPR in psychiatric institutions
File number:	1002/10 – 2010/435653

Representation:	Mr Peter AITKEN (Bar) instructed by Ms Lisa TURNER, Crown Solicitors Assisting the Coroner; Ms Zelie HEGER appearing on behalf of the LISLE family; Mr Stuart KETTLE (Bar) instructed by Ms Sarah LARK appearing on behalf of the Northside Cremorne Clinic; Mr Tim SAUNDERS (Bar) instructed by Mr Don GRANT, appearing on behalf of Dr Craig WILSON; Mr Michael SPARTALIS (Bar) instructed by Ms Kate BOSIE, appearing on behalf of NSW Police Force; Mr R WHYBURN (Sol) appearing on behalf of RN HILL-JOHNES and RN FOX.

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The Coroners Act in s81 (1) requires the coroner's inquest findings be recorded in writing. These are the findings of an inquest into the death of Hugh David LISLE.

Introduction

In the early hours of 1 May 2010, Hugh David Lisle, 24, was found dead in his bed at the Northside Cremorne Clinic (NCC). He had been admitted two weeks earlier for treatment for a depressive disorder and poly substance and gambling addictions against a background of chronic pain.

At autopsy a number of psychiatric medications were found in Hugh's blood but none was at a level usually considered toxic. One of them had not been prescribed to him. There was no obvious cause of death.

This inquest has received expert evidence to attempt to resolve that uncertainty and to:-

- Consider whether the care, treatment and supervision provided to Mr Lisle while he was a patient at the NCC was of an appropriate standard;

- Investigate how he came to have in his system pharmaceuticals which had not been prescribed to him;

- Critique the adequacy of the attempts to resuscitate Mr Lisle when he was found non responsive; and

- Determine whether any changes to the policies and procedures of the NCC would reduce the likelihood of similar deaths occurring or otherwise contribute to and improvement in public health and safety.

The evidence

Social history

Hugh David Lisle was born in Armidale, New South Wales on 25 August 1985 to David and Anna Lisle. As a young child he lived with his parents, his older brother, Sam, and younger sister, Anna, at the family property in Walcha.

When Hugh was almost 12 years old he moved to Sydney to attend school. He would continue to reside in Sydney except in times of crises when he would return to live with his parents in Walcha.

Between 1997 and 2003, Hugh boarded at Knox Grammar School in Wahroonga. While he may have had disciplinary issues early on, he was determined to change his behaviour and by the end of secondary school he was a high-achieving and well-rounded student. In Year 12, he was appointed Head of Boarders and Vice-Captain, a member of the First XV rugby union team, and achieved a Universities Admission Index of 99.3.

In 2004, Hugh commenced a combined Bachelor of Science and Mechanical Engineering degree at the University of Sydney. He lived at St. Andrew's College in

Camperdown then with his sister or friends in Sydney. During university he began experimenting with illicit drugs (primarily dexamphetamine but also marijuana and ecstasy) and gambling.

From about July 2005, he began to experience unexplained pain in his feet, shoulders and sternum. In February 2006 Hugh was diagnosed with undifferentiated spondyloarthopathy (a form of rheumatoid arthritis). From March 2006, he was prescribed medication – often in large doses and in various combinations – to relieve pain from the arthritis and, later, to treat depression.

While Hugh reported that he had experienced depressive symptoms before his diagnosis, it was about this time that (perhaps not coincidentally) Hugh's friends and family noticed a lowering in his mood. His mother said that the debilitating pain caused by the arthritis, and the ensuing physical and social restrictions, had a hugely detrimental impact on Hugh's mental wellbeing.

Although his arthritis and depression were medically managed from about 2006 and 2007 respectively, these were chronic conditions. At times Hugh would function reasonably well, maintaining friendships, working part-time at an engineering firm and continuing his tertiary studies. However, increasingly often Hugh would abuse licit and illicit drugs, drink alcohol to excess and gamble.

Between 2008 and 2010, he was charged three times for drug and/or alcohol fuelled assault and traffic offences and made at least two, but possibly as many as four, suicide attempts. On occasions Hugh would voluntarily seek treatment for his depression and drug and alcohol abuse, either by staying with his parents in Walcha or by seeking admission to a hospital or a Northside Group Clinic.

While Hugh's behaviour led to many of his friends distancing themselves from him and placed immense stress on his family, many remained supportive. It is clear from the evidence before me that despite his difficulties later on in life, Hugh was dearly loved and missed by his close and supportive family. They have my sincere condolences.

Medical history

Hugh was an athletic young man in apparently good health until he fractured his left foot in 2003. Despite tests the injury was initially undiagnosed and, thereafter, his left foot caused chronic pain.

As referred to above, in about July 2005, Hugh started to experience pain in his shoulders and sternum. He had pre-existing pain from his left foot (which at the time was still undiagnosed) and started experiencing pain in his right foot. The pain was such that Hugh struggled to sleep and, eventually, could not walk. He would describe the pain in his feet as akin to walking on broken glass. This pain would be present, in varying degrees of severity, for the rest of Hugh's life.

On visits home to Walcha, Hugh consulted with his general practitioner and later with a rheumatologist in Tamworth, Dr Jim Croker. After a series of tests, in February 2006 Dr Croker diagnosed Hugh with undifferentiated spondyloarthropathy. Dr

Croker prescribed Salazopyrin but this was ceased in July 2006 after Hugh experienced side effects.

Hugh was still living and studying in Sydney. In April 2007, he started consulting a general practitioner in North Sydney, Dr Maria Cigolini, who in October 2007 referred him to rheumatologist Professor Philip Sambrook. Over a number of months, both medical practitioners trialled Hugh on different medications including Salazopyrin (again), Mobic, methotrexate, Prexige, Celebrex, prednisone, Tramadol, Arava, cortisone and folate. At some stage, Hugh was prescribed Sertraline, presumably because he was exhibiting depressive symptoms.

Mr Lisle was faced with many challenging circumstances in 2008. In February, he had his driver's licence suspended for three months following a traffic offence. That year he also had financial difficulties caused by gambling, experienced a difficult break up with his girlfriend, and was using cocaine.

An MRI scan conducted in May 2008 showed that his joints were chronically dislocating. On 23 August 2008, Hugh overdosed on Tramadol tablets and was admitted to the Royal North Shore Hospital for treatment. While his mother is of the view that the overdose was accidental, his treating psychiatrist during the admission, Professor Roger Bartrop, considered that it was an intentional overdose triggered by the aforementioned stressors.

During that admission, Hugh was reviewed by two anaesthetists from the chronic pain team. They recommended that Tramadol be ceased because of the risks of serotonergic syndrome and that oxycodone be administered for a few days at the end of the admission and then a switch to Oxycontin. Professor Bartrop noted Mr Lisle's arthritis was now more obviously psoriatic and reported that he was feeling much better with the institution of Oxycontin.

Adjustments were made to Mr Lisle's treatment following the overdose referred to above. Professor Sambrook ceased prescribing Tramadol and commenced Oxycontin. Additional attempts were made to treat his mental illness. He saw Professor Bartrop and meditation coach, John Barter. However, Hugh only saw the former twice before his retirement and the latter three times before he refused to attend further appointments.

In 2008 and 2009, Hugh's friends observed him abusing prescription drugs by snorting it through a straw. He told one friend that he was using up to 300mg of Oxycontin a day. Mr Lisle would later repeat these assertions to his treating psychiatrists. It appears from the evidence that he was quite open about his drug use with his friends, sister and treating doctors but, whether for fear of upsetting them or another reason, would not similarly confide in his parents.

Nevertheless, Hugh's mother also noticed a change in him. In a letter dated 19 February 2009, she told Dr Cigolini of her concerns about Hugh's increasing alcohol intake, smoking, gambling, aggressive driving, mood swings and paranoia.

Possibly as a consequence of the letter, on 27 February 2009 Dr Cigolini referred Mr Lisle to psychiatrist Dr Craig Wilson. Dr Wilson is a private psychiatrist who works in

both private outpatient rooms in Sydney's north shore and in the NCC. While he works in general psychiatry, he has particular expertise in mood disorders, depression and bipolar disorder. From the first consultation on 27 February 2009, Dr Wilson remained Hugh's primary treating psychiatrist and would see him on a semi-regular basis.

Mr Lisle consulted with Dr Wilson on ten occasions between 27 February 2009 and 3 September 2009. After the first consultation, Dr Wilson formed the opinion that Hugh suffered from a major depressive illness with a concurrent tendency to addiction (in Hugh's case, to gambling and Oxycontin). A number of Dr Wilson's observations suggest that Hugh's issues were interrelated – Dr Wilson noted that the arthritis medications, including methotrexate, were contributing to Hugh's depressive illness; that gambling losses were accompanied by alcohol binges; and that Hugh's excessive alcohol consumption was "*perhaps inadvisable*" in the context of his medication regimen.

Following the first consultation with Mr Lisle, Dr Wilson wrote to Dr Cigolini and noted that it was "*perhaps inadvisable*" for Hugh to drink. His notes of the 9 March 2009 consultation records "*Alcohol is not actually dangerous with the medication*" and that he suggested that Hugh attempt to increase his alcohol free days. Dr Wilson records that on 21 May 2009 he told Hugh that he should not be drinking.

His parents are concerned that Dr Wilson did not prohibit Hugh from drinking alcohol while medicated. They interpreted the 9 March entry quoted above as tantamount to telling Hugh he could drink.

Dr Wilson explained at the inquest that Hugh had a very good understanding of the chemical make up of all the medications he was prescribed and could readily appreciate the likely interaction between them and drugs or alcohol. I am of the view that while it would obviously have been better for Mr Lisle not to have consumed alcohol to excess, it was equally important that Dr Wilson not undermine the therapeutic alliance he was developing with Hugh by giving him false information. I conclude it was not inappropriate for him to tell Mr Lisle the truth about the interaction between alcohol and his medication.

It is clear from Dr Wilson's notes of those ten consultations that Mr Lisle presented with a complex range of conditions and that his mood fluctuated, with a particularly low period after Hugh spent his $1000 Commonwealth Government stimulus money gambling.

Dr Wilson referred Hugh to the St. Vincent's Hospital gambling program on 7 May 2009 but there is no indication that Hugh attended.

In July 2009, Dr Wilson was informed that Hugh had broken into the family's gun safe and that he had failed all of his university subjects because of poor attendance and alcohol abuse.

By 19 August 2009, Dr Cigolini had retired and Hugh saw another general practitioner in the same practice, Dr Marcia Manning. Dr Manning referred him to rheumatologist Dr Rodger Laurent, apparently for only one consultation until he

could be reviewed again by Professor Sambrook. Dr Laurent noted that Hugh's arthritis had worsened in his feet, lower back, hips and shoulders. At that time, he was prescribed Etanercept 50mg per week, Oxycontin 120mg per day, Efexor 300mg per day, Meloxicam 15mg per day, Zyprexa 10mg per day, Panadol Osteo twice a day, Methotrexate 10mg per week, and folic acid 5mg per day. However, he had temporarily stopped taking Etanercept and methotrexate.

