CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 13th, 14th and 29th days of April and the 21st day of June 2021 and the 3rd day of March 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Mathew George Paxford.

The said Court finds that Mathew George Paxford aged 27 years, late of 5 Regent Court, Mount Gambier, South Australia died at the Mount Gambier and Districts Health Service, Wehl Street, Mount Gambier, South Australia on the 24th day of March 2016 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. On 24 March 2016 Mathew George Paxford died whilst an inpatient at the Integrated Mental Health Inpatient Unit (IMHIU) at the Mount Gambier Hospital, when he used a bedsheet to hang himself from his ensuite bathroom door.

1.2. Mathew was 27 years of age and for some time had been suffering from deteriorating mental health. He was supported by loving parents who were as involved as Mathew allowed them to be in getting the best care for him. On the day before his death, Mathew was admitted to the Mount Gambier Hospital as a voluntary patient. On the day of his death one of the mental health nurses caring for him became sufficiently concerned at suicidal ideation being expressed by Mathew, together with information provided by his parents, that she went to the nurses' station and asked the other nurse on duty to prepare the paperwork to institute an Inpatient Treatment Order (ITO), which would allow Mathew to be treated without his consent.

1.3. The nurses agreed that an ITO should be imposed and that Mathew should be subject to observation every 15 minutes.

1.4. Whilst the paperwork for the ITO was prepared, Mathew was left unattended for between 10 and 20 minutes, during which time he took his own life.

2. Cause of death

2.1. A post mortem examination was undertaken by Dr Stephen Wills, a forensic pathologist at Forensic Science South Australia. In accordance with the conclusion expressed by Dr Wills, I find that the cause of Mathew Paxford's death was hanging.[1]

3. Mandatory inquest

3.1. The Coroners Court must hold an inquest to ascertain the cause or circumstances of a death in custody.[2]

3.2. The definition of 'death in custody' includes a death which arose or may have arisen whilst a person was being detained within the State under any Act or law. An ITO is an order under section 21 of the *Mental Health Act 2009* which requires a person to stay in a treatment centre and receive treatment for their mental illness. A person subject to an ITO is thus 'detained'.

3.3. It cannot be determined with certainty whether the ITO had commenced at the time Mathew Paxford died, but his death at least 'may have arisen' after the ITO commenced, so his death was nevertheless a 'death in custody' as defined in the *Coroners Act 2003* and a mandatory inquest was held.

4. Investigation, affidavits and witnesses

4.1. An investigation was undertaken on behalf of the State Coroner by Detective Brevet Sergeant Dennis McManus of SA Police (SAPOL), who compiled a number of affidavits of witnesses and provided a comprehensive and helpful report.[3] In reaching my findings I have had regard to these affidavits and the report, which were tendered as exhibits at the inquest.

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[1] Exhibit C2a
[2] Coroners Act (2003), subsection 21(1)(a)
[3] Exhibit C14

4.2. The following persons gave evidence during the inquest:

- Jacqueline Campbell,[4] Registered Mental Health Nurse, IMHIU, Mount Gambier Hospital, Country Health SA;
- Mathew Beverley-Stone,[5] Operational Manager for Mental Health, IMHIU, Mount Gambier Hospital, Country Health SA; and
- Dr Brian McKenny,[6] Clinical Director, Rural and Remote Mental Health Service (RRMHS) for the Barossa Hills Fleurieu Local Health Network.

4.3. Ms S Mitchell, instructed by the Crown Solicitor, represented the Department for Health and Wellbeing, as well as Ms Campbell and Dr McKenny.

4.4. Ms H Doyle represented Mr Beverley-Stone.

4.5. Mr S Plummer appeared as counsel assisting.

5. Background

5.1. Mathew George Paxford was born on 13 July 1988. His parents are Amanda and Warren Paxford. His siblings are his younger sisters Natalie and Jessica.

5.2. At the time of his death, Mathew and Jessica were living with their parents in the family home at Mount Gambier.

5.3. Mathew's family members regarded him as a very private person, who was disinclined to share details of his private life with his parents. He was somewhat reclusive, spending a lot of time in his room and often eating dinner there on his own.

5.4. Mathew was proud of his 10 year full-time work history as a surveyor's assistant. In October 2015, Mathew's mother Amanda had a telephone call from Mathew's employer, who was very concerned about how Mathew was handling things at the time.

5.5. In the months leading up to that, Mathew had told his mother that he was seeing general practitioner, Dr Roy Jayakody, for depression and anxiety and had been prescribed medication. By November 2015, Mathew's mother became aware that his employer

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[4] Statement, Exhibit C22

[5] Statement, Exhibit C24

[6] Statements, Exhibits C25, C25a and C25b

had recommended a counsellor. She tried to get Mathew to make an appointment, but he would get angry with her.

5.6. Mathew's parents were aware that in the last couple of years of his life Mathew went regularly to the shed in the evenings to smoke cannabis. He had been smoking cannabis since the age of about 15.

6. Medical history

6.1. Dr Jayakody was Mathew's general practitioner from July 2012. Dr Jayakody saw Mathew quite a few times in the ensuing years and regarded him as an anxious person in general.

