CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATHS OF MARK JOHN FURLAN AND RICHARD JOHN MILLER

[2025] SACC 6

Inquest Findings of his Honour State Coroner Whittle

17 April 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the deaths of two men who each took their own life by hanging while detained at the Royal Adelaide Hospital under inpatient treatment orders. The inquest examined the circumstances in which these patients under strict observational regimes in secure facilities had access to the means and opportunity to commit suicide.

Held:

1. Mark John Furlan, aged 50 years of Glenunga, died at Royal Adelaide Hospital on 27 February 2018 as a result of hypoxic brain injury due to acute neck compression due to hanging.

2. Richard John Miller, aged 37 years of Adelaide, died at Royal Adelaide Hospital on 15 July 2021 as a result of neck compression.

3. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MS S GILES

Family: MRS C FURLAN
Counsel: MR G GRIFFIN - Solicitor: GRIFFINS LAWYERS

Family: MS R BETTS
Counsel: MS L BOWERING & MR C CHARLES THEN MS C MARKS - Solicitor: ABORIGINAL LEGAL RIGHTS MOVEMENT

Interested Party: SA HEALTH & CENTRAL ADELAIDE LOCAL HEALTH NETWORK
Counsel: MR B GARNAUT - Solicitor: DW FOX TUCKER LAWYERS FOR CROWN SOLICITOR

Witness: MS L SMITHAM, MS A CHARLESWORTH, MS E SHAW, MS J LEGG, DR A KING & MS J TAYLOR
Counsel: MR B GARNAUT - Solicitor: DW FOX TUCKER LAWYERS FOR CROWN SOLICITOR

Witness: DR R STAUGAS
Counsel: MR A CROCKER - Solicitor: ILES SELLEY LAWYERS

Witness: MS S FOSTER
Counsel: MR R BONIG - Solicitor: FINLAYSONS

Witness: MR P VELCHUMY
Counsel: MS H DOYLE - Solicitor: UNION LEGAL SA

Witness: MR J CHAN
Counsel: MR J HOMBURG - Solicitor: GILCHRIST CONNELL

Hearing Date/s: 20/01/2023, 20/02/2023, 12/04/2023, 17/05/2023-19/05/2023, 22/05/2023-24/05/2023, 09/06/2023, 13/06/2023-16/06/2023, 25/07/2023, 04/08/2023, 08/09/2023, 07/11/2023 & 16/11/2023

Inquest No: 10/2022 **File No/s: 0376/2018 & 1487/2021**

This judgment contains discussion of suicide and may be distressing to some people

There is always help available

If you need support, contact

Lifeline Australia
Call 13 11 14 or Text 0477 13 11 14
or chat online at www.lifeline.org.au/crisis-chat

Aboriginal & Torres Strait Islander Support
Call 13YARN (13 92 76)

Kids Helpline
Call 1800 55 1800

MensLine Australia
Call 1300 78 99 78

INQUEST INTO THE DEATHS OF
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Introduction

1 Mr Mark Furlan was 50 years of age when he died on 27 February 2018. He was married to his wife, Costanza, for 25 years. They had two children. Mr Furlan had a close relationship with his extended family, including his brother Stephen. Mr Furlan worked in the pharmaceutical industry for many years, and at the time of his death he was employed by Mayne Pharma International. On 24 February 2018 he was admitted to Ward 2G at the Royal Adelaide Hospital (RAH) under a Level 1 inpatient treatment order (ITO) after his mental health had declined in the preceding weeks, primarily due to what he described as work-related stresses. The following day, 25 February 2018, he was found by a nurse in his room, room 205 of Ward 2G, hanging from the ensuite door by his own hooded jumper. At that time Mr Furlan was to be under close observations (that is, observations no more than 15 minutes apart)[1] by mental health staff. Mr Furlan was in asystolic arrest, and it took approximately 24 minutes for the return of spontaneous circulation. Brain death was confirmed on 27 February 2018, and he was declared deceased.

2 Mr Richard Miller was 37 years old when he died on 15 July 2021, also in Ward 2G at the RAH. Mr Miller had spent most of his life in Port Lincoln. His mother, Mrs Regina Betts, described him as a happy child who excelled at AFL and aimed to be drafted to an AFL team when he was older. However, by the age of 17 Mr Miller was diagnosed with schizophrenia. Over the ensuing years he spent much time in and out of the custody of the Department for Correctional Services (DCS) and mental health facilities. In June 2021 he was taken into custody by DCS at the Adelaide Remand Centre (ARC). Once in custody his mental state began to further decline and on 22 June 2021 he was detained at the RAH on a Level 1 ITO. He was placed in the Psychiatric Intensive Care Unit (PICU) of Ward 2G while he awaited a bed at James Nash House. However, on 15 July 2021 Mr Miller was located in his room with a ligature around his neck. He too was purportedly under close observations by staff at the time of his death.

Cause of death

3 In relation to Mr Furlan, an external examination including toxicology was undertaken on 2 March 2018 by specialist forensic pathologist, Dr Cheryl Charlwood, at Forensic Science South Australia. The cause of death stated was:

> Ia) hypoxic brain injury
> b) acute neck compression due to hanging

I find the cause of Mr Furlan's death to be hypoxic brain injury due to acute neck compression due to hanging.

4 In relation to Mr Miller, a post-mortem examination was conducted on 19 July 2021 by specialist forensic pathologist, Dr Karen Heath, at Forensic Science South Australia. The

[1] All references to 'close observations' in this finding refers to observations to be conducted at intervals of no more than 15 minutes.

cause of death was given as neck compression, which I find to have been the cause of Mr Miller's death.

The purpose of the inquest

5 As both Mr Furlan and Mr Miller were detained pursuant to an ITO under Part 5 of the Mental Health Act 2009, their deaths fall within the definition of a 'death in custody' under the Coroners Act 2003 and inquests into their deaths were mandatory pursuant to Section 21 of that Act.

6 The circumstances preceding each of Mr Furlan's and Mr Miller's detentions in Ward 2G at the RAH were vastly different. Mr Furlan's detention was his first involuntary inpatient stay, having had no history of any significant mental health concerns. Mr Miller on the other hand had a complex history of mental health concerns, many previous psychiatric admissions, and was being detained in Ward 2G whilst also in DCS custody. Yet despite their somewhat different predicaments, Mr Furlan and Mr Miller were both detained in Ward 2G and placed under a close observations regime for the same reason - their own safety. However, despite that, they both had the means and opportunity to take their own life.

7 At the conclusion of the inquest, the Central Adelaide Local Health Network (CALHN) submitted that it is unfortunately the case that it is not always possible to prevent a death in a psychiatric inpatient treatment unit, notwithstanding that all practical measures should be taken to minimise the means and opportunity for an individual to take their own life. Whilst this is true, as much should be done as possible to prevent such occurrences. The purpose of the inquest was to explore whether more should have been done to prevent the deaths of Messrs Furlan and Miller, and whether more could be done to prevent future similar deaths.

8 The standard of proof to be applied in making coronial findings is the civil standard, the balance of probabilities. In considering making findings which imply or express criticism of individuals, I am guided by the principles enunciated in Briginshaw v Briginshaw[2] and I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made.

9 In this finding I shall not summarise all the evidence tendered or heard at the inquest, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

Evidence at inquest

10 At the inquest, I heard evidence from the following witnesses:

- Ms Lorraine Smitham: Ms Smitham is a registered nurse who was employed in 2018 at Eastern Community Mental Health as a mental health nurse. In the course of that employment she treated Mr Furlan while he was being managed in the community.

[2] Briginshaw v Briginshaw (1938) **60 CLR 336**

- Ms Alison Charlesworth: Ms Charlesworth was the Nurse Unit Manager of Ward 2G at the RAH at the time of Mr Furlan's admission and death.

- Dr Rima Staugas: Dr Staugas is a psychiatrist. Dr Staugas was one of the on-call consultant psychiatrists on the date of Mr Furlan's admission to the RAH, and in that capacity undertook an assessment of Mr Furlan to assess whether the ITO should be confirmed.

- Ms Erin Shaw: Ms Shaw was a registered nurse/registered midwife acting as Team Leader on Ward 2G at the time of Mr Furlan's act causing his death.

- Ms Suzanne Foster: Ms Foster was an enrolled nurse who was employed on a casual basis by CALHN at the time of Mr Furlan's admission. She was assigned to Mr Furlan's care on the date of the act causing his death, as well as the previous day.

- Ms Jean Legg: Ms Legg was both Co-Director and Nursing Lead of CALHN mental health. She commenced employment as Co-Director in November 2017. She was on leave at the time of Mr Furlan's admission and death.

- Dr Maria Naso: Dr Naso was engaged by the Court to provide an expert overview of the treatment of Mr Furlan and the circumstances relating to his death. Dr Naso obtained her Fellowship of the Royal Australian and New Zealand College of Psychiatrists in 2002, having completed a Bachelor of Medicine and Bachelor of Surgery at Flinders University in South Australia in 1992. At the time of giving evidence, Dr Naso was the Senior Staff Psychiatrist at the Modbury Hospital.

- Dr Andrew King: At the time of Mr Miller's death, Dr King was a resident medical officer completing the Adelaide Pre-Vocational Psychiatry Program. He assessed Mr Miller on a number of occasions during Mr Miller's inpatient admission to the PICU. He was also present when Mr Miller was first discovered deceased.