Mr Lisle saw Professor Sambrook on 2 September 2009 and a gradual reduction in Oxycontin was discussed. He saw Dr Wilson the following day and an improvement was noted. However, that month Dr Wilson also recorded that he had received a call from Hugh's general practitioner in Walcha (presumably Dr Allen) regarding his concern that Hugh was hoarding Oxycontin for a suicide attempt.

Hugh was living with his parents in Walcha at the time. He had returned home with the intention of withdrawing from Oxycontin after confessing to his mother that he was addicted to it. She had taken him to see Dr Allen, who referred him to drug and alcohol counsellor, Amanda Akers.

On 9 September 2009, during a discussion with his mother about gambling, Hugh said that life was not worth living and that he had let them down. Cathy Lisle later found Hugh in the shed, climbing a ladder with a rope fashioned into a noose. She shook the ladder until Hugh came down. Hugh was admitted to Walcha Hospital then transferred and admitted overnight to Tamworth Base Hospital's Banksia Unit. There was no follow up following discharge into his parents' care the next day.

Mrs Lisle said that the extent of Hugh's Oxycontin dependence became apparent after a month of weekly sessions with Ms Akers. Arrangements were made for Mr Lisle to be admitted to the Northside Clinic at Greenwich on 4 November 2009 for medical withdrawal.

The Northside Clinic at Greenwich was one of three (but now four) private clinics, including the NCC, known collectively as the Northside Group Clinics. The Northside Group Clinics are owned by Ramsay Health Care. They do not have accident and emergency facilities and their policies require acute, high risk patients to be referred to the nearest public hospital. Admission to each clinic must be voluntary and patients who are overly psychotic and not controlled on medication; those with a sociopathic, impulse control or aggressive behaviour history; patients with actively suicidal intent or plan who are schedulable because they present a danger to themselves or others; and, with the exception of acute and disorder units, children and adolescents under the age of 18 are not admitted.

Each clinic has one or more specialist unit. The NCC is a 36 bed hospital with a primary focus on mood disorders, depression, anxiety and psychiatric disorders. According to its director of Clinical Services, it is an acute adult mental health facility. The NCC is generally used for short stays. It does not admit "scheduled" patients.

Patients might go between the clinics and where necessary the staff of the various clinics can communicate with each as required.

Twenty-four hours prior to his planned admission to the Northside Clinic at Greenwich, Mr Lisle ran out of Oxycontin. His mother, who drove him to Sydney for his admission, states that Hugh was in an agitated state during his appointment with Professor Sambrook at 8.30am on 4 November 2009 and then at the Northside Clinic at Greenwich at 10.00am.

She said that staff at the Northside Clinic at Greenwich were so concerned about Hugh's presentation that they immediately called an ambulance. Dr Wilson noted that; "*On that occasion he had experienced severe withdrawal symptoms and it was suspected that he had also overdosed on paracetamol*."

Mr Lisle was admitted to the Royal North Shore Hospital and commenced on a buprenorphine reduction regime. That evening, he was discharged and transferred to the Northside Clinic at Greenwich and admitted under the care of Dr Seema Sharma.

While admitted to the Northside Clinic at Greenwich Hugh consulted with Dr Wilson and other psychiatrists frequently, participated in family sessions and other therapy, and started exercising. His family was happy with his progress and the standard of care and treatment he was receiving.

By 13 November 2009 Hugh thought that he was cured and discharged himself against medical advice.

Over the next three days he experienced symptoms consistent with continuing opioid withdrawal. He took speed, 'Nails' and ecstasy and started drinking alcohol heavily to relieve his symptoms. His deterioration culminated in a drunken assault for which he was charged. A friend said that the night before the incident, Mr Lisle had taken MDMA supplied by 'Dan', whom he had met at the Northside Clinic at Greenwich.

On 16 November 2009, Hugh attended the Northside Clinic at Greenwich and sought readmission. However, he was refused on the basis of its policy that a patient who discharges himself against medical advice cannot be readmitted for a week.

Mr Lisle saw Dr Wilson on 17 November 2009. Dr Wilson noted the "*many problems*" since the last consultation, including violence, drug and alcohol use and gambling. Mr Lisle reported feeling "*really depressed*". His mother called Dr Wilson on 23 November 2009 and informed him of Hugh's deterioration since discharge.

Mr Lisle voluntarily readmitted himself to the Northside Clinic at Greenwich on 23 November 2009. This time he was admitted under the care of general adult and drug and alcohol psychiatrist Dr Stephen Hook.

His withdrawal was managed with a buprenorphine reduction regime in combination with diazepam, olanzapine and quetiapine for anxiety. Dr Hook states that:

> *The medical aspect of his detoxification proceeded relatively well, but he was intolerant of group therapy and did not see any value in participation. His mood became more positive towards discharge. He did not want any follow-up by D&A* [drug and alcohol] *services, indicating he would continue seeing his psychiatrist, Dr Craig Wilson.*

Hugh was discharged on 7 December 2009. His medications on discharge were as follows: quetiapine 25mg midi, 25mg 6.00pm; quetiapine 50mg nocte; Efexor XR 300mg daily; Enbrel injection 50mg SC once a week (Friday); methotrexate 10mg once a week (Friday); Solian 200mg bd; Somac 20mg bd; Mobic 15mg daily; folic acid 1 twice a week; and multivitamin 1 daily.

Mr Lisle next saw Dr Wilson 8 February 2010, at which time Dr Wilson recorded that "*everything appears to be going very well now*".[1] In his statement, Dr Wilson added to this that treatment of Hugh's depression was difficult "*in the context of other lifestyle chaos*" and that he felt Hugh was dishonest about his gambling and substance use.[2]

Mr Lisle's assault charge was finalised in March 2010. A Magistrate made an order pursuant to s. 32(2) of the *Mental Health (Forensic Provisions) Act 1990* which required him to see the Salvation Army and/or St. Vincent's, take medication and attend regularly on Dr Wilson.

He did not attend on Dr Wilson until 30 March 2010 by which time his condition had deteriorated. He reported gambling "a bit" to pay for a $250 a week cocaine habit, taking 180mg of codeine a day and drinking two to three beers a day (which, in oral evidence, Dr Wilson said he suspected was an underestimation). Dr Wilson suggested to Hugh that he start exercising and that his medication regimen be amended to increase Efexor to 375mg daily, add Abilify 5mg (to increase to 10mg if there were no side effects), and to try Phenergan 75mg to aid sleep.[3] In his statement, Dr Wilson also said[4] that he advised hospitalisation but Hugh declined to attend the Northside Clinic drug and alcohol service because he believed it was too regimented.

By April 2010 many of Hugh's friends had drifted away. His mother said that this affected Hugh greatly and his sister described this as his lowest point.

On a Sunday in April 2010 (which must be either 3 or 10 April 2010) Hugh sent his friend, Winston Stearn, a text message saying that he was suicidal. Winston visited Hugh at his apartment that evening and observed him to be sedated. He felt that Hugh did not intend to harm himself and stayed until Hugh fell asleep but it appears that Mr Stearn was sufficiently concerned to call his mother, who said that she would contact Hugh's parents.

Mr Lisle's condition came to a head on 10 April 2010. On that day, he drank a bottle of wine and eight beers. He was later observed by police driving the wrong way down a one way street in Kings Cross. A breath test returned a reading of 0.06 and Hugh was charged with a low range drink driving offence.

[1] See Exhibit 2, V2, T66, p. 53.

[2] See Exhibit 2, V1, T29, p. 3.

[3] See Exhibit 2, V1, T66, p. 57.

[4] See Exhibit 2, V1, T29, p. 3 under the "March 2010" heading.

Dr Wilson later formed the view that this incident was almost deliberate, as Hugh said he was "*surprised*" at the charge given the amount of alcohol he had consumed. Nevertheless, Hugh was distressed at the prospect of facing a second traffic offence and told police that he did not want to live anymore and that he couldn't cope. He attempted suicide by ingesting 30 clonazepam 20mg tablets while in police custody.

Police took him to St. Vincent's Hospital where he was scheduled under the *Mental Health Act 2007*. While the medical records of that admission were not before me, it appears that he was treated and discharged on 11 April 2010.

At 3.30pm on 11 April 2010, he called the NCC and spoke to Registered Nurse Anthony Tyrell. He informed her of his arrest and said that he was anxious and upset about it and feeling desperate. RN Tyrell formed the view that Hugh did not have a plan to commit suicide. After encouraging him to ventilate, she suggested that Mr Lisle contact the crisis team at the Prince of Wales Hospital. He did not want to be hospitalised but requested that Dr Wilson be informed of his call. RN Tyrell noted the discussion and placed it into Dr Wilson's pigeon hole. A copy of RN Tyrell's note is contained in Dr Wilson's records for Hugh.

Mr Lisle consulted with Dr Wilson on 13 April 2010. Dr Wilson had, on that day, received a letter dated 10 April 2010 from Hugh's mother in which she expressed her concern that "*Hugh's situation is now… at crisis level.*" She referred to his debts, his arrest and the impending court date on 3 May 2010. She also said that he "*can put on a normal face for a while but is now lying all the time.*" At the bottom of the letter she included an authorisation for Hugh to sign which would grant consent for Dr Wilson to discuss Hugh's health with her. That was never signed and Dr Wilson told the inquest Mr Lisle was not agreeable to his condition being discussed with his parents.

At the consultation on 13 April 2010, Hugh admitted to regular use of sedatives, cocaine, opiates and alcohol. He said that he was gambling as much as possible. Dr Wilson strongly advised hospitalisation but he declined.

Despite his refusal to be hospitalised Hugh was distressed. He called and text messaged his mother until 2.00am on 14 April 2010, by which time she had persuaded him to attend the Prince of Wales Hospital. He was voluntarily admitted to the hospital's Psychiatric Emergency Care Centre (PECC) where he described suicidal ideation with thoughts of a methotrexate overdose, injecting himself with a cleaning agent or hanging. He was a treated with a gradual reduction in Efexor and, at his request, was commenced on antidepressant medication Mirtazapine 15mg. After complying with the requirements of his admission he requested transfer to a Northside Clinic under the care of Dr Wilson. Only the NCC had a bed available.

On 16 April 2010, Hugh was discharged from the Prince of Wales Hospital and transferred to the NCC.

Dr Hook reviewed Hugh during his admission. He considered that notwithstanding the NCC did not have a specialised drug and alcohol unit, Hugh's withdrawal could be effectively managed at there under Dr Wilson's supervision. He gave evidence that Mr Lisle had previously expressed no interest in engaging with drug and alcohol

services so a transfer to the Northside Clinic at Greenwich would not have been acceptable to him. Dr Hook gave evidence that Hugh "*hated*" drug and alcohol programs. He said that Hugh saw his use of drugs as a means of self-medicating to alleviate pain and it was very difficult to convince Hugh otherwise.

The final admission

Hugh was voluntarily admitted to the NCC on 16 April 2010 at 7.20pm under the primary care of Dr Wilson, following referral from the PECC of the Prince of Wales Hospital.