6.2. Mathew first disclosed to Dr Jayakody in May 2015 that he was suffering work and home related stress and was struggling to sleep. He told the doctor that his boss had told him he was unfit to work, which caused him anxiety. He also expressed that he was really worried about his younger sister.

6.3. Dr Jayakody counselled Mathew regarding his mental health and prescribed diazepam to help him sleep. Although Mathew promised to see the doctor two weeks later to discuss how he was progressing, it was two months later, in August 2015, that he next saw Dr Jayakody.

6.4. On 11 August 2015 Mathew told Dr Jayakody that the medication was helping him sleep, but he complained of being depressed and low. He said he planned to take some time off work and go somewhere to relax. The record of this appointment reveals the first suggestions of suicidal thoughts, noting:

> 'Losing interest, not really suicidal but getting thoughts closer to it but never believes will suicide, need to change the life instead.'

Dr Jayakody prepared a mental health care plan for Mathew, referring him to psychologist Mr Ben Ramsey, and prescribed antidepressants. Dr Jayakody asked Mathew to make another appointment in about three weeks to assess how the medications were working.

6.5. On 19 October 2015, Mathew saw Dr Jayakody and presented as being very happy, saying that he was much better and that his boss was helping him work through his

issues and was very understanding. Mathew had not yet seen the psychologist and Dr Jayakody encouraged him to make an appointment immediately.

6.6. From October 2015 to March 2016 Dr Jayakody saw Mathew several times for non-mental health related issues and noted that his mental health seemed much better, and he did not appear to be depressed. Mathew had still not seen the psychologist, but Dr Jayakody did not press him about that because he was presenting in a better state of mind.

6.7. It was clear by 6 March 2016 that Mathew's mental health had deteriorated dramatically. Mathew's mother was so concerned that she persuaded him to come with her to the Mount Gambier Hospital in the early hours of that Sunday morning. Amanda Paxford described in her statement what occurred: Mathew initially would not get out of the car, stating he had no intention of going into the hospital. Amanda went in and spoke to a nurse, advising that her son was not in a good place and needed help. A nurse and another staff member came out and spoke to Mathew, following which he went inside the hospital and talked with a nurse, during which Mathew asked Amanda to leave them alone.

6.8. This attendance is recorded in the Mount Gambier Hospital notes and a discharge summary was sent to Dr Jayakody.[7] Mathew was described as having presented to the Emergency Department with acute exacerbation of generalised anxiety and difficulty sleeping. Thoughts of worry and anxiousness for his sister's safety were noted. He was assessed by a medical student under the supervision of Emergency Department consultant Dr Sushant. A risk assessment was undertaken, and risk was found to be low with no suicidal ideation. A mental state examination was conducted. Mathew was noted as being well groomed, of stable affect and mood, having speech of appropriate rate, tone and volume. Cognition was intact and he was alert and oriented, with no formal thought disorder. He had good insight and rapport was established. Mathew was asked to attend an already planned appointment with Dr Jayakody for further management, and to attend his psychology appointment. He was given 5mg of diazepam and a prescription for diazepam 5mg to be taken at night.

6.9. On 8 March 2016 Mathew saw Dr Jayakody asking for a full-body check-up, stating he thought he had throat cancer and a defective heart. He had stopped taking his

[7] Exhibit C18, page 15

medication and Dr Jayakody was understandably concerned that Mathew's health fears were as a result of his recurring mental health problems. He noted that Mathew had an appointment with the psychologist Mr Ramsey later that day. Dr Jayakody encouraged Mathew to follow up with Mr Ramsey and strongly advised him to go back on his medication as his anxiety was increasing.

6.10. Mathew attended the appointment with Mr Ramsey that afternoon. This transpired to be Mathew's only psychology appointment, despite having first received the referral from Dr Jayakody in August 2015. Mr Ramsey described Mathew's basic presentation as suffering from anxiety, which Mathew described as a cycle he wanted to get out of.[8] Mathew said his anxiety started in school and, upon initial probing, Mr Ramsey thought it appeared to stem from a fear of failure or rejection. Mathew made no mention of feeling suicidal or wishing to self-harm and by the end of the 50-minute session Mr Ramsey felt there was nothing to support or suggest that Mathew intended to take his own life. Mathew told Mr Ramsey that he wanted help and wished to engage with treatment to work through his issues.

6.11. On 17 March 2016 Mathew again saw Dr Jayakody for an ECG and spirometry to address his concerns relating to his physical health. Dr Jayakody noted him to be sweating, despite being in an air-conditioned room and recorded that he was 'anxious++'. Mathew told Dr Jayakody that he was happy with the consultation with Mr Ramsey and that he had recommenced taking his prescribed paroxetine, as Dr Jayakody had urged him to do. Dr Jayakody also prescribed nitrazepam for Mathew's anxiety.

6.12. Amanda Paxford states that in the three weeks before his death Mathew was difficult to engage with. His parents tried to talk to him, but he would shut down and walk away. When Mathew did talk to his mother, he would talk about people harming the family if he did not disappear. He would also say that they were going to hurt his sister Jess, to get back at him. Amanda could not get any more out of Mathew; he kept telling her that it was too dangerous for her to know.

