STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of JY
Hearing dates:	23-26 May, 24-25 October, 29 November 2022
Date of findings:	5 July 2023
Place of findings:	State Coroners Court, Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – acute psychotic episode – schizophrenia – was mental health care appropriate – recommendation to expand REACH program in public mental health settings
File number:	2018/180472
Representation:	**Counsel Assisting the Coroner:** Ms Donna Ward SC, instructed by Ms Ellyse McGee (Crown Solicitor's Office). **Family:** Mr Simon Grey, instructed by Slater & Gordon. **Northern Sydney Local Health District, Western Sydney Local Health District and Dr D Paul:** Mr Ben Bradley, instructed by Hicksons Lawyers. **Dr A Jacob and Dr L Kondadasula:** Mr Cameron Jackson, instructed by Avant Law. **RN N Muller:** Mr Neale Dawson, NewLaw. **RN S Freeman and NUM W Hunt:** Ms Pat Robertson, NSW Nurses & Midwives Association.
Non-publication order:	Non-publication orders were made on 23 May 2022 prohibiting the publication of certain evidence identifying JY and his family. The orders can be obtained on application to the Coroners Court Registry.

Findings:	**Identity**: The deceased person was JY. **Date of death:** JY died in the morning of 8 June 2018. **Place of death:** JY died at Westmead Children's Hospital, Westmead, NSW. **Cause of death:** The cause of death was multiple stab wounds. **Manner of death:** JY died as a consequence of the acts of his father, BS.
Recommendations:	To the Chief Executives of all of the Local Health Districts in New South Wales, and to be provided to the NSW Ministry of Health: a. That consideration be given to expanding the REACH program to Community Mental Health settings, with appropriate information being provided to consumers, families, and other carers on how to use the program in that setting.

Table of Contents

Introduction

1. In the preparation of these findings, I have been assisted by the written submissions of Counsel Assisting, Donna Ward SC. I have also been assisted by the written submissions of counsel for the interested parties.

2. In making these findings, I extend my sincere condolences to the family of JY, in particular to JY's mother, TY, and grandmother, JS. The heartache of JY's loss continues to be felt daily by JY's family who continue to support BS in his care and treatment. It is hoped that from the inquest process some small measure of solace can be felt by the family in the form of information, answers, agency accountability, recommendations and reforms to prevent the occurrence of another similar tragedy.

The purpose of an inquest and role of the Coroner

3. This inquest was held for the purposes of a public examination into the circumstances of JY's death. The purpose of an inquest is not to blame or punish anyone for the death.

4. Pursuant to section 81 of the *Coroners Act 2009 (NSW)* (**the Act**), the role of a Coroner is to make findings as to the identity of the person who died, and the date, place, cause, and manner of the person's death.

5. The Coroner has the power to make recommendations under section 82 of the Act where it is necessary or desirable to do so in relation to any matter connected with the person's death which is the subject of the inquest. This power allows the Coroner to consider whether anything should or could have been done to prevent the death and recommend the necessary changes to prevent a similar death from occurring in the future. I considered a number of proposed recommendations in this matter, which are dealt with below.

The proceedings

6. The hearing of the inquest into the death of JY was held at the Coroners Court in Lidcombe from 23-26 May, 24-25 October, and on 29 November 2022. There were delays arising from the Covid-19 pandemic in setting the matter for hearing. Once the inquest commenced, it was required to be extended after the first week of hearing due to developments requiring further sufficient interest parties to be notified and brought into the proceedings. I extend my gratitude to JY's family and to the interested parties in this inquest for their patience in these circumstances.

7. On the first day of the inquest, I made non-publication orders prohibiting the publication of certain evidence identifying JY and his family. As such, I will not use the names of JY and his family members in these findings.

8. Following careful review and consideration of the brief of evidence tendered at the hearing, the additional exhibits, the oral evidence of the witnesses who appeared at the hearing, and the written submissions, I make the following findings in relation to the factual background of the inquest.

JY's life

9. While much of the focus of this inquest was on JY's father, BS, I would like to stress the centrality of JY to this inquest.

10. JY was born in 2012 to his parents TY and BS. JY was their only child and was adored by his parents, grandparents, and extended family.

11. JY spent a lot of time with his paternal grandparents, particularly his grandmother, JS. His family lived with JS for a time, and even when living apart, JS was involved with JY's care and saw him regularly. JY also enjoyed spending time with his grandfather, AS, at his workshop and he developed a keen interest in cars.

12. Much of JY's maternal family live overseas, and while physical distance limited the time they could spend together, JY was able to travel to visit them.

13. JY loved spending time with his family, and was also popular with his neighbourhood friends and friends at school. It is evident to me that JY grew up very much cherished by his family and friends.

14. The circumstances of JY's death were tragic, but his life was filled with love and joy. I would like to acknowledge the profound grief that JY's family continue to feel after his passing, and acknowledge that the circumstances of JY's death have forever changed the family's relationship with BS.

Overview

15. In her written submissions, Counsel Assisting circulated to the interested parties a detailed chronology, cross referenced against the brief of evidence and the transcript of the hearing.

16. None of the interested parties sought to make any amendments to that chronology, although their submissions in reply drew my attention to, or addressed, different aspects to the factual matrix.

17. I do not intend to address the factual background of this matter in detail, but rather have annexed Counsel Assisting's chronology these findings as **Annexure A**. However, a brief overview of the context of JY's death is as follows.

18. On the morning of 8 June 2018, JY was stabbed multiple times by his father, BS. Despite commendable efforts of JS, NSW Police officers, NSW Ambulance officers, and civilian bystanders, JY was unable to be revived and he tragically died.

19. There was no dispute as to the cause of JY's death. A post-mortem examination was performed by forensic pathologist Dr Elsie Burger, who found the direct cause of JY's death to be multiple stab wounds. JY had 76 stab wounds across his chest, arms, and legs, and scattered bruises on his legs.

20. BS suffers from schizophrenia, having been diagnosed in 2003. This is a life-long mental health condition that often requires a combination of medication and therapy to manage effectively in the community. As such, BS had had extensive interactions with various hospitals and health agencies for many years. Whilst BS enjoyed periods of stability, it appears that he was able to identify that his mental health was deteriorating, and often sought a voluntary admission to hospital for treatment. For example, BS spent periods as an in-patient in 2003, 2004, 2005, 2014-2015, and 2016.

21. In the months prior to JY's death, BS was admitted in April 2018 to Hornsby Hospital following a deterioration in his mental state. BS was discharged on 16 May 2018 and referred to a community mental health team for review. BS had various engagement with the Hills Mental Health Team (**Hills MHT**) from May to June 2018.

22. Following JY's death, BS was arrested and tried for the offence of murder. On 24 July 2019, his Honour Acting Justice Hidden of the Supreme Court of New South Wales found BS not guilty by reason of mental illness. The judgment describes BS' actions in killing JY as having occurred during the course of a psychotic episode.

23. As such, BS' mental health is directly relevant to the manner and cause of JY's death. Accordingly, it was the focus of this inquest.

Issues examined at inquest

24. The inquest focussed on the following issues, as outlined in the issues list provided to the interested parties ahead of the hearing:

    a. What triggered or otherwise contributed to the deterioration in BS' mental health leading up to his admission to Hornsby Hospital on 19 April 2018? To what extent was it a result of possible non-adherence to medication or potential treatment resistance or other matters?

    b. How was BS' medication regime recorded and managed during the admission to Hornsby Hospital and how did BS respond to changes in his medication whilst an inpatient?

    c. What was the plan for BS upon discharge from Hornsby Hospital on 16 May 2018 and was the plan adequate and/or adequately documented?

    d. What information was available to the Hills Community Mental Health Team (located in a separate Local Health District to Hornsby Hospital) at the time BS was transferred to that service?

    e. What role did the Hills Community Mental Health Team have in BS' ongoing mental health care and were there 'red flags' suggesting a deterioration in his mental health that should have prompted additional measures?

    f. Were adequate attempts made to investigate BS's long term mental health history, recent deterioration, response to medication and concerns raised by his closest family members, notwithstanding assurances from BS that he was not presently suicidal or experiencing thoughts of self-harm or thoughts of harming others?

    g. Should BS have been seen by a doctor or admitted to Hospital on 6 June 2018 when he attended the Palmerston Centre with his mother and partner?

    h. What was known about any risk BS posed to his child in May-June 2018, were family concerns about risk appropriately considered, and to what extent were such matters factored into decision making around BS' progress and treatment?

    i. What, if any, relevant changes have been implemented to systems and processes within the Northern Sydney Local Health District and the Western Sydney Local

Health District or at NSW Ministry of Health level since June 2018 whether or not in response to JY's death?

A note on medications

25. For the sake of clarity, I have adopted Counsel Assisting's summary of nomenclature of medications prescribed to BS and discussed in detail during the inquest and in these findings:

    a. risperidone (generic name) = Risperdal Consta (brand name)

    b. aripiprazole (generic name) = Abilify (brand name)

    c. quetiapine (generic name) = Seroquel (brand name)

    d. paliperidone (generic name) = Invega (brand name)

Issue 1: What triggered or otherwise contributed to the deterioration in BS' mental health leading up to his admission to Hornsby Hospital on 19 April 2018? To what extent was it a result of possible non-adherence to medication or potential treatment resistance or other matters?

26. Prior to 2018, BS had a period of relatively stable mental health. He appears to have been compliant with medications and had not sought hospital admission (as he had done previously) since 2016.

27. Prior to his admission to Hornsby Hospital in April 2018, BS' condition had fluctuated. BS had begun to refer to himself as God and he reported experiencing delusions about the devil. BS had also felt pressure to "save the world by going to sleep in order to pass away peacefully". BS' mental illness had included delusions about God as far back as 2005 and complaints about the devil trying to control his thoughts were also recorded in earlier hospital admissions.

28. As such, an examination of the medications prescribed to, and taken by, BS in the period prior to JY's death are relevant. The following chronology of prescribing, along with the information available about the actual administration of medications to BS is available to me:

29. In January 2018, GP Dr Huang prescribed BS two medications:

a. Quetiapine (an antipsychotic with sedative effects) (150mg in the evening).

   Notwithstanding Dr Huang's prescribing, from the records available to me, it appears that BS likely ceased taking the quetiapine in January or February 2018. I accept the evidence of the two forensic psychiatrists[1] who gave evidence at the inquest, that the cessation of the quetiapine could have triggered BS' deterioration.

b. Risperdal Consta (an extended-release antipsychotic) (two injections[2] of 37.5mg every fortnight). This dose reflects what BS had been taking since January 2016.

   TY administered these depot injections. I accept the evidence of Dr Sullivan and Dr Roberts that it is not known whether TY was able to administer the depot medication effectively and appropriately (either by using the "Z-track" technique or otherwise). I agree with Counsel Assisting's observation that being responsible for administering the depot injections put TY in a difficult position of being both nurse and partner.

30. TY gave evidence that BS had started to skip injections for a few weeks in a row. However, it is not apparent to me from the evidence as to precisely when BS began to skip the depot injections.

31. On 10 April 2018, BS saw a new GP, Dr Athavale, and requested a script for Seroquel. BS appeared to be weaning himself off Seroquel (which I note had some side effects which were undesirable to BS), but sought a "back-up" script if his symptoms worsened. Dr Athavale recorded that BS felt "very stable" and also wrote another script for Risperdal Consta, consistent with Dr Huang's prescribing. It is not clear whether Dr Athavale administered the injection at this appointment, or, whether the prescription was obtained with a view to TY administering the depot medication to BS at a later time.

32. At inquest, I heard evidence from Dr Sullivan and Dr Roberts that there was a real possibility that the Risperdal Consta and Seroquel (prescribed and taken in the dosages described above) only ever exerted a "tenuous control of [BS'] psychotic symptoms". This was in the context of what both psychiatrists agreed was a "moderate" (or not a

[1] Dr Danny Sullivan (consultant forensic psychiatrist and Executive Director of Clinical Service at Forensicare, Victoria) and Dr Samson Roberts (General and Forensic Psychiatrist) gave evidence in conclave at the inquest.

[2] Note: Several antipsychotic medications are administered in an intra-muscular injection, commonly referred to as a "depot" medication or injection.

"particularly efficacious") dose of risperidone for someone with ongoing symptoms. Dr Sullivan explained:

> "… we're talking about hovering just over the edge of therapeutic benefit but with the potential that at any time you'll have breakthrough symptoms, symptoms which indicate that the illness is not sufficiently controlled…"

33. Of course, where TY was reporting was BS had started to skip several depot injections in a row, it appears to me that BS was likely not receiving the total therapeutic effect of the 'modest' dose prescribed.

34. Considering the matters above, I find there to be insufficient evidence to establish BS' compliance with Seroquel or Risperdal Consta prior to his admission to Hornsby Hospital in April 2018. However, I find it likely that inconsistent compliance with medication, in addition to concern regarding the efficacy of the doses prescribed to him, contributed to BS' deterioration.

35. Further, considering the evidence and submissions I received regarding the psycho-social stressors, such as housing arrangements and financial stress that BS was experiencing also likely contributed to his deterioration.

Issue 2: How was BS's medication regime recorded and managed during the admission to Hornsby Hospital and how did BS respond to changes in his medication whilst an inpatient?

Issue 3: What was the plan for BS upon discharge from Hornsby Hospital on 16 May 2018 and was the plan adequate and/or adequately documented?

36. The written submissions of Counsel Assisting and the interested parties addressed these two issues jointly, so I will take that same approach.

37. On 19 April 2018, BS was voluntarily admitted to Hornsby Hospital following an outpatient appointment where the consulting psychiatrist recorded a "relapse of psychosis". His mental health care plan for the admission included three clinical issues of mental state (deterioration), medication compliance and physical health.

38. BS remained at Hornsby Hospital until he was discharged on 16 May 2018. The key issues during the admission are outlined below.

Medication changes during admission – aripiprazole

39. On 23 April 2018, BS was reviewed by psychiatrist Dr Jacob (Senior Staff Specialist). Dr Jacob discussed the possibility of moving from Risperdal Consta to either aripiprazole (Abilify via depot) or lurasidone (oral medication). These alternate medications had several advantages over the Risperdal Consta: they needed to be administered monthly (rather than fortnightly), and had a lesser tendency for weight gain and sedation. Dr Jacob noted that BS had a raised prolactin level (a side effect of the Risperdal Consta). Abilify is not associated with this side effect either – a further appropriate factor in considering a medication change.

40. A discussion between Dr Jacob, BS, JS, and TY was had later that day about the alternate medications. Despite provision of the Abilify consumer information, it appears that JS did not understand that aripiprazole and Abilify were the same medication.

41. While I accept that Local Health Districts use medication information sheets which typically refer to both generic and brand names of medication, I consider that this highlights the need for patients and their carers to receive information in a manner which is consistent and able to be easily absorbed.

42. Following this discussion on 23 April, Dr Goriparti (Staff Specialist) considered a trial of depot paliperidone (another monthly depot). This trial did not ultimately proceed, although there is nothing in the progress notes to address why.