On admission he signed a "*Medication and safety*" form in which he agreed to transfer ownership of any medications brought by him into the NCC, to keep no medications with him while he was a patient at the NCC; to only take those medications prescribed by his doctor and given to him by staff at the NCC; not to consume any illegal drugs or alcohol while he was a patient at the NCC; and to abide by the rules and regulations of the NCC. No medications were recorded as being brought in and/or sent home with a relative at the time of admission.

A number of medical assessments were also conducted. A physical examination showed that he weighed 110kg and was 182cm tall. That put him in the clinically obese range of the BMI.

Various histories were taken by nursing and medical staff during which, it later transpired, Mr Lisle understated his issues. He reported to one person that he had two beers every night, 20 cigarettes a day and cocaine once a week. To another he admitted to heavy alcohol, speed and 'Nails' use. He denied any current legal action but told another staff member of his arrest for low range drink driving. He was formally assessed by a locum, Dr Gaurab Tandom, who took a lengthy history. As a consequence, Dr Tandom diagnosed Hugh with poly substance abuse and mood disorder (Axis I disorders), an Axis II disorder, which is illegible on the "*Doctors Admission/Discharge Form*"[5] (and which does not appear on the discharge form completed by Dr Wilson after Hugh's death[6]) and psoriasis (an Axis III disorder). Dr Wilson reviewed Dr Tandom's diagnosis and substituted pathological gambling and major depression with suicidality in lieu of the mood disorder diagnosis. He noted his opinion that Mr Lisle's main current issue was addiction.

Dr Wilson gave evidence that, given the competing disorders, priority was given to stabilising Hugh's mood and substance abuse issues. This was generally to be achieved by gradually replacing his doses of venlafaxine with mirtazapine, placing him on an Alcohol Withdrawal Scale (and treating him with diazepam pursuant to that protocol), and treating his pre-existing conditions with clonazepam (with a view to gradual reduction), quetiapine (for agitation), clonidine (for withdrawal symptoms) and meloxicam and etanercept (for arthritis).

Dr Wilson formed an initial treatment plan whereby Mr Lisle was to be administered adequate pro re nata (PRN) medication for sedation, hydrazole cream for psoriasis,

[5] See Exhibit 2, V2, T67, p. 52.

[6] See Exhibit 2, V2, T67, p. 29.

Efexor 225mg (a decrease in his current prescription) and mirtazapine at 30mg. Contrary to Mr Lisle's expectation that he would be admitted for one week, Dr Wilson expected him to be an in-patient for four weeks.

Dr Wilson's initial treatment plan also required Mr Lisle be placed on Category 3 observations. Although Dr Wilson gave evidence that he was not aware of a formal policy regarding the categorisation of patients entitled "*Patient Observation Categories (Psychiatric Facilities)"* (which existed at the time and was admitted into evidence), his decision for Mr Lisle to be placed on Category 3 observations was consistent with it.

That policy provides that a patient placed on Category 3 observations is required to be sighted at intervals of at least 30 minutes with a record made of the time and location that the patient is observed. Where possible, a "*safety contract*" is to be made. The patient may only take supervised leave with prior approval.

Over the next 48 hours, nursing staff observed that Mr Lisle was becoming increasingly agitated. He was administered PRN medication on a number of occasions, with the Seroquel proving ineffectual. He reported low mood and possible auditory hallucinations.

In light of Hugh's response to the withdrawal, Registered Nurse Michael Nolan conducted a review on 18 April 2010. It became apparent that he had understated his alcohol and substance use on admission. Mr Lisle disclosed that prior to his admission, he was consuming six to eight standard drinks each day, one bottle of red wine on alternate nights, 21 standard drinks on one week night out, extracting codeine from two to three packets of Panadol Extra every two or three days, taking clonazepam 2mg at night for restless legs, taking cocaine "*at every opportunity*" and that he would use *speed* and *ice* if he could obtain it. He had been prescribed up to 300mg of diazepam and had been snorting it until his withdrawal from it at the Northside Clinic at Greenwich. The extent of his drug use is perhaps apparent from his description of Seroquel as like "*a mosquito bite*".

After the review, RN Nolan called Dr Wilson and duty doctor, Dr Raj Choudhray, who increased Hugh's dose of diazepam. He was reviewed the following day by Medical Officer Dr Wade, who approved the amended medication regimen.

Mr Lisle saw Dr Wilson on 19 April 2010 and described significant withdrawal symptoms. He told Dr Wilson that he had previously required 80mg of diazepam per day. Dr Wilson requested that Dr Hook, the drug and alcohol psychiatrist who had treated Hugh during his second admission to the Northside Clinic at Greenwich, conduct a review.

Dr Hook assessed Hugh on the following day. Dr Hook notes in his statement:

> *At that consultation he told me he had been using distilled codeine regularly, up to an estimated 450mg/day. The main symptoms he reported were dysphoria, agitation and anxiety. There were also muscle aches, but no other opioid specific symptoms such as lacrimation, rhinorrhoea or gooseflesh. He also had high tolerance for benzodiazepines (he was able to have 120mg*

over 24 hours with no reported sedative effect) so some of his symptoms were probably also benzodiazepine withdrawal.

I noted that his last use of codeine was approximately 10 days prior to this interview. The peak of codeine withdrawal is around 7-10 days. As he was not reporting opioid-specific withdrawal symptoms, my assessment was that he was probably past this peak. We discussed the option of using buprenorphine again, but this would have the effect of prolonging the withdrawal phase. The other option was to continue on the diazepam regime but add clonidine (an antihypertensive that dampens opioid withdrawal effects). This had the advantage that the opioid withdrawal phase would be over sooner (another few days). This was Mr Lisle's preference.

However, there was still the problem of his benzodiazepine dependence, which I expected would need to be managed over weeks or possibly months. I left instructions in the file regarding an appropriate short-term diazepam dosing regime (where doses could exceed 120mg/day) followed by guidelines for phased reduction over the following weeks.

Dr Hook's instructions were to add clonidine 75 to 150mg to the regimen to reduce agitation; to expect over 120mg doses of diazepam to be necessary for two days, possibly administered in 20mg doses; and after four to five days, to reduce the diazepam dosage, typically starting at 60 – 80mg per day then reducing 5mg per day to about 30mg then with a more gradual reduction.

Dr Hook gave oral evidence that the primary concern was managing Hugh's very acute withdrawal phase. He said that even though Hugh had not reported high use of benzodiazepines he had been administered 120mg of Diazepam with no effect. At that stage, Dr Hook was "*more worried about under treating than over treating"* Hugh.

Dr Wilson gave evidence that Hugh had the commitment to change but was struggling with the process. The hope was that the medication regimen would stop Hugh's cravings.

At the time of the next review, Dr Wilson was aware that a patient at the NCC had made two recent reports that Hugh had attempted to obtain non-prescribed medication. The first report was recorded in Hugh's progress notes on 19 September 2010 by Registered Nurse Paula Muriwai. It notes that the patient alleged that Hugh asked if the patient could get Xanax. The second report was recorded in the progress notes on 20 April 2010 by Clinical Nurse Consultant Fowler. It notes that the patient alleged that Hugh asked him how to obtain Endone (which contains oxycodone) and how to get it prescribed. CNC Fowler then spoke to Dr Wilson about the reports.

Dr Wilson confronted Mr Lisle about the reports and advised him that he would be discharged if the behaviour continued. He also told Hugh that his room would be searched. A Ramsay Health Care policy entitled "*Room Search/Personal Belongings"* existed at the time and applied to the NCC. It outlined the circumstances when a search could be conducted and how it should be conducted.

RN Muriwai conducted the room search that evening. She located nicotine gum, inhaler cartridges, a few venlafaxine capsules and an empty, small plastic bag. Hugh said that the bag had contained cocaine but assured her that he had not taken it while admitted to the NCC.

A personal search was conducted on 21 April 2010 after Hugh could not be located during a routine observation. After informing staff on the telephone that he was outside the NCC having the cigarette, he was observed "*running at full tilt*" from Wycombe Road to the NCC. Hugh's pockets were emptied on his return and only a mobile telephone and tobacco were in his possession.

Mr Lisle was reviewed again by Dr Wilson on 22 April 2010. He formed the impression that Hugh was much calmer and that his requirement for diazepam had greatly reduced. Hugh was able to assure Dr Wilson of his safety. Dr Wilson ceased the Alcohol Withdrawal Scale and reduced the diazepam dosage to 20mg at 8.00am, noon, 4.00pm, and 8.00pm. He also placed Hugh on Category 1 observations to facilitate exercise.

A patient on Category 1 observations enjoys the greatest freedom of any patient at Ramsay Health Care Facilities providing psychiatric care. According to the policy, risk factors and key indicators to consider when placing a patient on Category 1 are as follows:

- Voluntary status and little evidence of risk
- Is able to provide assurance of personal safety
- Patient's physical status is within normal limits
- Independent with daily living skills and functioning
- Self directed with inpatient group program/activities
- Established medication regimen
- Participating in discharge planning.

The policy requires that a patient on Category 1 observations be sighted every two hours, unless other arrangements (such as arrangements to take unsupervised leave) are made.

While this is not stated in the policy, it became clear from the evidence of a number of nursing staff at the NCC that all patients were required to be observed on an hourly basis from 11.00pm when the clinic was locked. Nursing staff also believed that, while Category 1 patients were entitled to take unsupervised leave without prior approval, patients were restricted to one two-hour leave period each day.

Patients taking leave were required to sign in and out in a Patient Leave Book and record their name, destination, the person (if any) who was to accompany them, the time out, estimated time of return, and the actual time of return. During Hugh's admission the Patient Leave Book was located near the reception desk, near the front door. Patients were not required to have their entry or exit oversighted by nursing staff. There was a general practice of checking the Patient Leave Book if the patient could not be located during a routine observation.

The NCC's practice with respect to patient leave has changed since Hugh's death. Since 2012, NCC patients require patients to personal report to staff on their exit and re-entry. NCC staff record periods of leave in the patient's clinical file. [7]

Mr Lisle's entries in the Patient Leave Book suggest that there were days where he left the NCC more than once and/or for more than two hours on each occasion. There is a record of only one such occasion being followed up. On 23 April 2010 Hugh signed out of the leave book at 11.00am. Enrolled Endorsed Nurse Gail Hooper made a progress note at 2.00pm which indicates that she telephoned Hugh and left a message and was awaiting instructions from Dr Wilson. Registered Nurse Dolby later noted that Hugh returned to the NCC at 3.00pm and there was no evidence that Hugh had taken non-prescribed substances. There was one occasion, on 25 April 2010, when Hugh self-administered a 50mg injection of Enbrel for his arthritis whilst on leave. However, he informed RN Muriwai on his return and Dr Wilson was notified.

Mr Lisle would sometimes record his destination in the Patient Leave Book as the TAB. As was clear from his diagnosis on admission, staff at the NCC were aware (or should have been aware) of Hugh's gambling addiction and, indeed, Dr Wilson raised this with Hugh on 27 April 2010.