6.13. Mathew's father Warren stated in his affidavit that in the two weeks before his death, Mathew told his parents that he was fearful that someone was going to hurt the family if he did not hurt or kill himself.

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[8] Statement, Exhibit C10

7. 22 March 2016

7.1. On 22 March 2016 Amanda Paxford was very concerned about Mathew, who was very agitated. She came home at lunchtime to see him because she knew he had not gone to work, but Mathew would not engage with her and drove off in his car without saying anything, still obviously agitated. Amanda tried unsuccessfully to contact Mr Ramsey for help and then went to his clinic, but he was not there. As she was driving away from the clinic, she found Mathew in a nearby street and told him she was worried about him. Mathew said she should be more worried about his sister Jess. He was talking about needing to go to Maple Court. This did not make sense to Mathew's mother; Mathew's sister Natalie lived in a street by that name about seven kilometres away.

7.2. Amanda Paxford drove to the Mount Gambier Hospital and spoke with nurses, who advised her to bring Mathew to the hospital for assessment. She returned home and she and her husband persuaded Mathew to attend the Emergency Department, where he was seen at 4:20pm.

7.3. Shortly after 5pm, an emergency assessment was undertaken by mental health nurse practitioner Leigh Peterson, who noted that Mathew presented reluctantly and was very sullen towards his parents. Mathew attempted to leave several times and it was noted that he 'manhandled his mother trying to get car keys off her to go to Maple Avenue'. Nurse Peterson noted that Mathew's parents gave an account of Mathew as:

> 'Highly agitated, erratic behaviour with a fixation on the safety of his younger sister which is intrusive and frightening for her. Feeling trapped or followed by a force that is dark'.

Mathew told Nurse Peterson that he had barely slept since the earlier presentation in March. He was noted as 'hyper aroused with a guarded affect and thought blocking was evident with delay answering questions and asking for questions to be repeated'. Nurse Peterson noted that it was difficult to elicit content of paranoia or persecution due to Mathew's level of guardedness. Nurse Peterson also noted:

> 'Psychotic symptoms evident which is frightening his family but not able to elicit any command hallucinations today. Responded to unseen stimuli though he is quite good at masking this.'

7.4. Nurse Peterson assessed Mathew as being at 'medium', risk of self-harm or suicide, absconding and vulnerability and 'low' for violence or aggression. Mathew was given olanzapine and lorazepam, which had little discernible effect over an hour. Although Mathew was very reluctant to have a blood screen performed, this was subsequently

done and was negative for illicit drugs and otherwise normal, with no signs of any drug overdose.

7.5. Nurse Peterson attempted to arrange for Mathew to be admitted to the Inpatient Mental Health Unit but the unit was full, so she liaised with other staff to attempt to have someone moved from the IMHIU to a medical ward, but was advised this could not occur after hours. Mathew refused an offer of admission to a shared room in a medical ward but under the bed card of a psychiatrist.

7.6. Nurse Peterson considered an ITO with admission to the Emergency Department overnight, but this was considered inappropriate because of the volatility and noise overnight in the Emergency Department. Instead, Mathew was sent home with his parents on the basis he would return the next day, with a view to imposing an ITO if he did not.

8. <u>23 March 2016 - Mathew Paxford returns to hospital</u>

8.1. Mathew re-attended at the Mount Gambier Hospital Emergency Department the following day as planned.

8.2. Nurse Peterson recorded that he had slept overnight and remained very perplexed and distracted with marked delay in responding to questions. He was denying auditory hallucinations or perceptual disturbances but was responding to unseen stimuli. He had an unnerving fixed intense stare at times. He was less tearful and remained very worried about his family's safety, particularly his younger sister.

8.3. Although it was initially thought that a bed would not be available in the IMHIU, one became available, and Mathew was admitted to the IMHIU as a voluntary patient.

8.4. Registered Nurse Jacqueline Campbell was Mathew's named nurse. She had responsibility for half of the patients in the unit, that is three of the six. Nurse Campbell is a registered mental health nurse who trained in the United Kingdom. She had worked at the IMHIU since July 2015.

8.5. During her shift, Nurse Campbell reviewed Mathew's notes. She ascertained that he was quite psychotic, his parents were fearful for his safety and had been taking it in turns to sleep in order to keep a watch on him, that he was very reluctant to attend the Emergency Department and that he had required the administration of medication

before his admission. At that stage, Mathew was required to be observed at least every hour. The charts used to record these observations were kept in a folder. I was told at the Inquest that they were not able to be found. While this is unsatisfactory, there is no reason to think that hourly observations did not occur as scheduled. The hospital records are now kept on the Sunrise electronic case management system so no further issue should arise of such paper documents not being found.

8.6. Late in the evening, towards the end of her shift, Nurse Campbell found Mathew in the courtyard of the IMHIU, apparently out of breath. She asked him what he had been doing and he said he had jumped over the wall surrounding the courtyard and gone for a run around the hospital and come back. At the time, Nurse Campbell did not believe that he had had time to go for a jog and come back without her noticing because the seat where he was sitting was visible from the nurses' station; she thought he might have been having a cigarette. Upon the change of shift she told the night staff of this event. She later came to believe that he had jumped the wall.