43. On 30 April 2018, BS commenced a trial of Abilify (10mg, orally). The psychiatric notes do not explain why Abilify was ultimately selected to replace Risperdal Consta. However, Dr Roberts did not think it unreasonable. He did point out during his evidence that it would have been open to Dr Jacob to maintain Risperdal Consta and vary the Seroquel (noting its' weight gain and somnolence side effects, which BS had expressed an interest in avoiding).

44. Dr Sullivan thought that despite aripiprazole's less therapeutic benefit, it was an appropriate and reasonable option given it offers a reduced adverse effect profile and BS' preference to avoid further weight gain.

45. Dr Paul (Staff Specialist) introduced Abilify at a modest oral dose to see how BS would tolerate the side effects and to assess BS' response to the medication. Dr Jacob agreed

with this approach, stating “the initial phase of the oral aripiprazole is to ensure a person can tolerate the medication in terms of the side effects or adverse effects and see some at l[e]ast some partial response.”

46. Contrary to the dosage approach taken by Dr Paul, Dr Roberts was of the view that oral antipsychotics should be administered at a therapeutic dose for up to four months, with a view to ensuring effectiveness of the treatment whilst waiting to achieve a ‘steady state’. However, Dr Sullivan thought it was appropriate and consistent with good practice to first determine tolerability and then introduce a dose of 400mg monthly long-acting injections. He observed that during this period, “…[BS] was maintained on a higher dose of quetiapine until depot medication had been administered.”. Dr Sullivan went on to explain that in circumstances of switching antipsychotics, oral aripiprazole was rarely intended to be the mainstay of antipsychotic treatment. As such, Dr Paul’s approach appears to have been consistent with the views of Dr Sullivan.

47. Whilst assessing BS’ tolerance of Abilify, Dr Paul withheld the next Risperdal Consta depot. In this respect, Dr Sullivan drew my attention to the Maudsley Prescribing Guidelines in Psychiatry which provide:

> “start oral aripiprazole 4-6 weeks after the last risperidone injection. Start aripiprazole LAI antipsychotic 2 weeks later, discontinue oral aripiprazole 2 weeks after that”.

48. I note that BS’ last Risperdal Consta injection was administered on or around 10 April 2018 and he commenced oral Abilify on or around 30 April 2018. I agree with Counsel Assisting’s submission that, as such, BS was likely still getting some benefit from the Risperdal Consta when the modest dose of Abilify was introduced, noting that the Abilify was introduced a little earlier than the Guidelines recommend.

Medication changes during admission – quetiapine

49. While Abilify was being trialled, Seroquel was also re-introduced and increased. At the time of discharge, BS’ prescription for Seroquel was increased from 200mg daily to Seroquel XR (extended release) 300mg per night.

50. Both experts understood Seroquel to be supplementing the Abilify in its introductory phase and agreed this was appropriate. However, Dr Roberts was of the opinion that the Seroquel prescribed to BS were “very modest dose[s] if we’re [re]lying on it to moderate psychotic symptoms in the long term.” He went on to suggest that the approach

"… represent[ed] a short term plan where attached to which I would have limited expectations of benefit."

51. Notwithstanding that BS' Seroquel dosage had ultimately increased during the admission, Dr Sullivan agreed that 300mg was the minimum effective dose for a multi-episode schizophrenia.

52. Of note, it appears from the evidence available to me, that the change of Seroquel dosage was not conveyed to JS at the discharge meeting with BS and JS on 16 May 2018. In her oral evidence, Dr Jacob did not have an independent recollection of advising JS about the increase of quetiapine, but thought she "…would have certainly covered the matter of medication…" during her discussions with the family.

53. This is significant, as Dr Roberts observed:

> "…that was the window during which it was most likely that he was going to deteriorate because the medication in which we had confidence had been stopped and a new medication was in place, and we could not yet be confident that I (sic) was going to have the desired effect."

54. The family's submissions regarding their awareness of the depot medication change are discussed in further detail below at 63 - 72.

Observations of BS in the context of the medication changes

55. I find it important at this point to record some of the observations of BS during this admission, noting Dr Roberts' caution that the hospital environment and BS' removal from psycho-social stressors may have contributed to the impression of his improvement.

56. During admission, BS was experiencing thoughts that he needed to die to save the world. These were similar to previously reported symptoms during earlier episodes of mental ill health.

57. BS was regularly observed by nursing staff and allied health professionals, in addition to his treating psychiatric team and family. There were occasions when staff reported that BS was isolating in his room and engaging only superficially with staff. Although in evidence Dr Paul placed limited weight on these reports, Dr Jacob opined this could have been a sign that BS continued to experience negative symptoms.

58. Notwithstanding these observations, there were also signs of overall improvement. Staff observed that BS was less distressed and that he was displaying fewer psychotic symptoms. JS agreed that BS had "improved significantly".

59. During the admission, BS had stabilised to a point where he was able to have periods of leave with his family. Dr Paul put some emphasis on these successful leave periods, as it was a way of trying to anticipate how BS might respond to the daily challenges he could expect upon discharge.

60. On 14 May 2018, Dr Jacob returned from a period of her own leave. She observed BS to no longer be experiencing positive symptoms such as delusions or hallucinations. The treating clinicians formed the view that BS had stabilised *sufficiently* to warrant discharge. In this context, discussions around and planning for BS' discharge commenced.

61. On this point, Dr Roberts warned about the long-acting nature of depot antipsychotics and the time in which it takes for them to achieve a "steady state". He told the Court that treaters "…would not envisage keeping a patient in hospital until such a time as a steady state [of the antipsychotic medication] had been achieved".

62. Ultimately, Dr Paul described the goal of BS' inpatient admission as "symptom control". He said that clinicians may make the decision to discharge even if patients had residual symptoms present. In this context, I also accept Counsel Assisting's submission (with which the two interested party LHDs agreed) that it was not appropriate to continue BS' admission until a time when he was entirely symptom-free.

Discharge and family meeting on 16 May 2018

63. Upon BS' discharge, it was submitted by JY's family that Dr Jacob failed to advise them of:

    a. the change of the depot medication from Risperdal Consta to Abilify. The family submitted that the reduced therapeutic effect of Abilify was one feature that made it all the more important to communicate the change in depot;

    b. what medication was provided to BS upon discharge; and

    c. whether they should be alert to any specific symptoms following discharge.

64. This submission was grounded on the basis, which I accept, that JS and TY were those who were the most familiar with BS and his mental health. JY's family submitted that:

> "[b]y not communicating (or not communicating effectively) the change in medication regime, [BS]'s family were less aware of what symptoms and warning signs to be aware of associated with the new depot, and the time period in which they should be particularly vigilant…..the family had experienced [BS]' previous episodes of mental health decline and knew where to gauge his baseline when he was on Risperdal depot."

65. The family submitted that there appeared to be general consensus amongst the experts and senior executive Local Health District witnesses that the change in medication regime should have been communicated as part of the discharge planning process. Noting the key role that JS and TY played in supporting BS in his chronic illness, I accept this would have been ideal.

66. While JS indicated she was unaware that BS' medication had changed during the admission, I note that paternal grandfather AS recalled JS being handed Abilify tablets and told that BS had been given an earlier injection of it, on 16 May 2018. Further instructions were provided that BS was to take the tablets for a week and then stop. This is not to say that JS was definitely told that Abilify would be the new depot medication.

67. Unfortunately, and likely impacted by the passage of time, Dr Jacob could not recall the specifics of her discussion with JS on 16 May 2018 other than discussing the medication, the need for BS to have regular consultations, and the need for the depot to be administered by a GP. In circumstances where there are no detailed notes recording the family meeting, Dr Jacob gave evidence of her usual practice to discuss medication changes at discharge.

68. Counsel Assisting submitted that it does not follow that because Dr Jacob could not recall the specifics of her discussion with BS and his family on 16 May 2018 that she did not discuss certain matters. Counsel for the LHDs drew my attention to Dr Jacob's "…specialist skills and prolonged experience…" when arguing that I should not be satisfied to the requisite standard that there was a deficiency in communication as to the change in BS' medication and treatment plan during the family meeting on 16 May 2018.

69. It appears to me that a number of matters arising in the evidence would suggest that the change in BS' medication and treatment plan *were* communicated to JY's family by member/s of the treating team. For example:

a. Post-discharge, Dr Athavale assumed responsibility for the administration of depot injections. This would support a conclusion that at least the administration of BS' depot medication was discussed on or before 16 May 2018;

b. JS understood that one of the oral medications commenced during the admission was to cease upon completion of the 7-day hospital supply. As Counsel for Dr Jacob submitted, it was likely that Dr Jacob was the source of this information. JS then reported this to Dr Karandana-Vidanalage at Hills MHT. This example demonstrates that JS was aware of important information regarding at least one of BS' medications at the time of discharge; and

c. BS attended upon his local community health team for case management, in line with the discharge treatment plan.

Based on the evidence before me, I can't be satisfied to the requisite standard that there was a deficiency in communication as to the change in BS' medication and treatment plan during the family meeting on 16 May 2018.

70. Of course, JS may have been informed of the matters which Dr Jacob referred to as her usual practice, and did not retain it. This is understandable when considering all the matters discussed during the admission and the discharge.

71. Importantly, I received evidence regarding the introduction of the electronic medication prescribing system, eMeds. Dr Samuels identified this as a "significant improvement to the paper-based process of prescribing" and also told the Court about medication reconciliation data being collected for inpatient units to assist ongoing oversight compliance with medication reconciliation targets.

72. Further improvement implemented since JY's death, such as the HealtheNet Clinical Portal and the Single Digital Patient Record (outlined below at 186 - 187) will hopefully assist in streamlining the discharge and medication processes moving forward. With accurate information about discharge and medication being made available across all NSW Health facilities, the pressure on carers to be the repository of information about their loved one's treatment should be alleviated.

Record-keeping and the Hornsby Hospital discharge summary

73. The detail contained in the Hornsby Hospital discharge summary became a key issue in this inquest, and will be explored below. Before moving to that topic, I pause to make

some broad observations of the Hornsby Hospital record-keeping and discharge summary itself.

74. Dr Roberts and Dr Sullivan gave evidence that some of the entries in the medical records arising from BS' psychiatric assessments were "sparse" or demonstrated a "paucity of psychiatric documentation". For example:

    a. the progress notes did not record the fact that Dr Jacob took into account BS' elevated prolactin level when considering the depot medication change;

    b. there is only a nursing note (and not a psychiatric progress note) available regarding Dr Jacob's consideration of commencing BS on Abilify or lurasidone during BS' admission; and

    c. There is no psychiatric progress note evidencing why Abilify was ultimately preferred and commenced.

75. It also appears to me that the difficulties encountered with the dispute regarding what was discussed during the planning meeting on 16 May 2018 and the confusion arising from the detail in the discharge summary could have been avoided by more detailed record keeping.

76. Turning now to the discharge summary itself. The discharge summary referred to "aripiprazole 10mg morning, new medication, 7 day hospital supply" and also recorded: "[t]o continue his medication (including seven more days of Aripiprazole tablets".

77. I accept that it was the intention for BS to cease the oral aripiprazole at the end of the 7-day hospital supply because the aripiprazole depot had been administered (given that the oral dose was to continue for 14 days after the initial depot dose). This approach was in accordance with the Maudsley Prescribing Guidelines discussed above at 47, as well as the medication product information.

78. At the time of discharge, BS had 7 of the 14 days of oral aripiprazole remaining. The discharge summary noted that BS was to "continue his medication (including seven more days of Aripiprazole tablets). It is, however, unclear as to whether the Hills MHT saw this part of the discharge summary due to errors in the *complete* document being faxed to them (discussed further below at 94 - 100, in addressing Issue 4).

79. The LHDs submitted that the discharge plan clearly identified that BS was to "continue his medication (including seven more days of Aripiprazole tablets)", supported by several

examples of the instructions being followed by Dr Athavale's further prescribing of the depot Abilifiy only, and JS telling Hills MHT staff, that the oral aripiprazole was meant to cease at the conclusion of the hospital supply.

80. However, the fact remains that the Hills MHT found the document ambiguous in practice:

    a. Mental Health Clinician at Hills MHT, Mr Musa Lule, was unclear on what was to happen. Of the ambiguous discharge summary reference to the aripiprazole, he said in evidence, "…. [p]robably he may need more. It doesn't say whether that was to cease or to continue."

    b. Career Medical Officer at Hills MHT, Dr Karandana-Vidanalage, recorded in a progress note that: "Aripiprazole 10mg mane (patients' mother has told that this is to be stopped after 7 days, I could not see any documents in that regard …".

81. Dispute this confusion, it does not appear that any attempt was made to clarify with Hornsby Hospital what the intention was once the 7-day hospital supply of the oral aripiprazole had finished.

82. To my mind, the wording of the discharge summary did not clearly set out the plan for BS' Abilify medication post-discharge. As Counsel Assisting submitted, neither the progress notes nor BS' discharge summary explained the role that the oral Abilify was to play (i.e. to determine BS' response to the new medication rather than for therapeutic effect) and that the oral medication should cease once the 7-day hospital supply had finished.

83. In addition, Dr Sullivan observed that the discharge summary did not contain detail about contingency plans in the event that BS' treatment post-discharge was ineffective. I agree that it would have assisted the Hills MHT to have been better informed by Hornsby Hospital staff of BS' medication regime and any contingency plans if rebound symptoms emerged.

Referral to the Hills MHT

84. Upon discharge, BS was referred to a community mental health team in his local health district (Western Sydney Local Health District) – the **Hills MHT**. This had to occur as BS did not live within the Northern Sydney Local Health District boundary (where Hornsby Hospital is located).

85. The Hills MHT was going to be responsible for BS' follow-up and community case management. As such, the issue of communication and referral between Northern Sydney

Local Health District and Western Sydney Local Health District was a central issue for consideration.

86. Dr Samuels, former Clinical Director for Mental Health Drug and Alcohol for the Northern Sydney Local Health District, gave evidence about discharge planning for a patient who would receive care via community mental health on discharge. He told the Court that when discharging a patient to a community mental health service within the *same* Local Health District:

> "… the case manager, who may have been involved in the community prior to admission, may be invited to the discharge planning meeting or may be invited to provide thoughts or comments on the discharge arrangement… when you are discharging to a different district as what happened here, one couldn't always expect representatives from the community services to attend a discharge planning meeting but I would expect that there'd be at least some communication between the, the two services prior to discharge."

87. The LHDs submitted that a meaningful handover occurred – noting that ultimately the Hills MHT was aware Hornsby Hospital thought BS required case management. When looking at the sufficiency of communication between Hornsby Hospital and the Hills MHT regarding BS' discharge plan, the following matters emerge:

    a. There was reference in the materials before me to a handover from Dr Mashhadi (Hornsby Hospital) to Mr O'Sullivan (Hills MHT) which occurred on 16 May 2018. However, the specifics of that handover are not detailed.

    b. Also on 16 May, BS was placed on the Acute Care Team (**ACT**) board to ensure follow-up by the appropriate community team.

    c. An incomplete discharge summary was provided, by fax, to the Hills MHT by Hornsby Hospital. It is not clear on the evidence precisely what pages of the discharge summary were actually sent or received. For example, when mental health clinician Musa Lule saw BS on 30 May 2018, he noted BS had "self-ceased his oral 10mg Abilify seven days ago when his seven days supply from hospital finished," which means Mr Lule must have been alerted to the provision of the seven-day hospital supply but not necessarily to the intention that the oral Abilify should then cease. In this respect, it is not clear what Mr Lule inferred from the

words “To continue his medication (including seven more days of Aripiprazole tablets)” in the discharge summary.

d. Finally, on 17 May 2018, Mr O’Sullivan completed a triage for BS. Notably, this did not record any cessation of one of the current medications at the end of the hospital supply.