- Dr Sophie Davison: Dr Davison was, at the time of giving evidence, the Chief Medical Officer of the Medical Health Commission Western Australia. Dr Davison was commissioned by the Office of the Chief Psychiatrist of South Australia (OCP) to provide an independent review of the clinical care of Mr Miller up to six months prior to his death. At the time of publishing this finding, Dr Davison is the Australian Government's Chief Psychiatrist.

- Ms Jaimee Taylor: Ms Taylor was a registered nurse working in PICU at the time of Mr Miller's admission.

- Mr Prakash Veluchamy: Mr Veluchamy was a registered nurse employed at the RAH and working in the PICU at the time of Mr Miller's admission. He was caring for Mr Miller on the day of his death.

- Mr Jack Chi Him Chan: Mr Chan was a registered nurse working in the PICU at the time of Mr Miller's admission.

11 In addition to the oral evidence, the Court received into evidence records from various agencies including CALHN and the South Australian Prison Health Service (SAPHS) (in relation to Mr Miller) as well as affidavits from a number of witnesses who were not called to give evidence. I will not list them all here due to the sheer number. However, due consideration was given to each of those affidavits in writing this finding.

12 Before any evidence was called at inquest, the Court went on a view of Ward 2G at the RAH. The purpose of the view was to have an understanding of the design of the facility and, in particular, layout of the ward and features of the rooms in which Mr Furlan and Mr Miller were accommodated. The view was particularly helpful in understanding the setting in which the events the subject of the inquest unfolded.

Ward 2G

13 Mental Health Services moved to the new RAH on 5 September 2017. Ward 2G was intended to have three sections:

- a 10-bed psychiatric intensive care unit (PICU);
- a 6-bed short stay unit; and
- a 24-bed acute area.

14 The acute area was designed for both voluntary patients and those detained under the Mental Health Act (MHA) who were not violent and otherwise compliant with taking medication and directions from staff. PICU is essentially a closed ward for patients with challenging behaviours and who resist treatment and are involuntary under the MHA.

15 The opening of the various beds for patient use was a staggered progress which I need not detail in this finding. Of relevance to the inquest is that in February 2018 (when Mr Furlan was admitted to Ward 2G) there were 20 beds open in the 24 open acute ward, and 6 beds in the short stay area. Subsequently, PICU opened at the new RAH on 30 January 2019.

16 Concerns were raised throughout the inquest about certain design features of the ward, particularly that some features created challenges for staff in relation to patient supervision. These challenges and their impact on the supervision of Mr Furlan and Mr Miller will be raised throughout this finding. It was because of these concerns that the inquest sought to understand the rationale behind the inclusion of certain design features in this newly constructed facility.

17 Evidence on this topic revealed that in 2011 and 2012 the builder held a series of meetings in relation to the construction of the mental health ward. These meetings were known as the Mental Health Planning Group, and the group included representatives from the State, SA Health, SAPHS, HYLC (Hansen Yuncken Leighton Contractors), architects, and the facilities services provider. The builder was responsible for creating and distributing meeting minutes. Some minutes from these meetings were provided to the Court.

18 During this time Glenside Hospital was also undergoing redevelopment, with significant consultation with staff regarding the design of a mental health unit, based on a 'recovery model'. The minutes from the meeting on 9 August 2011 reflect the State's intention to:

> 'Adopt the concept of decentralised staffing, as per the Glenside model'.

19 However, neither Karen Polley nor Nurse Charlesworth, both of whom were part of the planning group, could explain why this decision to adopt decentralised staffing was made or who was responsible for it.

20 Following this decision, the then Project Director wrote a letter in April 2012 proposing a change to the functional brief for the mental health area. The proposal suggested shifting from what was previously planned to be three pods of eight beds to 24 open beds, as was eventually implemented.

21 The 'Mental Health Directorate Model of Care New RAH' from March 2017 describes the model of care for the new RAH mental health ward, indicating that the design incorporated 'lessons learned from the redeveloped Glenside Health Unit'.

22 Several aspects of the decisions related to the design of Ward 2G remain unclear:

- **Staff input in the design process:** It is unclear whether the input of staff working on Ward 2G was considered during the design process. Nurse Charlesworth, who attended planning group meetings for a period of time, raised concerns in a letter she wrote in April 2012 to the then Nursing Director of RAH Mental Health at Glenside and the Director of Nursing at Ward C3 RAH (the mental health ward at the old RAH). In the letter, Nurse Charlesworth expressed concerned that decisions were being made by individuals who were not nurses. However, it remains unclear whether her concern reflected what occurred.

- **Consideration of Australasian Health Facility Guidelines (AusHFG):** The relevant AusHFG assist in planning and designing health facilities to promote optimal patient care through an appropriate physical environment. In April 2012, HPU 134 Revision 5 replaced Revision 4, which had been in place since 2010. Both versions of the guideline recommended that 'bedrooms should be grouped into clusters or pods'. The decision to move away from this guidance by not clustering the beds appears to have been a departure from these guidelines, but the reason for that departure is unclear. Additionally, HPU 134 provides recommendations on fixtures and fittings to minimise the risk of self-harm, but there is no evidence that this was considered in the planning phase. Indeed, ligature audits completed post the opening of the new RAH and tendered at the inquest indicate a lack of adherence to this guideline in HPU 134.

- **Lack of vision panels in acute rooms:** The beds in the short stay unit and the beds in PICU all have vision panels allowing viewing into the rooms. The beds in the acute unit do not. It remains unclear why the acute rooms in Ward 2G are the only patient rooms without vision panels and what the rationale for this design decision was.

- **Ward 2G's shape:** Nurse Charlesworth recalled the footprint of Ward 2G was influenced by the presence of supporting pillars as well as the desire to place the mental health ward next to the Emergency Department (ED), but the exact reasoning behind the ward's shape remains unclear. Ms Legg conceded in her evidence that the layout of the ward makes the work of the nurses more challenging than it should be.

Mark John Furlan

Background

23 At the time of his death Mr Furlan had been married to his wife, Mrs Costanza Furlan, for 25 years. It was from all accounts a happy marriage. They have two children: Olivia, who was aged 20 at the time of her father's death and attending university, and Luke, who was aged 16 and attending high school.

24 Mr Furlan had an older brother, Stephen, who seemingly provided him with much support. Mark and Stephen grew up in an Italian family. Mr Furlan's father was struggling with dementia, Parkinson's Disease and prostate cancer, which were sources of stress to the family around the time of the onset of Mr Furlan's mental illness.

25 Mr Furlan was employed by Mayne Pharma International.

26 According to Dr Naso, Mr Furlan was perfectionistic and placed high expectations on himself as a father, husband, son and worker.

27 Mr Furlan's son Luke read statements to the Court on behalf of his mother, Costanza, himself and his sister Olivia. The love they had for their husband and father was evident, as was the profound impact this tragic event has had, and continues to have, on them. They shared stories of his generous spirit and joyful nature. Just weeks before his passing, Mr Furlan had spent time with his son creating a 'father and son bucket list', planning for the future and discussing upcoming milestone birthdays. His sudden decline was unexpected, leading to a tragic outcome.

Onset of depressive symptoms

28 During the December 2017 and January 2018 holiday period, Mr Furlan began experiencing feelings of depression. It appears that his depression was largely triggered by events occurring at his workplace.

29 Ms Kate Rintoul, Executive Vice President at Mayne Pharma, provided an affidavit for the purposes of the inquest. Ms Rintoul detailed that Mr Furlan was appointed as Director of Quality in May 2017, where he reported to the General Manager and Operations Director. His position was later retitled to Head of Quality in January 2018, and he directly supervised nine staff members. Ms Rintoul described Mr Furlan as a capable employee, though under stress.

30 Mr Furlan learned that the company was undergoing a restructuring process. He was reportedly concerned about how this would impact his team, as well as how it might affect his own financial situation. Mrs Furlan noted her husband became concerned for his staff and had poor sleep during the period of the reorganisation. She states he felt unsupported and that he unsuccessfully sought renegotiation to retain certain key staff. Ms Rintoul notes that there were no plans to make Mr Furlan redundant or freeze his salary, despite concerns Mr Furlan may have had.

Involvement of Dr Waters, general practitioner

31 On 10 January 2018 Mr Furlan visited his general practitioner, Dr Martin Waters, at the Norwood Village Medical and Dental Centre. Prior to this visit Mr Furlan had only consulted Dr Waters for depression once before in 2016. During the 10 January 2018 appointment, Mr Furlan reported feeling depressed and anxious, citing ongoing financial stress and pressure at work. Mr Furlan had been attending counselling sessions through the Employee Assistance Program (EAP) provided by Mayne Pharma. He felt he needed additional support. Despite this, Mr Furlan declined medication, stating he would continue with the EAP counselling.

32 The following day Mr Furlan returned to Dr Waters, again expressing feelings of anxiety, including stomach knots and difficulty sleeping. Once more, he declined medication, opting to continue with the EAP counselling instead.

33 On 25 January 2018 Mr Furlan returned to see Dr Waters, reporting feeling extremely anxious and depressed. Dr Waters prescribed him Lexapro and advised him to take a few days off work. A mental health plan was created, and Mr Furlan was referred to Dr John Gould, a psychologist at the Norwood Village Medical and Dental Centre.