9. <u>24 March 2016 - the day of Mathew's death</u>

9.1. On the morning of Mathew's death, Warren and Amanda Paxford visited him at about 8:30am. According to Amanda, Mathew was very teary. He kept saying that they should not worry about him, it was Jess that they needed to worry about and that they should all stay safe. He would get angry and say, 'Mum you don't know how it works, you don't know how bad these people are'. She had heard him say similar things in the previous three weeks, and on one occasion Mathew had told her that voices in his head were telling him this.

9.2. Mathew was reviewed by psychiatrist Dr Jill Gladish at 10:05 that morning. It was noted that he 'hopped the fence' the previous night saying he needed a jog. Paranoid ideation was noted, and he could not answer definitively whether he had been having auditory and visual hallucinations. He reported vague suicidal ideation with no plan and stated, 'I'd never do that to my family'.

9.3. Nurse Campbell was working the afternoon evening shift with Lianne Newman, both commencing at 1pm. Lianne Newman was also a registered mental health nurse with the IMHIU at the Mount Gambier Hospital. She was an Associate Clinical Services Coordinator and an 'authorised health professional' under the *Mental Health Act 2009* as in force at the time, who had received the relevant training and authority to

implement Level 1 Inpatient Treatment Orders. Although she had been on duty on the previous day, 23 March 2016, that was her administrative duties day, and she was not involved with Mathew Paxford's care.

9.4. At handover it was noted that Mathew had an appointment with his psychologist Mr Ramsey during the afternoon, but that the appointment had been cancelled due to Mathew's admission. He was to have another appointment on 31 March 2016. There were no concerns noted during handover and Mathew was subject to hourly checks.

9.5. During the afternoon it was discovered that Mathew had absconded from the IMHIU, again over the courtyard wall, and it was quickly ascertained that he was with his parents and they were bringing him back to the hospital.

9.6. Amanda Paxford stated that she was at work when her daughter Jess called her at about 3pm, telling her that Mathew had left the hospital. She left work and went home, finding Mathew there crying, hot and sweaty. She convinced him, without significant resistance, to go with her back to hospital. Amanda and Warren Paxford took Mathew back to the hospital, where the nurses found him distressed, anxious and preoccupied. At 3:50pm he was administered 5mg of olanzapine and Nurse Campbell discussed with Mathew's parents the possibility of an ITO. Amanda and Warren Paxford went out to do some shopping for Mathew and returned after 5pm. They had a couple of bags of clothing and other items, which Nurse Campbell searched for potentially dangerous objects, removing a pencil sharpener before they were taken into Mathew's room. In Mathew's room, Amanda saw that a blue sheet, which had been the top cover of the bed, was gathered up and snaked across the bed. Mathew then picked up the sheet and laid it out on the bed before lying on top of it. Although Amanda Paxford had no reason to regard it as suspicious at the time, it appears that this was the sheet Mathew later used as a ligature with which to hang himself and I consider it likely that he was by then contemplating using it for that purpose.

9.7. When his parents left him, Mathew gave them a hug, said that he loved them and kept saying goodbye. They were concerned for his safety and informed Nurse Campbell that Mathew was distressed. They told her that Mathew had said he would need to die to save his family, and that at home he sleeps with two knives next to his bed. They, too, were distressed and Nurse Campbell spent some time reassuring them that Mathew was safe and would receive the appropriate care and treatment.

9.8. Nurse Campbell went back into Mathew's room and spoke with him, discussing his thought processes. He was not keen to engage with her, stating his head was too busy. She offered him extra medication to help with his thoughts and at 6:30pm, with his consent, she administered 5mg of olanzapine and 1mg of lorazepam.

9.9. Mathew then asked to use his mobile phone, which Nurse Campbell provided to him. Nurse Campbell and IMHIU manager Matthew Beverley-Stone watched from nearby while Mathew made a private telephone call from the courtyard. They were mindful that he had jumped the courtyard wall twice in the previous two days.

9.10. Mathew's phone call, at 6:57pm, was to his parents Warren and Amanda, speaking to each of them during the call. They found it very worrying and strongly suggestive of suicidal intent. During the call Mathew asked his father how Jess was, and he told him she was fine. Mathew then told his father that he loved his mum and said, 'Tell the girls that I love them and goodbye'. His mother said, 'No, goodnight, and we'll see you tomorrow'.

9.11. After he had made that call, Nurse Campbell went into Mathew's room and discussed his safety with him. She did not know what he had said to his parents. She told Mathew that he could use the telephone at any time. She asked if he had thoughts of ending his life and he said, 'Yes'.

9.12. Nurse Campbell immediately went out to the nurses' station and told Nurse Newman of this conversation. She asked Nurse Newman to implement a Level 1 ITO, with Mathew's observations also to be made more frequent, moving from hourly to 15 minute intervals. In the meantime, Nurse Newman had taken a call from Amanda Paxford, telling her about the phone call they had just had from Mathew. Nurse Newman assured Amanda that they were watching Mathew very closely and that he would not be able to go outside without someone being present with him. In this, it may be seen that Nurse Newman's principal concern was that Mathew would jump the courtyard wall.