88. On the point of discharge between Local Health Districts, JY’s family submitted that I should consider making a recommendation as follows:

> “That consideration be given to developing policies and providing education that give effect to, in substance, the following:
>
> a. When a patient is referred to the community mental health team from a hospital, as part of the initial process in that transition, and subject to appropriate privacy safeguards, a consultation also takes place between a team member/s at both the discharging facility and, if relevant, the Mental health Team assuming care, during which clinicians advise the carers about any changes made while an inpatient to the medication regime, the current medication regime and, in particular, signs or symptoms to be alert to.
>
> b. That in respect of such communications between clinicians and carers, medication is referred to by a single name (e.g. Seroquel or Quetiapine), to avoid confusion on the part of non-clinicians.”

89. The LHDs carefully considered the recommendations proposed by JY’s family, and advised that they were not considered necessary or likely to improve public health and safety.

90. In response to the first proposed recommendation, the LHDs submitted that it would not be an effective use of limited resources to develop policies and fund education programmes aimed at arranging a tripartite meeting with carers for the sole purpose of sharing medication information. The LHDs argued that the introduction of the HealtheNet Clinical Portal and the move towards to the Single Digital Patient Record (discussed in detail below at 186 - 187) should “…reduce the risk of miscommunication between health care providers concerning discharge medications and in turn, allow them to communicate more confidently with involved carers.”

91. In relation to the second recommendation, the LHDs indicated it was not supported. The LHDs submitted to me that it would not improve patient safety to limit practitioners' ability to refer to both a 'brand' or 'generic' name.

92. Whilst the communication between Hornsby Hospital and the Hills MHT appears to fall short of the type of meaningful discussion referred to above in Dr Samuels' evidence, and while there was some contact from the Hornsby ACT team alerting the Hills MHT that a referral was on its way, it seems to me that more could have been done in this instance. However, I accept the LHD's submissions on this point, which emphasised Dr Samuels' evidence that "one couldn't always expect representatives from the community service to attend a discharge planning meeting".

93. Noting the particular issues submitted by the LHDs, I am not convinced that the recommendations proposed by JY's family are necessary or desirable in the circumstances. I decline the make the recommendation sought by JY's family.

Issue 4: What information was available to the Hills Community Mental Health Team (located in a separate Local Health District to Hornsby Hospital) at the time BS was transferred to that service?

94. It was important for the Hills MHT to receive a complete and detailed discharge summary given that none of its staff had met BS on the ward prior to discharge nor participated in discharge planning. Further, the Hills MHT, being in a different local health district, was unable to access Hornsby Hospital's records of BS' admission or details of medications prescribed to him.

95. On 16 May 2018, Hills MHT received an incomplete discharge summary. The LHDs submitted that I may infer that this 6-page fax comprised of Dr Jacob's *complete* discharge summary and a cover page. However, this fax is not contained on the Hills MHT file, and as such, I am unable to definitively confirm what information was sent on 16 May.

96. However, it seems unlikely that the complete discharge summary was faxed on 16 May. On 21 May 2018, Mr Lule realised that the Hills MHT team only had details of BS' discharge medication and not the complete discharge summary. He wrote to Hornsby Hospital, seeking a copy of the discharge summary and the last psychiatrist review report for BS.

97. However, when Hornsby Hospital replied later that day, a second incomplete version of the discharge summary was received by facsimile.

98. On 30 May 2018, Mr Lule followed up Hornsby Hospital again. It was only at this stage that the complete discharge summary was received.

99. I note the work of Northern Sydney Local Health District in respect of discharge summaries, as outlined in the statement of Dr Samuels. He told the Court that Northern Sydney Local Health District in ensuring that discharge summaries are forwarded to treating clinicians within 48 hours of discharge. A monthly audit is undertaken of the discharge summary completion rate, and that ongoing work is being undertaken ensure ongoing high rates of compliance.

100. Finally, as the LHDs submitted, I hope that the introduction of the HealtheNet Clinical Portal and the Single Digital Patient Record (discussed in detail below at 186 - 187) reduce the risk of communication errors of this nature occurring for other vulnerable patients in the future.

Issue 5: What role did the Hills Community Mental Health Team have in BS' ongoing mental health care and were there 'red flags' suggesting a deterioration in his mental health that should have prompted additional measures?

Issue 6: Were adequate attempts made to investigate BS' long term mental health history, recent deterioration, response to medication and concerns raised by his closest family members, notwithstanding assurances from BS that he was not presently suicidal or experiencing thoughts of self-harm or thoughts of harming others?

101. The written submissions of Counsel Assisting and the interested parties addressed these two issues jointly, so I will take that same approach.

102. As referred to above, the Hills MHT were to be responsible for BS' follow-up and community case management following his discharge from Hornsby Hospital. Accordingly, their interactions with, and assessments of, BS in the period from 16 May until the death of JY are of particular importance.

BS' engagement with his general practitioner

103. Following discharge from Hornsby Hospital, it was intended that BS would see the mental health clinicians at the Hills MHT as well as a regular GP.

104. As the LHDs submitted, Dr Jacob's discharge plan stipulated the roles and responsibilities of BS' general practitioner. Namely, these were to follow up BS after discharge, prescribe his medications and monitor his mental state.

105. On 22 May 2018, BS consulted Dr Athavale who reviewed the discharge summary from Hornsby Hospital and noted "meds clarified and scripts given". Dr Athavale was clear in speaking to BS about ensuring that he attend upon her only for his depot medication and ongoing scripts. Maintaining a consistent relationship with a single GP appeared to have been a sensible way in which to ensure monitoring of BS's presentation and symptoms and administration of depot medication.

106. On 5 June 2018, BS saw Dr Athavale for his next depot injection. Dr Athavale recorded her observation of BS as: "flat affect, very difficult to read patient at all consultations".

107. Notwithstanding BS' care plan clearly envisaged the involvement of both Hills MHT and a GP, there does not appear to have been any direct contact between Dr Athavale and the Hills MHT to discuss BS, his needs or progress. The LHD rightfully submitted that this task falls within the GP liaison officer described by Professor Brakoulias (discussed below at 189).

Review by Hills MHT

108. I accept Counsel Assisting's submission that BS did often actively engage with the Hills MHT although he missed some appointments and failed to take phone calls at times.

109. A more detailed examination of BS' engagement in the week prior to JY's death is set out below.

<u>30 May 2018</u>

110. On 30 May 2018, Mr Lule reviewed BS and recorded "rebound symptoms", such as distressing voices. Mr Lule noted: "says he is strong enough not to listen to the voices and what they are saying to him". TY reported that BS was more sensitive than usual, and attached to her, with BS becoming anxious when TY was preparing to leave for work.

111. Mr Lule discussed BS with Registrar, Dr Karandana-Vidanalage, under the incorrect assumption that BS had "self ceased" his oral 10mg Abilify seven days prior. It was Dr Karandana-Vidanalage's opinion that BS should continue aripiprazole 5mg nocte and 5mg PRN, subject to further review.

112. It appears to me that Counsel Assisting's observation of the Hills MHT's hypothesis at this time is correct: Hills MHT thought that the "emerging symptoms like irritability and auditory hallucinations…started to appear after [BS] finished supplied aripiprazole", as if the former was caused by the latter (and without exploration of other factors).

113. Notwithstanding Dr Karandana-Vidanalage's re-introduction and variation of the oral aripiprazole, both Dr Roberts and Dr Sullivan agreed that 5mg of Abilify was "therapeutically inconsequential" or "subtherapeutic". It is, therefore, unsurprising that the variation did not prevent further deterioration in BS' mental state.

<u>31 May 2018 – 3 June 2018</u>

114. On 31 May 2018, TY reported to psychologist Zhiwen Gao that BS' mood was "still not very stable" but believed that it was manageable. TY was advised of the Mental Health Intake Line and agreed to call for help if needed.

115. On 1 June 2018, Ms Gao was appointed as BS' case manager. That day, she attempted to conduct a home visit, but no one was home. She later spoke with TY, and then with BS, over the phone. BS reported "auditory hallucinations and paranoid thoughts, male voice asking him to have boxing match with himself".

116. TY had told Ms Gao that the family would work together on BS' mental health issues over the coming weekend. TY also said that she would be present with JY and BS, otherwise JY would be with his grandparents.

117. Notwithstanding the matters reported by BS and TY on 1 June, Ms Gao told the Court that she did not detect acute mental health concerns. Nevertheless, she contacted the ACT to explore if they could offer follow-up care after hours, as needed. The ACT declined this referral (revisions to the ACT referral criteria made since JY's death are discussed in further detail below at 197 - 198).

118. Although the ACT referral was declined, I accept that it is likely that at this time BS' name remained on the Hills MHT "crisis board", used to highlight the names of clients requiring additional support.

4 June 2018

119. On 4 June 2018, BS and TY attended an appointment with Ms Gao. BS indicated ongoing paranoid thoughts and believed that his thoughts were trying to control him. Whilst BS denied current auditory hallucinations, he said that the voice could "come back into his head". Overall, BS reported that his mood, appetite and energy were better, although his sleep quality was not. Ms Gao's opinion was:

> "…at that time was that [BS] still had ongoing psychotic features, his mental state was not very stable and he needed to have a medical review appointment with our doctor soon".

120. She booked BS for a review with a doctor to occur the following day.

5 June 2018

121. On 5 June 2018, Dr Athavale administered BS' next depot.

122. Later in the day, BS attended his first medical review with the Hills MHT and saw Dr Lakshmi Kondadasula. Ms Gao and TY also attended.

123. There were some inconsistencies noted between the evidence in Dr Kondadasula's written statement, and her contemporaneous progress note. I agree with the submission of Counsel Assisting (with which the family concurred), that the progress note should be preferred. As such, Dr Kondadasula recorded:

> "bizarre delusional ideas involving devil and religion, denies thought controlling or thought broadcasting, responding to auditory hallucinations of a male voice making derogatory comments, denies command hallucinations, denies current suicidal or homicidal thoughts, denies current thoughts to harm himself or plan, feels safe given guarantee for his safety."

124. Again, these observations were markedly different to those recorded at the time of the Hornsby Hospital discharge on 16 May 2018. As such, Dr Kondadasula recognised that BS needed extra support and made variations to BS' medications as follows:

    a. She ceased the oral Abilify (which had originally been intended to cease at the completion of the hospital supply and was exerting a subtherapeutic effect in any event); and

b. added a further 100mg Seroquel every morning and an extra 100mg PRN in the afternoon.

125. This amounted to a regular dose of 400mg Seroquel per day with an additional 100mg PRN. Dr Roberts was of the view this increase was "modest" but had the potential to provide "…some short term transient symptomatic relief if a patient becomes distressed or agitated". Dr Sullivan agreed and noted that this modest increase occurred in the context of a "longitudinal engagement" with the Hills MHT service, which included management plans - presumably taken to be protective factors.

126. In terms of the plan moving forward, Dr Kondadasula was considering whether BS might need to change his depot medication if he did not respond to the aripiprazole. It was agreed that TY would supervise medications and Ms Gao was to "closely monitor" and review the situation with the family prior to the June long weekend. Dr Kondadasula recommended a review by a medical officer in two weeks, and instructed that BS go the nearest emergency department if he felt suicidal or if there was a deterioration in his mental state.

127. It is clear that at this stage, Hills MHT were cognisant of the deterioration in BS' mental health since discharge from Hornsby Hospital but they did not consider that hospital admission was necessary. A criticism is raised by JY's family that Hills MHT failed to facilitate a voluntary admission of BS on 5 June 2018 (notwithstanding that the records do not reflect that BS sought a voluntary admission on this date). They also submitted that I should find that this medical review reflected "… an under-appreciation of the vulnerability of [BS] to his psychotic symptoms and to the risks posed…".

128. I note that Dr Kondadasula did not consider voluntary admission at that time because:

> "… [BS] was talking about all his symptoms and his partner or wife…both of them were actually engaged in the treatment planning and the medication, and the, the risks I explored…I had a clear plan... And in the past when [BS] was unwell, his wife always used to take him to the emergency department…"

129. The LHDs submitted that Dr Kondadasula's actions in this respect were appropriate, noting that she had: increased the prescription of Seroquel, requested close monitoring, raised an issue about whether a change in the depot to paliperidone should be considered in the long term, and ensured escalation plans were in place in the event of deterioration.

130. When asked about the 5 June 2018 review in oral evidence, Dr Sullivan did not express any concerns about the nature or quality of Dr Kondadasula's assessment. He noted that collateral information had been available from family members; Dr Kondadasula collaborated with other team members and a well-documented mental state exam occurred.

6 June 2018

131. Notwithstanding the review, medication increase, and ongoing plan formulated on 5 June, BS continued to deteriorate. On 6 June 2018, BS, JS, and TY attended the Palmerston Centre at Hornsby Hospital seeking that BS be voluntarily admitted (the particulars of this visit are discussed below at Issue 7 at 144 - 171).

132. I pause here to note again that BS was out-of-area for Hornsby Hospital. I acknowledge although geographical boundaries for Local Health Districts typically guide hospital admissions, BS was entitled to express a preference as to where he wished to be treated.

133. As will be explored further below, BS was not ultimately admitted to Hornsby Hospital (nor any other hospital) on 6 June. However, BS was reviewed and recommended to take the additional 100mg Seroquel regularly each afternoon instead of PRN.

134. Later in the day at Hills MHT, NUM Wayne Hunt spoke with RN Freeman about the family's attendance at the Palmerston Centre. NUM Hunt had not read the Hornsby Hospital discharge summary and, therefore, had not read about the family's concerns about the risk BS posed to JY. However, it is possible that this detail had been conveyed with the reviewing RN at the Palmerston Centre had contacted Hills MHT earlier in the day.

135. Notwithstanding being short-staffed (NUM Hunt described the Hills MHT as "pretty hectic"), NUM Hunt called TY to offer an additional appointment in the Hills MHT clinic the next day.

7 June 2018

136. On 7 June 2018, BS attended the Hills MHT clinic. Ms Gao was sick on leave and the team remained short-staffed so BS met with NUM Hunt. This was only time they met in person.

137. NUM Hunt had now read the Palmerston Centre discharge summary completed by RN Muller from the day prior. This included details of the specific concerns reported by

JS and TY to RN Muller – namely, that BS might hurt JY and that he thought JY was the devil.

138. Whilst NUM Hunt spoke with BS about any thoughts he might have to harm anyone in the family, he did not go into the alleged delusion that JY was the devil. In evidence, NUM Hunt recounted his probing of BS' auditory hallucinations during his review:

> "I recall saying to him… "… have you got any thoughts of hurting anyone in your family – yourself, and including your son?" And that's when he turned around and said, "My son is safe.""