34 On 28 January 2018 Mr Furlan presented again to Dr Waters. He was reportedly agitated with no evidence of psychosis. He had an appointment scheduled with Dr Gould on 2 February 2018. Quetiapine 25mg nocte was added in order to aid with his insomnia. It was suggested that if there was no improvement that Mr Furlan should attend the RAH and be transferred to The Adelaide Clinic.

35 On 13 February 2018 Mr Furlan again visited Dr Waters, expressing fear of a financial crisis and stating that all he wanted to do was sleep. He was seeking additional appointments with the psychologist, but Dr Waters explained that Mr Furlan had already attended two sessions within a two-week period, which was considered fairly standard practice. At this point, Dr Waters provided a referral to a psychiatrist at The Adelaide Clinic and recommended that Mr Furlan consider seeing a different psychologist if he felt that Dr Gould was not the right fit for him. Mr Furlan attended two sessions with Dr Gould however, after these two sessions, Mr Furlan did not return to see Dr Gould.

36 Dr Waters did not see Mr Furlan after the appointment on 13 February 2018.

37 I note that Dr Naso has no criticisms of the care provided by Dr Waters to Mr Furlan.

38 On 15 February 2018, Mr Furlan sent his wife a distressing text message. He was sitting in his car in the carpark at work and was feeling highly agitated. Mrs Furlan contacted his brother, Stephen, who called him and managed to get him to go into work.

39 On 17 February 2018, Mr Furlan and his wife attended a party, and her husband appeared to cope. However, after the party he began comparing himself negatively to his friends and voiced feeling like he was a failure.

40 The following day he was reportedly highly agitated, and he declined to speak to a psychiatrist friend in fear of being judged. Mrs Furlan states he could not be reassured and believed they were ‘ruined’. At the suggestion of his wife, Mr Furlan contacted the

Mental Health Triage (MHT) line. Mrs Furlan reported he seemed somewhat better after this call.

41 On 19 February 2018 Mr Furlan dropped his son off at school and then began to have severe suicidal ideations of driving his vehicle into a tree. He attended at Montefiore Hill, parked his car and called his brother. After speaking with his brother, they decided it was best for Mr Furlan to wait for him and they would attend at the RAH. Mr Furlan had written a suicide note which, after deciding not to take his own life, he provided to his wife.

42 On the same day, Mr Furlan and his wife attended the RAH, where Mr Furlan was assessed by emergency staff.

43 As Mr Furlan already had an appointment with Eastern Community Mental Health (ECMH) that afternoon (the evidence was unclear on this, but it seems this may have been made during his call to the MHT the previous day), he was released into his wife's care and went directly to that appointment.

Eastern Community Mental Health

44 On 19 February 2018 Mr Furlan attended at ECMH at Tranmere. He was assessed by nurse practitioner Sally Hampel and clinical nurse Cate Rowlands.[3]

45 He shared that he had started feeling depressed before Christmas 2017 and mentioned the difficult process of having to lay off staff as part of his role, which he found incredibly challenging. He also expressed fear about losing his own job. During the assessment Nurse Hampel provided psychoeducation to Mr Furlan, explaining the chemical imbalances in the brain that can occur with depression and how medication can help address this. When asked about his current medication, Mr Furlan reported that he was still struggling with poor sleep. Given his ongoing sleep difficulties, Nurse Hampel decided to increase his quetiapine dosage, concerned that the lack of sleep was likely exacerbating his anxiety and distress. Mrs Furlan informed Nurse Hampel that Mr Furlan had made superficial cuts to his wrists the previous morning but had only disclosed it to her at that moment because he did not want to be taken to the hospital. The cuts had not broken the skin and were not visible to Nurse Hampel when Mr Furlan was assessed. Based on the assessment Mr Furlan was determined to be severely depressed. Dr Latt Latt Aung, the senior consultant psychiatrist for ECMH, assigned Dr Alvin Asan to interview Mr Furlan the following day, 20 February 2018.

46 On 20 February 2018 Mr Furlan attended ECMH again with his wife and was assessed by Dr Asan.[4] According to Dr Asan, Mr Furlan spoke in detail about multiple chronic and acute stressors, including the downsizing at his workplace, uncertainty about his long-term job stability, and his frustration with himself for 'letting everyone down' and allowing things to get to this point. Although Mr Furlan reported that he had no current active plans for suicide, he struggled to foresee any improvement in his situation. He acknowledged having suicidal ideation but stated he did not feel he could go through with

[3] Exhibit C10
[4] Exhibit C11

it, as his children were a protective factor, and he did not want to harm himself because of the impact it would have on them. Mr Furlan believed he could control these feelings.

47 Dr Asan transitioned Mr Furlan from Lexapro (escitalopram) to mirtazapine, due to its effectiveness in promoting sleep and increasing appetite. Dr Naso confirmed that the decision was evidence-based, and the titration schedule was intentionally assertive. The potential side effects of this change were explained to the Furlans, and Mr Furlan was advised not to drive until he had another consultation with Dr Asan. During their meeting, Dr Asan explored with Mr and Mrs Furlan the options of home-based care versus inpatient care. It was decided that home-based care would continue, with daily visits from ECMH staff and regular phone check-ins. Inpatient care would be considered if Mr Furlan's condition did not improve. Dr Naso agreed with the decision to maintain home-based care at this time, as the risks and benefits were appropriately balanced.

48 On Wednesday 21 February and Thursday 22 February 2018, Ms Julie Murison, clinical nurse from ECMH, visited Mr Furlan at his home. Mrs Furlan contacted Ms Murison, expressing growing concern about Mr Furlan's increasing catastrophising, particularly related to their financial situation. Ms Murison spoke with Mr Furlan about the possibility of inpatient treatment and its benefits, however Mr Furlan expressed concerns about the stigma of inpatient care and declined voluntary admission. While Ms Murison remained concerned, there were not enough grounds to place Mr Furlan under an involuntary ITO at that time. It was agreed that the least restrictive option - acute home-based care - should continue until his next appointment with Dr Asan on Tuesday 27 February 2018. Ms Murison consulted with Dr Asan, and it was decided that Mr Furlan should start taking quetiapine: 25mg in the morning and 50mg at night to help manage his agitation.

49 On Friday 23 February 2018, Mr Furlan was scheduled to be seen in person as part of his acute home-based care plan. Ms Lorraine Smitham, who provided an affidavit which was tendered at the inquest, visited Mr Furlan's home but found that he was not there. When she contacted him by phone, Mr Furlan stated that he was fine and did not want to be seen. He was at his brother Stephen's house, so Ms Smitham requested to speak with Stephen. Stephen reported that Mr Furlan had made concerning statements, such as 'I want to end it', 'I want out', 'there is no future', and 'what have I done to my family, leaving them in this financial mess'. Based on this information and her mental state examination, Ms Smitham, accompanied by Ms Marianne Wright, visited Stephen's house to assess Mr Furlan. After a private conversation with him, Ms Smitham concluded that Mr Furlan needed to be detained under an ITO.

50 Nurse Smitham contacted an ambulance to transport Mr Furlan to hospital, however there was a considerable wait and, after two hours, a decision was made that they would transfer Mr Furlan to the RAH ED themselves, with Stephen Furlan accompanying them.[5]

51 Nurse Smitham's evidence was that once at the RAH she did a verbal handover to the consultant liaison (a mental health staff member in the ED).[6] Her evidence was that she would have handed over a copy of the ITO but no other paperwork.[7]

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[5] Transcript, page 122
[6] Transcript, page 123
[7] Transcript, page 148

52 Following handover, Nurse Smitham completed her paperwork at the hospital. That included a risk assessment[8] in which she has recorded her assessment that she considered Mr Furlan to be at a high risk of suicide and that the risk was frequent, intense and enduring.[9] Although Nurse Smitham has no specific recollection of telling the consultant liaison that she considered Mr Furlan to be at a high risk of suicide or self-harm at that time, her evidence was that she 'absolutely would have' because 'that was my reason for being there'.[10]

Assessment of care provided by ECMH

53 Dr Naso's opinion was that ECMH provided timely and assertive follow-up, working collaboratively and involving Mrs Furlan in discussions. Dr Naso did express that, in her opinion, following the institution of the Level 1 ITO, there should have been a documented discussion with a consultant psychiatrist or with Dr Asan. She expressed that that conversation would have been important so discussions could be had about medication changes, the need for a nurse special, and the suitability of the patient for open bed management. Nurse Smitham's evidence was that rather than discussing those matters with an ECMH consultant, the practice was to discuss it with the consultant liaison in the ED, and decisions about mental state and risk would then be up to them. Dr Naso expressed that the value of that conversation occurring with somebody from the ECMH treating team rather than just the consultant liaison, is that they know more about the patient than the consultant liaison service in the ED.

54 Dr Naso's assessment was that it seemed that once Mr Furlan was admitted, that ECMH relinquished their responsibilities. She opined that a transition period would have helped make sure the vital information was not missed. It was of some relevance that the ITO was issued on a Friday evening, as the evidence revealed that there would have been no doctor on call within ECHM, but rather an on-call psychiatrist consultant was available through CALHN. In these circumstances, it seems to have been an appropriate decision for Nurse Smitham, being a highly experienced nurse consultant from the community team, to have the discussion with RAH staff at the time of transfer, given there was no psychiatrist or registrar within the ECMH treating team available. It is also accepted that Nurse Smitham passed on relevant information both verbally to a clinical member of the mental health staff of the RAH ED and then also in writing in CBIS,[8] which could be accessed by RAH medical staff.

