CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Simon Myles Mackay
Hearing dates:	10 November 2025-13 November 2025
Date of findings:	19 June 2026
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Judge Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – involuntary psychiatric patient – hanging – death intentionally self-inflicted
File number:	2022/00221112
Representation:	W de Mars, Counsel Assisting the Coroner, instructed by R Muniz, Crown Solicitor's Office B Bradley, instructed by K Hinchcliffe of Makinson d'Apice Lawyers for the Northern Sydney Local Health District S Barnes instructed by J Kamaras of Avant Law for Dr Amanda Bray and Dr Deepthi Darapaneni
Non publication order:	A non-publication order has been made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) in relation to parts of the brief of evidence.
Findings:	**The identity of the deceased** The person who died was Simon Myles Mackay **Date of death** Simon died on 27 July 2022 **Place of death** Simon died at Royal North Shore Hospital, St Leonards, NSW 2065 **Cause of death** Simon died of neck compression and the complications thereof **Manner of death** Simon died as a result of an attempted hanging which was intentionally self-inflicted while he was an involuntary patient in the Mental Health Inpatient Unit of Royal North Shore Hospital.

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1 Introduction

1.1 Simon Mackay died on 27 July 2022 in the Intensive Care Unit (**ICU**) at Royal North Shore Hospital (**RNSH**). He was 37 years old.

1.2 Fifteen days earlier, on 12 July 2022, Simon had been admitted as an involuntary patient to the High Dependency Unit (**HDU**) in the Mental Health Inpatient Unit (**MHIU**) at RNSH. On 21 July 2022, while still an involuntary patent, Simon attempted to take his own life. He was found in his room, having suspended himself with a sheet from the bathroom door. He was able to be revived but never regained consciousness prior to a decision being made on 27 July to cease life support measures.

1.3 Although Simon's mental illness could make him challenging when he was unwell, this was not the *real* Simon. His friends and family remember him as someone who loved to be around others and who enjoyed having a good time. His mother described Simon as a wonderful son, brother, uncle and father. He was also an organ donor. Simon's generosity in donating his organs changed the lives of three individuals, one of whom had written to Simon's family just before the inquest thanking them, and Simon, for what was described as *the best gift I could ever receive in life.*

1.4 In making these findings, I acknowledge the profound impact that Simon's death has had, and will continue to have, on his family and friends and on behalf of the Coroners Court of NSW, I extend to them my sympathies for their loss.

2 Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death. A secondary function of a coroner is to, when considered necessary or desirable, make recommendations, arising from the evidence, in relation to any matter connected with the death.

2.2 In NSW, a death that occurs while a person is in, or temporarily absent from, a declared mental health facility is a reportable death pursuant to section 6 of the Act. It has long been accepted that the *rationale for singling out the deaths of psychiatrically unwell people who*

die while involuntary patients is that they constitute an especially vulnerable group within the community who are deprived of many of their rights through no fault of their own, but because of their symptoms.[1] A coronial investigation into the death of such individuals is conducted in order to ensure transparency and accountability in relation to the care and treatment provided to involuntary patients, due to the barriers such patients often experience in advocating for themselves.

2.3 A wide range of material was obtained during the coronial investigation, including records of Simon's treatment over the 12 months preceding his death, both in hospital settings and in the community. This material was tendered at the commencement of the inquest in the form of a five-volume brief of evidence. There was no factual dispute in relation to the circumstances leading to Simon's attempt to take his own life and many of the issues that the coronial investigation explored had been satisfactorily answered by the time of the inquest. For this reason, not all the witnesses who provided statements were required to give evidence.

2.4 An issues list was developed to guide the coronial investigation and the conduct of the inquest. These issues were:

1. *In relation to Mr Mackay's treatment as an inpatient from 12 July to 21 July 2022, was that treatment appropriate and in particular:*
    - a. *Was it appropriate for him to remain as an involuntary patient throughout that period?*
    - b. *What was the nature of any "treatment plan"?*
    - c. *Was the use of medications appropriate?*
    - d. *Was any risk of self-harm adequately recognised and were observation levels appropriate and complied with?*
    - e. *With specific reference to Mr Mackay's engagement with clinicians on 21 July 2022, was the clinical engagement with Mr Mackay adequate and appropriate?*
    - f. *Could Simon's self-inflicted hanging be prevented?*

[1] *Death Investigation and the Coroner's Inquest*, Freckelton. I and Ranson D, Oxford University Press, 2006, p 17.

2. *Is it likely that Simon Mackay had access to and ingested cannabis while an inpatient during the period from 12 to 21 July 2022, and if so did this affect his mental state on 21 July 2022?*

3. *Was the time taken for a medical officer to assist in response to the Code Blue on 21 July 2022 in compliance with relevant policy and procedure?*

4. *Since Mr Mackay's death, has any action been taken in relation to identifying and modifying potential ligature points in patient rooms in the Mental Health Inpatient Unit?*

5. *What, if any changes to policy, practice or staff training have occurred, arising out of the incident that occurred on 21 July 2022 and any aspects of Mr Mackay's clinical care over the period from 12 to 21 July 2022 that led up to that event?*

6. *What, if any, recommendation(s) should be made in relation to any matter connected with Mr Mackay's death?*

2.5 In Simon's case, there was no controversy in relation to the identity, date, place, cause, and manner of his death. Instead, the focus of the inquest was on the adequacy of the care and treatment Simon received while he was an involuntary patient at RNSH between 12 July 2022 and 21 July 2022. Although I don't propose to address each of the issues in the issues list discretely, all are covered under the broad headings below.