During consultation on 27 April, Dr Wilson considered that Mr Lisle appeared brighter. While Hugh admitted to a small amount of gambling he denied using drugs. He was discussing his future in a reasonable fashion and had been for a run. In light of his improving presentation and his tolerance of the diazepam reduction, Dr Wilson instructed that diazepam be gradually reduced further (to dosages of 20mg, 15mg, 20mg, and 20mg per day) and continued Category 1 observations.

There is conflicting evidence as to whether this improvement continued in the following days.

David V prepared a statement and gave evidence at the inquest. Mr V was a patient at the NCC during Hugh's admission. He said that at about 10.30pm on 28 April, he was at the coffee machine in the NCC kitchen when Hugh entered to his right, took something from the kitchen and ate it. Mr V said that Hugh's eyes were "*pinned*", he was swaying and looked like he was "*drug induced drunk*". Mr V formed the impression that Hugh had taken heroin or sedatives. He said that he told Hugh, "*Mate you look really smashed and out of it*" and Hugh said that he was ok.

Mr V said that after much consideration, at 6.15am the next morning he told a nurse named "Amelia" (who he thought at the time was named "Emelda") about his conversation with Hugh, that he noticed Hugh's eyes to be extremely "*pinned"* and that he was concerned for Hugh's safety. He also said that he expressed concern for other patients' safety, since he felt that Hugh was able to come and go as he pleased and addicts "*take a few extra patients with them when they go.*" He said that he also told nurse "Amelia" that he believed that Hugh's blood and urine should be tested because he knew that they sometimes conducted such tests at the NCC. His

[7] Diane Hollings at Exhibit 2, V1, T40, [21] – [23].

evidence was that RN “Amelia” told him that she would speak to “Sue”, the nurse from Unit 1.

Nurse “Amelia” was identified as Registered Nurse Amelia Fox. While RN Fox, in her supplementary statement dated 7 February 2014 and in oral evidence, agrees that she had a discussion with Mr V about Mr Lisle, she disputes his version of that discussion and when it occurred. RN Fox states that she recalls Mr V talking to her about Hugh at least a week before Hugh’s death and saying that it was his opinion that Hugh was “*dealing or pushing drugs on other patients and getting money.*” She does not recall that he used words such as “*smashed*”, “*pinned*” or the phrase “*take a few extra patients with them when they go*” but concedes that it is possible Mr V may have said those things.

RN Fox claims that shortly after she spoke to Registered Nurse Sue Hills-Johnes, the Registered Nurse in charge, and told her what Mr V had reported. On the night shift of the day she had spoken to RN Hills-Johnes, she said that RN Hills-Johnes confirmed that she had passed the information on. RN Fox also recalls seeing a note written by RN Hills-Johnes concerning the information. Days later, she checked Hugh’s progress notes to see if any action had been taken as a consequence. She saw an entry by Dr Wilson to the effect that he had spoken to Mr Lisle about reports that he had asked other patients for drugs and that he would be discharged if he did it again. RN Fox gave evidence that she was satisfied, on the basis of Dr Wilson’s entry, that the information had been actioned. She said that she was “*comfortable*” that it was acknowledged and she felt that she had seen something from RN Hills-Johnes, perhaps on a handover sheet.

RN Hills-Johnes does not recall having a discussion with RN Fox about a conversation with Mr V, but does not deny that she may have. She said that had such a discussion occurred, she would have handed that information over to the incoming nursing shift for the nurse in charge of that shift to hand over to a medical officer.

No record of any such discussion between RN Fox and RN Hills-Johnes exists. RN Fox gave oral evidence that Mr V did not want her to record his report. She said that she had to remain “*non-judgmental*” and if she were to record confidential patient reports she would probably note “*inappropriate behaviour*”. In any event, she gave evidence that she believed that RN Hills-Johnes, as nurse in charge, would record her report, particularly since Hugh was not under her care. RN Hills-Johnes gave oral evidence that she would expect RN Fox, as the nurse to whom Mr V’s report was made, to make a record of it.

Excerpts of Mr V’s diary were admitted into evidence. One entry, dated 28 April 2010, reflects Mr V’s assertions as to his observations of Hugh and his subsequent report to RN Fox. However, another entry refers to a telephone conversation with a police officer following Hugh’s death and is obviously erroneously also dated 28 April 2010. Mr V gave evidence that he did not have a particular practice as to when he would record diary entries. The purpose of the diary was to help him remember significant events. He said that he had undergone some mental health treatment including electro-convulsive therapy (in about April 2010) around the time of Hugh’s

admission but he did not feel that it significantly affected his memory – he mainly cannot remember words.

Both agree that RN Fox told him that she would inform nurse "Sue", or RN Sue Hills-Johnes. Nursing rosters[8] exhibited in this inquest show that both nurses worked together on the night shift on 22, 23 and 28 April 2014. The only progress note by Dr Wilson which matches the description of the events given by RN Fox is dated 20 April 2014.

Dr Wilson's entry relevantly notes: "*Told Hugh about the comments that he had asked for drugs from other patients. Told he would be discharged if he does this again.*" RN Fox asserts that, on the basis of that entry, she was satisfied that Mr V's information was acted upon. However, the information that Dr Wilson referred to was the opposite of what RN Fox claims Mr V reported; that is, that Hugh was dealing or pushing drugs on patients.

An issue also arises as to the weight that should be given to Mr V's observations. Mr V said that he had completed a two year TAFE course which qualified him to become employed as a drug and alcohol counsellor at the Royal Prince Alfred Hospital between July 1999 and May 2002. As a consequence, he learnt to recognise if a person was drug or alcohol affected. While his evidence on this point was unclear, he apparently stopped working as a drug and alcohol counsellor after being pressured to sign a contract which would make him personally liable for sharps accidents at the hospital.

Mr V's report to RN Fox of Mr Lisle dealing or consuming drugs, the report by one patient to RN Muriwai and CNC Fowler of Hugh making enquiries as to how to obtain drugs, and a letter from his mother to Dr Wilson dated 23 April 2010 expressing concern about Hugh's intention to discharge himself, are the only instances where patients or visitors made reports of inappropriate behaviour or observations to NCC staff before Hugh's death.

Mr V gave evidence that he saw Hugh intoxicated from drugs at the NCC on two other occasions. On one occasion he said that Hugh was sitting at the back of the NCC and looked "*off his face*" and "*drowsy like he was dopey*" and like he had taken sedatives. He said that the other time he saw Hugh near the laundry. He looked intoxicated again like he was drugged and had taken a sedative. Mr V said that the first time he met Hugh he formed the impression that he had problems with drugs because his speech was slurred.

Mr Lisle was visited often by friends and family during his admission. Brooke Gregory was one of the former. She said that when she visited, he sometimes sweated a lot and he attributed this to his heavy medication. On one occasion he mentioned having an elevated heart rate. She never observed him to slur his words and she said that staff appeared attentive and always seemed to notice her visiting Hugh.

[8] Exhibit 2, V2, T79.

His house mate Lucy King visited him for about ten minutes at lunch time on 27 April 2010. She said that he didn't seem to be "*drugged up*". He told her that they had given him a lot of Valium but he couldn't feel it working. Conversely, Hugh said that if she was to take the same amount of Valium she would probably pass out.

Hugh was visited regularly by Winston Stearn. Sometimes they would attend the TAB where Hugh would place small bets. Mr Stearn said that on one visit Hugh offered him some yellow or white coloured powder in a glad wrap resealable bag. Although in his statement he had not described the resealable bag as having any print or colour, when giving evidence during this inquest, Mr Stearn said that the bag may have been the same as the plastic resealable bag with a green and black 'Ranch' logo which was located in Hugh's room after his death. He said that these events occurred on his second last visit. According to the visitor's log book, that was on 26 April 2010.

Winston recalls that Hugh told him it was medication and he is "*fairly sure*" that Hugh told him that he had sourced the medication from another patient at the NCC. Winston gave evidence that he did not inform staff of that Hugh was in possession of another patient's medication. He said that he did not want Hugh to get kicked out of the NCC.

On three or four occasions at unknown times during Hugh's admission, he sent his friend Jade Mickley text messages asking if he could get cocaine and accept some of Mr Lisle's prescribed medication in exchange. Mr Mickely said he refused.

Hugh's mother and sister visited him regularly. His sister gave evidence that on one occasion, Hugh said that he was unhappy with the medication and he regularly complained that he had no energy. His mother said that; "*Hugh had complained to me a couple of times that his heart was racing, that it was pounding. I remember having conversations on the phone with Hugh and he would be slurring his words. Hugh told me that he had complained to staff that he felt over sedated and over medicated but that the staff didn't seem concerned about it*."

The medical records suggest that by 29 April 2010 staff had serious concerns about Mr Lisle's behaviour. Dr Wilson gave evidence that a group meeting was held that day during which Hugh's condition was discussed. A record of that meeting notes: "*encourage to attend groups*" and "*on thin ice*". The sentiment is echoed in a progress note by Registered Nurse Mark O'Sullivan which records his discussion with Dr Wilson where he formed the view that Hugh was "*pushing boundaries and close to being asked to leave.*"

The Patient Leave Book for 29 April indicates Hugh took periods of unsupervised leave. From 8.30am to 8.55am he went to Balmoral Beach by himself. It indicates that between 10.30am and 12.00pm he went out for coffee. Between 5.55pm and 6.15pm he went to Woolworths, and between 6.45pm and 7.30pm he left the NCC to attend the TAB.

A former patient at the Northside Clinic at Greenwich, Daniel L, claims that on 29 April, he received a text message from Hugh asking if he had any "*submarines*". He

replied that he wasn't sure what Hugh meant, to which Hugh replied, "*sorry wrong Dan*".

Daniel B was admitted to the NCC during Hugh's last admission. He gave evidence in this inquest and identified "*submarines*" as slang for Subutex, which contains buprenorphine. He agreed it was valuable on the street and probably worth $40 for 1/8mg.

Buprenorphine is a drug of addiction listed in Schedule 8 of the *Poisons and Therapeutic Goods Regulation 2008.* Its manufacture, packaging, storage, prescription, supply, and record-keeping are accordingly subject to those regulations.

The NCC was supplied Subutex in tablet form by pharmacist Anthony Vass. The ward register of drugs of addiction maintained by the NCC for Subutex 2mg and 8mg shows that Mr B was the only patient administered buprenorphine at the relevant time.

Registered Nurses Tyrell and Nolan are both recorded as having administered medication to Hugh and to Mr B and they each provided statements regarding their general practice of administering medication. Relevantly, two nurses would be present for the administration of a Schedule 8 medication. They said they would observe the patient to ensure he/she swallowed the medication while standing at the Medication Room door. Both nurses would record the administration of medication then check that it was returned to the cupboard and lock it while supervised by the other nurse. Mr B gave evidence that he felt that he was always observed to have taken the medication when administered. He also claimed that he was administered Subutex in sublingual form – a wafer formulation that dissolves almost as soon as it is put in the patient's mouth.

Mr B was discharged on 29 April 2010 into the care of his community treatment team without medication. His telephone records show that at 9.38pm he sent a text message to Hugh's mobile telephone. Hugh's telephone records show that at 9.42pm he sent two text messages to Mr B. At 9.43pm, Mr B made a 13 second telephone call to Hugh, followed by a text message at 9.46pm. At 9.47pm, Hugh made a 207 second telephone call to Mr B.