55 Despite a concern about whether vital information may have been missed in that transition process, there was no evidence that any was in fact missed in the transition between ECMH and the RAH. Dr Staugas said she felt she had enough information from the CBIS notes,[11] and had she not, she could have contacted ECMH, but she did not feel the need to based on the information that she had read, which she viewed as adequate.[12]

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[8] Exhibit C35, Appendix 3, page 19
[9] Transcript, page 143
[10] Transcript, page 148
[11] Transcript, page 381
[12] Transcript, page 378

Admission to RAH

56 Dr Nina Osei-Tutu completed an assessment of Mr Furlan at 1:09am on Saturday 24 February 2018. Dr Osei-Tutu was working as a locum in the position of a resident mental health doctor, and she assessed Mr Furlan in the ED.

57 According to information provided by CALHN, the ED doctors requested the presence of doctors with mental health experience to work overnight, specifically to manage mental health patients who may require assessment, discharge, or other support. Due to negotiations with the South Australian Salaried Medical Officers Association (SASMOA), CALHN-employed mental health doctors could not be scheduled for these shifts. The employed registrar's shift ended at 10pm, which led to the use of locum doctors such as Dr Osei-Tutu.

58 In her role, Dr Osei-Tutu was responsible for assessing mental health patients presenting to the ED during her shift and making decisions about their care, including discharging them or placing them on the inpatient bed list if necessary. She had access to the ED doctors, the on-call psychiatrist, and the community mental health team (when involved) to gather additional information or seek further assistance in her assessments.

59 Dr Osei-Tutu documented that Mr Furlan had no suicidal intent and no delusions, but mild paranoia. She noted his insight and judgement were poor. Her documented diagnosis was major depression and generalised anxiety disorder.

60 She wrote up his regular medications as mirtazapine 15mg mane and quetiapine 50mg nocte. Dr Naso noted that the mirtazapine dose was written up incorrectly, as it was halved and prescribed in the morning when it is usually prescribed in the evening to assist with sleep. Nevertheless, Dr Naso opined this particular medication error would not have had any effect on Mr Furlan in that short time period between that and his death.

61 Dr Osei-Tutu's plan was for Mr Furlan to be admitted, and later that day have a consultant review of his Level 1 ITO. Dr Naso's evidence was that she would have expected Dr Osei-Tutu to have had a discussion with a consultant psychiatrist about open versus closed ward management, and the level of observation that Mr Furlan would be under, but the documentation provides no indication that either of those things occurred. In fact, there was no evidence that indicates that, at the time of Mr Furlan's admission into Ward 2G, any psychiatrist turned their mind to whether Mr Furlan should be an open or closed ward admission, or the level of observation that Mr Furlan should be under.

62 Nevertheless, any failure for this to have occurred at the instigation of either the ECMH or the consultant liaison was not a factor that ultimately enabled or contributed to Mr Furlan ending his own life in Ward 2G as, between the event of his admission into Ward 2G and his death, these matters were actively considered by consultant psychiatrist Dr Rima Staugas.

63 When Mr Furlan was admitted to Ward 2G, all items that were thought to pose a safety risk were removed due to the risk of suicide. Once settled in room 205 of the acute ward, he was seen by Nurse Gonsales, the night shift nurse coordinator. According to Nurse Gonsales' affidavit, she ensured Mr Furlan was as comfortable as possible and, noticing that he appeared very tired, allowed him to rest. No medication was given that night as he seemed naturally fatigued and not particularly agitated. Although he was offered

lorazepam to help him sleep, Mr Furlan declined. He was informed that the decision to place him under an ITO would be reviewed the next morning.

64 Mrs Costanza Furlan wanted to stay overnight with Mr Furlan. She was told by Nurse Gonsales that she was not allowed to stay overnight. In fact, the policy in place at the time stated that it left such a decision to the treating team's clinical judgment. Being a weekend, Mr Furlan was not to have a treating team until Monday. Dr Naso agreed that such a decision is one best left to the treating team as there are obvious benefits, but also potential risks involved with having carers stay overnight. She opined that the decision not to allow Mrs Furlan to stay was appropriate until the treating team could give due consideration of the suitability of that arrangement, noting that would not have occurred until the treating team commenced their work with Mr Furlan on Monday.

65 As Mr Furlan was a new admission onto the ward he was under close observations for the first two hours. Mr Furlan reportedly fell asleep quickly and was sleeping soundly for the remainder of the 15-minute checks over the two hours. There were no issues observed with Mr Furlan overnight during his first night in the ward. After the two hours were complete and upon a review, it was determined that it was safe to conduct one hourly observations overnight.

66 I pause here to observe that because Mr Furlan was admitted to Ward 2G in the early hours of Saturday morning, he did not have a 'treating team' at all during his admission. Save for the on-call psychiatrists, there are no treating teams on Ward 2G on weekends. This is somewhat perplexing given the evidence from Dr Naso that the first 48 hours post admission is one of the periods of greatest suicide risk. It is curious that in other medical disciplines the treating team would be available on a weekend, but seemingly not in psychiatry, despite the risks associated with the first 48 hours of admission.

Assessment by Dr Rima Staugas

67 On Saturday 24 February 2018 Dr Rima Staugas was one of the on-call psychiatrists at CALHN. Dr Staugas was on-call for a period of 24 hours commencing at 8:30am on the morning of Saturday 24 February 2018 and concluding at 8:30am on Sunday 25 February 2018. In that capacity she undertook an assessment of Mr Furlan to assess whether the ITO imposed by Nurse Smitham should be confirmed.

68 On the date of her assessment of Mr Furlan, Dr Staugas had been working at the RAH for approximately one month. Whilst Dr Staugas had previously worked on-call shifts as a psychiatric registrar at the old RAH, her shift on 24 February 2018 was her first on-call shift as a consultant at the new RAH.

69 Upon commencing her on-call shift on 24 February 2018, Dr Staugas was informed at the ED handover meeting that a psychiatrist was required to see Mr Furlan because he was the subject of an unconfirmed ITO.

70 Dr Staugas' evidence was that nursing staff informed her that a dominant feature of Mr Furlan's presentation was his preoccupation with his finances. Dr Staugas was also informed that Mr Furlan had previously written a suicide note and that since Mr Furlan was admitted he seemed slightly withdrawn, but he had not caused any disturbance. Dr Staugas was also advised that whilst Mr Furlan had been expressing the view that he

did not require inpatient treatment, he had not made any attempt, nor expressed any desire, to leave.

71 Dr Staugas' evidence was that before she saw Mr Furlan she read his clinical records on CBIS. Whilst Dr Staugas was not shown a copy of the suicide note its content was reproduced and referred to in CBIS. Dr Staugas' evidence was that she spent approximately 20 to 30 minutes reading the material contained on CBIS. Her evidence was that having read the CBIS notes, she felt she had sufficient information from the ECMH about Mr Furlan's condition and she did not consider it necessary to contact a member of the ECMH to obtain any further information. She did not do so.

72 Prior to commencing her assessment of Mr Furlan, Dr Staugas had a discussion with Nurse Foster who she understood had been assigned to observe Mr Furlan. Dr Staugas' evidence was that in that conversation, Nurse Foster advised her that:

- Mr Furlan was a 50-year-old male who had been admitted to Ward 2G on the evening of Friday 23 February 2023, pursuant to a Level 1 ITO;
- Upon Mr Furlan's admission to Ward 2G he was initially subject to close observations (consistent with the applicable policy at the time), which had been reduced to hourly following Mr Furlan's first two hours on the ward;
- Whilst Mr Furlan appeared slightly withdrawn following his admission to Ward 2G, he had not caused any disturbances;
- Whilst Mr Furlan had expressed the view that he did not require inpatient treatment, he had not made any attempt to abscond from the unit; and
- A dominant feature of Mr Furlan's presentation was his preoccupation with financial issues.

73 Prior to seeing Mr Furlan, Dr Staugas had also reviewed Mr Furlan's medication chart and so was aware that Mr Furlan had been prescribed 15mg mirtazapine in the morning, 50mg quetiapine in the evening and PRN lorazepam and olanzapine, but that, at the time of her assessment, he had not been provided with any PRN medication. Dr Staugas assumed that Mr Furlan had not been provided with any PRN medication because he had slept well overnight and had not been acutely agitated.

74 Dr Staugas was also aware that upon his admission to the ward, Mr Furlan had been placed on close observations as was standard practice for all patients admitted to, or transferred between, psychiatric wards for the patient's first two hours on the ward. However, immediately prior to her assessment of Mr Furlan, he was being observed on an hourly basis.

75 Dr Staugas assessed Mr Furlan in one of the assessment rooms with Nurse Foster present for the duration of that assessment. The assessment commenced at approximately 1:15pm and concluded at approximately 2:30pm.

76 Dr Staugas decided to confirm Mr Furlan's ITO. Immediately after concluding her assessment of Mr Furlan, Dr Staugas began writing up her notes of the assessment in the nurses' station while Nurse Foster escorted Mr Furlan back to his room, and then also returned to the nurses' station.