139. Contrary to the discharge summary, BS told NUM Hunt that the day before he had wanted to be admitted to Hornsby Hospital and that it was TY and JS who opposed it. Whilst NUM Hunt acknowledged the inconsistency, in his evidence he said he did not discuss it further because he wanted to establish rapport with BS. NUM Hunt thought that BS' confidence in coming to see the service was important and that he "… didn't want to push the triggers with [BS] and get aggressive…".

140. NUM Hunt's legal representative submitted that his observations and assessment of BS on 7 June was consistent with JY's family's observations of BS. My attention was drawn to the following examples:

a. On 6 June 2018, NUM Hunt spoke with TY twice on the phone. TY informed NUM Hunt that BS had "settled better than before";

b. On 7 June 2018, JS made two phone calls to AS, on each occasion reporting that she thought BS was "getting better"; and

c. On 7 June 2018, BS cared for JY on his own, whilst JS took TY to work. BS also picked JY up from school following the appointment with NUM Hunt.

141. NUM Hunt was confident that BS could be managed in the community, notwithstanding ongoing confusion regarding the medications and dosages BS was actually taking. NUM Hunt recorded BS taking 200mg Seroquel per day (100mg twice a day) with an additional 100mg PRN. This did not match Dr Kondadasula's prescribing earlier in the week (400mg with an additional 100mg PRN) nor RN Muller's approach the day prior (recommending doses of Seroquel amounting to 500mg a day). On this point, in oral evidence, NUM Hunt said this inconsistency in his progress note may have reflected BS reporting consuming a lower dose than was prescribed.

142. It is impossible to know precisely how much Seroquel BS was actually taking across this period (either due to BS' own non-compliance or as a result of confusion regarding dosage). Nevertheless, the confusion documented by various different treaters reiterates the need for clear communication about prescribing medication between clinicians, with the patient, and with caregivers.

143. The LHDs rightly acknowledged that there is a need to clearly record prescribed medications, as well as non-compliance. I hope that the introduction of the HealtheNet Clinical Portal and the Single Digital Patient Record (discussed in detail below at 186 - 187) will ensure that clinicians and patients have more ready access to consistent and accurate information about medications prescribed.

Issue 7: Should BS have been seen by a doctor or admitted to Hospital on 6 June 2018 when he attended the Palmerston Centre with his mother and partner?

144. As briefly referred to above, on 6 June 2018, BS, TY and JS attended the Palmerston Centre at Hornsby Hospital seeking a voluntary admission for BS in the context of his deteriorating mental health. BS was not admitted.

145. The seeking of this admission was, understandably, a central concern for JY's family in this inquest. Tragically, the concerns voiced by JS and TY about the risk BS posed to JY during the review at the Palmerston Centre came to fruition.

146. As such, much of the exploration of this topic was devoted to examining different witnesses' evidence of this crucial attendance, with a view to reconciling the clinical decisions taken and the tragic events which occurred only days later. The accounts and written records as to what transpired on 6 June 2018 vary somewhat. As noted at the start of these findings, I will not repeat here the details of all events, which are set out in the attached Chronology.

Review by RN Muller

147. On 6 June 2018, BS, TY and JS were seen by RN Muller. RN Muller had no previous involvement with BS during earlier admissions at Hornsby Hospital.

148. As BS was a "walk-in" from out of area, RN Muller reviewed his file and medical records for the Northern Sydney LHD. She noted his recent April 2018 admission. She later also

obtained background information from the Hills MHT, where she spoke with RN Freeman and obtained a copy of Dr Kondadasula's 5/6/18 progress note.

149. BS, TY and JS were clear that they were seeking a voluntary admission for BS. For example, JS told RN Muller about BS' delusion about JY being the devil. JS also gave an account of her grave concern that BS posed a risk to others. RN Muller records JS as saying: "how do I sleep at night? I worry that I will wake up and find my grandson dead as [BS] has snapped overnight…" . Further to this, JS gave evidence that RN Muller asked BS a question about JY, to which BS replied: "He's annoying, he's the devil". In oral evidence, RN Muller denied hearing this exchange.

150. RN Muller's contemporaneous note records that BS was reporting to be struggling with delusional thoughts regarding the devil and religion, wanting to go to heaven, denying thoughts to harm to himself or others, denying having thoughts to harm his son, and stating he found JY annoying but that he was a good boy.

151. As for BS' denial of thoughts to harm JY in the context where JS was expressing her fear that BS would "snap" and kill JY, RN Muller was unable to explain why she favoured BS' denials over JS' assertions. The LHDs submitted that I should accept that RN Muller's determination as to the appropriate management pathway for BS was not a "binary assessment".

152. Indeed, RN Muller placed some reliance upon what she understood to be a plan whereby JY would be cared for by JS whilst BS continued to engage with the Hills MHT. She also appeared to place weight on BS current medication regime, telling the Court:

> "…. I can also reflect that [BS] was most likely minimising his symptoms to me when he presented. However, I think I assumed because he was receiving his depot, he was engaging in the treatment and he had been given some extra antipsychotic via the quetiapine, that he was, that he was being treated…"

153. It was ultimately RN Muller's assessment that BS did not meet the *Mental Health Act 2007* criteria for an involuntary admission. She recorded in her progress note: "… his mother and partner had hoped for a voluntary admission, advised no beds available at Hornsby." However, she took steps to explore the options for a voluntary admission for BS.

154. RN Muller took the following steps after speaking with BS, JS, and TY:

a. She requested the Hills MHT speak with TY later that day and conduct a home visit (RN Muller was aware that TY had taken the day off work and could facilitate a home visit);

b. Requested that Hills MHT provide a medical review before 19 June 2018; and

c. Advised BS to take an extra 100mg of Seroquel of an afternoon (which she thought was reinforcing Dr Kondadasula's prescribing from the previous day).

Should BS have been reviewed by a psychiatrist or been involuntarily admitted?

155. Notwithstanding that BS was not admitted to hospital on 6 June 2018, RN Muller did recognise that BS needed additional support from his community mental health team and took the steps outlined above. However, she did not seek a review by a psychiatrist.

156. Counsel Assisting submitted (and the family agreed) that with the benefit of hindsight, it is simple to conclude that BS should have been seen a doctor and admitted on 6 June 2018. The family further submitted that I should find that there was an under-appreciation of BS' deterioration and the resultant risks posed generally on 6 June, in addition to systemic failures in not facilitating a voluntary admission. They drew my attention to the fact that BS had been reviewed by Dr Kondadasula only the day prior – suggestive of a deterioration overnight.

157. Dr Roberts and Dr Sullivan gave differing evidence as to whether BS should have been assessed by a psychiatrist or whether the requirements for involuntary admission were satisfied on 6 June 2018. It was clear, that this issue was a nuanced one.

158. Dr Roberts was of the view that an assessment by a psychiatrist should have been sought. He emphasised BS' "prominent psychotic symptoms…consistent with the nature of the symptoms that had led to his prior admission to hospital" and the concerns expressed by JS and TY that BS "represented a risk to the safety of his son".

159. On the other hand, Dr Sullivan concluded that RN Muller's review of BS was "comprehensive and appropriate". He confirmed there were a range of possible courses of action open to RN Muller, and that the move towards community management was appropriate based on her clinical assessment. The LHD agreed with the views of Dr Sullivan on this point, submitting that RN Muller made a reasonable clinical decision based on the information available to her.

160. Whilst the Court had the benefit of RN Muller's contemporaneous progress note, Dr Roberts cautioned the Court regarding what he described as "a fundamental problem" in examining another clinician's written assessment without "getting a feel for the effective experience". Dr Roberts said that "[w]e have to accept that clinical notes … [are] not necessarily there to illustrate the entirety of the clinician's experience in the room."

161. On the issue of whether BS should have been involuntarily admitted, Dr Sullivan went on to state:

> "there were not clear grounds for assessment by a psychiatrist during this contact…In the absence of explicit and current risk concerns and evidence of non-compliance with management plans there is no indication that he would have satisfied the…criteria for involuntary treatment."

162. Counsel Assisting submitted, and I am inclined to agree, that the "absence of explicit and current risk concerns" is dependent on the acceptance of BS' denial over JS and TY's report. It is particularly unfortunate that RN Muller cannot explain why she favoured BS' denials of thoughts to harm JY over what JS was reporting.

163. Dr Roberts was of the view that BS should have been admitted, although he was unsure whether this should have been on an involuntary basis. With reference to BS' longitudinal history, it was Dr Robert's opinion that "one could have readily justified preparing the paperwork to admit him involuntarily if the decision was made that a voluntary admission was not feasible."

164. Further, Dr Sullivan said that when a patient is presenting as complying with assessment and indicating a willingness to take medication, it becomes very difficult to raise the spectre of involuntary admission "…. simply because there's one element of their presentation which you don't agree with, unless that's clearly demonstrated risk".

165. It is difficult to ignore the fact that JS and TY were concerned particularly where JS was expressing her fear that BS would "snap" and kill JY. The fact that BS was re-presenting on 6 June 2018 after he had been reviewed by Dr Kondadasula only the day prior is suggestive of a deterioration overnight. I find that BS should have been seen a doctor on 6 June 2018.

Questions re "bed blocks" and industrial action on 6 June 2018

166. One issue raised by JY's family was whether BS had somehow been prevented from being admitted in Hornsby Hospital on 6 June. JS recalled RN Muller telling her about a "bed block" for self-admitting patients on the North Shore, however, the progress note only recorded that JS and TY were advised there were no available beds at Hornsby Hospital. While RN Muller accepted that she may have referred to a "bed block" during her discussion with the family, there is insufficient evidence to suggest that this term referred to self-admitting patients on the North Shore (as opposed to Hornsby Hospital).

167. JY's family further submitted that industrial action had prevented BS from being admitted to hospital on 6 June 2018. I find there to be insufficient evidence to make such a finding, accepting Counsel Assisting's submissions on this point as follows:

    a. RN Muller indicated the term "bed block" could be used to refer to the situation where beds are full and there are no pending discharges.

    b. RN Muller gave evidence that she would not have differentiated between self-admitting or involuntary admissions.

    c. RN Muller did not know the bed status at other hospitals within the Local Health District. There was, however, a discussion about taking BS to other hospitals until he got admitted. RN Muller also offered for BS to wait in the emergency department for a bed, which was declined. The LHDs submitted that this referral was appropriate, noting the supports and systems existing in the Emergency Department (including access to the bed flow manager – discussed further below at 169 - 171).

    d. Finally, Dr Samuels, former Clinical Director for Mental Health Drug and Alcohol for the Northern Sydney Local Health District, said he was not aware of any industrial action limiting the number of mental health beds at the time. He told the Court that industrial action is flagged in advance to allow for contingency planning for services. He told the Court that he "…would regard it as absolutely exceptional that beds are not used because of industrial action". I accept that Dr Samuels would have been made aware of any industrial action given his role at the time.

168. Addressing evidence on the process for clinicians to identify available beds within the Northern Sydney Local Health District, JY's family submitted that I consider making the following recommendation to the Northern Sydney Local Health District:

> "That consideration be given to implementing a system whereby clinicians within the Palmerston Centre can access the Bed Flow Manager directly rather than via the ED in order to see bed availability and pending discharges in facilities across the LHD."

169. Dr Samuels' evidence on this point was that the Bed Flow Manager is the appropriate escalation pathway for patients waiting in Emergency or admitted to hospital.

170. Further, the LHDs indicated that this recommendation was not supported. They submitted that the triage process would not be greatly improved by having additional lines of communication from non-hospital services to the bed flow manager. The LHDs said:

> "If a patient requires admission and a ward bed is not immediately available, the safest and most effective point is entry is the Emergency Department. … systems exist for [a] patient to be escalated to the bed flow manager who can see bed availability and pending discharges in facilities across the LHD."

171. As such, I am not satisfied that the recommendation proposed by JY's family is necessary or desirable.

Issue 8: What was known about any risk BS posed to his child in May-June 2018, were family concerns about risk appropriately considered, and to what extent were such matters factored into decision making around BS' progress and treatment?

172. As has been discussed above, following discharge from Hornsby Hospital on 16 May, BS began to experience "rebound symptoms".

173. Counsel Assisting submitted, and I accept, that there is an inherent level of risk to any child living with a parent experiencing a deterioration in mental health. Indeed, JY's family were taking steps to mitigate these risks and to support TY and BS in caring for JY safely. It was understood that JY was spending more time with JS, or, that TY would be present with JY and BS at home. Whilst this approach appeared appropriate in the short to medium term, it does not appear to me (and indeed, many witnesses agreed in oral evidence) to have been sustainable in the long term.

174. The records appear to reflect that, following discharge, BS first reported a specific delusion that JY was the devil after meeting the Hills MHT on 5 June 2018. TY reported this to JS on this date.

175. On 6 June 2018, this delusion was reported to RN Muller during the attendance at the Palmerston Centre. As was outlined above, BS denied this delusion during the review with RN Muller. I note that during this review, JS' very specific concerns about the risk BS posed to JY were put to RN Muller during this meeting.

176. Finally, NUM Hunt was aware of this delusion during his review of BS on 7 June 2018. However, as was discussed above, he decided not to explore this further with BS.

177. The LHDs submitted that, noting a range of factors, the risk of violence that BS posed to others was appropriately factored into decision making in BS' management. However, ultimately, the specific events of 8 June 2018 were unable to be predicted.

178. It appears to me that the family concerns about the risk that BS posed to JY were known to BS' treating mental health team in June 2018. Whilst these concerns were considered, they do not appear to have been the primary factor in decision-making regarding BS' treatment. Indeed, it appears that whilst BS' deterioration was recognised, the acute risk that he posed to JY was not able to be predicted. I note that neither of the experts gave an opinion to the contrary.

179. I am confident that if TY or JS had had the least indication that BS posed an acute risk to JY on the next morning of 8 June 2018, neither of them would have left JY at home alone with BS. I am satisfied that BS' deterioration in this period was recognised, however, sadly, the acute risk that the deterioration posed was not able to be predicted.

Issue 9: What, if any, relevant changes have been implemented to systems and processes within the Northern Sydney Local Health District and the Western Sydney Local Health District or at NSW Ministry of Health level since June 2018 whether or not in response to JY's death?

180. The changes within each Local Health District since June 2018 were outlined in detailed statements received by me from:

a. David Pearce (Executive Director, Mental Health Branch, Health System Strategy and Planning Division, NSW Ministry of Health);

b. Professor Vlasios Brakoulias (Executive Director, Mental Health Service for the Western Sydney Local Health District); and

c. Dr Owen Samuels (former Clinical Director for Mental Health Drug and Alcohol for the Northern Sydney Local Health District).

181. Professor Brakoulias and Dr Samuels also appeared before the inquest and gave evidence in conclave on 26 May 2022.

182. Following JY's death, NSW Health facilitated an investigation team to explore the events of 8 June 2018. The investigation team comprised of representatives from both the Northern Sydney and Western Sydney Local Health Districts, and independent team members. The investigation team made four recommendations directed to Northern Sydney Local Health District.