2.6 Counsel assisting provided a succinct summary of the evidence in this matter in his very comprehensive opening and closing submissions. In preparing these findings I have relied heavily on his submissions which, in my view, accurately reflect the evidence contained in the coronial brief of evidence and the oral evidence given by the witnesses called during the inquest.

3 Simon's life

3.1 While any inquest inevitably focuses on the circumstances of a death, it is important to recognise and acknowledge the life of the person the subject of the inquest in a brief and hopefully meaningful way, to appreciate what their life, and their loss, meant to those who knew and loved them.

3.2 Simon was born at Sutherland Hospital in 1984. He was a brother to Amy and stepbrother to Jemma and Cassie. Simon was a talented and hard-working chef for much of his adult

life. He had worked in some of Sydney's most well-known restaurants, as well as various restaurants in Europe and as a private chef on cruise ships in the Mediterranean Sea.

3.3 Simon married a woman he met in France. The couple subsequently had a son, Yves. Sadly, the marriage lasted only 18 months and after Simon and his wife separated, she returned to France with Yves. Simon stayed in contact with his son although his separation from Yves was clearly at times a source of great sadness for Simon. Yves was aged 12 at the time of Simon's death. Simon's mother, Julie, and family continue to maintain a close relationship with Yves and his mother.

4 Simon's mental health

4.1 Simon began using illicit drugs as a teenager and unfortunately struggled with addiction for significant periods of his adult life. Simon's addiction resulted in involvement with the legal system and interpersonal conflict with family members. By 2020 he was beginning to experience significant episodes of paranoia associated with his drug use, which resulted in periods of admission to hospital.

4.2 It was when Simon was admitted to St Vincent's Hospital in Sydney in September 2020 that it was first noted that Simon suffered symptoms of psychosis.

Concord Hospital: August 2021-September 2021

4.3 Simon was admitted to Concord Hospital Mental Health Unit on 31 August 2021 after police brought him to Royal Prince Alfred Hospital (**RPAH**) the day before. He had been found wandering the streets in Glebe while openly carrying a knife. Simon was expressing paranoid ideation and was described as hostile and uncooperative towards clinical staff. He was admitted as an involuntary patient. While at the hospital he was commenced on medication including an antipsychotic injection.

4.4 On 28 September 2021, following a hearing before the Mental Health Review Tribunal (**MHRT**), Simon was released on a 6-month Community Treatment Order (**CTO**). His Treatment Plan was managed by psychologist, Dylan Lane, of the Lower North Shore Acute Care Team of North Shore Ryde Mental Health Service (**NSRMHS**). He was prescribed a monthly injection of 100mg of Paliperidone.

Treatment in the community: September 2021 onwards

4.5 After his discharge from Concord Hospital, Simon moved into boarding house accommodation in McMahon's Point.

4.6 Simon first attended the NSRMHS on 5 October 2021. He was reviewed by Psychiatry Registrar, Dr Alexandria Campbell, who recorded that Simon had ongoing problems with addiction from the age of 15. The doctor noted her impression as:

> *Primary drug addiction and mis-use*
>
> *Psychosis and*
>
> *Cluster b personality traits*

4.7 At that stage Dr Campbell noted that Simon appeared to have good insight into his illness, was currently well, and recognised the importance of continuing treatment. Simon's treatment plan was to recommence on Sertraline medication, continue with his monthly Paliperidone injections, and it was recommended that he be reviewed by the Drug and Alcohol Service. In his oral evidence, Mr Lane explained that although staff of the NSRMHS could have assisted Simon with making an appointment with the Drug and Alcohol Service, this would have required Simon's consent and motivation on his part to engage with the service.

4.8 In compliance with the conditions of the CTO, Simon attended the Community Mental Health Centre (**CMHC**) for his monthly Paliperidone injection in October, November and December 2021.

4.9 On 29 December 2021, Simon was reviewed by a Psychiatrist Dr David Bell. Simon's mental state was noted as stable and it was observed that he was in frequent contact with his mother. He had relapsed a week prior by taking ice and continued to use cannabis, but in moderation. He had stopped taking sertraline. Dr Bell considered that Simon was showing some insight into his circumstances, but he noted a robotic quality to Simon's speech and queried the sustainability of his present mental state. The documented plan was for Simon to keep receiving support from his case manager and for there to be a future reduction in his monthly Paliperidone medication from 100mg to 75mg.

4.10 Simon attended the CMHC for his Paliperidone injections in January and February 2022. On 22 February 2022 he was reviewed by Psychiatrist Dr Jeremy Resnick. At the review Simon

was observed to be affected by cannabis, but he indicated that he never intended to give up cannabis use. Dr Resnick reported that Simon was working hard as a chef. He considered that there was no *mental state abnormality*. The plan remained to reduce the Paliperidone due on 7 March to 75mg, with a view to potentially reducing it further to 50mg in May. Dr Resnick noted that as Simon reported that he wanted to stay in touch with the Acute Care Team, it did not seem necessary to consider extending the CTO, which was due to expire on 27 March 2022.