9.13. As Nurse Campbell left Mathew's room, she closed his door behind her. She gave evidence during the inquest of her reasons for doing so, namely that she thought that the risk was that Mathew would abscond by leaving his room and going over the courtyard wall.

10. The Inpatient Treatment Order

10.1. Nurse Newman's statement[9] details that Nurse Campbell came to her at the nurses' station and expressed concerns that Mathew may abscond from the IMHIU again. This is consistent with the concern of which Nurse Campbell gave evidence.

10.2. Nurse Newman agreed and decided that a Level 1 ITO was warranted. The matters of which she had to be satisfied were set out in subsection 21(1) of the *Mental Health Act 2009* which then provided as follows:

> **21—Level 1 inpatient treatment orders**
>
> (1) A medical practitioner or authorised health professional may make an order that a person receive treatment as an inpatient in a treatment centre (a ***level 1 inpatient treatment order***) if it appears to the medical practitioner or authorised health professional, after examining the person, that—
>
> (a) the person has a mental illness; and
>
> (b) because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
>
> (c) there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness. [10]

10.3. Nurse Newman did not consider it necessary to make another assessment of Mathew, regarding it as counter-productive to his therapeutic treatment and considering there were sufficient grounds based on her previous observations and Nurse Campbell's report to her. There is no reason to criticise the decision to impose an ITO.

10.4. Nurse Newman prepared the paperwork to give effect to the ITO, a form requiring very little writing to complete. She inserted her name and signature onto the form as 'Details of Health Professional Making Order', recording the time of doing so as 1920pm.

10.5. Nurse Campbell then recorded under the heading 'Notification of Order' that she had sent it to the Guardianship Board and the Chief Psychiatrist. She recorded the time as 1925pm.

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[9] Exhibit C28

[10] From 5 June 2017, s.21 of the Mental Health Act was amended by varying the words within brackets in s. 21(b)(1) to read *'(whether physical or mental, and including harm involved in the continuation or deterioration of the person's condition)'.* Subsection 21(ba) was also inserted, after s. 21(b): *(ba) the person has impaired decision-making capacity relating to appropriate treatment of the person's mental illness*

11. Mathew Paxford found hanging from the bathroom door

11.1. After forwarding the ITO as required, Nurse Campbell re-entered Mathew's room to provide him with the necessary documents relating to the ITO and to explain his rights regarding the order. According to her statement she did so at about 7:30pm.

11.2. She found Mathew suspended from the neck by a blue bedsheet, the other end of which had been jammed between the bathroom door jamb and the top of the door, which was closed.

11.3. Nurse Campbell called for help and with the assistance of an orderly tried to lift Mathew upwards to relieve the pressure on his neck. Nurse Newman came in and unsuccessfully tried to open the bathroom door, which seemed to be locked from the inside. She then cut the sheet with a ligature knife obtained from the treatment room.

11.4. An emergency medical call was made and despite the best efforts of the resuscitation team, Mathew was not able to be revived.

12. How long was Nurse Campbell out of the room?

12.1. Nurse Campbell estimated that she was out of the room for a maximum of 20 minutes before she re-entered.

12.2. Nurse Newman said in her statement that it was approximately 10 minutes between Nurse Campbell coming out to her and going back into Mathew's room.

12.3. Mathew's call to his parents was made at 6:57pm.

12.4. Nurse Campbell could not be certain exactly how long she spent with Mathew once he returned his room. She gave evidence:

> 'I can't recall the conversation but I knew I would have tried to get him to speak to me to let me know what was happening. I would have said like, you know, your family love you, we're here for you. I can't remember the exact conversation but I would have spent time trying to just provide reassurance and let him know that we were here for him and try to explore what else I could do to help.'[11]

She stated, having regard to her usual practice as a mental health nurse, that she would have encouraged Mathew to talk to her about his thoughts and why he was feeling them, and whether they had increased, so that she could explore them with him and let him

[11] Transcript, page 67

know that there is help available and there is hope. She described how just talking can assist to settle thoughts and reduce anxiety and let them understand that the thoughts would pass.

I accept that Nurse Campbell spent some time in this conversation with Mathew. I cannot find with any certainty what time Nurse Campbell came out of Mathew's room.

12.5. There was no suggestion on the evidence that there was any significant delay from the time Nurse Campbell came out of Mathew's room asking for the ITO to the time at which Nurse Newman completed the ITO.

12.6. The ITO is recorded as having been made at 7:20pm and faxed by Nurse Campbell at 7:25pm.

12.7. I cannot find on the evidence exactly how long Nurse Campbell was out of the room, but I think it unlikely to have been as much as 20 minutes. It is more likely, in my opinion, that Nurse Campbell re-entered the room within the 15 minutes required by the updated frequency of observations.

13. <u>Should Mathew Paxford have been left alone</u>?