183. Considering the totality of the statements and oral evidence I hear at Inquest, the relevant changes to systems and processes within each LHD can be summarised in relation to six issues arising in this inquest, as set out below.

Provision of discharge summaries

184. As was outlined above at 95 - 98, there was delay in the Hills MHT receiving the complete discharge summary from Hornsby Hospital. Whilst this may not be a significant event in isolation, it was significant in the circumstances of an out-of-Local Health District referral. The Hills MHT staff had not been involved with discharge planning, hadn't met with BS on the ward and did not have access to the records of BS' admission. As such, the timely provision of the complete discharge summary was crucial.

185. On this issue, my attention was drawn to Mr Pearce's statement, which addressed several improvements which the LHDs have implemented following JY's death. These improvements aim to address, amongst other things, more reliable information sharing between different Local Health Districts.

186. The first is the development and roll out of the HealtheNew Clinical Portal. This portal allows patient information (including discharge summaries) to be shared across Local Health Districts. It has the aim of overcoming issues associated with patients having multiple electronic medical records. The portal displays an aggregated view of patient summary information originating from other Local Health Districts and includes information from a patient's discharge summary.

187. The second improvement is the roll out of the Single Digital Patient Record across the Ministry of Health. As can be seen from the discussion above at 95 - 97, the reliance on facsimile communication between different Local Health Districts was a real issue of concern in this matter. The LHDs submitted that in the wake of JY's death, this had been the focus of a significant system improvement. As outlined in Mr Pearce's statement, the Single Digital Patient Record will consolidate existing electronic medical records and patient administration systems to ensure that all patient records can be accessed in any public health facility around the state in real time. The LHDs submitted, and I am hopeful that, the introduction of these two systems will reduce the risk of communication errors seen in this case occurring for other patients in NSW. This improvement was essential as the problems with information sharing has been an issue in many inquests. It is positive that the Single Digital Patient Record system is now being rolled out.

188. While this these key systems improvements will not overcome the challenges in involving out-of-Local Health District community mental health teams in discharge planning, it should provide a way to easily access important material without relying on a fax.

189. Professor Brakoulias and Dr Samuels also gave evidence about roles within each of their respective LHDs with a focus on GP liaison and community mental health, with a view to sharing information, and where possible, co-ordinating shared care.

190. In respect of changes within the Northern Sydney Local Health District, Dr Samuels told the Court that since JY's death, the Mental Health Drug & Alcohol is now tracking the completion of discharge summaries within 48 hours of discharge across their services. Dr Samuels provided data to support the completion rate across the captured sectors.

191. These are all positive steps that should lead to more reliable information sharing between different Local Health Districts.

Accurate recording of prescriptions

192. As I have addressed above, BS' discharge summary was less than clear in terms of the intention to cease the oral Abilify upon completion of the 7-day hospital supply. In my view, this was a problem with the clarity of the prescribing as detailed in the document, rather than a systemic issue.

193. Northern Sydney Local Health District has since undertaken initiatives about medication reconciliation and the details available for clinicians, patients, and carers. For example, Medication Reconciliation is a formal process of obtaining, verifying, and documenting an

accurate list of patient's current medication on admission and comparing that list to the admission, transfer and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care, the verified information is transferred to the patient and next care provider.

194. Further, the "You + Your Medicines" brochure and the "My Medications List" should assist patients and carers to understand current prescribing.

195. Finally, Professor Brakoulias gave evidence that Western Sydney Local Health District has made improvements in medication documentation through the transition to the "eMeds" system. This was implemented in September 2018 and is a system whereby medication prescribing and administering occurs within the patients' Electronic Medical Record.

Referrals to the Acute Care Team

196. The materials before me reveal two attempts by Ms Gao to refer BS to the Acute Care Team on 31 May and 1 June 2018. The purpose of these referrals was to obtain extra follow-up care for BS over a weekend when the Hills MHT would not be available. These referrals were refused.

197. Ms Gao gave evidence that her referrals were declined because BS was not "in an acute process". However, the ACT's criteria has now been revised, and they accept all the requests from the Hills MHT case management team based on client's needs (regardless of whether the patient is in an acute phase or not).

198. Professor Brakoulias described this revision as occurring in the context of "major revisions to the models of care for each of the community teams." The LHDs further submitted that the revisions expressly targeted consumers such as BS in their model of care, identifying people who require more "… intensive community treatment or extended hours care than is possible through non-Acute Care Teams".

199. This seems to me to be a positive improvement to support vulnerable mental health clients in after-hours settings.

The REACH program

200. As outlined above, BS was not admitted to Hornsby Hospital on 6 June 2018. Rather than wait in ED for a bed to become available, JS told RN Muller that she would take BS to other hospitals in Sydney until BS was admitted. In my view, this raises consideration of

how carers can escalate concerns if not satisfied with a clinical response to their family member.

201. The REACH (Recognise, Engage, Act, Call, Help) program is relevant to this issue and extends to some mental health settings. The program is designed for "consumers to raise their concerns about worrying changes in a patient's condition".

202. It appears to me that the success of the REACH program depends upon patients and carers being aware of its existence and how to use it, in addition to mental health clinicians recognising when patients or carers are seeking to invoke REACH.

203. As at October 2022, the REACH program was not in use in the Community Mental Health setting at the Palmerston Centre (notwithstanding a pilot scheme seeking to assess its use in community settings). However, since then, Northern Sydney Local Health District conducted a pilot program which was a success. I note that the REACH program is already rolling out within that Local Health District.

204. Accepting that local settings would need to develop individualised models to give effect to the REACH program, it is sensible to me that the REACH program should be expanded to community mental health settings. This is particularly so, given that the Policy Directive on "Recognition and management of patients who are deteriorating" is of such broad application and the REACH program assists in the recognition of deteriorating patients.

205. I note that whilst the Western Sydney Local Health District has a similar program in place, it does not go by the REACH name.

206. I acknowledge JY's family's scepticism of the REACH program. It is clear that they took steps as outlined in the program: they recognised, engaged, acted and called for support in response to their concerns about BS' presentation, but this ultimately did not prevent the death of JY.

Proposed recommendation regarding the REACH program

207. In her written submissions, Counsel Assisting proposed that I consider a recommendation directed to the Chief Executives of each of the Northern Sydney and Western Sydney Local Health Districts and provided to the NSW Ministry of Health as follows:

> "That consideration be given to expanding the REACH program to Community Mental Health settings, with appropriate information being

provided to consumers, families and other carers on how to use the program in that setting."

208. Notwithstanding the concerns raised by JY's family regarding the efficacy of the REACH program, this case does highlight how patients can move from one Local Health District to another and may fall between the cracks of this transition. Therefore, it seems sensible for there to be a consistent availability of the REACH program across Local Health District boundaries.

209. In this regard, the LHDs submitted that the principle behind Counsel Assisting's proposed recommendation was "strongly supported by NSW Health, Northern Sydney Local Health District and Western Sydney Local Health District". I also note the intention of NSW Health that REACH (or similar programs) are adopted across all community mental health setting in NSW.

210. The LHDs submitted that in these circumstances, it is not necessary that I make the recommendation as proposed by Counsel Assisting. However, I consider that it is desirable to do so. I make the recommendation.

Adequacy of assessing an out of area patient

211. When BS attended the Palmerston Centre as a walk-in on 6 June 2018, he was an out of area patient. This presented challenges in terms of the level of care he received.

212. I have received evidence regarding the changes implemented to processes at the Palmerston Centre since JY's death. Dr Samuels gave evidence regarding the steps that have been taken to ensure that all patients attending the centre are now subject to Care Zoning Practice Guidelines, regardless of whether or not they live within the geographical boundaries of the Northern Sydney Local Health District.

213. According to Dr Samuels, this was implemented to ensure that even if a patient is from out of the area, they still go onto the patient board and are reviewed by the clinical team during the multi-disciplinary review of patients. The plan is that out of area patients are to be discharged to another area's mental health team whilst ensuring that the clinical decisions are reviewed, and it is the most appropriate decision.

214. These changes should go some way to ensuring that patients do not fall between the cracks when trying to access out of area care.

Increasing the number of consultants and senior consultants

215. Finally, throughout both the written statements and the oral evidence I heard at inquest, the issue of short-staffed and underfunded public mental health services loomed large. One particular issue was the availability of consultants to provide specialist input.

216. Both Western Sydney Local Health District and Northern Sydney Local Health District have made attempts to increase consultant and senior consultant availability since JY's death. This has extended to both the number of positions available to cover the patient load and in terms of the way that services are delivered, so that consultant time is more efficiently targeted.

217. Whilst this will not solve all the challenges of an overworked and under-resourced public mental health system, this is a good start.

Findings required by s. 81(1)

218. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to make the following findings pursuant to s. 81(1) of the *Coroners Act 2009*:

Identity – the person who died was JY.

Date of death – JY died on 8 June 2018.

Place of death – JY died at Westmead Children's Hospital, Westmead, NSW.

Cause of death – the cause of JY's death was multiple stab wounds.

Manner of death – JY died as a consequence of the acts of his father, BS.

Recommendations

219. I therefore make the following recommendation to all the Chief Executives to all of the Local Health Districts in New South Wales, and to be provided to the NSW Ministry of Health, as follows:

    a. That consideration be given to expanding the REACH program to Community Mental Health settings, with appropriate information being provided to consumers, families, and other carers on how to use the program in that setting.

Concluding remarks

220. I again express my deepest sympathies to JY's family, friends and loved ones.

221. JY's death is a tragedy for those who love him, and I appreciate that this inquest must have been an incredibly painful experience for his family. I thank them for their patience and participation in this inquest.

222. I also thank JY's family again for their generosity in sharing with me their beautiful words and memories of JY during their family statements on the last day of the inquest. It was lovely to hear more about such a loved little boy.

223. I also thank my counsel assisting team, Donna Ward SC and Ellyse McGee of the Crown Solicitor's Office, for their respectful approach, collaboration with the interested parties and tireless work in assisting me in this inquest. I am grateful for all their efforts.

224. I close this inquest.

Magistrate Teresa O'Sullivan
NSW State Coroner
Date 5 July 2023

ATTACHMENT A

Glossary of anti-psychotic medication:

Aripiprazole	Brand name Abilify
Paliperidone	Brand name Invega
Quetiapine	Brand name Seroquel / Seroquel XR (extended release)
Risperidone	Brand name Risperdal Consta

Treating health professionals:

General Practitioner

Dr Tegan Athavale

Hornsby Hospital Admission

Dr Suresh Goriparti – Staff Specialist in Psychiatry, admitting doctor

Dr Anila Jacob – Senior Staff Specialist in Psychiatry, allocated care as attending doctor

Dr Dominic Paul – Staff Specialist in Psychiatry, allocated care when Dr Jacob on leave

Dr Iman Mashhadi – GP doing psychiatry training, Registrar working with Dr Jacob and Dr Paul

Hills Community Mental Health

Musa Lule – Psychologist/Mental Health Clinician

Zhiwen Gao – Psychologist/Mental Health Clinician

Dr Wijemanne Karandana Vidanalage – Career Medical Officer

Skye Freeman – Registered Nurse/Mental Health Clinician

Dr Lakshmi Kondadasula – Career Medical Officer

Wayne Hunt – Registered Nurse/Nurse Unit Manager

Palmerston Centre

Naomi Muller – Clinical Nurse Specialist

Chronology of significant events

22/06/81	BS, JY's father, is born. BS is aged 36 at the time he kills JY [6.1].
2002	Earliest criminal matters on BS' criminal record [55.1].
10/03	According to Hornsby Hospital notes: BS admitted to South Pacific Private Hospital for detox, with drug induced psychosis [50B.17] scheduled from there to Manly Hospital after allegedly assaulting female patient…BS' parents noticed an eighteenth month period of change in personality, believed by his parents to be the result of drug use. Previously a gentle child [50B.17].
10/11/03	BS commences case management by Hornsby Early Psychosis Intervention Service, under Community Treatment Order [50B.24]. Later discharged to Acute Care Team for case management [50B.25].
27/08/04- 02/09/04	BS admitted to Hornsby Hospital [49B.224]. Per discharge summary "Admitted following an appointment with Dr Anna Lee where he was severely agitated, thought disordered and aggressive towards his mother, [BS] is known to the Community Mental Health team. Has one year history of psychosis but has been inadequately treated due to poor compliance and polysubstance abuse. Has no previous admissions. His behaviour has been more settled when medications were supervised. CT Brain –NAD" [49B.226].
09/05/05- 17/05/05	BS admitted to Hornsby Hospital, "was brought to ED by his father after he told a friend he 'had to kill someone to save the world'…this occurred in the context of marijuana and amphetamine use, and non-compliance with medication. He had a previous psychotic presentation 8/12 ago. During this admission he had delusions of being a messiah, a lack of insight into the effect of substances on his psychosis and blunted affect. He was commenced on risperidone IMI depot and oral risperidone. He settled well on the ward and was discharged on a CTO" [49C.230].
12/03/09	Letter from treating psychiatrist to BS' solicitor re criminal charges in Local Court (fail submit breath analysis and drive whilst suspended). "[BS] has been treated for Paranoid schizophrenia by this service since 2003. He had poor insight and his cooperation with treatment has been patchy. He has been treated for the past few years with the aid of a Community Treatment Order which has ensured that he has stayed in treatment…his diagnosis is that of paranoid schizophrenia. In the past his disorder had been complicated by the fact that he abused alcohol and recreational drugs. However over later years our impression is that he is greatly improved in these areas. His prognosis is difficult to predict with confidence. Since he has been receiving regular medications he has managed to avoid hospitalisation. He has not managed to stay free of delusions and hallucinations but his behaviour usually remains reasonable and there have been very few complaints about his behaviour from family or the community. Medications can often prevent the gross behavioural difficulties that result in community turmoil and hospitalisations. They however do not cure the disease. Often residual signs of the illness remain and considerable disorganization and the previous

psychoses can often leave patients with fixed ideas about … sections of the community. Patients often show poor judgment, behavioural disinhibition and suspicious ideas. BS has certain fixed ideas about the police and appears to have great difficulties relating to them in a respectful way. We intend to continue applying to extend the CTO indefinitely. Surveying the thick clinical file does show that the latter entries do indicate a clear trend for improvements in his symptoms…If he does not continue to take his medications I believe that the cycle of hospitalisations and community crisis will continue.

His erratic behaviour described in the facts sheet is not surprising to me. Even without alcohol he can be angry and abusive when provoked. He has difficulties inhibiting his anger and his judgement is suspect especially in situations where he may feel under pressure" [50A.9].

2010 BS and TY meet [6.3]. TY moves in with BS and his parents [11.1].

27/09/12 JY born (aged 5 at time of death) [1.1]. Family living with JS (paternal grandmother) [6.3] [11.2].

06/14 BS discharged from Hornsby Community Mental Health after family move out of area [47A.1].

01/12/14-
05/01/15 BS admitted to Cumberland Hospital, referred by Parramatta CMHT as he felt somebody was hacking his brain. He has a long H/O psychosis and was followed by Hornsby CMHT for 10 years. 6 months ago they shift, so he was discharged from their service. He was going to GP for his injections, but there he got angry and started giving injections by himself. Principal diagnosis schizophrenia [47A.1].