4.11 Simon attended for his Paliperidone injection on 7 March at the 75mg level.

Brief hospital admission: March 2022

4.12 On 24 March 2022 Simon was taken to RNSH by ambulance. He had consumed a large quantity of alcohol 48 hours earlier and *admitted to injecting ice* four days prior. He complained of cyclical vomiting and being unable to tolerate oral intake. He was not considered to be mentally unwell and was discharged on 25 March after one night.

Further treatment in the community March 2022 onwards

4.13 On 28 March 2022 Psychiatry Registrar Dr Bonnie Tse from the NSRMHS conducted a further medical review of Simon. He was noted to have a previous history of suicidal ideation. He was upset that he had recently relapsed into using ice. It was also observed that his CTO had lapsed. The plan was for continuation of the Paliperidone injection at 75mg dosage and monitoring of Simon's mental state in the context of his *substance relapse*. Simon declined a drug and alcohol review.

4.14 Simon again attended the CMHC for administration of his Paliperidone injection on 4 April, 9 May, and 15 June 2022. On the last occasion, the nurse observed Simon to be dishevelled, highly distressed and agitated. Simon reported that he was *not doing well*. Mr Lane suspected that Simon had relapsed into drug use and staff tried to convince Simon (without success) to let them take him to the Emergency Department (**ED**).

Brief hospital admission: June 2022

4.15 Simon was admitted to RNSH from 19 to 21 June 2022. This came about after his mother, Julie, received a text message from Simon suggesting he was suicidal: *I can't do this anymore, Mum*. Julie contacted the NSRMHS and a psychologist and police attended Simon's address in McMahon's Point and conveyed him to hospital.

4.16 At the hospital Simon denied being suicidal. He reported recent use of ice, heroin and GHB. He was noted to be irritable and hostile, and demanding to be discharged. He was initially kept at the hospital on an involuntary basis, as a mentally disordered person. Upon review on 21 June, it was observed that Simon was settled in his mental state and that stressors around his accommodation had resolved. On discharge there was no evidence of ongoing suicidal ideation. He was discharged for follow-up by his case manager and it was suggested that he discuss Drug and Alcohol Service input with his case manager. It was arranged that a social worker would assist Simon in advocating with Simon's employer.

4.17 Appropriately, Mr Lane, and other clinicians maintained contact with Simon following his discharge from RNSH on 21 June 2022. Simon gave some indication that his circumstances were improving. Mr Lane continued to encourage Simon to engage with the Drug and Alcohol Service and Simon expressed a willingness to do so. However, at review on 1 July 2022 with Psychiatry Registrar Dr Yin Wai Jaclyn Lam, Simon said that he was continuing to use ice. He was noted to be anxious and exhibited some paranoia.

5 Simon's admission to the Mental Health Inpatient Unit (MHIU): 12 July 2022

5.1 On 11 July 2022, Julie spoke to Simon after she had received text messages from him which suggested he was upset about his life circumstances. Julie describes Simon as sounding *a bit out of it* during a subsequent call.

5.2 On 12 July Simon did not attend the CMHC during the morning for his routine monthly Paliperidone injection. Mr Lane phoned Simon. He noted that Simon sounded distressed and guarded. Simon told Mr Lane that he was *in a bit of trouble*. Mr Lane encouraged Simon to attend the CMHC for his injection, and he informed the Psychiatry Registrar on duty, Dr Lam, that he was concerned about Simon's mental state.

5.3 Simon attended the CMHC at about 1:00pm on 12 July. He was reviewed by Dr Lam and was administered a 100mg paliperidone injection. During the review, Simon admitted to recent illicit drug use. He was displaying extreme levels of paranoia, and was very loud, disruptive and distressed. Dr Lam was of the view that Simon was at high risk of harm to himself and others. It became necessary for security staff and police to convey Simon to the ED of RNSH.

5.4 Dr Lam's view that Simon required inpatient management to contain a safety risk was discussed with and endorsed by the on-call community psychiatrist, Dr Mark Yates. Mr Lane contacted Julie and advised her of Simon's circumstances.

5.5 Simon was triaged in the ED at 1:40pm. During the afternoon he was reviewed by the ED Psychiatry Junior Medical Officer, Dr Jonathan Smithson. Dr Smithson also reviewed a range of past clinical notes and discussed Simon's circumstances with two duty consultant Psychiatrists. A decision was subsequently made to admit Simon as an involuntary mental health inpatient to the MHIU. A provisional diagnosis of methamphetamine-induced psychosis was made. In addition to the risk of harm to Simon and or to others posed by Simon's psychosis, a risk associated with withdrawal from GHB was also noted.

5.6 Dr Smithson completed a *Form 1* document for the purposes of Simon's continued detention under the Mental Health Act (**MHA**). The basis for Simon's continued detention stated on the form was *psychotic, may harm others due to paranoia*.