13.1. I have mentioned that Nurse Campbell said she closed the door of Mathew's room when she left. She gave evidence that she felt that if he was more contained in his room, with the door closed, he was safe and would not be absconding. This was a reference to the two incidents of which she was aware of Mathew going over the courtyard wall. When Nurse Campbell spoke to Nurse Newman, she was really concerned and assessed him with a high risk of absconding and maybe doing something to harm himself.[12]

13.2. She had just had a conversation with Mathew in which he said he had thoughts of ending his life. She had been told by Mathew's parents as they were leaving the hospital that Mathew had stated to them that he needed to die to ensure their safety. Nurse Campbell was also aware of the information contained within the notes kept on his medical record, with the possible exception of handwritten notes from the Emergency Department which may not yet have been brought to the inpatient ward. Nurse Campbell had noted in the risk assessment she conducted on 23 March, 'reports nil self-harm or suicidal ideation'. She also recalled him saying the words, 'life not worth living' but she could not say whether this was during the risk assessment or another time. She was aware of

[12] Transcript, page 30

Nurse Peterson's assessment of Mathew being at medium risk of suicide/self-harm and having experienced psychotic symptoms. In addition, once she spoke to Nurse Newman, Nurse Campbell learned that Mathew had just telephoned his parents to say goodbye.

13.3. Nurse Campbell said in evidence that once she learned the content of the conversation, she regarded Mathew's risk as having increased, but that her belief was that he was at a higher risk of absconding and then doing something.[13] Mathew had just told her that he had thoughts of ending his life. She still did not think that he would kill or harm himself in his bedroom. Nurse Campbell explained:

> 'I honestly believed he was in the hospital and he was in a safe place. We were obviously – I was obviously monitoring and keeping an eye on him but I assessed him as high risk because he previously absconded and went over the wall. My main concern was that he was going to go over the wall and attempt to self-harm or suicide.'

13.4. Nurse Campbell gave evidence that it did not occur to her that Mathew should be under constant observation. When directly asked, the reason she gave was:

> 'Because he was there. I had given medication and believed he was safe in the room because my biggest concern was that he was going to abscond and then do something. I didn't think for one minute that he would do anything in the room.'

13.5. Nurse Campbell was aware that the bathroom door was a potential ligature point, although there is no suggestion she was specifically thinking about that on this occasion. She also agreed that at some time previously, it had occurred to her that the blue bedsheet, of the type used by Mr Paxford, could be used as a ligature.[14]

13.6. Nurse Campbell agreed that with the benefit of hindsight and on reflection having regard to the outcome, she should have called for a one-to-one special nurse. Nurse Campbell impressed me as a truthful witness. I accept her evidence as to the reason she closed the door. I also note the evidence that even if the door was open, this did not give a clear view from the nurses' station of the inside of the room. Nurse Campbell also gave evidence that Mathew always closed the door when he was in the room and that most clients do, just for some privacy. I accept her evidence that if she thought Mathew was at imminent risk of self-harm, she would not have left him alone in the room.

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[13] Transcript, page 60
[14] Transcript, page 78

13.7. I bear in mind the evidence of Dr McKenny, psychiatrist and Clinical Director of the Rural and Remote Mental Health Service, who was not critical of Nurse Campbell for leaving Mathew at that time to undertake the task of arranging for the ITO. Dr McKenny gave evidence that statements of suicidal ideation cannot lead to continual observation in every case, pointing out that some people, particularly with severe personality disorders, are suicidal, or have suicidal thoughts all day.[15]

13.8. In my opinion, however, Mathew Paxford should not have been left alone once he had expressed to Nurse Campbell that he had thoughts of ending his life and she then learned from Nurse Newman (she was by then at the nurses' station) that he had just telephoned his family to say his goodbyes, against the background of having shortly before told his parents that he needed to die to ensure their safety. Nurse Campbell properly assessed that an ITO was necessary in order to provide appropriate treatment and protect him from harm but was diverted from considering other means available to Mathew by her knowledge of his earlier occasions of absconding, and her reasonable fear that if he did so again, he might harm himself.

13.9. Of course, Nurse Campbell's knowledge that Mathew had telephoned his parents to say goodbye did not arise until after he had left the room but it was open to her to return immediately. There were also other alternatives. When she was in Mathew's room she could have called for Nurse Newman or, once she was out, she could have brought Mathew out of his room into the communal area to be observed while the ITO paperwork was completed.

13.10. If Mathew Paxford had been observed more closely in the 10 to 20 minutes between Nurse Campbell leaving him and returning, his death might have been prevented. Nevertheless, it cannot be said that strict compliance with 15 minute observations (if Nurse Campbell was away for more than 15 minutes) would have prevented his death. There is no reason to think that Mr Paxford could not have done the same thing in less than 15 minutes.