Mr B denies that anyone approached him to purchase prescription medication at the NCC. He conceded that it was possible that he had received a text message from a person asking for Subutex. He claims that he never sold or gave away his medications. Records of audits of the NCC's medication completed in April and May 2010 show that its stocks of Subutex were accounted for.

That evening, RN Hills-Johnes and RN Bernard Clarke were working on the night shift in Unit 1, where Hugh's room was located. A progress note records that night staff saw Hugh "*weaving up and down the corridor*". This was noted by RN Nolan who recalls that he was informed of this during the usual shift handover. At inquest, neither RN Hills-Johnes nor RN Clarke recalled making those observations or informing RN Nolan.

Dr Wilson thought it was possible that Hugh woke up and was fighting sedation, causing the weaving. He said that while it was "*something worthy of discussion"* it would not cause alarm bells to ring.

The Patient Leave Book suggests that on 30 April 1010, Hugh went to the TAB between 10.50am and 11.30am.

On or before 2.00pm, Hugh complained to staff of "*oversedation*" and "*feeling really tired all the time".* The medication chart suggests that Hugh was administered quetiapine 100mg, Meloxicam 15mg and venlafaxine 225mg at or around 8.00am. Although he was also prescribed diazepam 15mg to be administered at the same time, there is no signature to show that was done, but he was administered diazepam 20mg at noon by Registered Nurse Geraldine Carvey.

Mr Lisle saw Dr Wilson after 2.00pm on 30 April. They discussed Hugh being out and not attending group therapy. However, Dr Wilson generally thought that the admission was proceeding steadily. Hugh was apparently tolerating the reduction in diazepam and he denied having suicidal thoughts. He presented sufficiently well for Dr Wilson to permit long day leave over the coming weekend and to contemplate discharge around 12 or 13 May. Category 1 observations were continued. Dr Wilson gave oral evidence that he had seen the progress note recording Hugh's complaint of "*oversedation"* and "*feeling really tired all the time."* He gave evidence that he was very confident that Hugh was not slurring, sedated or weaving during this consultation. He said that he would not describe a person as "*brighter in mood*" if they were overly sedated.

Dr Wilson also gave evidence that he was not aware of Mr Lisle using illicitly obtained or non-prescribed drugs.

The Patient Leave Book for 30 April indicates Hugh signed out at 2.20pm or 2.30pm for a long walk and that he was expected to return at 4.00pm. The medication chart suggests that RN Tyrell administered diazepam 15mg to Hugh at about 4.00pm.

Between about 4.15pm and 5.00pm,[9] Hugh spent time with his friend Natalie Moffett. They had coffee at nearby cafe and spoke at length. Natalie gave evidence that Hugh seemed relatively well and in good spirits. He spoke about how he was looking forward to discharge, selling some of his paintings and graduating. Natalie noticed a thick wad of money in Hugh's wallet when he paid for the coffee. They returned to the NCC where they had another coffee and a cigarette for twenty to thirty minutes before Natalie left.

Unusually, observations made at 5.00pm record Hugh in the medication room. I am aware of no explanation for this but nor is any sinister conclusion justified.

The Patient Leave Book suggests that Hugh went for a walk by himself between 6.00pm and 7.00pm.

[9] In Natalie Moffett's statement, she gives times between 4.00pm and 6.00pm. Hugh signs out of the leave book at 1.30pm for coffee with a friend and signs in at 5.00pm.

After Hugh's death, a patient told Dr Wilson that she had seen Hugh at about 7.00pm on 30 April and she found him to the *"bright, cheery and the best she had seen him."*

His mother and sister arrived to take Hugh to dinner at about 7.00pm. They dined at a nearby restaurant during which Hugh consumed no alcohol. Both Cathy and Anna recall he spoke positively of plans for the future, including continuing his employment at the engineering firm. They made plans to breakfast together the next morning. They also recall he was slurring his words. At the inquest, Anna described Hugh as having "*lazy eyes*", akin to a sleepy person. They said that they had never observed Hugh in such a state.

Cathy and Anna say that they dropped Hugh at the NCC at about 9.00pm. The Patient Leave Book shows that Hugh signed in at 8.30pm. Hugh's medication charts note that RN Tyrell administered diazepam 15mg, mirtazepine 30mg, quetiapine 100mg and clonazepam 2mg at 8.00pm. However, given Hugh was at dinner at this time this must be in error. The *Principles of Administering Medication* policy in force at the time requires that "*When the RN/EEN is satisfied that the medication has been taken, the treatment sheet/S8 register is to be completed, including date, time and signature."* RN Tyrell gave evidence confirming it was usual practice to record the "*right time*", meaning the prescribed time, as the time at which the medication was administered provided it was actually given within 30 minutes of the scheduled time.

His mother said that Hugh was in a hurry to return to the NCC. Indeed, the leave book indicates he signed himself back out of the NCC soon after his return from dinner: his time of exit is recorded as 8.45pm; his destination is recorded as the TAB, and his estimated return is predicted to be 10.25pm. He did not sign himself back in. Perversely, routine two hourly observations were made at 9.00pm, which noted that Hugh was in his room resting.

Mr V states that in the evening he told nurse "John" on Unit 2 of his conversation with nurse "Amelia" the previous morning. He said that he may have done so because he saw Hugh intoxicated in the NCC that night, but he cannot recall.

The NCC night nursing staff routinely commenced their shift at 9.30pm. Relevantly, Registered Nurses Bernard Clarke and Amelia Fox were on shift with Assistant in Nursing Marlene Tait. They participated in a verbal and written handover by way of a "handover sheet" with the outgoing nurses.

AIN Tait gave evidence that, towards the start of her shift, she saw Hugh with two patients walking up the stairs towards his room. She said "*hello*" to the patients and they replied in kind. She said that did not notice anything unusual about any of the patients. At inquest, she gave evidence that she observed them for about seven minutes. Having regard to the content and context of her evidence, I am of the view that, like many people, she has trouble accurately recalling time and that in fact she only had him under observation for a minute or two.

The NCC was routinely locked at about 10.30pm or 11.00pm.

From 11.00pm, all patients at the NCC were observed on at least an hourly basis. RN Clarke was responsible for observing the patients in Unit 1, where Hugh was

staying. His record of the 11.00pm observations of Hugh noted that he was downstairs in the dining room.

After Hugh's death, another patient told Dr Wilson that he had spent most evenings at the NCC with Hugh and he felt that he knew him well. The patient told Dr Wilson that during the last week or so Hugh was trying to sell his belongings including his telephone charger, telephone and a book voucher. He felt that Hugh was "*desperate for money*". He said that Hugh had spoken about taking drugs, including amphetamines, at various times.

The patient said that Mr Lisle Hugh was usually clear and lucid but at about 11.00pm on 30 April he seemed "*intoxicated, disinhibited and far from his normal self*". The patient reported that Hugh wanted to "*break out*" of the NCC and he did not care about setting off the alarms. The patient said that he was "*100% sure*" that Hugh was not himself and had taken something.

The officer in charge of the investigation, Detective Senior Constable Tara-lee Janco, attempted unsuccessfully to obtain a statement from this patient. He did not provide a statement but did provide some information by email. Detective Senior Constable Janco formed the view that the patient was an unreliable witness.

The observation chart records Mr Lisle in his room resting at midnight. RN Clarke states that he had a brief conversation with him and he seemed to be in good spirits. According to him there was nothing unusual extraordinary about his behaviour or appearance.

Mr Lisle was again observed by RN Clarke at 1.00am. He has provided inconsistent accounts of this. In the relevant entry in the observation chart, the NSW Ambulance patient health care records, and police notebook entry made by Constable Martin Ganley at the scene – RN Clarke has written or said that Hugh was *"asleep*". RN Clarke gave evidence that his practice was to shine a torch on patients and observe a rise and fall which would indicate breathing. However, in his statement dated 15 August 2011 and in oral evidence, RN Clarke was adamant that he observed Hugh lying on his stomach in bed using his computer. He said that the observation record of Hugh being "*asleep*" at the time was an error on his part.

His mother said that Hugh never lay on his stomach because of the pain in his sternum, shoulders and feet.

Before moving to the events from 2.00am onwards on 1 May 2010, two other matters should be noted.

First, on 23 April 2010, Registered Nurse Sue Hills-Johnes recorded that she "*noticed a lot of negative writing on the floor*" in Hugh's room. There was no record of those notes in Hugh's medical records.

Second, on 28 April 2010, Registered Nurse Geraldine Carvey recorded in the progress notes that Hugh stated he woke up with two biscuits on each side of his mouth. He spoke of feeling hungry during the night because of medications. RN Carvey says she spoke to him regarding the "*safety of having food in his mouth*

whilst fast asleep" and Hugh *"understood and agreed he would try not to fall asleep while eating.*" Staff had previously observed Hugh waking and snacking or eating biscuits late in the evening or early morning on 19, 20, 21, 23 and 27 April 2010.

The death is discovered

When RN Clarke conducted the 2.00am observations in Unit 1 he found Hugh lying face down on his bed. He says Hugh's computer was on the pillow above his head. RN Clarke noticed that Hugh was not breathing and immediately called for assistance. RN Fox and AIN Tait responded and came into Hugh's room.

At that time, RN Fox had worked at NCC for about a month.

RN Fox said that RN Clarke told her he could not detect a pulse. RN Clarke and RN Fox then managed, with some difficulty, to turn Hugh over on to his back on the bed.

AIN Tait, in a handwritten note made for the NCC after Hugh's death, her statement prepared for this inquest and in oral evidence, has maintained that she observed "*yellow gunk*" in his nostrils and biscuits in his mouth. At inquest, she gave evidence that his nostrils were blocked with mucous, his mouth was swollen, he was very sweaty and there were empty biscuit packets on the bed, near his computer.

In her statement, RN Fox said that Hugh's nostrils were blocked by a "*yellow substance*", which she assumed to be vomit, and his tongue appeared to be swollen and purple and was protruding from his mouth.

RN Clarke provided varying accounts of his observations of Hugh. In his statement prepared for this inquest, RN Clarke stated "*other than Mr Lisle being unresponsive, I do not recall anything unusual about him*". RN Clark stated, in an undated addendum to a handwritten account prepared for the NCC after Hugh's death, that there were biscuits in his mouth and yellow mucous in his nose. At inquest, he gave evidence that he observed biscuit crumbs around Hugh's bed but he checked Hugh's airways and there were no biscuits in his mouth nor anything resembling food matter. He does not recall checking Hugh's nose or anything about his tongue.

Either RN Clarke or RN Fox[10] pressed the duress alarm to notify the NCC's security company to the clinic to see if police or ambulance officers were required and to notify patients to remain in their rooms. Both she and RN Clarke recall that he asked AIN Tait to call an ambulance.