5.7 Simon was to be monitored every two hours in relation to withdrawal symptoms and his medications were charted. These included daily olanzapine, a continuation of his monthly Paliperidone injection, next due on 9 August 2022, and other medications to manage Simon's ongoing severe symptoms, to be administered on an *as needed* basis, namely Droperidol, Accuphase, Lorazepam and Diazepam.

5.8 Simon was admitted to the HDU of the MHIU at 7:05pm. A mental health admission note was completed by a nurse at 7:38pm, which stated Simon's acuity as *level 3*, requiring observations every half hour.

6 Care and treatment in the MHIU leading up to 21 July

6.1 On 13 July Simon was reviewed by a Psychiatry Registrar, Dr Matthew Lennon, and Psychiatrist Dr Resnick. Dr Resnick completed a second *Form 1* authorising Simon's continued detention for reasons similar to those articulated by Dr Smithson.

6.2 Simon was admitted to the MHIU under the care of consultant Psychiatrist Dr Amanda Bray. Dr Bray was assisted by Dr Deepthi Darapaneni, who was, in July 2022 an Unaccredited Psychiatry Registrar (also known as a Junior Medical Officer, or JMO). By the time of the inquest, Dr Darapaneni had been accredited as a Psychiatry Registrar.

6.3 On 14 July Dr Bray noted that an opinion had been received from Dr Shane Woods of Addiction Psychiatry that Simon did not show signs of GHB withdrawal. Dr Bray noted that:

> *He was given accuphase and then droperidol, as well as 6mg in total of IM lorazepam today with little immediate effect, and this could be due to his level of activation and his acquired tolerance to sedatives. Simon continues to refuse physical obs, but if he does go to sleep as a result of this last dose of medication, he should have his respiratory rate checked regularly. Level 2 obs.*

6.4 Following this assessment, Dr Darapaneni, in consultation with Dr Bray, determined that Simon's observation level should be increased from Level 3 to Level 2. This meant that Simon was to be observed at 15-minute rather than 30-minute intervals. This was, as Dr Darapaneni explained in her oral evidence, because Simon's agitation and aggression suggested he posed a risk to himself and others, and because the medication he had been prescribed had a sedative effect and for this reason his breathing needed to be closely monitored.

6.5 A nursing shift summary on the evening of 14 July by Registered Nurse (**RN**) Agius noted that it was difficult to manage Simon in the environment of the inpatient unit:

> *… Simon became verbally rude and threatening, throwing the fruit given to him at the nurse's station. Banging loudly at nursing station for a haircut and his mobile phone (his mobile was still in his room). Sitting outside the nurse's station using his mobile, intermittently headbanging. Threatening to assault staff with a taser because we were unable to provide him with custard. Discussion with AHNUM and AH psychiatry, his nocte 2mg lorazepam was given.*

6.6 Dr Bray's consultant review conducted at 11.30am on 15 July noted as follows:

> *Simon remains abusive and angry today, though slightly sedated after accuphase 150mg yesterday.*
>
> *Still no tremor or subjective sensation of GHB withdrawal.*
>
> *Still maintains the police are stalking him.*
>
> *Cries, shouts, angrily demands that I see him but then just swears at me.*

Dr Bray completed a third *Form 1*, in similar terms to those previously completed by Dr Smithson and Dr Resnick.

6.7 Dr Darapaneni reviewed Simon on 17 July. Her impression was that he appeared more settled than when she had seen him on 14 July, although this was in the context of him having been administered sedating medications. She considered that Simon should remain an involuntary patient under the Mental Health Act, that level 2 observations were to continue and that in accordance with Dr Bray's plan recorded on 15 July 2022, there should be a low threshold for the administration of sedating drugs if Simon displayed increased agitation.

6.8 On 18 July Dr Darapaneni determined that Simon's observation level could be reduced to Level 3, requiring observations at 30-minute intervals. This was in the context of a reduction in the level of sedating medication and a perception that although Simon remained agitated and irritable, he was less so than he had been in previous reviews.

6.9 The nursing shift summary prepared at 8:08pm on 18 July by RN McPherson observed that upon being given his evening medications, Simon was observed to be teary. He indicated that he was upset in connection with a phone call he had had with his mother. He would not go into further detail and denied thoughts of self-harm. He was encouraged to speak to nursing staff if he experienced further distressing thoughts.

6.10 In a statement made by RN Gough, she states that on 19 July she thought Simon was of low mood and remained isolative. He reported being upset because of a phone conversation and reported distressing thoughts and anxiety. However, he denied having thoughts of self-harm.

6.11 On 19 July, Dr Bray and Dr Darapaneni again saw Simon. Dr Darapaneni's impression was that Simon appeared more settled and was engaging better than he had previously. He continued to appear irritable and was requesting to go home/be discharged from the hospital, which indicated to her that he had little to no insight into his need for the hospital admission. Dr Bray formulated a plan that included administration of Olanzapine, an antipsychotic, 5 mg in the morning and at midday each day with no *as needed* Lorazepam.

6.12 On 20 July Simon asked to be seen by the treating team. After nursing staff consulted with the Psychiatry Registrar, Simon was told that he would not be reviewed that day. That evening Simon told RN Wong that he wanted to *get the fuck out of here* and was wanting to speak to the doctors the following day.