14. Frequency of observations - 15 minute observations replaced with 1:1 specialling in acute mental health units

14.1. By the time of the Inquest, the appropriateness of 15 minute observations at the Mount Gambier IMHIU was not a matter requiring consideration of recommendations for

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[15] Transcript, page 189

change, as the Court was informed by Dr McKenny[16] that there was a change introduced on 22 March 2018 to replace the use of 15 minute observations with one-to-one special nursing in acute units such as the IMHIU, with a recommendation that special nursing occurs until the clinical risk is assessed as being suitable for 30 minute observations. In his statement Dr McKenny noted that 15 minute observations were still sometimes used during the initial two hours on admission to an open acute unit, 'unless there is significant risk of harm identified'.

14.2. Evidencing the change were two emails dated 22 March 2018 from Dr McKenny, in his then capacity as Chief Psychiatrist, notifying clinical directors throughout SA Health of his recommendation:

> 'That continuous observation (1:1 specialling), in place of 15 minute observations, be used for any mental health patient considered to be at significant risk to themselves or others. This change in practice should be considered for open acute units. Where 15 minute observations are used during the initial 2 hours on admission to an open acute unit, to commence therapeutic engagement, this can continue unless there is a significant risk of harm identified.'[17]

15. The bathroom door as a ligature point

15.1. Mathew Paxford died by using a ligature suspended from the bathroom door. He could not have taken his life by that means if the nature and design of the door did not allow it. Anti-ligature doors are commercially available.[18] The designs of some lead to sacrifice of a measure of consumer privacy.

15.2. The fact that doors such as those in the IMHIU were capable of being so used was well-known within the mental health service community. So much was clear from the evidence of Nurse Campbell. Nurse Campbell gave evidence that all the staff who were working at the IMHIU when it opened in June 2015 were concerned about the bathroom doors from the outset. Nurse Campbell said that they were recognised by her and others as a risk, both as a ligature point and as a means of a client concealing that they were self-harming in the bathroom. In addition, she held a concern that the bathroom doors could be locked from the inside, so if a client was self-harming inside, nursing staff could not enter to prevent it. Another concern for her was that the doors were of full

[16] Exhibit C25, paragraph 20
[17] Exhibit C27, annexure JDP1
[18] Exhibit C26 was tendered as an example

height, so they could be used to suspend a ligature, by the exact method which Mathew employed.

15.3. Consciousness of potential ligature points, identifying and eliminating or managing them to the extent practicable, is fundamental to the delivery of a modern mental health service.

16. Ligature point audits

16.1. Prior to the official opening of the IMHIU within the Mount Gambier Hospital in June 2015, a ligature point audit was conducted on 11 September 2014.[19] No ensuite or bathroom door within the IMHIU was identified as a ligature point. The suicide risk presented by the doors was present at the time of that audit and the doors should have been identified. This was plainly an error.

16.2. By contrast, a ligature point audit conducted in April 2016, after Mathew's death, identified the risk constituted by the ensuite doors being full height to the doorframe and that a gap should be created at the top of the door. It was also recommended that a gap beneath the door should be considered to reduce anchor points. A mitigation strategy was proposed, namely 'Monitor closely, high observation'.

16.3. Several versions of SA Health ligature audit procedures were received in evidence, one dated August 2016,[20] and a version dated December 2018 which was still current in December 2020.[21] In September 2019, the Chief Psychiatrist issued a Standard for Ligature Risk Management pursuant to subsections 90(2) and 90(3) of the *Mental Health Act 2009*.

17. Action taken in relation to the doors

17.1. Dr McKenny's affidavit detailed action taken following a review of ligature points on ensuite doors in inpatient units, which was undertaken after Mathew Paxford's death.[22] These included modification of all doors in Rural and Remote Mental Health Service Inpatient Units to a push/pull type and installing door handles of an anti-ligature design.

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[19] Exhibit C14e
[20] Exhibit C14e
[21] Exhibit C25, annexure BM-8
[22] Exhibit C25

17.2. Following that review, the then Chief Psychiatrist was consulted as to the possibility of cutting down the tops of the ensuite doors and,

> 'It was concluded that this would not mitigate the ligature point risk to a level that outweighed the rights to privacy and the sense of personal safety for consumers who are often highly traumatised.' [23]

17.3. It was considered that the risk had been mitigated by the modification of door handles and the use of 'specialling' patients with an identified risk in units such as the Mount Gambier Hospital IMHIU.[24]

17.4. A subsequent event proved this approach to balancing a risk with such devastating consequences (suicide) against consumer privacy to be unacceptable.

18. Another suicide attempt involving the Mt Gambier Hospital IMHIU ensuite doors

18.1. By further affidavit, Dr McKenny advised that on 13 July 2021 a consumer at the Mount Gambier IMHIU attempted to hang themself using a ligature on the ensuite door.[25] Fortunately, they were able to be revived and made a full recovery.

19. Response instigated by the Chief Psychiatrist

19.1. The 13 July 2021 incident was reported to the then and current Chief Psychiatrist, Dr John Brayley, who recommended that all the ensuite doors in the IMHIU be immediately removed, as an interim measure. This was done on the following day.