Dr Staugas' diagnosis at conclusion of the assessment

77 Dr Staugas' diagnosis at the conclusion of the assessment (and before further information was then provided to her by Nurse Foster about comments Mr Furlan subsequently made) was that Mr Furlan had major depression with a possible early or emerging psychosis. She described that what she meant by that description was that 'he had symptoms which would be indicative of an emerging psychosis, established psychosis, psychotic depression'. In her oral evidence Dr Staugas explained that, in her mind, there was no difference between the terms 'early psychosis' and 'emerging psychosis' and that she used those phrases interchangeably. Dr Staugas also explained that she used those terms to indicate that Mr Furlan was displaying symptoms which were consistent with psychosis and that Mr Furlan may develop a 'full-blown psychotic depression', although this was not certain.

78 Dr Staugas considered Mr Furlan's low mood, flat affect and overarching themes of excessive guilt were in keeping with a major depression. Mr Furlan's seeming inability to accept that his depressive illness may affect the rationality of his decision making and work performance was also in keeping with a major depressive illness.

79 Dr Staugas also formed the view that Mr Furlan may have been suffering from a possible early or emerging psychosis on the basis that he:

- had made some odd comments;
- appeared to be excessively catastrophising the severity of his workplace and financial issues; and
- had expressed some nihilistic and potentially paranoid thoughts.

80 Whilst Dr Staugas thought that Mr Furlan may be losing perspective about the severity of his financial and workplace issues, she did not consider Mr Furlan to be suffering from a fully formed psychotic depression because:

- Mr Furlan was generally lucid and ordered in his thoughts during his conversation with her;
- Mr Furlan was able to relay an accurate and ordered history (which Dr Staugas cross-checked against the information in CBIS);
- Mr Furlan was not agitated;
- whilst Mr Furlan was focussed on issues surrounding his financial stressors, he was able to be directed away from, and converse lucidly about, other topics;
- Mr Furlan had not displayed any anger or hostility; and
- the CBIS records revealed that Mr Furlan was sleeping well.[81]

81 Dr Naso was not critical of that diagnosis at that time (before the comments subsequently reported by Nurse Foster). I find that Dr Staugas' diagnosis at the end of the assessment, but before the comments reported to her by Nurse Foster which I will come to in a moment, was reasonable.

Additional comments to Nurse Foster

82 Whilst Dr Staugas was writing the notes of her assessment of Mr Furlan, Nurse Foster returned to see Mr Furlan in his room for the purpose of exploring whether he had a problem with gambling. There was a divergence in the evidence of Nurse Foster and Dr Staugas about whose idea it was for Mr Furlan to be asked questions about this, but the evidence was clear that it was agreed between the two of them that this conversation about gambling, and whether it was a factor causing Mr Furlan's financial concerns, should occur. It was submitted by counsel for Dr Staugas that it is not necessary to resolve this factual dispute in circumstances where it is not in dispute that the question was put to Mr Furlan. I agree.

83 Dr Staugas continued to write up the notes of her assessment of Mr Furlan while Nurse Foster was out of the room. Nurse Foster returned to Mr Furlan's room. Her evidence about what transpired when she returned to Mr Furlan's room was as follows:

> 'I questioned about the gambling, he looked at me very sharply, quite in a psychotic manner in my experience, had experienced, and he said to me 'Thousands of people are going to be affected by this and children will be taken'. I then queried what he said and that start had gone and he shook his head and said, 'Don't worry, don't worry about it'. I was quite frightened by this, so I left Mr Furlan's room, but returned to the Nurses' Station to advise Dr Staugas what had occurred.' [13]

84 A short time later Nurse Foster returned and relayed the comments that Mr Furlan had made to her in response to her questions about gambling. Dr Staugas made a note of the information which Nurse Foster conveyed to her.

85 Dr Staugas recorded what Nurse Foster told her in the margin on the paper on which she had made her notes during the assessment. The notes record the following:

> 'Later to nurse who asked about gambling - 'NO' appeared paranoid.
>
> 'This will affect 100's of people; children will be taken away this will catastrophic, I will 2 jobs.
>
> This can't be fixed'.'

86 In recounting this conversation to the Court, Nurse Foster did not recall some of the comments recorded by Dr Staugas in her notes, as having been reported by her to Dr Staugas but Nurse Foster accepted that if Dr Staugas recorded them at the time, then they were reported by her to Dr Staugas. Dr Staugas' contemporaneous notes provide the most reliable account of the comments which Mr Furlan made to Nurse Foster.

87 In Dr Staugas' mind, the comments which Mr Furlan made to Nurse Foster corroborated her view that Mr Furlan was probably developing psychotic symptoms. However, in Dr Staugas' view, the fact that Mr Furlan had made those comments to Nurse Foster did not guarantee that Mr Furlan's condition would progress to a full psychosis, or how quickly that might happen, if at all. The comments that Mr Furlan made to Nurse Foster also caused Dr Staugas to form the view that the confirmation of the ITO had exacerbated Mr Furlan's distress.

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[13] Transcript, page 523

88 Nurse Foster's evidence was that, following reporting this to Dr Staugas, she asked Dr Staugas to go back and see Mr Furlan. Dr Staugas did not go back to see Mr Furlan. Dr Staugas' evidence was that Nurse Foster did not ask her to go back, but that even if she had, she would not have returned.

89 Dr Staugas explained that her decision not to revisit Mr Furlan was based on the fact that the comments were made shortly after she had completed a thorough 75-minute assessment. In her view, and considering the detailed assessment she had just conducted, the comments did not justify the need for further evaluation or a revision of her proposed treatment plan. On the contrary, Dr Naso's opinion was that the fact that these comments were made so quickly after the 75-minute meeting was one reason why Dr Staugas should have gone back to review Mr Furlan further once Nurse Foster provided her with this information, in order to explore those comments.

90 Dr Naso also expressed her view that the fact that Mr Furlan was displaying a psychotic stare was another reason why Dr Staugas should have returned to see him. As to whether that psychotic stare described by Nurse Foster was in fact reported to Dr Staugas, Dr Staugas' evidence was that she thinks Nurse Foster might have told her about the stare, but she is not sure. Dr Staugas did not record it in her notes. However, Dr Staugas' evidence was that even if that was reported to her that would not have changed anything in terms of her feelings about the situation, nor her assessment of the situation (including the need for her to go back and see Mr Furlan).

91 In my opinion, it would have been prudent for Dr Staugas to return to see Mr Furlan. I observe that Dr Staugas was very busy during this shift and returning to assess the same patient after a long assessment might cause delays for other patients, although Dr Staugas stated this did not influence her decision. However, what was reported by Nurse Foster appeared to be quite a sudden shift, out of step with Mr Furlan's presentation during Dr Staugas' 75-minute assessment. In coming to my conclusion on this matter I have accepted the opinion of Dr Naso and concluded that exploration by the psychiatrist of this sudden shift and these comments was of importance.

92 It is not helpful to speculate as to what may have transpired had Dr Staugas returned to explore those comments with Mr Furlan – indeed, the events that followed may still have transpired as they did. However, Dr Naso was of the view that the comments alone were enough for Dr Staugas to positively diagnose Mr Furlan with psychotic depression,[14] and that a diagnosis of psychotic depression should have dictated his management from that time forward and that that management should have included continuous observations.[15] Dr Staugas agreed that, had she positively diagnosed Mr Furlan with psychotic depression, she might have arranged for him to be under continuous observations, though she commented that she would not definitely have done that as she had managed people with psychotic depression on close observation in the past.[16]

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[14] Transcript, page 754
[15] Transcript, page 758
[16] Transcript, page 391

Psychotic depression

93 According to Dr Naso, Mr Furlan fulfilled criteria for psychotic depression which is a specifier of Major Depressive Disorder in DSM-5.

94 Psychotic depression is conceptualised as melancholic depression with psychotic features. Melancholic depression includes sudden and significant change in behaviour leading to social withdrawal, intense agitation, poor sleep, sudden unexplained weight loss, inability to work effectively, ruminations and preoccupations (there may be some reality basis, but the level of concern is out of proportion but not at delusional intensity) and suicidal ideation.

95 Psychotic major depression is a severe form of depression with significant mortality. It is estimated that patients with psychotic depression have double the risk of dying compared to patients diagnosed with non-psychotic depression, and higher odds of completed suicide. Patients who have psychotic depression have a longer duration of episodes, higher likelihood of future recurrence, poorer outcomes and greater functional impairment and residual symptoms.

96 Psychotic depression is further classified as presenting with either mood congruent or mood incongruent psychotic features.

97 There is evidence which suggests that clinicians frequently miss the diagnosis of psychotic depression due to not recognising the psychotic features. Mental health clinicians expect depressed patients to have fearful and pessimistic concerns. Differentiating depressive ruminations from psychotic delusional beliefs requires several assessments and collateral information.

98 If a patient is highly anxious, psychosis should be anticipated. The most frequent psychotic symptoms are mood congruent delusions. The delusions commonly include delusions of poverty, nihilism, delusions of guilt and unworthiness and hypochondriacal delusions. It is evident that Mr Furlan had delusions of poverty, guilt and unworthiness. Mr Furlan also had a delusional belief that he would lose his job, despite reassurance and evidence to the contrary.

Dr Staugas' diagnosis and plan

99 As previously stated, Dr Staugas assessed Mr Furlan as presenting with 'Major Depression - possible early psychosis'. In the statement of reasons which Dr Staugas completed as part of confirming Mr Furlan's ITO, she described her 'provisional diagnosis' as:

> 'MAJOR depression. Associated anxiety.
> Possible emerging psychotic symptoms.'