7 Events on 21 July 2022

7.1 On the morning of 21 July, RN Gough recalls that Simon was waiting in the lounge area for his medical review. He asked her when the doctor was coming and whether he would be discharged that day. She recalls Simon being *more reactive, less hostile and more willing to talk and engage with staff that morning*. At 11:30am Simon told his mother, by phone, that he was waiting to see a doctor, and that he wanted to go home. Julie describes Simon as sounding calm during this phone call and that he was easy to speak with.

7.2 It appears that a nursing shift handover meeting commenced at 1:30pm. Nurse Team Leader RN Sunil Thapa recalls being told by a nurse at the handover that Simon was asking for leave and for discharge, and that he had been a bit sad after a conversation with his mother. He also recalls being told that Simon had guaranteed his safety and remained suitable for level 3 observations.

7.3 Between 2:14 and 2:22pm, Dr Bray and Dr Darapaneni conducted a review with Simon in the courtyard area of the HDU. RN Simon Nugent was also present at the review. During this review Simon was *[a]dvised he needs to stay in hospital for at least few weeks until he gets better*.

7.4 Nurse Unit Manager Lauren Ashe recalls being told by RN Nugent that Simon was upset following the review because he had wanted to be discharged, and that he had wanted to phone a friend, and went to his room for that purpose.

7.5 RN Thapa's oral evidence was that he conducted the 2:30pm observation round, at which time he observed Simon in the courtyard using his mobile phone. However, CCTV footage of the courtyard area suggests that although Simon had one hand to his head, he was not using a mobile phone. After making this observation RN Thapa says that he had a discussion with RN Nugent about Simon, during which RN Nugent told him that Simon was frustrated at the denial of his discharge request. RN Thapa says that he suggested to RN Nugent that he *keep an eye on Simon*. In his oral evidence, RN Thapa suggested that the reason he suggested this was because of the possibility that Simon may engage in impulsive behaviour after being denied discharge. His intention was that if any change in Simon's behaviour was observed that there may need to be some change in the frequency of observations.

7.6 CCTV footage shows Simon leaving the courtyard, entering his room and closing his door at 2:36pm. At 2:43pm RN Nugent is captured on CCTV walking briefly up to the door of Simon's room, although the door is not opened.

7.7 At 2:57pm RN Gough is captured on CCTV entering Simon's room, at which time she discovers him hanging from the bathroom door.

8 The Emergency Response

8.1 RN Gough activated the duress alarm and promptly sought the assistance of other nurses who were nearby at the nurses' station to lift Simon and remove the ligature.

8.2 Nursing staff promptly commenced cardiopulmonary resuscitation (**CPR**) and attached a defibrillator to Simon which did not detect any heart rhythm.

8.3 CPR by nursing staff continued until a *Code Blue* team arrived on scene at 3:05pm and took over the emergency response. A return of spontaneous circulation was achieved at 3:17pm and Simon was transferred to the ED at 3:27pm.

9 Simon's admission to the ICU: 21 to 27 July 2022

9.1 During the afternoon Dr Bray contacted Julie to inform her of what had occurred.

9.2 Simon was admitted to the ICU at 6.14pm on 21 July 2022.

9.3 At a family meeting with ICU clinicians on 22 July, it appears that the gravity of Simon's condition and the extent of his injuries were explained and that the plan was to monitor Simon for a further 72 hours. Sadly, Simon's condition did not improve over this period and following a further family meeting, Simon's life support was removed on the afternoon of 27 July, and he underwent an organ donation procedure.

10 Autopsy and Expert Evidence

10.1 On 1 August 2022, Forensic Pathologist Dr Sairita Maistry conducted an external autopsy. She recorded Simon's cause of death as *neck compression and complications thereof*.

10.2 Toxicological analysis of the postmortem blood sample detected the presence of the drugs GHB and Tetrahydrocannabinol (**THC**) (consistent with cannabis use). By contrast, an ante-mortem blood sample taken in the ICU on 22 July did not indicate the presence of GHB.

10.3 Expert toxicologist Professor Alison Jones concluded that the GHB detected in Simon's postmortem sample was most likely the product of endogenous production within the body, a phenomenon known to occur amongst individuals who have previously used the substance, and that it was therefore unlikely to be indicative of Simon using GHB while at the RNSH.

10.4 By contrast, Professor Jones concluded that it seemed likely that exposure to *cannabis* occurred sometime during Simon's admission at MHIU, sometime between 12 and 21 July. However, she was unable to determine exactly when, during Simon's admission as an involuntary patient, this exposure occurred.

11 The appropriateness of the care and treatment given to Simon during his admission to the MHIU

Was it appropriate for Simon to remain an involuntary patient during the period he was in the MHIU?

11.1 Simon had a history of psychotic illness characterised by persecutory delusions, disorganised thought and behaviour, irritability, aggression, agitation and impaired judgment. On 12 July 2022 when Simon presented to the ED at RNSH, Dr Smithson documented that he was intensely paranoid, believed people were following him, and that he was in fear of harm and referred to weapons. Dr Smithson diagnosed Simon as having a substance-induced psychotic disorder and assessed him as being at risk of harm to himself and others. In view of this, his detention for treatment under the MHA was appropriate. Simon continued to be assessed as being a risk to himself and others when he was reviewed by other clinicians over the following week.