19.2. The Chief Psychiatrist then sent a letter sent to Ms Ngaire Buchanan (CEO, Limestone Coast Local Health Network (LCLHN)) advising of a number of concerns identified during the Office of the Chief Psychiatrist inspections of the IMHIU and the Emergency Department at the Mount Gambier Hospital.[26] One concern was that the IMHIU might not at the time have been compliant with the Chief Psychiatrist Standard, Ligature Risk Management.[27] Dr Brayley noted that following the incident on 13 July 2021 the doors had been or were being removed and he welcomed further discussions about future strategies, particularly having regard to a range of safer door solutions, including the installation of door top sensors (as had recently deployed at the Women's and

[23] Exhibit C25a, paragraph 7
[24] Exhibit C25, paragraph 32
[25] Exhibit C25b
[26] Exhibit C25b, annexure BM-1
[27] Exhibit C25, annexure BM-9

Children's Hospital), magnetic swing doors, cut down doors or not having ensuite doors at all.

19.3. Dr Brayley foreshadowed placing Gazettal conditions upon the Mount Gambier Mental Health Service (including the Emergency Department) which would require an intervention plan be submitted to the Office of the Chief Psychiatrist to enable more intensive monitoring of clinical practice, to address the several matters which he had raised and to put in place training and supervision arrangements to assist in the long-term.

19.4. Conditions were then gazetted which required that an intervention plan approved by the Chief Psychiatrist be put in place to monitor and manage the quality and safety of care in the Mental Health Service at Mount Gambier.

19.5. Under the sponsorship of Ms Buchanan (CEO, LCLHN) and Dr McKenny, (in his capacity as Director of Rural and Remote Mental Health) a Work Out Plan was devised and submitted to the Chief Psychiatrist. Among the issues addressed by the plan it confirmed that the ensuite doors in the IMHIU had been removed and that the Chief Psychiatrist was to be consulted regarding solutions to be put in place. A committee of senior staff of the LCLHN and RRMHS was established to address all of the issues highlighted by the Chief Psychiatrist.

19.6. The Court was advised that the LCLHN was liaising with the Australian distributor for a manufacturer of several different types of anti-ligature door systems in order to identify an appropriate solution, but in the meantime the ensuites at the IMHIU remained without doors.

19.7. In February 2023 the Court enquired of the LCLHN as to progress and was advised by the Regional Clinical Risk Manager at the LCLHN that for the time being the ensuite rooms in the IMHIU remained without doors. A set of saloon style anti-ligature doors[28] is soon to be delivered with a plan to trial them in one room at the IMHIU and seek feedback from patients and staff before a decision is made about whether the doors will be used in all rooms.

[28] similar to those depicted and described in Exhibit C26

20. Conclusions

20.1. Mathew Paxford, born on 13 July 1988, died on 24 March 2016 at 27 years of age, whilst a patient at the Mount Gambier Hospital Integrated Mental Health Inpatient Unit.

20.2. Mathew used a bedsheet to hang himself from an ensuite bathroom door which should have, but had not been, identified in a ligature point audit as a potential ligature point.

20.3. At the time of Mathew's death his mental health had deteriorated to the extent that, because of his mental illness, he required treatment in order to protect him from harm and the registered mental health nurses caring for him properly determined to impose a Level 1 Inpatient Treatment Order.

20.4. A decision was made to subject Mathew to observations every 15 minutes, and he was left alone for between 10 and 20 minutes whilst the Inpatient Treatment Order was prepared.

20.5. By the time of Mathew's death, the accumulated evidence as to his risk of suicide was such that he ought not to have been left alone.

20.6. Whether Mathew Paxford's death was ultimately preventable is unclear. However, if he had not been left alone for that period of between 10 and 20 minutes he could not have taken his life at that time.

21. Recommendations

21.1. Pursuant to section 25 of the *Coroners Act 2003* I am empowered to add to my findings any recommendation that, in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

21.2. Ensuite door ligature points

I have referred to the removal of the Mount Gambier IMHIU ensuite doors and the ongoing consideration of an appropriate anti-ligature solution to the privacy of the ensuite bathrooms.

21.3. To the Minister for Health and Wellbeing: I recommend that ensuite bathroom doors in acute inpatient mental health units be reviewed to identify potential ligature points and be removed, modified or replaced to eliminate potential ligature points.

21.4. 15 minute observations

The Court heard evidence that in March 2018 the then Chief Psychiatrist recommended that 'continuous observation (1:1 specialling), in place of 15 minute observations, be used for any mental health patient considered to be at significant risk to themselves or others' in open acute units.

21.5. The effect of the evidence was that following this recommendation, 15 minute observations were no longer being used in such circumstances.

21.6. For this reason, the appropriateness of 15 minute observations for mental health patients considered to be at significant risk to themselves or others in acute open units was not considered during this inquest and no recommendation is made.

21.7. Design of acute mental health units

During this inquest there was evidence that due to the design of the IMHIU at Mount Gambier it was not possible for nursing staff at the nurses' station to see into some or all of the rooms at the unit. The appropriateness or otherwise of this feature of the unit's design was not addressed in detail.

21.8. This issue is likely to be considered in a forthcoming inquest and in this matter no recommendation is made.

Key Words: Death in Custody; Inpatient Treatment Order; Hanging

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 3rd day of March, 2023.

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State Coroner

Inquest Number 01/2021 (0543/2016)