Nurses attempt CPR

Generally, it is clear that thereafter RN Clarke and RN Fox conducted CPR on Hugh while AIN Tait assumed primary responsibility for telephoning emergency services. After Hugh's death they each prepared handwritten accounts to the NCC which, with the exception of RN Clarke's handwritten addendum prepared some time afterwards, are counter-signed by each other. Those accounts are reasonably brief and consistent. However, the accounts provided in the statements prepared for this

[10] RN Fox gave oral evidence that she pressed it while AIN Tait recalls that RN Clarke pressed it and that's what alerted RN Fox to the emergency.

inquest and in their oral evidence differ in points of detail. Those accounts, in some respects, also differ from the 000 recording.

The call to emergency services was made at 2.09am. AIN Tait gave evidence that she called emergency services from a fixed telephone in the nurse's station. She gave basic details. At inquest, both AIN Tait and RN Fox gave evidence that AIN Tait then transferred the call to RN Fox because the operator wished to speak to a registered nurse. This is not captured on the 000 recording in evidence.

The 000 recording lasts approximately eight minutes. It was played during the inquest and the transcript references to "N1" were identified as RN Fox, "N2" as AIN Tait, and the male voice as RN Clarke. RN Clarke gave evidence, without having listened to the 000 recording, that he did not speak to the 000 operator. It seems clear from the transcript of the call that he did.

The 000 recording commences with a 2 minute and 20 second exchange between the 000 operator and RN Fox, during which she described Hugh as a 24 year old male patient who is unrouseable, unconscious and not breathing. In response to a query from the operator as to whether a defibrillator was available, RN Clarke is heard to say, "*No I don't think so*" and RN Fox tells the 000 operator, "*No we don't…no.*"

Immediately afterwards, RN Fox tells the operator that she is in the office. She is unable to provide a mobile number on which the 000 operator could contact her.

RN Clarke gave evidence that Hugh's room was small and that it would have been crowded in there with three people. He said that Hugh's room was "*within calling distance*" of the office.

The operator – more than 2 minutes and 20 seconds into the recording – commenced providing CPR instructions to RN Fox. RN Fox then told AIN Tait to take over communication with the 000 operator so that she could assist RN Clarke with CPR.

In her statement, AIN Tait said she used a cordless telephone to speak to the operator. At inquest she said that although she made the initial call from a fixed landline she obtained a cordless telephone and gave the operator an account of the CPR and other matters as the incident unfolded.

In response to the 000 operator's queries as to whether there was anything in Hugh's mouth and whether she could feel or hear any breathing, there were pauses of 46 seconds and 38 seconds respectively. AIN Tait claimed that during one pause she was unlocking the NCC's doors in anticipation of the paramedics' arrival and that during the other pause she was wheeling the oxygen with suction into Hugh's room.

RN Fox said that she obtained the emergency resuscitation equipment which included a Guedel's airway, oxygen and a defibrillator. She asked AIN Tait to bring oxygen with suction to Hugh's room with the intention of using it to clear his airway (but did not ultimately use it). She gave evidence that she believed AIN Tait may have brought the equipment. AIN Tait gave evidence that she did not recall bringing

in anything other than the oxygen with suction. She did not recall a defibrillator being used.

Five minutes and five seconds into the recording, AIN Tait told the 000 operator that the registered nurses were performing compressions; "*Just now, they've just started it, yep."*

AIN Tait gave evidence that she does not recall whether by, "*just now"* she meant within the last few seconds or the last few minutes. RN Clarke gave evidence that he did not think AIN Tait was wrong in saying that "*they've just started it*" but he was saying that he and RN Fox started CPR straight away and, in any event, much sooner than three minutes after the 000 call commenced. He later said that they started CPR "*immediately*". RN Fox also maintained that they commenced CPR as soon as they could.

The CPR was conducted on Hugh's bed. RN Fox gave evidence that the bed was very hard with a very hard mattress on it. Clinical Nurse Director Diane Hollings gave evidence that the beds were not hospital beds. Both registered nurses said that Hugh was large and they had difficulty turning him on to his back. RN Clarke gave evidence that he did not know that it was not optimal to conduct CPR on a bed. However, he later said that he was aware that it was not optimal but that he thought it was important to start CPR in any case. RN Fox said that it may have been dangerous for them to move Hugh to the floor because they may have given him a head injury. Counsel Assisting asked RN Fox whether, in the chaos and anxiety of the situation, perhaps no consideration was given to moving Hugh to floor. RN Fox said that no thought was given by her because that was not her understanding of the procedure at the time. AIN Tait gave evidence that she did not recall whether the CPR training addresses where to put a person for resuscitation, that she was sure it would have been too difficult to move Hugh, and that she did not discuss moving him with anyone.

RN Fox gave evidence that she put a mask on Hugh and gave two strong breaths with the air viva bag. RN Fox said that she then twice attempted to insert a Guedel's airway but failed and RN Clarke eventually managed to insert it. She said that AIN Tait provided her with the requested oxygen and she applied the mask attached to it to Hugh's face, turned on the cylinder and gave two bagged breaths,

RN Clarke said that he did the compressions while RN Fox performed the breathing. RN Fox gave evidence that RN Clarke's compressions were strong.

Although none of the nurses referred to the use of a defibrillator in their handwritten accounts provided to the NCC, RN Fox said in her statement and in her oral evidence that a defibrillator was used. She said they placed the defibrillator pads on Hugh's chest. RN Clarke's evidence is less consistent, but he did give evidence at the inquest that a defibrillator was used. He gave evidence that he placed a rubberized sheet on top of Hugh's clothing (although he vaguely recalled trying to take Hugh's shirt off) and that there were no pads.

Both say that the defibrillator issued a command. In her handwritten account, RN Fox stated that the defibrillator "*commanded CPR which was being attended".* She

said, in oral evidence, that it issued the aural command: "*continue CPR"*. RN Clarke, in his handwritten addendum, states that "*the shock pack indicated that he still had a pulse*." At inquest, RN Clarke gave evidence that the defibrillator commanded "*Don't shock*" or something similar which he interpreted to indicate that there was a heartbeat. He said that this was a written command and he did not know whether it also issued an aural command. He explained that the phrase in his statement that "*we did not defibrillate him*" meant that he and RN Fox did not shock Hugh.

RN Fox gave evidence that RN Clarke removed the defibrillator pads[11] and continued CPR. She acknowledged that while the paddles would normally be left on, she did not think there would have been any other instructions issuing from the defibrillator because, in her view, Hugh was "*very deceased."* Both say that ambulance officers arrived immediately after RN Clarke made the decision to remove the pads.

At 7 minutes and 28 seconds into the recording, RN Clarke spoke to the 000 operator. At 7minutes and 40 seconds he confirmed that compressions were still being performed on Hugh. Immediately afterwards, AIN Tait resumed conversing with the 000 operator.

Soon afterwards, AIN Tait informed the operator that the ambulance had just arrived. The 000 call ended at 2.18am.

Paramedics arrive

Two crews of ambulance officers arrived on the scene. The first crew arrived at 2.17am and comprised of paramedic Luke Ridley and paramedic Lucinda Reid. The patient health care record L381279, completed by Ms Reid and countersigned by Mr Ridley, noted "*Ineffective CPR in progress*". Mr Ridley explained that as the CPR was conducted on a bed, he considered it to be ineffective. He and Ms Reid moved Hugh to the floor because they could perform more effective compressions on a firm surface. He said that they did not have difficulty moving Hugh to the floor but he performed such manoeuvres regularly. They commenced CPR and bag mask ventilation.

RN Clarke recalls that an ambulance officer said that Hugh still had a faint pulse. Mr Ridley gave evidence that when he arrived with Ms Reid, they could not detect any electrical activity or pulse.

Mr Ridley did not recall seeing any defibrillator machine or AED on scene. He also said that it was his usual practice to make an effort to *"look around to see why he's in the situation that he's in."* He could not recall whether he observed any drug paraphernalia in Hugh's room but said that, had any such observations been made, it would have been recorded by him or Ms Reid. The patient health care record L381279 does not contain any such note. Mr Ridley also could not recall Ms Reid

[11] In the submissions filed for the NCC at p. 17 [64(f)] it is asserted that "*the defibrillator pads remained in place until removed following the ambulance arrival."* In the submissions filed for RN Fox and RN Hills-Johnes, it is noted at p. 3 [9(i)] that RN Clarke removed the pads. The latter accords with my notes of RN Fox's oral evidence.

saying that she needed to clear Hugh's airway and noted that no record of clearing his airway was made.

At 2.19am the second crew arrived, comprised of paramedics Scott Edwards and Roland Pok. The second crew were sent because both Ms Reid and Mr Ridley were paramedic interns at the time and could not cannulate. The paramedics conducted a short handover. Mr Pok gave evidence that there was no mention at handover that a defibrillator had been used, nor could he recall it being on scene, but he had no reason to doubt that it been used.

Patient health care record L314476, signed by Mr Pok and Mr Edwards, notes "*staff state attach defib + instructed to perform CRP [sic]. CPR performed on bed … ineffective CPR noted. Pulled onto floor…*". Mr Pok clarified that "*ineffective CPR*" generally meant that it was not being performed correctly. He expressed the opinion that it was not reasonable to perform CPR on a bed (unless it was a hospital bed) to avoid delay because the CPR would be ineffective.

Mr Pok and Mr Edwards, with some difficulty, intubated and cannulated Hugh. Adrenaline and atropine were administered with nil response. At 2.50am they ceased resuscitation efforts.

Dr Magee certified Hugh to be dead on arrival at Sydney Hospital at 6.00am on 1 May 2010.

The investigation

Scene examination

Detective Sergeant Phillip Elliot of the Forensic Services Group of attended and conducted a scene examination. In the top drawer of a cupboard near Hugh's bed, he located $750 cash in a packet of "Champion Ruby" tobacco, a bag of "Tally-Ho" filters, a piece of "Tally-Ho" packaging fashioned into a tube, and a resealable plastic bag marked "Ranch" containing a quantity of white powder.

The white powder was later analysed and certified to be 0.54g of buprenorphine. No analysis was conducted on the rolled "Tally-Ho" packaging.

Hugh's bank records indicate that deposits of $556.88 and $713.95 were made into Hugh's bank account on 30 April 2010. That day, he withdrew $980 across seven transactions. Given the $750 located at the scene, $230 is unaccounted for.

Autopsy results

On 5 May 2010. Dr Jennifer Pokorny, a Pathology Registrar, conducted an autopsy on Mr Lisle's body. No significant injuries or abnormalities were detected either by visual observation or microscopic inspection. Histology showed no cardiac abnormality. There was no indication of airway instruction by food or other material, although the pathologist noted resuscitation attempts which would have involved the insertion of artificial airways had been undertaken.