He was not completely compliant with his medication and would take injections whenever he thought he was unwell. His family noticed that he was getting unwell for past 6 months [47A.1]

After admissions he was restarted on risperidone depot and oral olanzapine. As his condition started improving olanzapine was cut down. Olanzapine was stopped and he was started on oral risperidone…his condition improved and he was not having any psychotic symptoms [47A.1].

05/01/16-
25/01/16 BS admitted to Cumberland Hospital, remained as a voluntary patient:

"…chronic schizophrenia, relapse, on DSP, Has been on risperidone consta since about *[indecipherable]* years, Known to Hornsby Hospital and Cumberland. This time there has been reported non-compliance with oral medication. He stated that the devil is trying to control his thoughts, and thoughts are being put in his mind. He stated that he was alright between his admissions. He was really distressed with these thoughts and required PRN medications on many occasions…Also during family meeting it was presumed that dinking 3 cans of beer daily, very heavy smoking and ongoing financial problems could be contributors to relapse. BS also has issues with gambling… family explained that these symptoms somethings persist and they should not have unrealistic expectations from BS and should not force him to do things [47B.3].

Meds:
Olanzapine 5mg PO nocte – plan to stop olanzapine after 2 weeks
Risperidone consta depot 75mg IM every 2 weeks
Haloperidol 2.5mg PO PRN (only 3 doses given) [47B.4].

Referred to Parramatta CMH for acute follow-up, Plan for regular follow up and case management by Dundas, ongoing reviews with Case Manager and psychiatrist will be beneficial."

08/03/16-06/04/16 BS admitted to Cumberland Hospital, chronic schizophrenia, self-presented with increase in auditory hallucinations and negative thoughts [47C.5].

…believed olanzapine was not working. We ceased this and started seroquel which he has tolerated well. We held family meetings with his mum who was concerned BS was not at his usual baseline [47C.5].

It seems there are marital issues with his partner as well as financial problems, stress, communication etc which may be detrimentally affecting his mental health and as such he would benefit from rehab [47C.5].

Transferred to Melaleuca for further treatment [47C.6].

Current meds:
Quetiapine 100mg PO BD [By mouth, twice a day]
Quetiapine 50mg PO MIDI [By mouth, at midday]
Risperidone Consta 75mg IM fortnightly [Intramuscular] [47C.6]

Early 2018 BS, TY and JY move to Carlingford [6.3].

16/01/18 BS sees Dr Huang GP to obtains a script for seroquel 150mg tablet in the evening, script for Risperdal consta 37.5mg, 2 injection every fortnight [51A.2].

02/18 BS stops taking medication and according to TY, his health deteriorated by 03/18 and started referring to himself as God [6.3].

When JS learns BS had stopped taking one of his medications, she told him he can't just go off medication but he said he was okay. JS told BS to tell her if he was no longer feeling okay [8.3].

10/04/18 BS sees Dr Athavale GP (new patient to Dr Athavale):

"…schizophrenia, no psychiatrist involved in patients care…not taking seroquel, weaned off this, wants it as a backup if symptoms worsening, currently feels very stable, prescription printed Risperdal consta 37.5mg injection, as directed every fortnight" [51A.4].

04/18 Dr Dominic Paul starts work at Hornsby Hospital as a part time Year 1 Staff Specialist [17.1]. Doing inpatient work two days a week and asked to cover for Dr Jacob's patients when she went on leave [17.1]. Had known BS from working as Registrar/Career Medical Officer in the Clozapine clinic at Hornsby Hospital some years ago [17.1].

19/04/18 – 16/05/18

BS admitted to Hornsby Hospital after he attended an outpatient appointment [16.1].

BS first sees occupational therapist on outpatient appointment:

"BS has a long term hx of schizophrenia and has been a client of HKH for many years, he was DC from the service in June 2014 for follow up with his GP…was prescribed Seroquel 200mg daily which he ceased in January2018…his depot is now being administered by his partner who is an RN. One week ago a former friend called to see BS, someone who he has not seen for many years – after the meeting he began saying this man was evil but that BS could cure him because he was the lord and had special powers. Since then he has been saying to his partner that he is the lord and that his mission is to save people and he must do this through dying – no plan to suicide. Reporting poor sleep as the devil is putting thoughts in my head, ruminating on the fact that he needs to control my heart and my mind against the devil…Paranoid thoughts that his father is out to get him [50D.91]…has not seen a psychiatrist since 2014.. requires admission for containment for safety and for medication review, willing to come into hospital as voluntary patient" [50D.93].

Dr Goriparti working with the Acute Care Team at Hornsby Hospital, where BS is brought in by family to ACT for assessment due to recent deterioration in mental state. He is seen by an OT who recommends admission for further assessment due to relapse of psychotic symptoms on background of paranoid schizophrenia [18.2].

Dr Goriparti sees BS with Dr Mashhadi (described as GP doing psychiatry training), need to decide on initial management plan. Symptoms included: guarded, passivity phenomenon, delusions about the devil and that he needed to save the world, wanting to go to sleep and pass away peacefully to save the world, partial insight these were signs he not well, explicitly denied thoughts of harming self or others. Agreed meds needed to be adjusted and go back on oral quetiapine [18.2].

Dr Goriparti and Dr Mashhadi then meet with mother and partner to corroborate his history: "last admitted year ago and refused to engage with psychiatrist or community team, partner who is also a nurse administering depot risperidone (fortnightly injection) in the community, never aggressive and not a religious person, living in Mt Colah and had a 5 year old child" [18.2].

Dr Goriparti recommended trial of depot paliperidone injection which can be given monthly instead of depot risperidone which has to be given fortnightly, also recommended BS recommence oral quetiapine 200mg at night until new medication started working [18.3].

"Progress notes: Feels anxious, feels pressured to save the world "someone needs to do it", difficulty sleeping for few nights, not slept last night, does not want to elaborate as feels he will be locked here, explain that he wants to sleep and pass away peacefully to save the world, does not want to harm himself or others, states evils are around, feels it's a sign of being unwell, has been on Risperdal Consta, gets his script from his GP and his wife gives him the injection, He states he was on 200mg before, reduced it himself to 100mg and then ceased [probably a reference to the Seroquel not the Risperdal], agreed to start it again as thinks he is unwell and needs to start his medication [50D.94].

Trial of paliperidone depot injection next Monday with plan to monthly Paliperidone, Start Quetiapine 200 mg nocte" [50D.95].

BS nominates TY and JS as designated carers [49.78].

20/04/18 Dr Anila Jacob attends nursing handover to the multidisciplinary team and is allocated BS' care as his attending doctor, noted during handover: "presence of religious delusions, anxiety, thoughts of self-harm, believing he was Jesus and wanting to save the world" [16.1].

Social worker calls JS to arrange family meeting, meets with BS. BS said he felt his heart was not pure, he said he had been feeling this for the last 15-20 minutes and said it was not something he had experienced before [49.210].

Notes for MDT daily handover meeting record: current mental state "religious delusions, anxious, thoughts of DSH, believes he is Jesus and wants to save the world" [49.212].

23/04/18 Dr Jacob meets with BS for the first time, JS and TY there too.

Reported: "…recent worsening of mental state, beliefs there were devils around him, distressing dreams and wishing to passively die, said that since admission distressing thoughts were less intrusive, he could focus better, expressed no thoughts of or intentions for self-harm, suicide or harm to others, said on monthly Depot Injection Risperidone Consta given by partner, ceased taking his quetiapine 200mg in January but had re-initiated 100mg week prior to admission, asked to be treated with medication not cause drowsiness and weight gain, agreed to further period of admission" [16.2].

Dr Jacob recommended quetiapine 200mg be continued, discussed alternate meds with lesser tendency for weight gain and sedation, plan to leave the ward for staff accompanied activities [16.2].

Dr Jacob noted BS had a mildly raised prolactin level, previous medications might have contributed to this, aripiprazole (potential new anti-psychotic) is not associated with increased prolactin levels [TN 23/05/22 31.7].

Hornsby Hospital call Hornsby Mall Medical Centre: the last time BS had been to the medical centre was in 2015 and was on Risperdal Consta 50mg fortnightly, no contact since then [48.67] [49.201].

Progress notes from RN: "Family meeting this morning with the treating team, mother and partner attend, plan to commence him on either Abilify or lurasidone oral, given consumers information to mother [49.198] Pt stated that his thoughts are improving…does not believe that he should die to save the world, sleep getting better, no more nightmares about green devil trying to kill him, believes medication starting to kick in" [49.199].

Progress note from Dr Mashhadi: "BS states been dealing with the thoughts in the wards, less intrusive, reports he can now focus on some of the thoughts that are bothering him, states being a religious person dreams which are putting him in distress, states he has been suffering from these thoughts more within the past few weeks, affecting his sleep, still reports the same type of thoughts, does not want to disclose the nature of thoughts in this meeting, denies any thoughts

of self harm or harm to others…Patient and family states that injections are given by TY…mum states his father is supportive in workplace however BS disagrees with this…Seroquel 200mg daily, been on this medication after most recent admission however self ceased it in January 2018 and restarted again two weeks ago after his mental state deteriorated…ongoing delusions with similar context (devils around him, more at night, interfere with his sleep, does not want to die now, wants to die when he gets well) [49.200] No depot injection at this stage (Patient states that he understands that he needs medication, agrees to continue oral medication and wants to be on a medication that is less associated with weight gain and sedation)" [49.201].

27/04/18-13/05/18 Dr Jacob on leave, Dr Dominic Paul caring for BS in interim [16.2].

30/04/18 BS interviewed by Dr Paul and Dr Mashhadi: "poor quality sleep…states the pills helped his symptoms, states that had the depot but still were suffering from the symptoms…found the mind racing and difficult to get to sleep at night…laughing inappropriately, feels powerful, special powers by death, feels happy and cheerful, manic features present" [49.168].

Plan Increase Quetiapine from 200mg to 300 mg XR, Start aripiprazole tablets with the plan to change to depot injection" [49.169].

According to Dr Paul there were two things behind the increase in the Quetiapine: "One was to help with the sleep, and also to control the mood symptoms…psychotic symptoms as well." [TN 24/05/22 47.6].

Per Dr Jacob: "The initial phase of the oral aripiprazole is to ensure a person can tolerate the medication in terms of side effects or adverse events and see some at least some partial response." [TN 23/05/22 40.42].

Per Dr Paul: "It may be a bit too soon to see any positive effect in managing mental health within a week but the trial is "to see the side effects to see whether there is any side effects that are intolerable. Especially akathisia [restlessness]." [TN 24/05/22 48.28] In terms of therapeutic effect "we can start seeing an improvement within about three weeks if it works." [TN 24/05/22 49.38].

Practice guidelines and product information suggest continuing oral aripiprazole for 14 days after the initial depot given [TN 23/05/22 41.7].

02/05/18 BS interviewed by Dr Mashhadi: BS explained his mood is fine, denies any suicide ideation, explains that he does not want to die now, denies any side-effects with current medication [49.161].

03/05/18 Social worker speaks to JS: JS said she noticed BS was quite bright and cheerful on Saturday but then seemed to have crashed on Monday, she reported that he said he had not slept well for the nights prior. She agreed that the psychotic symptoms seem to have eased but he is still depressed. JS said that JY visited a few days ago. She said that the first few minutes seemed to go well. They hugged and played appropriately for 10 minutes or so but then JY sat on BS' lap and BS didn't touch him or pay any attention to him. JS said that they ended the visit early because they were worried JY would get upset by BS' lack of interest [49.156].

MDT meeting with Dr Paul and Dr Mashhadi and others: grandiose delusion on admission, passive suicidal ideation (die to save the world).

Progress notes: isolated in his room, no evidence of risk to himself reported [49.159].

07/05/18 Dr Paul meets BS with Dr Mashhadi in room on subacute ward: due to be started on Abilify depot because had tolerated oral meds, due to go out with family on leave, reported feeling much better, did not voice persecutory delusions, did not have hallucinatory experiences, mood stable and no thoughts harm self or others, post assessment plan to start Depot Abilify 400mg intramuscular as soon as possible, Dr Mashhadi to discuss with wife [17.2 and 17.5].

Psychologist entry in progress notes: “Bed +++ isolating in room, no engagement with others, superficial when staff approach, sleeping well, restricted in affect, no overt signs of psychosis” [49A.142].

Progress notes BS states his mood has been stable, no side effect from his medication, agrees to have depot injection, well engaged in the interview [49.140].

08/05/18 Depot injection Abilify 400mg [49A.138]].

Social worker: “Superficial, avoidant of staff, minimal engagement on approach, delusions easing. Leave went well with family.” [49A.136].

OT assessment: “Pt reported imbalance between work/leisure/rest ADLs by working 2 jobs/feeling over worked…Pt reported that up until hospitalisation he was working as a mechanic as well as delivering newspapers in the morning from 430-630, Pt reported suffering increase stress from over working” [49.134].

10/05/18 Dr Paul involved in multidisciplinary team meeting (occurs once a week): BS’ escorted leave increased to 5 hours per day and reportedly going well, no concerns raised by MDT.Plan to discharge next week when Dr Jacob back from leave if remained stable and with adequate community supports [17.2].

Dr Mashhadi makes entry in MH progress notes: “has a case manager after discharge” [17.7].

11/05/18 Progress notes: Social worker met with [BS] “…he was pleasant and interacted appropriately…P/C to mum: [JS] reported that there have been no issues while on leave. She thinks it would be great for [BS] to have more leave on the weekend and would be happy for him to be d/c early next week” [49.121].

14/05/18 Dr Jacob returns from leave, BS discussed at MDT. Dr Jacob assumes she read the most recent medical records to update herself (her usual practice and there is no reason to doubt that occurred here). Team Registrar gives summary:

BS improving, feeling hopeful for future and sleeping well, medication changed with new Depot Injection Aripiprazole at 400mg, increase in Quetiapine to 300mg and continuing Aripiprazole at 10mg every day (which was also new), aware discharge planned for week of 14 May 2018.

Dr Jacob and registrar plan to meet with BS and family on 16 May 2018 to discuss progress and further discharge planning [16.3].

According to Dr Jacob, during admission there were daily assessments by staff, clinical status and treatment discussed at MDT clinical meetings, handovers and discussions with family. No reports of ongoing symptoms so ultimately concluded remission of reported psychosis had had extended leave from ward with family with no issues [16.3].

Progress note (RN): “keeping low profile, very minimal engagement, observed to be guarded and slightly paranoid, RIB most of the time, appears to be pre-occupied, however settled in MS, nil psychotic symptoms noted nil SI/ToSH reported” [49A.109].

Same nurse later in shift: “[BS] continues to be isolative in his room, appears to be pre-occupied but polite and pleasant on approach, very minimal engagement with others this shift, eating and drinking well, compliant with nursing care, nil concerns ator.” [49A.108].

Progress note by ACT RN Sarah Rumbel: “[BS] for Community Case Management upon discharge…discharge address confirmed …Telopea, discussed local community mental health team will provide follow-up on discharge…update address in , liaise with AMHU treating team and local Community MH team as appropriate” [49A.111].