100 Dr Staugas stated that in general, when determining how a patient should be managed, the clinician is required to consider various matters, including:

- the patient's level of agitation;
- the patient's ability to accept treatment;
- whether the patient is settled on the ward;

- whether the patient is sleeping and eating; and
- the patient's mental state, including whether their condition is improving or deteriorating.

101 Following her assessment of Mr Furlan, Dr Staugas recorded a plan which was to:

- confirm the ITO;
- place Mr Furlan under close (no more than 15 minute intervals) observations; this was a change from the one hourly observation regime that he had been under prior to the assessment by Dr Staugas.
- change his medication. Dr Staugas changed Mr Furlan's mirtazapine dose to be given in the evening, as opposed to the morning, to assist with Mr Furlan's sleep. She also added olanzapine as one of Mr Furlan's PRN medications. Dr Staugas also noted that Mr Furlan's PRN olanzapine and lorazepam were to be utilised by nursing staff if Mr Furlan displayed any signs of agitation.
- obtain some collateral information. Whilst Dr Staugas was aware that some collateral information had been obtained from Mr Furlan's family which tended to suggest that, consistent with Dr Staugas' initial views, Mr Furlan was overemphasising the extent of these issues, Dr Staugas thought that some further collateral about the severity of Mr Furlan's financial issues might be helpful, although it was not something that, in her mind, would substantially change Mr Furlan's management. Dr Staugas gave evidence that, in the past, she has been surprised by the additional information which patients or their families may provide over time.

102 Dr Staugas gave evidence that whilst she did not consider it her role as the on-call psychiatrist to decide about whether Mr Furlan should be admitted to an open or closed ward, she accepted that upon confirming Mr Furlan's ITO, it was open to her to transfer Mr Furlan to a closed ward if she thought it would benefit him. As of February 2018, the PICU at the RAH had not been gazetted and was not operational. Accordingly, if Dr Staugas had ordered that Mr Furlan be transferred to a closed ward, Mr Furlan would have been transferred to Glenside Campus. In any event, Dr Staugas did not consider it appropriate or necessary to transfer Mr Furlan to a closed ward. Dr Naso agreed with that decision.

103 Dr Naso's evidence was that the confirmation of the ITO and the medication modification as part of the plan was appropriate.

104 The final aspect of Dr Staugas' plan was to obtain some collateral information from Mr Furlan's family. Dr Staugas' evidence was that she read some collateral information about Mr Furlan's financial situation in the CBIS notes, and that she understood that the family did not feel that it was as bad as he was expressing, but she felt that more information from the family about why they thought there were no problems might assist. Whilst Dr Naso's view was that Dr Staugas should have attached more significance to the collateral information that was included in the documentation, a plan for the treating team to explore that further over the coming days was obviously of no adverse consequence.

105 The aspect of the plan of which Dr Naso was critical was the decision to place Mr Furlan under close observations rather than continuous observations.

Observations regime

106 Dr Staugas described the process of determining the appropriate observation level as a 'balancing exercise' which required her to take all relevant information into account, some of which indicated positively for Mr Furlan, and some of which indicated a greater level of concern.

107 At the relevant time the applicable observation policy provided for five categories of approved observations. Of those five approved categories, three were able to be deployed on Ward 2G, namely, continuous observations, close observations at intervals of no more than 15 minutes and regular observations at intervals of between 15 and 60 minutes. The policy stipulated that observations should be set at the least restrictive level, for the least amount of time, within the least restrictive setting consistent with maintaining the patient's safety.

108 The policy emphasised that observations were an opportunity for continuing assessment and engagement with the patient in order to develop the therapeutic relationship and ensure regular engagement with, and monitoring of, each patient's mental state in order to enable a prompt response to their therapeutic needs.

109 To maintain patient safety, the time period associated with each observation category was the maximum interval allowed between each observation. The policy provided that:

- clinical judgement should be exercised in decreasing the interval where a consumer was deteriorating or at an increased risk;
- in certain circumstances, it might be prudent to observe a consumer on close observations at shorter intervals – i.e., every 5 minutes; and
- observations should be undertaken at random intervals where possible.

110 Although Dr Staugas was not aware of the observation policy in February 2018, it was consistent with the practice that she had observed and participated in as both a psychiatric registrar and, later, as a consultant psychiatrist.

111 Dr Staugas made the decision with Nurse Foster to increase the frequency of Mr Furlan's observations from 'regular' (hourly) observations to 'close' (no longer than 15 minute intervals) observations. Dr Staugas' evidence was that the decision about the frequency of observations was made in conjunction with Nurse Foster after Nurse Foster had returned from asking Mr Furlan about gambling. Dr Staugas' rationale for increasing Mr Furlan from hourly observations to observations every 15 minutes was that she thought Mr Furlan was at a high risk of suicide and needed a higher level of observation as a result.

112 The CBIS material which Dr Staugas read prior to assessing Mr Furlan contained a number of 'risk assessments' dated from 19 February 2018, when the ECMH first had contact with Mr Furlan, up to the morning of Saturday 24 February 2018, when Mr Furlan was admitted to the acute ward. Those risk assessments had been completed by mental health nurses and Dr Osei-Tutu. Of the six risk assessments conducted between 19 and

24 February 2018, Mr Furlan was assessed as being at 'high risk' of suicide on only two occasions, namely:

- at the time Nurse Smitham imposed the initial ITO in the early evening of Friday 23 February 2018; and
- upon assessment by Dr Osei-Tutu in the RAH ED in the early morning of Saturday 24 February 2018.

113 Dr Staugas was aware that Nurse Smitham, who placed Mr Furlan under the ITO, had the evening before considered him to be at a high risk of suicide that was imminent, but her evidence was that she did not think Mr Furlan's suicide risk was imminent, based on her assessment that day, though she noted that 'part of the problem with risk assessments is that no-one can actually know whether a suicide is imminent or not'.

114 Dr Staugas stated that one of the limitations of standardised risk assessments is their subjectivity as the results can vary depending on who completes them. She also mentioned a body of literature suggesting that standardised risk assessments are not reliable indicators of a person's true risk of suicide or self-harm and should not be used to determine how a patient should be treated or managed. This view aligns with the report from Dr Davison, who also noted that risk assessments have limited value and are ineffective when it comes to assessing individuals at risk of suicide.

115 Dr Staugas expressed that she did not consider that Mr Furlan had a clear intent to seriously self-harm and, therefore, if she was aware of the continuous observations policy at the time, her assessment would have been that Mr Furlan did not fit the criteria for continuous observations. Thus, even if Dr Staugas had been aware of the relevant policies, her decision to place Mr Furlan under close observation rather than continuous observation would likely have remained the same.

116 Dr Naso testified that, in her opinion, Mr Furlan met the criteria for continuous observation according to the policy in effect at the time. She believed there was significant concern from the community team, who were familiar with him, that he was at an extremely high and imminent risk of suicide. Given his guarded behaviour, Dr Naso felt that the risk should not have been downgraded.

117 Nurse Foster was also of the view that close observations was the appropriate choice for Mr Furlan at that time. She was asked whether, in light of the policy that continuous observations should be undertaken when a patient has a clear intent to seriously self-harm, she thought that Mr Furlan met the criteria for continuous observations and stated that she did not think that he had a clear intent to self-harm at that time. Nevertheless, she expressed that she did not realise that Dr Staugas considered Mr Furlan to be at a high risk of suicide and, if she had, she would have thought he should have been under continuous observations rather than close observations.

118 Dr Naso's opinion was that, after hearing the comments made by Mr Furlan, Dr Staugas should have ordered continuous observations, regardless of whether or not she returned to reassess him or obtained additional information. As detailed above, Dr Naso's view was that these comments alone should have solidified a diagnosis of psychotic depression, and such a diagnosis should have led to the ordering of continuous observations on Mr Furlan. Dr Naso's opinion was also that the comments made to Nurse Foster and

reported by her to Dr Staugas should have caused Dr Staugas additional concern in terms of Mr Furlan's risk of suicide or self-harm at that time. Dr Naso's view was that the comment 'this can't be fixed' is a persecutory or suicidal thought and that she would expect Dr Staugas, upon hearing that comment, to have been concerned that it was an expression of suicidal intent. However, Dr Staugas' evidence was that she did not take from any of the phrases reported to her by Nurse Foster that they were an expression of suicidal intent.

119 Dr Naso's opinion that continuous rather than close observations were more appropriate must be considered in light of Dr Staugas' evidence that she was unaware of any difficulties the nursing staff on Ward 2G might have had in ensuring close observations were carried out. This contrasts with Dr Naso's experience that close observations were often ineffective. While continuous observations would have been the best practice at this time, it is recognised that Dr Staugas' decision to opt for close observations was likely influenced by her lack of knowledge regarding the challenges faced by nursing staff on Ward 2G in completing them.

120 There is no evidence to suggest that anyone attempted to contact Dr Staugas after she left Ward 2G, whether in relation to Mr Furlan or otherwise. Indeed, Dr Staugas gave unchallenged evidence that she did not receive any such communication. Dr Staugas said she would have returned to see Mr Furlan if she was asked to do so. Dr Staugas also gave evidence that no-one ever indicated to her that they did not consider close observations to be appropriate for Mr Furlan. Pursuant to the observation policy in force at the time, it was open to the Nurse Unit Manager or Team Leader to initiate an increased level of observations where appropriate.