Toxicological analysis detected the following drug levels:

Blood Diazepam	.32mg/L
Blood Mirtazapine	0.1mg/L
Blood Nordiazepam	0.55mg/L
Blood Oxazepam	.03mg/L
Blood Quetiapine	0.1mg/L
Blood Temazepam	0.02mg/L
Blood Venlafaxine	0.3mg/L
Blood Buprenorphine	0.4ug/L
Blood 7-Aminocloanzepam	0.04mg/L
Urine Buprenorphine (total)	0.10mg/L
Urine Norbuprenorphine (total)	0.04mg/L

As a result of having reviewed Mr Lisle's medical chart, the pathologist was aware that he had not been prescribed Buprenorphine (temazepam or oxazepam). She went on to provide the following opinion:

> *The medications detected at post mortem were a combination of benzodiazepines, an anti-psychotic, two anti-depressant's and an opioid: all of which have the potential to cause sedation an other toxic effect's (particularly if present at high levels). The concentrations detected in this case were, however, not significantly elevated. Much of the published data relating to the toxicity of medication is related to drugs taken in isolation. The clinical effects of multiple drugs when taken in combination even at modest concentrations, are poorly understood and it is possible that the clinical effects may be synergistic, the potential for toxic effect being greater than with any individual drug taken in isolation.*

The pathologist also noted that Mr Lisle was of a heavy build with a Body Mass Index (BMI) of 38.7 and that is body habitus, in combination with a face down position may have contributed by making him more susceptible to respiratory compromise if he was significantly sedated.

She noted there were none of the asphyxial features commonly found in suffocation cases.

As a result of considering the autopsy information the pathologist was unable to offer opinion as to likely cause of death.

Dr Pokorny noted that the possibility that Hugh's death was caused by a genetically related cardiac condition which cannot be detected at autopsy and recommended that his family seek medical advice.

The Lisle family subsequently submitted to relevant genetic testing and a copy of those results was admitted into evidence. While not conclusive, it revealed no genetic abnormality likely to result in a sudden, fatal cardiac event.[12]

[12] Exhibit 5.

An experienced forensic patholgist, Dr Johan Duflou, reviewed the autopsy material and also gave evidence. He said positional asphyxia was unlikely to have caused this death. He agreed with some of the other experts that a combination of the drugs found in Mr Lisle blood post mortem could have caused the death. With the exception of venlafaxine and quetiapine, all of the medications involved, including the buprenorphine, cause respiratory depression. In Dr Duflou's opinion, if there was no obstruction of the airway, more likely than not, multi-drug toxicity caused the death.

Dr Duflou discounted the significance of the yellow mucous seen in and around Mr Lisle's nostrils when he was found by the nurses. It is a common agonal artefact. He indicated that similarly, a person can regurgitate food around the time of death and that can also be caused by resuscitation if the airway is not protected by an endotracheal tube.

Toxocology

Reports were obtained from Professor Ian Whyte an eminent clinical toxicologist and clinical pharmacologist and he gave evidence at the inquest. In his opinion, the prescribed drugs were all at the lower end of their therapeutic range apart from the Venlafaxine and Diazepam, which were at the top of the recommended therapeutic range. Professor Whyte accepted however that as Mr Lisle was being withdrawn from alcohol, which has a pronounced cross-tolerance with Diazepam, the high dose of that drug was reasonable.

With respect to the sedating effect of the prescribed drugs he said that: -

> *The Diazepam Clonazepam, Mirtazapine and Quetiapine are all potent sedative drugs and the combination is likely to be at a minimum additive. This means the combination is equivalent to at least four times the therapeutic dose.*

He said the observations of Mr Lisle wheezing and his complaint that he was over sedated are both consistent with someone who is over sedated after their night-time medications.

Professor Whyte indicated the un-prescribed Buprenorphine would have produced additional sedation. The peak of that effect would occur approximately 100 minutes after it was taken.

In his first report Professor Whyte concluded: -

> *From the material provided, it seems reasonable to me that Mr. Lisle died as a result of respiratory obstruction from one or more biscuit's in his upper airway and his face-down posture in his pillow while under the sedative effects of a large number of drugs which in combination prevent him from waking to clear his own airway. Given the pathologist finding that there were no asphyxial features, I would suggest that his death was not pure asphyxia but that he had a cardiac arrhythmia as the terminal event. Venlafaxine in overdose is well known to cause cardia arrhythmia's which can be fatal. This effect is great in the presence of an acid environment in the body. Respiratory obstruction rapidly leads to a rise in carbon dioxide concentration in the blood and potentially sever acidosis. Even*

though the Venlafaxine concentration was only slightly above therapeutic it could potentially produce an arrhythmia if the acidosis was severe enough.

In a second report Professor Whyte was asked questions about the prescribed medication, in particular, whether having regard to the combined effects of the drugs, the dosage of Diazepam was appropriate. He responded as follows: -

> *The dose of Diazepam was 40% above the recommended therapeutic range (product information). Given that Mr. Lisle was being withdrawn from alcohol which has a pronounced cross-tolerance with Diazepam this dose although high on its own was not unreasonable.*

Professor Whyte acknowledged that in accordance with the need for caution, the doses of Clonazapine, Mirtazapine and Quetiapine had been given at reduced dosage. However he was still of the opinion: -

> *Nonetheless, the combination of drugs with sedative effect could have potentially been modified to the following more therapeutic appropriate and less sedating regime.*

Professor Whyte was provided with more investigation material including the statement of Mr V and his diary entries. He indicated that Mr V's comments about Mr Lisle appearing drowsy and "*off his face*" and intoxicated were consistent with Professor Whyte's previously stated opinion that the combination of sedative drugs had the potential to produce excessive sedation.

He advised that Mr V's statement that Mr. Lisle's eyes "*looked pinned*" was a classic feature of opioid effect. He noted that Buprenorphine is an opioid that will produce small pupils when used. None of the other drugs prescribed to Mr Lisle would have had this effect.

In evidence Professor Whyte confirmed his view that the prescribed medication was of itself unlikely to have caused the death. He conceded a person would have to be already very close to death before the person became dangerously acidotic and at that point venlafaxine can contribute to an arrhythmia. Otherwise it is therapeutic and causes no issues.

Psychiatric review

Associate Professor Michael Robertson is an independent consultant psychiatrist who reviewed the material gathered during the investigation. He provided to the Court two reports and gave oral evidence at the inquest.

Associate Professor Robertson noted that Mr Lisle had displayed a consistent pattern of reckless indifference to his safety, particularly in relation to his continued ingestion of psychoactive substances, his excessive gambling and his driving.

He said that it appeared Mr Lisle had consistently tested the limits of his clinical care during his admission to the NCC: "*he had chosen to breach an implied treatment contract by sourcing substances illicitly, gambling or taking contraband on the ward*".

He noted that Mr Lisle appeared to be experiencing significant symptoms of withdrawal from opiates and benzodiazepines. In his view, staff at the NCC managed these appropriately. He was of the view; "*due care was taken with the assessment of the deceased's mental state, a formulation of the risks posed by his various clinical difficulties, with appropriate utilization of clinical observations and leave provisions*".

In summary, Associate Professor Robertson said:

> *I am satisfied that the deceased's complex medical presentation was managed with due care and adherence to best practice. His complicated drug withdrawal syndrome was appropriately managed along best practice treatment guidelines with the addition of expert advice.*

The psychiatrist also said:

> *I have found no evidence that the NCC had operated with any sub-standard or inappropriate policy or procedure in relation to the assessment of leave status, level of clinical observation or other provisions of patient safety.*

Associate Professor Robertson considered treating Mr Lisle in a more restricted environment with no leave would have been inconsistent with the "least restrictive option" mandated by the Mental Health Act. Further, there was no basis on which Mr Lisle could have been made an involuntary patient.

In response to the specific enquiries put to him by those assisting the Court, Associate Professor Robertson indicated the medication regimen was appropriate in his opinion: "*there is no evidence that any of the medication combinations would have resulted in a predictable problematic drug interaction".*

He responded to the concern that Mr Lisle may have been excessively sedated by accepting that is often a complication of psychotropic drug treatment. However, he went on to say, Mr Lisle *"had not shown any signs of excessive sedation prior to 30 April 2010 and my strong suspicion is that his sedation was due to his ingestion of presumably buprenorphine, sourced illicitly".*

Associate Professor Robertson was provided with a copy of the Toxicology Report provided by Professor Whyte. While he accepted that Professor Whyte had appropriate qualifications to make the comments he did, they did not cause Associate Professor Robertson to alter his opinion that the use of multiple psychotropic drugs in this case was desirable and probably necessary. He was of the view that it would not be appropriate to be prescriptive about the dosages of the various drugs used in this, or similar cases.

Resuscitation

It was apparent from the transcript of the 000 call made from the NCC that there was some confusion among the nurses as to the availability of a defibrillator and possibly delay in the commencement of CPR. There was also inconsistent accounts as to whether the defibrillator was used and if so how it was used or indeed how it should be used. Further, ambulance officer's who attended noted the CPR being provided by the nurses was "*ineffective"* because it was performed on a bed, rather than with the patient on the floor.

Accordingly, an expert in resuscitation was briefed to review that aspect of the matter. Reports were obtained from Associate Professor Paul Middleton, the Chair of the Australian Resuscitation Council, NSW Branch.

Associate Professor Middleton expressed the view that to be effective on a patient suffering from cardiac arrest, defibrillation is needed as soon as possible, and that every minute of delay reduced the chances of a successful outcome.

It was also essential that the chest compressions should occur while the patient was in a supine position on a hard surface.

He was therefore critical of the apparent delay in the commencement of the defibrillation and in the nurses not moving Mr Lisle onto the floor. He accepted they were concerned that as Mr Lisle was a large, heavy man moving him to the floor involved a risk that Mr Lisle's head may suffer trauma. However, in Associate Professor Middleton's view, as he was almost certain to die without effective resuscitation, this was a risk worth taking.

He critiqued the performance of the nurses against the 2005 International Consensus on Cardiopulmonary Resuscitation, which was in effect at the time, and concluded that the performance of the nurses was to some degree sub-optimal.

He was also concerned about the training provided to staff at the NCC. In Associate Professor Middleton's view, there should always be at least one nurse on duty who had undergone advanced life support training.

The Clinical Director of the NCC advised that some of its staff attended training provided by the St John's Ambulance Course and they then relayed that training to others. Associate Professor Middleton pointed out that St John's Ambulance only provides a basic life support course and did not have any accreditation in the delivery of advance life support training. He was also of the view that having staff who are not accredited trainers attempting to provide the training to other staff at the NCC was inadequate.

Associate Professor Middleton was insistent that scenario training was necessary and that it needed to be frequently refreshed. He was of the view that having regard to the rate at which the practical skills and knowledge degrade when not used, this should occur at least once a year, if not more frequently.

He drew attention to the patient population at the NCC, which he considered to be high risk having regard to their mental illness, the proportion addicted to drugs and alcohol and the frequent need of high doses of sedatives. This led him to conclude that someone with current advanced life support training should always be on duty at the NCC.

Response of the NCC

Diane Hollings is the Director of Clinical Services at the NCC. She commenced working there after Mr Lisle's death. In her evidence she was defensive of the clinic, its staff members and its policies. While that might be understandable, it made assessment of the weight to give to her evidence difficult. It created doubts as to

whether she had sufficient insight to the shortcomings that were apparent to a more objective observer.