15/05/18 Registrar review with Dr Mashhadi: “[BS] states his mood has improved, denies any side-effects with current medication, agrees to continue the cover two weeks of oral Aripiprazole, sleeping well, feels positive about his future, wants to stay in his mother’s place for two weeks and then go to wife’s address … mood is stable, affect reactive, Denies any auditory hallucination, denies any other form of delusions, insight adequate to his mental illness, treatment, D/W Dr Jacob, no need for case management, for possible discharge tomorrow” [49.105].

BS ultimately discharged with a referral for case management [TN 23/05/22 43.48].

16/05/18 MH progress note on day of discharge (Dr Jacob and Dr Mashhadi): “ … reports his mood has improved, feels more positive about his future, does not want to die…going back home and being with family would help him, denies any type of delusions, states that he is willing to engage with the community team after discharge”.

Dr Jacobs explained the service provided by the community team including case management: “patient agrees with this plan, states that has no regular GP but goes to one family practice, Dr Jacob advised that he needs to see his GP for depot injection, patient agreed with this plan, understands that his wife cannot give him any injection…Mum agrees that he has improved significantly, his attitude improved, engaging well, not withdrawn, Mum thinks that he is ready to be discharged, mum states that they have discussed it with each other and family agrees that they need to attend follow up in the community and see their GP” [48.61].

According to Dr Jacob: “As discharge plan had been proposed earlier by Dr Paul and no new clinical concerns, BS deemed ready for discharge, including because responding and tolerating the prescribed medication” [16.3].

Dr Jacob thought he had improved from last time seen him as quieter and less distressed by experiences, voluntary patient asking for discharge [16.3].

Progress notes: Reports his mood has improved, feels more positive about his future, does not want to die [49A.100].

Handover given to Mark from Western Community Team: “DC to kindly be faxed” [49A.97].

Patient discharged with 7 days medication [49A.98].

Per discharge summary: “…presented with acute worsening of schizophrenia, admitted as a voluntary patient after his family contacted acute care team. He was recently more anxious and reported to feel being pressured to save the world “someone needs to do it.” He had difficulty sleeping for a few nights, not slept last night. He explained that he wanted to sleep and pass away peacefully to save the world. He denies thoughts about suicide or self-harm. He states that he knows evils are around and found it as a sign of being unwell. He requested help from family and the team [48.52] [49A.56].

He reports that he was seeing multiple GPs in Parramatta and Carlingford for script for his depot injection. His depots were administered by his wife who is working as a nurse in the aged care facility. He had his last depot on 4/4/18 75mg risperdal consta and was on Seroquel 200mg daily, been on this medication after most recent admission, however, self-ceased it in Jan 2018 as he felt he did not need it. He decided to start Seroquel again two weeks ago after his mental state deteriorated” [48.52].

MSE on admission: “Thought disordered, ongoing delusions with similar context (devils around him, interfere with his sleep, does not want to die now, want to die when he gets well) denies any self-harm or suicide, denies any thoughts about harming others, insight: partial” [48.52].

Summary of care: “during this admission, the depot antipsychotic changed to aripiprazole and the dose of quetiapine increased to 300mg nocte. His mental state improved. He [sic] reported his mood to be stable. He had reactive affect. He denied any psychotic symptoms or any auditory hallucination. No form of thought disorder identified upon discharge. He had no suicidal thoughts or plan and had appropriate judgement and insight on discharge. He could tolerate medications very well and agreed to continue the medication. He agreed to see his GP and local community team for follow up and agreed to have his depot injection prescribed and administered by a medical professional who is not a relative to him. He had several hours of leave which went well.
…

BS was discharged on 16/05/18 under the care of family. To continue his medication (including seven more days of aripiprazole tablets). Referral arranged to Western Sydney Community team for follow up after discharge would benefit with case management. Patient was advised to see his GP for follow up after discharge to provide script for his depot injection and monitor his mental state [48.52]

Medication on discharge:
Quetiapine XR 300mg night, new medication, 7 day hospital supply,
Aripiprazole 10mg morning, new medication, 7 day hospital supply,
Aripiprazole Depot 400mg, intramuscular every 4 weeks last given 8/5/18, Next due 5/6/18 [48.53-54]

To continue his medication (including seven more days of Aripiprazole tablets), Referral to Western Sydney Community team for follow up after discharge and would benefit with case management. Patient was advised to see his GP for follow up after discharge to provide script for his depot injection and monitor his mental state [48.56].

Dr Jacob's intention was for the aripiprazole tablets to continue for 14 days post initial depot and then cease, the hospital supply provided to BS would cover the supply of the medication until it was to cease" [TN48.41-49.11].

Hornsby send "relevant documents" by fax (13 pages) to Cumberland Community Mental Health Team [48.58].

JS says on discharge BS seemed better but not quite back to the old BS he had been when previously in hospital [8.3].

05/18 TY started to be worried about safety of JY so leaving him with JS on regular basis [6.4].

17/05/18 The Hills CMHT MH triage: …request for 7 day d/c f/u. Will be having depot from GP – referrer requests ongoing case management. Client agreeable…has a 5 yr old child – living in Mt Colah, ex wife a nurse and was administering depot – told to do so no longer, nil history of aggression confirmed by family…refer to Hills case management team [48.18].

MH progress note: "new client referred for seven day follow up post discharge and case management ..." [48.15].

18/05/18 Zhiwen Gao psychologist, on call at Hills MHT: BS discussed during morning hand over then Ms Gao rang him to arrange assessment meeting but no answer [25.1].

MH Progress note: phone called client, no answer [25A.7] [48.15].

Unknown date A few days after BS out of the Palmerston Centre TY calls JS and said BS having trouble with JY and was not coping [7.2].

21/05/18 Musa Lule, psychologist with Hills MH Team is on call clinician, attempts call BS because had been unable to contact him following his referral to the service. Did not answer mobile. Looked at file and saw Team had copy of discharge medication only, provided with 7 day supply of medication at discharge and Mr Lule worried may be running out of meds. Decided to make a home visit, short staffed so went alone. BS in drive way washing car, had a conversation, talked about attending HCMHT for full Mental Health Assessment within next day or so, said probably go to GP and get a script [23.3].

Hills CMHT short staffed that day so Mr Lule attends alone [TN 24/05/22 16.5].

MH progress note: H/visit [BS] to organize a c/visit for post discharge follow up after he did not answer his mobile. agreed attend centre tomorrow. Says he will go to his GP probably tomorrow to get scripts for his oral medication since he has two days' supply left. Nil acute risk issues at contact [48.15].

Booked appointment for 10am following day, also faxed Hornsby Hospital requesting full discharge summary [23.3] [48.44-45].

Hornsby send fax back to Musa Lule with discharge summary – 4 pages [49.52] another fax cover sheet [49.70].

Entry in Dr Athavale GP records "non visit", Risperdal ceased (stopped in hospital), medication started by specialist aripiprazole 400mg powder for injection once a month, Seroquel 100mg table changed to seroquel XR 300mg tablet, dose of seroquel XR 300mg tablet changed from 150mg in evening to 1 in the morning [51A.4].

22/05/18 BS visits Hills CMHT for mental health assessment and sees Ms Gao, reported all good since discharge, paranoid thoughts come and go but refused to talk about details, declined offer medical review appointment with the team, said felt safe at home and family supportive, next appt with GP later that day and aware Depot due 5/6, agreed to next appt 29/05 [25.1].

MH current assessment: "psychologist, in person and previous notes, met clients at the centre on time, client reported that he was "all good" after came back to his home. Client reported that still having paranoid thoughts come and goes, but he stated that he just needed to be positive to the thoughts, felt better now… client stated that he felt safe at home, family was supportive. Client stated that he doesn't want to talk about his strange thoughts, declined the offer of medical review appointment with the psychiatrist. He felt that his GP can manage his medication…"Does the person have command hallucinations?": Client refused to talk in details… client is staying with his partner and 3 years old son

"Immediate action plan": client declined the offer of medical review appointment with psychiatrist at the team, stated that his GP can manage his medications and mental health. Meet client again at 10am on Tuesday 29/05/18 [25B.8] [48.20].

Dr Athavale GP updates notes with hospital discharge information [51A.5]. Sees BS: meds clarified and scripts given, advised will only come to her for depot and for ongoing scripts and monitoring, insight somewhat. States taking medications and in contact with mental health team, with them today. Mood/affect stable: flat blunted affect, poor eye contact, bloods and baseline ECG, review in 2 weeks for results and depot with RN, dose of seroquel XR 300mg tablet changed from 1 in the morning to 1 in the evening [51A.5].

29/05/18 BS did not attend appointment Hills CMHT, Ms Gao rang and left message, case discussed at morning hand over [25.2].

MH progress note: phone called client no answer [25C.12] [48.14].

30/05/18 Musa Lule on call. BS attends with partner and says missed appointment previous day with his case manager, Ms Gao. Ms Gao not available so Mr Lule read Ms Gao's mental health assessment from 22 May then saw BS.

BS said he had self-ceased his oral 10mg Abilify seven days ago when supply from hospital finished, reported hearing distressing voices *[set out in MH progress note below]*…did not consider that he presented a risk to self or others because had insight into his symptoms and no thoughts of harm, however concerned had self-ceased oral medication which was a red flag as it showed non-compliance with treatment. Also concerned possible relapse of symptoms [23.4].

Action plan to discuss with psychiatrist in afternoon, might prescribe emergency medication or PRN until review on 5 June, agreed Hills MHT would increase ongoing contact to and assess mental state, telephone every day, organized earliest available appt for psychiatrist review (5 June) [23.4].

Partner appeared overwhelmed, gave info re support to carers, took partner's phone number as BS often unavailable [23.5].

MH review, Musa Lule Mental Health Clinician: "self-ceased his oral 10mg abilify seven days ago when his seven days supply from hospital finished. Underlying irritability and partner reported today occasionally he gets agitated with minor things at home life fixing Foxtel box. Rebound of symptoms, distressing voices playing "scare tactics on me, telling me I am not well, do not look at people, people are scaring [sic], and people staring at me". Says he is strong enough not to listen to the voices and what they are saying to him. Partner says he is increasingly getting too concerned about her welfare or what his illness is doing to her mentally. Partner says he is also increasingly [more] sensitive than usual and attached to her "gets anxious when I am about to leave him for work". Recently discharged from Hornsby Hospital, BS was admitted voluntarily to Hornsby Hospital on 19/04/18 after reducing his quetiapine dose and developing delusional belief that if he died peacefully in his sleep the world would be saved. Some insight into symptoms. During admission his depot injection, which his partner had been administering – risperdal consta was changed to aripiprazole depot injection and has had one injection so far on 08.04.18 [sic]. His quetiapine dose was also increased. He stabilised, had successful day leaves and he was discharged on 16/05/18…BS contact the centre this morning requesting for a review after he missed his follow up appointment with the team yesterday…assessment of risks: low…lives with his partner and his >10 year old son. Long standing diagnosis of schizophrenia, poor engagement with Community Mental Health Services and recently discharged from Hornsby Hospital…action plan following review discuss with our psychiatrist this afternoon to possibly prescribe some emergency medication or PRN until he is reviewed next week on Tuesday, increase contact with the team and respond in crisis if required [23B.11] [48.16].

Mr Lule understood the Abilify tablets introduced during the Hornsby Hospital admission were to continue: "…reading the discharge summary that was…it did say a seven-day supply. It never said cease the medication after seven days." [TN 24/05/22 33.12].

Dr Wijemanne Karandana-Vidanalage CMO in Hainsworth Ward Cumberland Hospital, typically spends 3 hours per week at Hills Community Centre to see patients discharged from Hainsworth and some patients on Clozapine [20.1].

MH progress note (Dr Karandana-Vidanalage (Registrar)): "Musa discussed this patient with me... recently discharge from the Hornsby Hospital…aripiprazole 10mg mane (patient's mother was told that this is to be

stopped after 7 days, I could not see any documentation in that regard)…according to information his mental state has changed about 7 days after his stopping aripiprazole. He has a doctor's appointment in 6 days. My opinion is to continue aripiprazole 5 mg nocte and 5 mg PRN if necessary. This dose can be changed after medical review [48.14].

Mr Lule spoke to Dr Vidanalage. Said contact with service sporadic, previously said would get a script for medication but instead self-ceased meds 7 days ago [23.5].

Mr Lule aware Dr Vidanalage later wrote script for Abilify 5mg morning and night and Ms Gao contacted mother and partner to discuss collection and dose. Script faxed to Priceline North Parramatta [23.5].

Ms Gao called BS and family for new prescription, no answer from BS so left message. Also called mother to inform of oral medication use, also rang partner who agreed to pick up medication that night from Priceline Chemist Parramatta. She called back later and she said on way to pick up meds [25.2].

MH progress note: …phone called client's mother …to inform the medication changes: abilify 5mg oral medication from tonight. If client still feel unwell, he can add another abilify 5 mg, however the maximum use of abilify is 10mg per day [25D.13] [48.13].

Script 5mg Abilify morning and 5mg PRN night [48.42].

Hornsby Hospital fax discharge summary to Musa Lule [48.51] in response to another fax from him with "urgent request" for discharge summary [49.75].

31/05/18 Ms Gao on call. Called BS and his partner twice but no answer, mother did not answer. Ms Gao wanted follow up re new medication. Contacted Merrylands Acute Care Team to see if they could make after hours follow up contact, declined because he not an acute client [25.2] [25E.14, 16, 17].

MH progress note: Phone called Merrylands [??] acute team intake staff Christon asking for after hour follow up. Case refused by acute team as he stated "client did not present any current suicidal/homicidal thoughts." [25E.17] [48.12].

Phone call client's wife, she stated that client's mood is still not very stable, but believed is manageable. She aware the mental health intake line and agreed to call for help if needed [25E.17] [48.12].

01/06/18 Hills CMHT morning handover meeting. Ms Gao appointed as BS' case manager, attempt call BS but no answer, attempt home visit and not home. Spoke to partner at 4pm, said BS stayed in bed all day fighting with his thoughts. Spoke to BS, reported current auditory hallucinations and paranoid thoughts, male voice asking him to have boxing match with himself. Impression he was stressed with auditory hallucinations and paranoid thoughts but no acute mental health concerns. Asked partner about safety concerns, said would work together on mental issues during weekend, son stayed home only when she was present, when she was at work he went to grandparents. Offered follow up via Acute team but partner declined after saying could manage by themselves [25.3].

MH Progress note: “Phone call to wife, she reported that client is agitated at the moment as he keeps walking around the house, client reported that he is frighting [sic] with his thought, which he stated that there is one male voice asking him to have a boxing match…wife declined the offer of refer client to acute team for the weekend follow up, wife reported that they have a 5.5 years old son. The son will stay at home when mother present but will under the grandparents care when mother out for work…they also aware they can go to hospital by themselves or call 000 for emergency” [25F.24] [48.11].

Ms Gao speaks to TY and to BS during the phone call [TN 25/05/22 53.37]. BS reports what Ms Gao describes a command hallucination/auditory hallucination [TN 25/05/22 54.5-54.15].