121 The fact that Dr Staugas was not contacted, nor did anyone else increase the frequency of observations following that, allows an inference to be drawn that the nursing staff who observed Mr Furlan for the remainder of Saturday afternoon and evening and Sunday morning did not have any concerns about the adequacy or appropriateness of close observations. That was the evidence of both Nurse Foster and Nurse Pinto, who observed Mr Furlan during that period.

122 In my view, due to the fact Mr Furlan had psychotic depression, continuous observations were the most appropriate to keep him safe. That of course is quite an obvious conclusion to draw given the outcome while he was under close observations. However, I accept that, when Dr Staugas ordered close observations, she did so in conjunction with Nurse Foster, and without being informed of the difficulty nurses may encounter in achieving those observations. Furthermore, I note that there was ample time for those observations to have been upgraded from close to continuous if anyone saw the need, and yet that did not occur. I infer that all of those involved in Mr Furlan's care post Dr Staugas' assessment and before the act causing his death, were of the view that close observations were sufficient.

Notes written by Mr Furlan in his room

123 Nurse Foster gave evidence that whilst Mr Furlan was in his room on the afternoon of Saturday 24 February 2018, she observed him writing on a sheet of paper at his desk. Nurse Foster took a brief look at what Mr Furlan had been writing. She observed that Mr Furlan's writing was 'very scribbled and erratic' and that there appeared to be calculations or information regarding finances written 'quite boldly'. Nurse Foster agreed

with Dr Naso's view that the writings were 'the product of a troubled mind'. Nurse Foster did not bring those writings to the attention of Dr Staugas, whether at that time or any other. Dr Staugas said that if she had been made aware of the contents of those writings, she may have ordered that Mr Furlan be specialled.[17] Dr Naso agreed that such a response by Dr Staugas, had she been aware of the contents of the writings, would have been appropriate. Nurse Foster conceded that it was a mistake not to present the writings to Dr Staugas or the on-duty psychiatrist.

124 Nurse Pinto also observed Mr Furlan sitting at his desk sometime during the Saturday evening and asked what he was doing. Mr Furlan advised Nurse Pinto that he was 'just getting down his thoughts'. It does not appear that Nurse Pinto made any attempt to read what Mr Furlan was writing nor did he report the writings to any other person.

125 According to Dr Naso, Mr Furlan's handwritten notes, subsequently located in his room, were clearly written by a severely unwell man. Dr Naso's opinion was that the content is not reality based, is catastrophic, nihilistic, rambling and thought disordered. Dr Naso stated that from reading the notes, she has no doubt that at the time of his death, Mr Furlan was suffering from a severe psychotic depression. She also opined that it appeared from Mr Furlan's notes that what he was telling staff was a highly guarded and minimised version of his thoughts.

126 Dr Staugas' evidence was that if Mr Furlan had written these notes, whether in part or in full, at the time she assessed him on 24 February 2018, she was certainly not aware of this. Dr Staugas agreed with Dr Naso that these handwritten notes appear to lack a coherent structure and are consistent with some level of thought disorder. If Dr Staugas had seen these notes at the time she assessed Mr Furlan on Saturday afternoon (if they were in existence then, in whole or in part) that would have increased her level of suspicion about an actual psychosis and/or his potential risk of suicide or self-harm. Dr Staugas stated she may have altered her orders at the time. Nobody contacted Dr Staugas at any time on the Saturday to bring these notes to her attention.

127 The fact that these writings were not brought to the attention of either the Team Leader or the on-call psychiatrist was a missed opportunity to provide those persons with information that, according to Dr Naso, confirmed that Mr Furlan was psychotic. Had that occurred, certain orders, including the instituting of continuous observations, may have followed.

128 It must also be noted that in addition to the handwritten writings, Mr Furlan also completed two other documents on the afternoon of Saturday 24 February 2018 - the SACAT review form[18] and the mental health care plan.[19] Mr Furlan signed both of those documents. The content of those documents suggests that, at least at the time of completion of those documents, Mr Furlan was contemplating a life beyond the next 24 hours. Indeed, in the mental health care plan, Mr Furlan wrote out a plan for the week beginning 26 February 2018.

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[17] One-to-one nursing
[18] Exhibit C36a, pages 35-38
[19] Exhibit C36a, pages 43-49

Observations following confirmation of ITO

129 Nurse Foster continued to care for Mr Furlan for the rest of her shift on 24 February 2018. Her evidence was that she could not recall if Dr Staugas informed her what she considered Mr Furlan's diagnosis to be, but that later in the shift she read the notes and saw Dr Staugas' assessment that she thought Mr Furlan may have had an emerging psychosis.

130 In her oral evidence, Nurse Foster stated that Mr Furlan's demeanour in the afternoon of 24 February 2018 after his assessment with Dr Staugas was the same as it had been prior to that assessment, namely, 'blunted and flat'. Nurse Foster gave evidence that Mr Furlan remained in his room for the duration of that afternoon. Nurse Foster finished her shift at 7:41pm on Saturday 24 February 2018. At no stage during her shift was Mr Furlan provided any of his PRN medications (that is, lorazepam or olanzapine) by Nurse Foster. An inference can be drawn from that that Nurse Foster did not consider Mr Furlan's level of agitation was such as to require the use of the PRN medication that had been authorised by Dr Staugas.

131 Nurse Jonathan Pinto was allocated to care for Mr Furlan overnight on Saturday 24 February 2018 until about 7am on Sunday 25 February 2018. The Court did not receive oral evidence from Nurse Pinto but received an affidavit.

132 Medication for Mr Furlan was dispensed by Nurse Cindy Galinato, as Nurse Pinto did not have access to the automated dispensary cabinet. Mr Furlan was administered mirtazapine 15mg and two quetiapine 25mg tablets at approximately 8pm. Mr Furlan advised Nurse Pinto when asked that he did not want any supper, as he felt uncomfortable being there and interacting with the other people within the ward. When Nurse Pinto entered the room, Mr Furlan had been sitting at his desk and was getting his thoughts down. Mr Furlan asked when he could go home, and Nurse Pinto again explained the ITO to him. Mr Furlan claimed he had not received a copy and was provided a copy by Nurse Pinto. Mr Furlan was adamant he should not be there.

133 The first recorded observation that Nurse Pinto made of Mr Furlan was at 8:30pm. There is no recorded 15-minute observation of Mr Furlan for the hour between Nurse Foster's last recorded observation and Nurse Pinto's first recorded observation.

134 Mr Furlan remained awake until at least 10:48pm. In the period from 8:30pm to 10:48pm, there were a number of occasions on which Nurse Pinto missed the required 15-minute observations. There is no evidence as to why Nurse Pinto did not maintain close observations during that period.

135 Mr Furlan was recorded as asleep between at least 11:05pm and 7:45am on Sunday 25 February 2018. Nurse Pinto states he was advised that Mr Furlan was to be on 30-minute observations from midnight until he woke in the morning, at which time he was to revert to 15-minute observations. This was contrary to the 15-minute observation regime instructed by Dr Staugas. Nurse Charlesworth stated that the practice of reducing observations overnight was not actually the procedure that should occur, however Nurse Foster explained that this was a practice that some nurses took upon themselves to implement, so as to cause less disruption to sleeping patients. There was no instruction from Dr Staugas that the observations on Mr Furlan should be reduced to 30-minutely overnight.

136 The only contemporaneous record of Mr Furlan's condition overnight is found in the CBIS entry made by Nurse Pinto. In that note, Nurse Pinto recorded that Mr Furlan was 'behaviourally settled' and 'engaging with staff when approached'. Nurse Pinto stated that whilst Mr Furlan was eager to be discharged, at no stage did he give any indication to Nurse Pinto that he was suicidal, nor did he advise Nurse Pinto that he had any ongoing suicidal ideation. It is implicit in that entry that Nurse Pinto did not hold any concerns about Mr Furlan.

137 Mr Furlan reportedly slept well overnight and at between 6am and 6:15am he came over to the nurses' station. He was pleading with Nurse Pinto to be discharged and questioning if there were any processes that could be put in place to lead to his discharge. It was explained that this process would have to wait until Monday. According to Nurse Pinto, Mr Furlan did not provide any indication that he was feeling suicidal, just desperate to be discharged to go home to his family.

Sunday 25 February 2018 – Nurse Foster commences shift

138 For the day shift on Sunday 25 February 2018, Nurse Foster was again allocated to care for Mr Furlan, who was still on close observations. Nurse Foster was also allocated to care for three other patients who were on one-hour observations. The four patients for whom Nurse Foster was caring occupied rooms which were somewhat spread out across the ward.[20]

139 Nurse Foster was not at the morning handover. She was late to work after being informed overnight that her mother-in-law had passed away. She stated that although she did not get a handover from Nurse Pinto, Nurse Shaw, the Team Leader, provided her with a handover.

140 There was a policy in place at the time of Mr Furlan's admission which dictated that the nurse to be allocated to his care in the first 48 hours was either a registered nurse level 2 or a permanent and experienced mental health nurse. Nurse Foster was neither of those. Thus, according to the policy at the time, she should not have been allocated to care for Mr Furlan on this day given his diagnosis.

141 Nurse Shaw's evidence was that the allocation of patients to nurses for the day shift on 25 February 2018 was done by the shift before her and when she came on shift, she reviewed it and did not see the need to make any changes to what was allocated. Her evidence was that she had no information about Mr Furlan having a possible early or emerging psychosis, despite attempts she says she made to understand from Dr Staugas what the diagnosis was.