Ms Hollings was asked to respond to the concern that incidents relevant to the management of Mr Lisle's condition were not always recorded in his chart. She indicated a handover sheet is held by staff coming on shift. It records the room number and patient name. There is one sheet for all of the patients. The people starting on the shift write on the sheet. They record what is said at the verbal handover. Following handover they will have their own sheet. So they have a record of what's being handed over. Staff members are trained and their professionalism as registered nurses should ensure that pertinent information is recorded in the file. The handover sheet is used as a tool to refer to as the nurses work their shift.

Since this death a communication book has been created to enable staff members to leave messages for each other about any patient.

Ms Hollings said she would not see reports of a patient requesting another patient to supply him with Xanax and asking about how to obtain Endone as necessarily requiring noting in the chart. In her view that was a clinical decision to be made at the time by the person receiving the information.

However, in response to RN Fox's assertion that because she wasn't the nurse in charge, she wasn't expected to record Mr V's report to her, Ms Hollings expressed the view that somebody should have be documented it in the file.

Ms Hollings advised that the temporary leave policy was changed in about 2012. A Category 1 patient is now allowed to take as many 2 hour leave periods as they like as long as it doesn't interfere with their taking of medication. The book in which leave is documented is now kept in the nursing station so that staff will usually be aware if a patient leaves the clinic.

All clinical staff members are trained in basic life support every 12 months. Attendance is monitored to ensure all complete the course and refreshers. The training has a practical and theoretical component. There is a lecture and a handout. It involves scenarios and the use of a dummy. The training is provided to some staff members by the St Johns Ambulance Service who then train the rest of the staff.

Ms Hollings acknowledged that no NCC staff and are required to have Advanced Life Support training. She pointed out that all of the clinics in the group are accredited to an international standard and are licensed by the Commonwealth Health Department which has not required any changes to their CPR training.

Conclusions

Context

The available evidence indicates Hugh Lisle had a relatively stable and happy childhood. He was an excellent student and had he been able to overcome his health problems, he had great career potential.

His parents, sister and brother dearly loved him and although his physical and mental health issues at times strained family relationships, it is apparent they continued to actively support him throughout his life. I offer them my sincere condolences for their sad loss and thank them for their constructive contribution to this inquest.

Hugh's chronic and deteriorating arthritis spawned a medication dependency that contributed to and exacerbated other destructive behaviours and conditions such as illicit drug abuse, gambling, social isolation and depression.

By the time of his last admission to the NCC, Mr Lisle was in crisis and at high risk of serious harm. Intensive intervention was essential.

My conclusions in relation to the issues of contention in the inquest are set out below.

Cause of death

No physical ailments or conditions likely to cause death were found at autopsy.

There is evidence that Mr Lisle had on occasions taken biscuits back to his room at night. There is also persuasive evidence that there were biscuit wrappings found on or near his bed on the night he died. However, I am not persuaded that when he was found unconscious, there was food in his mouth or airway that would have caused him to choke. The evidence of the three nurses involved in attempts to resuscitate him is unclear on this issue and the ambulance officers saw no foreign matter in his mouth. Although not always present in asphyxial deaths, none of the classic signs such as petechial haemorrhages or foreign matter in his lungs or airways were found at autopsy.

I accept the expert evidence that the sedative effects of the prescribed medications and the illicitly obtained buprenorphine are likely to have combined to severely repress Hugh's respiration.

There is some conjecture as to whether the proximate cause of death was an arrhythmia precipitated by one of the prescribed drugs in combination with the other prescribed drugs and the non prescribed drug repressing respiration and leading to acidosis; respiratory repression as a result of the combined effect of the drugs leading to cardio-respiratory arrest; or asphyxial hypoxia as a result of Mr Lisle's airway having been obstructed. As already mentioned, I am not satisfied the evidence supports that such an obstruction occurred. I am unable to determine which of the other two possible mechanisms was responsible for the death. I conclude that the exact mechanism cannot be ascertained but that the cause of death can adequately be described as mixed drug toxicity.

Manner of death

In simple terms, I find the manner of death to be accidental overdose of prescribed and non prescribed medication. There are however, aspects of the care and treatment of Mr Lisle and the emergency response to his collapse that warrant more detailed consideration.

Quality of care

The severe addiction to alcohol and other drugs that Mr Lisle was suffering when admitted to the NCC necessitated high levels of sedation to manage the effects of withdrawal. The reports of his complaining of being too heavily sedated and of his manifesting over sedation by slurred speech and an unsteady gate are concerning. However, it is clear that Mr Lisle needed more sedation at night and it is difficult to distinguish between effects of his prescribed medications and the combined effects of those and the illicitly obtained buprenorphine the evidence indicates he was taking in the days before his death.

The evidence establishes that during his admission Mr Lisle gained access to and consumed drugs other than those prescribed to him. There is a basis to suspect that another patient may have provided medication prescribed to him to Mr Lisle. However, this can not be proven and the possibility that Mr Lisle bought them when out of the clinic can not be dismissed.

Although Mr Lisle was engaging in high risk behaviour when he was admitted to the NCC, I accept that his condition was not such as would justify him having been made an involuntary patient in a mental health facility. Accordingly, the staff at the NCC could not prevent him from leaving the clinic and had no control over what he did when not there.

Hugh's family are understandably concerned that he was gambling when he could have been attending group therapy and that insufficient steps were taken to confront Hugh about this. Dr Wilson gave evidence that priority was given to treating Hugh's immediate substance abuse and mental illness issues and there was a risk that restricting Hugh's movements would lead Hugh to discharge himself.

Having regard to the opinion evidence of the independent psychiatrist who provided reports to the court and gave evidence, I accept that Mr Lisle's condition was appropriately assessed and that the treatment plan devised and applied to respond to his diagnosis was also in accordance with best practice treatment guidelines. That psychiatrist said the medication regimen was appropriate and I am aware of no evidence to contradict that opinion.

I conclude Mr Lisle's care and treatment while a patient of the NCC were adequate and reasonable.

Supervision

The adequacy of the supervision of Mr Lisle is brought into question by the claims he was seen on more than one occasion apparently affected by illicit drugs and that he had on at least two occasions sought to source such drugs from other patients. The nurses say they noted some of those reports and passed them onto the treating psychiatrist. That clinician gave evidence that he was told of some of this behaviour and he raised with Mr Lisle the inappropriateness of his using or seeking illicit drugs.

It seems that Mr Lisle was able to leave the clinic without that being known or recorded by staff. The court was told the procedures around unsupervised leave and its recording have now been tightened. However, not all incidence of drug seeking or

apparent intoxication were noted and responded to assiduously. There were also other deficiencies in note taking but none affected the treatment provided to Mr Lisle.

Overall, I consider the supervision of Mr Lisle while he was a voluntary patient at the NCC was adequate. The only leverage the treating team had over Mr Lisle was to discharge him from the clinic. That would not have been in his interest and would not have made him safer.

Adequacy of resuscitation attempts

I readily accept the three nurses who responded to Hugh being found unconscious were traumatised and distressed by the situation. When deconstructing their performance forensically, it is important to acknowledge that unlike the lawyers undertaking that process, the nurses, who remained responsible for 35 other patients, were suddenly faced with a critical emergency. There was no one there to assist them and they knew the incident could well end in Hugh's death. That is why their training and proficiency was so important.

While I accept they tried their best, I am of the view their response was sub-optimal in some respects: there was confusion about the equipment and its use and they did not appreciate the need to get the patient onto the floor. It seems likely there was avoidable delay in aspects of their response, although it is also almost certain that Hugh was dead and un-revivable when he was found.

In my view the arrangement whereby some staff members attend a course and then purport to train other staff is inadequate as was demonstrated by the confusion and unfamiliarity with the equipment that was evident in this case. That the NCC can despite this shortcoming maintain its registration does not negate this critique, rather it reflects a weakness in the registration process.

I shall return to this issue in the recommendations section of this report.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given 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 is Hugh David LISLE

Date of death

Mr Lisle died on 1 May 2010.

Place of death

He died at Cremorne, NSW.

Cause of death

He died of a cardio-respiratory arrest due to multi-drug toxicity.

Manner of death

Mr Lisle died from an accidental overdose of prescribed and non prescribed drugs.

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death with a view to improving public health and safety. The circumstances of this case raise the following issues for consideration from that perspective:-

- Monitoring of patients when medication is dispensed;
- Note taking and communication of clinically significant information; and
- Resuscitation capabilities of staff members

Monitoring medications

The monitoring of patients when medication is dispensed to them by staff at the NCC was brought into focus by the evidence indicating that one patient may have supplied his medication to the person whose death was investigated at this inquest and that the drug concerned contributed to the death. It was also made relevant by the possibility that Mr Lisle was under the effect of non prescribed medication when he was given his prescribed medication on the night he died[13].

While the possibility that a patient managed to secrete medication without ingesting it cannot be excluded, I am satisfied the procedures currently in place at the NCC are reasonable and that more intrusive arrangements cannot be justified by the small magnitude of the risk that they may be circumvented. Similarly, I am not persuaded a recommendation that staff look for signs of unexpected intoxication when administering medication is purposeful, rather than platitudinous. It seems to me that is intrinsic to good quality clinical care and would apply to all aspects of nursing. A recommendation to that effect would be superfluous in my view.

Communication of clinical information

There is evidence that nursing staff at the NCC involved in the care of Mr Lisle were unclear as to whose responsibility it was to record certain clinically relevant information. Further, some incidents were not accurately recorded or recorded at all. This problem is not unique to the NCC: it is endemic through-out the health care sector.

The submissions made on behalf of Ramsay Health acknowledge the shortcomings of this nature highlighted by the evidence in this case. I accept the assurance that this evidence will inform continuous improvement at the clinic around this issue.

Resuscitation

I have detailed earlier the evidence indicating the attempted resuscitation in this case was sub-optimal. I am convinced that was not due to any lack of concern or commitment on the part of the staff members involved and I repeat that it almost

[13] I don't accept the submission made on behalf of Ramsay Health that a recommendation directed at these issues would be beyond jurisdiction: it would clearly be connected with the death and relate to public health and safety.

certainly had no bearing on the outcome. However, that doesn't mean it should be overlooked.

I accept the independent expert evidence that the level of training and frequency of its revision was inadequate having regard to the anticipated patient population of the NCC. It is not to the point that the recommendations of that expert exceed what is required of public hospitals or ambulance services – patients in the care of those institutions/organisations have ready access to emergency medicine physicians and intensivists; patients at the NCC must rely on the resident nursing staff when critical care is required. Accordingly, the capacity to undertake advanced life support is necessary in my view; although I do not consider it appropriate that I attempt to prescribe how that should be provided for.

Recommendation 1 - Review of resuscitation training

Having regard to the illnesses suffered by some of the patients of the NCC and the treatment regularly provided to them, there is an elevated risk of cardio-respiratory arrest occurring among that population so that ready access to advanced life support is essential in my view. Accordingly, I recommend that Ramsay Health review the level of training currently provided to the staff at the clinic, the manner in which it is provided and the frequency with which it is refreshed to ensure that at all times there are staff on the premises who can adequately respond to foreseeable emergencies when they occur.

I close this inquest.

M A Barnes
NSW State Coroner
Glebe Coroners Court
8 May 2014