Although ACT had previously declined referral, Ms Gao thought ACT might accept request for follow up over weekend because BS expressing auditory/command hallucinations [TN 25/05/22 55.22].

RN Skye Freeman attends family home with Case Manager (Ms Gao) but BS didn’t answer the door [22.2]. Believes BS’ name on the “Crisis Board” often, used to highlight names of clients who require additional support.

02/06/18 JS has JY all day, TY picks him up in the evening [8.4].

03/06/18 JS has JY all day, Sunday and overnight, takes him to school the next day [8.4].

04/06/18
Monday BS and TY attend Hills CMHT for follow up meeting with Ms Gao.

MH Progress note: “client and wife visit centre, see psychologist, Client reported that his thoughts are consistent and they were always up and down. He reported that currently he didn’t hear any voice, but he felt that some thoughts in his brain were trying to control him. He needs continuously concentrate to these thoughts and fight back…client and his wife stated that his mental state is slightly better than last week… limited insight, the client was willing to seek help for his mental illness, but cannot recognise/describe his symptoms clearly. Plan: medical review at 3pm tomorrow” [25G.26] [48.10].

JY with his parents overnight [8.4].

05/06/18
Tuesday JS takes JY to school and picks him up, stays with JS that evening. JS takes him to school the next day [8.4].

BS has depot injection, aripiprazole depot 400mg Dr Tegan Athavale [48.3].

Per Dr Athavale: “flat affect, very difficult to read patient at all consultations, not had bloods as recommended, convinced today to have baseline blood tests to monitor with the depot/antipsychotics” [51A.6].

Dr Lakshmi Kondadasula sees BS at Hills Community Clinic. She first reads note including discharge summary from Hornsby Hospital then Case Manager Zhiwen Gao provided hand over. Told [BS] continuing on Abilify 5 mg for the past week and received his depot same day [21.1].

Ms Gao present for medical review with Dr Kondadasula: BS still having worrying thoughts (wanting to die) and hearing the devil's voice, believed if died peacefully in sleep world would be saved. Denied current auditory hallucinations and no feeling of being controlled by voice, oral medication of some help [25.3].

4:23pm MH Progress note: "note by CMO Dr Lakshmi, seen with wife and case manager. Case manager provided recent events and concerns. 36 year old male living with wife and 5 year old son on DSP. He was admitted to Hornsby Hospital for 4 weeks for relapse of schizophrenia due to non compliance and was discharged on inj abilify depot and Seroquel. [BS] reports he was having worrying thoughts. He says that he was frightened of his thoughts. The thought telling him that he need to end his life peacefully. He was trying to distract himself by sleeping on the bed. Says he was hearing a male voice, says it is devil voice. He believes that he dies peacefully in his sleep the world would be saved. Says he has no thoughts to hurt himself. Says today he had the depot and it made him to feel slightly relaxed…[BS'] partner was worried about his thoughts and contact mental health team and Dr Vidanalage suggested him to continue abilify 5 mg mane… current medications Inj abilify depot 400mg, monthly had his depot today, Seroquel 300mg nocte, abilify 5 mg mane

…slightly preoccupied, frightened, mildly anxious…affect anxious and restricted, NO FTD, bizarre delusional ideas involving devil and religion, denies thought controlling or thought broadcasting, responding to auditory hallucinations a male voice making derogatory comments, denies command hallucinations, denies current suicidal or homicidal thoughts, denies current thoughts to harm himself or plan, feels safe giving guarantee for his safety… schizophrenia with on going psychotic symptoms, low to moderate risk Plan: continue inj abilify depot 400mg, im monthly, cease oral abilify, Seroquel 100mg mane and 300 mg nocte if distressed he can have 100 in the afternoon, says he has 100mg, 300mg at home, partner to monitor compliance case manager to review by week end and to closely monitor MO appointment in 2 weeks…[BS] and his partner informed if he feel suicidal or notice further deterioration advised to present at nearest emergency dept or contact case manager or crisis team…" [25H.30] [48.8].

JS learns BS referring to JY as the devil on multiple occasions [6.4, 7.2]. JS says hard to get information out of TY and later says there was only one occasion TY told her BS said JY was the devil. TY never said anything about being scared of BS doing something physically violent to JY. BS never actually said to JS he thought JY was the devil [8.3]. JS later gives further account where she says she did witness BS saying JY was the devil on 05/06/18 [9.5].

06/06/18
Wednesday JS takes BS to Hornsby Hospital to try and get him a bed [6.4, 7.2].

According to JS, the MH Nurse said there was a "bed block" on the North Shore and no beds available for [voluntary] admission. JS tells nurse had fears for TY, JY and herself. Whilst there BS said "I want to go to heaven, I have not thought about a knife or anything, just want to go peacefully". Left hospital with new medication [7.2] JS says she asks BS in front of nurse "Do you think [JY] is the devil?" and he nods [8.4].

BS and family see RN Naomi Muller, Clinical Nurse Specialist Grade 2 (CNS2). She was alone in the Acute Care Room because of staff shortages, undertaking usual role in acute care team and informally working on in-take [19.5].

BS attends as a "walk in": "…reviewed file prior to seeing him and noticed recent admission to Hornsby Mental Health Unit where his depot had been changed from Risperidone Consta to Abilify 400mg 4/52, from discharge summary aware depot due on 05/06/18" [19.6].

RN Muller asked why attending Palmerston Centre given care transferred to Castle Hill Mental Health Team. Told not happy with their local team and disliked Cumberland Hospital. Asked how she can help [19.6].

Per MH Progress note ACT CNS2 Palmerston Centre Hornsby Hospital: "Centre visit by [BS], his partner and mother today. His mother states they have presented to Hornsby despite living out of area and under the care of Castle Hill team as they have preferred treatment via Hornsby. They advise he was seen at Castle Hill yesterday and had his depot of aripiprazole 400mg IMI yesterday. Phone call to Hills Community Team and spoke with Skye who kindly sent me notes from yesterday's review with CMO Dr Kondadasula… BS reports he is struggling with delusional thoughts regarding the devil and religion, is wanting to go to heaven to be "in a better place." He denies thoughts to harm himself or others, but states he would like to pass away from "relaxing and going into the darkness." … his mother is caring for 5yo son of [BS] – [JY]. Mother and partner worried about impact of mental illness on [JY] – discussed COPMI [Children of Parents with Mental Illness] engagement which they are interested in. Mother made statements such as "how do I sleep at night? I worry that I will wake up and find my grandson dead as [BS] has snapped overnight, do you have children? Do you watch the news and see what happens to people with mental illnesses and what they do to others?" [BS] denies thoughts to harm himself or others, denied having thoughts to harm his son. He did state he finds him annoying at the moment but feels "he is a good boy really."

Partner states she struggles with role of carer for [BS]: "I care for people at work I can't come home and do it." Both mum and partner distressed at role of carers and are at risk of carer burn out. Discussed involving [BS] in NGOs…

MSE…: "Good insight and willing to engage with local treating team. His mother and partner had hoped for a voluntary admission, advised no beds available at Hornsby. Option of waiting in emergency department until a bed was available was discussed but not agreed too. Mother initially saying she will take [BS] to another hospital in Sydney Metro until he got admitted. Eventually all agreed with following plan: medications…request for Hills team to call partner this afternoon and follow up by their team, home visit preferable if can be arranged. Has appointment booked for 19/06 at Hills Clinic, earlier review preferable if can be arranged…phone call to Skye at Hills Clinic and advised of above." [48.49] [50D.86].

Meds Quetiapine 100mg mane, 100mg afternoon (as regular, not PRN), 300mg evening [48.50].

Ms Gao (BS' case manager) on sick leave [25.4].

RN Skye Freeman at Hills CMHT working, short staffed, just Freeman and NUM available, receives phone call late in the morning from Naomi at Hornsby MH Clinic [22.2].

11:39am MH Progress note Hills CMT: "PC from Naomi, Hornsby Hospital, Client presented to hospital with wife and mother. Family seeking an admission due to his ongoing belief that he should die in his sleep and the world will be saved. Client not wanting admission and guaranteeing of his safety. …Naomi will call me back later with an outcome" [48.8].

RN Freeman recalls RN Muller saying mother and family concerned he had belief that he should die in his sleep, if she sent him home could we see him that day, RN Freeman said short staffed and could not guarantee could see him at home. Advised difficulty seeing him as wouldn't answer door previously, asked about home visit by after hours team that evening. Said couldn't guarantee (previous week had tried to refer BS to after hours team and they refused to take the referral), could try home visit following day, recalls saying he had self-presented to their hospital for a reason and he should be assessed by their service [22.3].

RN Muller rang Acute Mental Health Unit (AMHU) and Mental Health Intensive Care Unit (MHICU) and enquired about a bed.No beds available and unsure of pending discharges, could see 4 patients in the PECC, no one in emergency awaiting a MH bed [19.7].

RN Muller returned to speak to BS and family and said no beds currently available. BS' mother said she would take BS to another Hospital in Sydney metropolitan region, BS restless and asked to leave the room [19.10]. RN Muller concluded did not meet criteria for involuntary admission, option to go to ED and wait for MH bed, BS came back in and offered option wait in ED and he declined [19.7]. Said he was upset that his family were so concerned and that he was upsetting his mother [19.7].

When asked why not allow home visits by treating team he said he liked to go for walks and may not have been at home. Partner says in fact spends days laying in bed, long term issues part of mental illness [19.7].

Plan for medication as per doctor's plan from assessment previous day: Quetiapine 100mg morning and 300mg night time, option of 100mg PRN in the afternoon, Doctor had said if not respond well to Abilify depot option of changing depot to Invega [19.12].

RN Muller said would request an earlier than planned review by local team and encourage afternoon PRN dose of Quetiapine taken regularly (thought she was simply reinforcing Dr Kondadasula's recommendation) [19.12]. Said would recommend home visit the next day and phone call follow up that afternoon (so partner would be there to take the call) [19.12].

RN Muller said BS' partner agreed to plan she would return home with BS and their child remain with BS' mother, partner receive follow up phone call that afternoon to arrange home visit the next day [19.13].

12:52pm MH Progress note: Further PC from Naomi from Hornsby Hospital. Client not admitted, recommend PC in the PM [48.7].

Later call RN Muller to RN Freeman: told not being admitted and should give a call this afternoon, had offered a voluntary admission but long wait in ED and BS had declined [22.4].

RN Freeman discuss with Wayne Hunt [NUM] who said he would follow up [22.4].

NUM Wayne Hunt called wife at 1542. Said was having dinner and call back in 20 minutes time. 1613 called back and told just taken meds, PRN meds as advised by Hornsby Hospital. Settled better than before, offered appointment next day, wife said BS take himself as she had to work [24.2].

4:13pm MH Progress note: "Phone call to clients wife [TY] advised that client has just taken PRN medication as advised by Hornsby Hospital and has settled him better than before. Offered an appointment at 11am tomorrow…wife has to work tomorrow.

Plan: CM to see in clinic tomorrow at 11am" [48.6].

07/06/18
Thursday Ms Gao on sick leave [25.4].

JS takes TY to work, whilst BS watches JY. When JS returns to take JY to school she "… told him to give his dad a kiss good buy [sic]. [BS] gave [JY] the biggest smile and hug I had seen in a long time. It immediately made me feel that [BS] was starting to get better …" [8.4].

BS attends appointment Hills CMH with Wayne Hunt, about 40-minute interview [24.3].

Attempted call wife after appointment but phone rang out [24.3].

MH progress note: "Client seen in clinic for 11am appointment re follow up from presentation to Hornsby Hospital on 06/06/18. Client lives with his wife [TY] and 5 year old son, says his mother assists with his care during the day whilst his wife is at work. Says his son is safe. Given history of presenting to Hornsby Hospital yesterday and not admitted, says he wanted to be admitted but his wife and mother did not…MSE…

Plan: see MO notes 05/06/18 request to closely monitor, suggest H/V f/u by CM 08/06/2018…f/u phone call to wife to advise of clients visit for appt" [48.5].

08/06/18
Friday JY dies.

JS gets to family home about 6:30am.

When JS arrives to collect TY, TY says "he has not slept all night" [7.2].

JS takes TY to work, asks if BS will look after JY and said he would be fine. When JS returns a little after 7am BS still in bed, JS looks for JY and notices black stuff on the floor of the bedroom (JY sleeping on mattress in bedroom with his parents). JY face down on floor about 1 m away from mattress, JS sees knife on bedside table covered in blood, rolls JY over and sees multiple stab

wounds. Carries him to car, calls 000 and attempts drive to hospital, later stops on road and commences CPR whilst waiting for ambulance [6.5].

When JS discovers JY, she says “my god what have you done?” BS calmly says “I will open the door for you”, closes the door behind JS as she leaves with JY [7.4].

7:10am Per Ambulance EMR call received [35A.6].

7:13am Ambulance dispatched and en route [35A.6].

7:20am Ambulance on scene [35A.6].

8:02am JY pronounced life extinct at Westmead Children’s Hospital [1.3].

Asystolic traumatic cardiac arrest, multiple stab wounds to trunk [2.1].

Constable Jenna Hams on scene with JS. JS tells Hams: “He killed him. I shouldn’t have left him. I was gone two minutes.” “He’ll go to jail for this. I begged him. I begged him. I killed my grandson. He killed him.” “You know what my sick boy said, ‘I’ll open the door’ as I’m running out the door.” “He thought he was the devil. I should have said.” “She says ‘Mum, you go quick cause I’m worried” so I flew back and I get him and there’s [BS] in bed and [JY] on the floor dead.” [41.2].

When Police attend family home BS arrested without incident, tells police “I murdered my son...with a knife” [6.10].

10:00am Entry into MH progress note “case discussed in the morning meeting. Plan: home visit today as per Dr Lakshmi’s note” [48.5].

12/06/18 Autopsy report: direct cause of death multiple stab wounds.

24/07/19 Judgment of Hidden AJ – not guilty by reason of mental illness [46.1].

Draws from statement of agreed facts and recorded interview:

Police attended the accused’s home…there he said to police “I just murdered my son, I feel sick. I thought my son was the devil, well no, I know he is, but he’s dead now. Well I think he is. I thought I could save the world, well no, I know I can save the world. I can.” [46.6].

In the recorded interview, the accused provided a graphic description of the manner in which he killed the child… He reiterated his belief that the child was the devil, and described himself as the Messiah. He said that the child was ‘trying to tear my soul apart.’ Later in the interview he said ‘I knew it was the right thing to do but…I didn’t know how much time we had…I didn’t know how much time till Doomsday.’ [46.6].

Dr Olav Nielssen report refers to BS having long standing diagnosis of schizophrenia: “…in its typical from is a neurodegenerative disorder affecting the frontal lobes of the brain…deprived of the capacity to recognize that his actions were wrong, because of the effect of the delusional belief that his son was the devil, and that somehow by his killing his son he would ascend into heaven” [46.7].

Dr Adam Martin report refers to BS' motivation directly connected to his disordered belief system… had been experiencing sustained thoughts of his son being the Devil and of needing to kill him and go to Heaven, and believing that he would be reassembled by God. The offending occurred in direct nexus to delusional thinking…. schizophrenia not adequately managed by anti-psychotic treatment [46.8].