11.2 Consultant Forensic and Adult Psychiatrist, Associate Professor Danny Sullivan, was engaged as an expert to provide an opinion in relation to Simon's care and treatment while in the MHIU. Associate Professor Sullivan agreed with Dr Smithson's assessment that Simon was suffering from substance-induced psychotic disorder during his admission to the MHIU. Simon would also have met a diagnosis of severe substance-use disorder involving cannabis, stimulants, opioids, benzodiazepines and GHB. In his oral evidence, Associate Professor Sullivan explained that:

> *…the symptoms of a substance-induced psychotic disorder generally involve delusions and hallucinations. They involve disorganisation of behaviour of thought and of*

speech. When a person is making irrational decisions and poses a risk to themselves or to other people because of those symptoms, they satisfy the criteria under mental health legislation for admission.

11.3 Associate Professor Sullivan considered that there was clear evidence of signs of improvement in Simon's mental state from around 18 July. However, in his oral evidence, Associate Professor Sullivan noted that:

> *…the improvement of a couple of days is fairly limited in the, in the scope of the trajectory of a person's life, so there are two aspects. The first is that Simon had a history of telling the staff the things they wanted to hear to get released. He was very clear that he wanted to be released at all times. And the second is that between admission on the 12 and the assessment on the 21st, that's a really short period of time during an episode of psychosis.*

He added

> *So one or two days of settled behaviour really doesn't reassure anyone that the treatment has taken effect, that the symptoms are stable, that there's a level of insight, or that his mental state has improved sufficiently to release someone.*

11.4 Associate Professor Sullivan's view was that the treating team had no option but to treat Simon as an involuntary patient during the period of his admission to the MHIU. In his view:

> *[Simon] remained psychotic, and on 21 July, showed limited insight into the basis of his admission and the risks to others that his divisional[2] beliefs might pose. Had he been rendered voluntary, it is almost certain that he would have departed the unit immediately. Consequently, one can speculate that the admission would then have been of limited benefit and he would have required readmission soon thereafter due to ongoing psychosis.*

11.5 Conclusion

- Although the evidence suggests that by 18 July 2022 there had been some improvement in Simon's mental state, there is no evidence to suggest that as of 21 July Simon was no longer mentally ill, such that he should not have continued to be detained as an involuntary patient.

[2] This appears to be a transcript error. The word used was likely 'delusional'.

- I accept Associate Professor Sullivan's assessment as to the appropriateness of Simon being detained as an involuntary patient during the period of his admission to the MHIU between 12 July and 21 July 2022.

Was there an appropriate treatment plan in place?

11.6 Simon's treatment plan up until 21 July was limited to ongoing reviews and the giving of medications, in large part, aimed at calming his behaviour and resolving his psychosis. It also involved visual observations being undertaken at regular intervals.

11.7 In her oral evidence, Dr Bray explained that as of 21 July, Simon was just starting to turn a corner and was beginning to talk to his treating team. She explained that the treatment of a patient who is as unwell as Simon can take time. In her view, looking at the trajectory of Simon's recovery, he had only got to the stage of hiding his delusions, and of saying during reviews, what he thought his treating clinicians wanted to hear.

11.8 Dr Bray explained that she also wanted Simon to meaningfully engage drug and alcohol support, potentially in the form of inpatient rehabilitation, as Simon had indicated that he might be willing to consider changing his drug habits. Her belief was that that was the only thing that would have really helped in the long term. In the opinions of both Dr Bray and Dr Darapaneni, Simon was not yet at a point when he could have participated in formulating a plan with drug and alcohol or other services.

11.9 Associate Professor Sullivan's evidence was that Simon had not yet reached a point where a treatment plan could develop very far. He observed that initially Simon's unwillingness to engage made such planning difficult. He said:

> *What I saw from my review of the clinical records beginning on 12 July was that the initial focus was upon control of agitated and aggressive behaviour and maintenance in a secure environment while medication took effect, and while drugs came out of Simon's system. So that's quite appropriate. And then at the, at the sort of midpoint of, of an admission is when you're beginning to think about, "Where to from here?"*

And further:

> *…it's quite typical that the patient is saying, "I want to be out of here immediately", that the medication may not have been consolidated, or may not have really had the opportunity to take full effect, and there are a range of psychosocial issues which can be quite destabilising on a person's discharge from the unit. So at that stage, in the*

first or second - at the end of the first week, during the second week of an admission, you're really thinking about a range of ways that the person's trajectory will resolve.

11.10 Associate Professor Sullivan's evidence was that a more comprehensive plan with a longer-term trajectory would usually take place in the context of a longer discussion with the multi-disciplinary team rather than in the context of a brief review by the treating consultant and registrar.

11.11 In the view of Associate Professor Sullivan, *the treatment plan was appropriate because it required stabilisation of [Simon's] significantly disturbed mental state to determine what further options would be indicated.*

11.12 Conclusion

- Simon's treatment plan between his admission on 12 July and the review on 21 July was necessarily limited, and was focused on trying to stabilise Simon's behaviour, which due to his psychosis, initially involved a significant degree of aggression and hostility towards treatment.
- I accept the opinion of Associate Professor Sullivan that such a plan was appropriate at this stage of Simon's treatment.

Was the care and treatment provided to Simon between 12 July and 21 July reasonable and appropriate?

11.13 Associate Professor Sullivan conducted a comprehensive review of Simon's clinical notes both from the July 2022 admission and from previous mental health admissions, as well as key statements from those who had cared for Simon in the MHIU. In broad terms Associate Professor Sullivan noted the following:

- Given that Simon was already on a baseline antipsychotic medication, it was appropriate for the immediate focus to be on management of his acutely disturbed behaviour and that this generally involves short-acting antipsychotic medications and benzodiazepines, which were appropriately prescribed for him.
- At least over the first few days, assessment of Simon was difficult due to his irritability, poor engagement, and disgruntlement at being detained. A treatment plan was difficult for clinicians to formulate given the nature of Simon's condition.

- There was clear evidence of signs of improvement in Simon's mental state from around 18 July, although improvement over a few days is relatively short.
- Observations of Simon were set appropriately and were conducted by nursing staff in accordance with the frequency set by clinicians.

11.14 Associate Professor Sullivan concluded that in general, Simon's treatment during the admission in July 2022 was appropriate and reasonable.

11.15 Conclusion

- I accept the expert opinion of Associate Professor Sullivan that in general the care provided to Simon during his July 2022 admission to the MHIU was reasonable and appropriate.

12 Could Simon's act of intentional self-harm have been predicted or prevented?

12.1 During Simon's admission to the MHIU, clinicians had access to Dr Smithson's notes that included excerpts from previous clinical records. Those excerpts included the following:

- *Presented mentally disordered with mood and behavio[u]ral disturbance under influence of GHB and meth, he is at risk of harm to self and others Require inpatient management to contain safety risk* (review by Dr Lam 12 July 2022)
- *Brought to hospital by police having presented to them confessing drug use. In addition, the police reported that they had been informed that Simon was expressing suicidal thoughts and planning* (St Vincent's Hospital 21 September 2020);
- *Brought in by police under S22 after his mother contacted them concerned he had sent her and his sister text messages stating he was sorry and that he had "stuffed up his life and wants to end it all". He also wrote to his mother that he "doesn't want to be here anymore".* (RNSH 19 June 2022 – 21 June 2022);
- *There was no evidence of on-going suicidal ideations. Currently in situational crisis due to financial concerns following poor drug deals. This has caused his drug use to escalate and for him to threaten suicide in notes sent to his mother and sister.* (RNSH 19 June 2022-21 June 2022).

12.2 These notes indicate past expressions of suicidality in 2020 and June 2022. However, Associate Professor Sullivan's view was that although, on the materials, Simon had on a few occasions, voiced ideas of self-harm, he did not have a strong history of having acted upon those. Further, in her oral evidence, Dr Bray said that she did not consider that suicidality was a huge feature of Simon's presentation during his July 2022 admission. Additionally, the notes made at various times during the July admission by nursing staff at shift handover and during interactions with Simon consistently record that he was not indicating any ongoing thoughts of self-harm or suicidal ideation.

12.3 Dr Darapenini said that Simon was disappointed at the end of the 21 July review, although she did not recall that the level of any concern about his disappointment was such that there was any discussion about the need for more frequent observations or for any other measures to be put in place.

12.4 RN Nugent, who last engaged with Simon, appears to have recognised and reported to Nurse Unit Manager Ashe that Simon was upset after what he described as a *tough* review. It appears that the observation may have also been made by RN Thapa, and for RN Nugent to *keep an eye on* Simon. From these reports, Nurse Unit Manager Ashe did not consider there to be a need for additional steps to be taken in relation to increasing the frequency of observations of Simon, in circumstances where she was informed by RN Nugent that Simon was intending to make a phone call, something that she saw as potentially protective.

12.5 In relation to Simon's mental state after the 21 July review, Associate Professor Sullivan expressed the view *that the materials didn't determine that, that people had developed a clear concern that that particular episode of bad news would precipitate an episode of self-harm in Simon.* The effect of Associate Professor Sullivan's evidence was this was reasonable when viewed prospectively. He also observed that in hindsight, what may have been telling were past expressions of hopelessness, loss and futility related to not seeing his son, rather than active indications of self-harm or suicidality.

12.6 Associate Professor Sullivan considered that the observations levels during Simon's MHIU admission were appropriate, and he could find no evidence of deviation from procedures. Having considered the statements of nursing staff and reviewed the observations charts Associate Professor Sullivan considered that these showed compliance with the set observations levels. He considered that the changes between level 3 and level 2

observations during Simon's admission were appropriate and based on clear clinical rationale.

12.7 Associate Professor Sullivan was not ultimately critical in relation to the lack of recognition of the risk of self-harm following the review on 21 July.

12.8 Conclusion

- The evidence suggests that clinicians and nursing staff were aware that Simon had been disappointed by the outcome of the review on 21 July and that nursing staff were alert to the need to *keep an eye on* Simon.
- Simon's act of intentional self-harm was not readily predictable. In my view, no blame lies with any of the clinicians involved in Simon's care for the fact that his actions on 21 July were not prevented.

13 Did Simon's ingestion of cannabis while in the MHIU affect his mental state on 21 July 2022?

13.1 Professor Jones's evidence was that the level of cannabis in Simon's system would have been higher at the time of his death than was recorded in the postmortem sample. The level on 21 July would have been higher still.

13.2 The evidence of Professor Jones was that the recreational levels of Delta-9-THC in Simon's blood at postmortem is compatible with impaired cognition and poor judgment prior to the incident of self-harm when the Delta-9-THC concentrations would have been higher.

13.3 Professor Jones explained that:

> *[the] effects of cannabis on the brain are really quite complex, but I could summarise, perhaps, that it leads to disinhibition, that a voice in your head that would normally say not to do something is more diminished, and your judgments about outcomes and your own safety can well be impaired by, by cannabis being on board.*

13.4 She added that this was a very complex area and that factors such as how often an individual uses cannabis, what doses they use, whether they have a past psychiatric history, particularly a history of psychosis, are relevant to the effect it will have on an individual. But, she said, as broad summary, having cannabis on board can impair judgment and cognition.

13.5 Associate Professor Sullivan's evidence was that there was nothing in Simon's notes that suggested *that there was a shift in mental state suggesting that he suddenly became acutely intoxicated and that that led to impulsive or other shifts in his mental state.* Associate Professor Sullivan expressed the view that there were no acute changes in mental state documented in the notes, except perhaps that immediately preceding the self-harm incident. In his opinion, this appeared more likely related to his response to being told that he would not be discharged imminently, rather than due to cannabis intoxication.

13.6 Conclusion

- Although there is no evidence in Simon's notes of any change to his mental state suggestive of acute intoxication, in the light of Professor Jones' evidence, the possibility that Simon's mental state may have been affected to some degree by cannabis ingested while in the MHIU cannot be ruled out.

14 Changes to policy and practice since Simon's death

14.1 Sheila Nicholson, the Service Director of the North Shore Ryde Mental Health Service of Northern Sydney Local Health District (**NSLHD**) gave evidence of the changes that have been made by the NSLHD since Simon's death aimed at preventing similar deaths in the future and at improving responses in emergency situations.

14.2 Ms Nicholson advised:

- Since July 2022 a Duty Registrar within the MHIU is required to wear an *Emergency Code pager* which alerts that staff member to a Code Blue call being activated.
- A Ligature Risk Reduction Working Group was established in November 2022 and explored measures that could be used to reduce the use of ligatures and hanging points within MHIUs. Any future MHIU builds will be carefully reviewed for consideration of anti-ligature doors.
- In the interim, a pilot of anti-ligature and environmental safety training commenced at Macquarie Hospital in June 2025. This will be rolled out to other Mental Health areas within the NSLHD in due course.
- Since 2022, staff working within the MHIU have engaged in additional Code Blue training and drills and these continue to be performed on a routine basis.

- In September 2022 NSW Health published Policy Directive PD2022_043 *Clinical Care of People Who May Be Suicidal* which provides guidance on administrative controls associated with the therapeutic approaches to people who may be suicidal, in addition to protocols for the management of environmental hazards and education and training. The policy requires that all NSW Mental Health services must, regardless of setting, undertake training in identification and assessment of the person at risk of suicide, suicide risk formulation, safety planning, training and management.
- Health Education and Training (**HETI**) have released a suite of training specific to Zero Suicides in Care, available in My Health Learning. At the time of Ms Nicholson's August 2025 statement, staff working in the MHIU were undertaking this training.

15 Recommendations pursuant to s82 of the Act

15.1 Nothing in the evidence in this matter lends itself to the making of any recommendations pursuant to section 82 of the Act, particularly given the actions that have already been taken by the NSLHD in response to the circumstances surrounding Simon's death.

16 Findings required by s 81(1)

16.1 I make the following findings in relation to the matters listed in s 81(1) of the Act:

The identity of the deceased

The person who died was Simon Myles Mackay

Date of death

Simon died on 27 July 2022

Place of death

Simon died at Royal North Shore Hospital, St Leonards, NSW 2067

Cause of death

The cause of Simon's death was neck compression and the complications thereof.

Manner of death

Simon died as a result of an attempted hanging which was intentionally self-inflicted while he was an involuntary patient in the Mental Health Inpatient Unit of Royal North Shore Hospital.

17 Close of Inquest

17.1 I thank counsel assisting, Bill de Mars, and his instructing solicitor, Rosanna Muniz from the Crown Solicitor's Office, for the assistance they have provided in preparing and conducting this inquest. I also thank Constable William Quan for the work he did in investigating the circumstances of Simon's death.

17.2 Once again on behalf of the Coroners Court, I offer my sincere and respectful condolences to Simon's family and friends.

17.3 I close this inquest.

Judge Kasey Pearce
Deputy State Coroner
Coroner's Court of New South Wales

Date 19 June 2026