142 Nurse Shaw's evidence was that on 24 February 2018, while Dr Staugas was still in the nurses' station having just completed her notes from the assessment, she read the notes because she wanted to see what the diagnosis was and what the plan was for Mr Furlan. She said that upon her reading of the notes written by Dr Staugas, 'I could see 'major depression', and I couldn't read the rest'. Her evidence was that 'I thought 'I don't know what it says, therefore I'd better I'd better clarify what it says''. Her evidence was that she specifically asked Dr Staugas what was written there, and Dr Staugas told her 'major

[20] As indicated on Exhibit C72a

depression' but there was no mention of psychosis. Nurse Shaw said she asked Dr Staugas to rewrite her notes, but Dr Staugas said something along the lines of 'I am too busy'.

143 Dr Staugas denied that Nurse Shaw asked her to read the diagnosis to her. Her evidence was that if Nurse Shaw had asked her to do that, she would have told her the full diagnosis. Dr Staugas also gave evidence that Nurse Shaw did not ask her to rewrite her notes. Her evidence was she has never in her career been asked to rewrite her notes and therefore if that had occurred, she would recall.

144 Ultimately, what flowed from Nurse Shaw apparently not having this information is of little consequence. I say that because there is no basis for concluding that, had a registered mental health nurse been allocated to Mr Furlan as per that policy, that would have prevented Mr Furlan's death. Dr Naso expressed that in her view there is no reason to think that the allocation of a different nurse could have potentially resulted in a different outcome for Mr Furlan. Nurse Shaw gave evidence of her view that Nurse Foster, through experience, was better equipped than either of the registered mental health nurses rostered on for that shift to care for Mr Furlan. Furthermore, Nurse Foster's evidence was that she was aware that Dr Staugas had assessed Mr Furlan as having a possible psychosis, as she had reviewed the notes from Dr Staugas' assessment sometime later in the afternoon of 24 February 2018. She stated she 'had no difficulty reading the words major depression' or 'possible' or 'psychosis' in those notes. Her evidence was that even if Dr Staugas had told her that the diagnosis or assessment of Mr Furlan was major depression with a possible early or emerging psychosis that would not have changed the way she cared for Mr Furlan, and she still would have been comfortable caring for Mr Furlan.

145 Dr Staugas has directly responded to the allegations made by Nurse Shaw in her affidavit sworn on 18 July 2023. In that affidavit, Dr Staugas deposed to the fact that:

- she did not recall anyone asking her to read to them the words which appeared in the three lines below the words 'major depression' on page 83 of Exhibit C36a;
- had anyone asked her to read those words to them, Dr Staugas would have done so;
- if she had been asked what her diagnosis of Mr Furlan was, she would have said 'major depression with a possible early psychosis' as she had recorded in her notes, not just 'major depression' because that would have been an incomplete answer; and
- Nurse Shaw did not ask her to rewrite the notes of her assessment of Mr Furlan.

146 Dr Staugas was cross-examined in respect of that affidavit on 4 September 2023. Nothing of any relevance or significance was established in that cross-examination. Dr Staugas maintained her evidence that Nurse Shaw did not ask her to rewrite her notes.

147 Given that the allegations made by Nurse Shaw arose for the first time during her cross-examination, counsel for Dr Staugas could not cross-examine Nurse Shaw in relation to these allegations at that time. It was necessary for instructions to be obtained. Nurse Shaw was stood down for that purpose. However, Nurse Shaw did not return to complete her oral evidence for medical reasons. She has never been cross-examined about these allegations.

148 CALHN has submitted that in those circumstances the Court should make no positive finding on this topic of whether or not Nurse Shaw asked Dr Staugas about the diagnosis, including to read the note to her. CALHN has submitted that no positive finding is necessary as there is no basis to conclude that any such discussion directly or indirectly contributed to Mr Furlan's death. However, Counsel for Dr Staugas has submitted that the Court should make a positive finding as to whether this occurred or not. It is submitted on behalf of Dr Staugas that it is a very serious allegation against her. Dr Staugas has denied the allegation on oath. She was recalled to be cross-examined about her evidence on this issue. It is submitted that it would be unfair to Dr Staugas to leave this issue unresolved. I agree.

149 I accept Dr Staugas' evidence that she did not refuse to assist Nurse Shaw in understanding what the diagnosis was, either by telling her or rewriting the diagnosis. Whilst I note that Nurse Shaw did not return to complete her oral evidence on this topic for medical reasons, I regarded as implausible her assertion that she could not make out the word 'psychosis' in the notes.

150 It is also apparent that Nurse Shaw's failure to allocate according to the policy at the time was possibly explicable by her inexperience in the Team Leader role on the date of this shift. Saturday 24 February 2018 was Nurse Shaw's first day shift in two years, and her first day shift at the new RAH. She had just been made a level 2 nurse. Her expectation was that she would have had some orientation before being rostered on as Team Leader, but she found herself rostered on Saturday 24 February 2018 with no orientation having occurred. However, Nurse Shaw's evidence was that the fact she had not been trained as the shift coordinator did not have any impact on the events that transpired on 25 February 2018 in relation to Mr Furlan.

151 It is clear that, according to policy in place at the time, Nurse Foster should not have been allocated to care for Mr Furlan. Nurse Shaw, in her role as Team Leader should have amended this allocation. Nonetheless I find that, all other things remaining the same, the allocation of another nurse in accordance with the policy in place at the time would not necessarily have affected the outcome. The fact that Nurse Foster was not a registered nurse level 2, or a permanent and experienced mental health nurse was not a contributing factor to Mr Furlan's death.

Observations of Mr Furlan on the morning of 25 February 2018

152 Nurse Foster recorded her first observation of Mr Furlan at 7am and did them every 15 minutes up until 9:15am. Her evidence as to his demeanour that morning was:

> 'I recall vividly that his demeanour had changed. He was very elated; he was very helpful in wanting to complete the bloods; he actually - when he'd woken up he'd remembered that that's what we'd gone over in the - before I'd left my shift previously; and he was very consenting to do it, and do it straight away.' [21]

[21] Transcript, page 535

She went on to say:

> 'I felt his, yes, demeanour had improved, and I'd still assess, but at that stage there was a thought that maybe 15 minutes wasn't required.' [22]

153 One of the patients Nurse Foster was assigned to care for that morning was scheduled to be discharged to another facility. Nurse Foster stated that she continued to carry out checks on her other patients while managing the discharge process. However, the discharge took longer than expected due to the patient's OCD. Nurse Foster also stated that she did not inform Nurse Shaw that she was unable to complete close observations of Mr Foster while handling her other responsibilities.

154 Nurse Shaw's evidence was that she thought Nurse Foster had a small amount of work to do in relation to the discharge of the other patient and that she did not think it would have had any impact on her ability to undertake close observations of Mr Furlan. Nurse Shaw further explained that had she known Nurse Foster was too busy with the discharge to properly conduct Mr Furlan's observations, another staff member could have been assigned to ensure the checks were carried out as required.

155 Nurse Foster's last recorded observation of Mr Furlan was at 11:10am. She stated at this time Mr Furlan was in his room and she observed him standing up, moving about the room. Nurse Foster agreed with a proposition from her counsel that if she observed Mr Furlan at 11:10am, then the next observation would have been due no later than 11:25am. She was asked why she did not carry out that observation and her evidence was that she could not recall. She then agreed with the proposition that on that basis the next observation would have been due at about 11:40am, which was close to the time when the code blue occurred.

156 Nurse Maghsoudi provided an affidavit.[23] She described that Mr Furlan's wife presented at the ward to visit him, and so she looked up his details and room number and made her way towards the room. She described that when she entered the room the room was mostly dark, the toilet door was widely ajar to the inside of the room, and she saw Mr Furlan hanging from a grey jumper which was affixed to the top corner of the ajar toilet door. She screamed for help and nurses and security guards immediately came to her location.

157 I pause there to mention the fact that Mr Furlan used an item of his own clothing in this act of self-harm. The topic of whether use of a patient's own clothing in 2G acute was appropriate was briefly considered. I note Dr Naso's view as expressed in her report that the Investigating Officer suggested the idea of standardised hospital attire, unable to support a significant amount of weight, as a way to mitigate the risk of hanging attempts. She disagreed with this idea, explaining that Mr Furlan was already experiencing shame and stigma. Wearing one's own clothes helps preserve dignity and individuality, making it easier for patients to transition onto the ward. Her view was that introducing standardised clothing for patients with suicidal thoughts would effectively compromise their confidentiality, signalling to other patients and visitors that they are the 'suicidal

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[22] Transcript, page 537
[23] Exhibit C19

patients'. Given this, it seemed entirely appropriate for Mr Furlan to have his own clothes in his room.

158 As to the exact time that Nurse Maghsoudi entered the room, multiple duress alarms were pushed at 11:47am in response to the discovery of Mr Furlan hanging and, based on the evidence heard that there was a scream which caused multiple nurses to run to Mr Furlan's room, Nurse Maghsoudi must have discovered Mr Furlan seconds before the duress alarms were pushed. Thus, the time at which Mr Furlan was located can be reasonably established as a time between 11:46am and 11:47am.

159 That means that if Nurse Foster had last sighted Mr Furlan at 11:10am, as per the observation chart, then she in fact missed two observations that should have occurred at no later than 11:25am and 11:40am.

160 However, upon further examination, Nurse Foster gave evidence that she had in fact sighted Mr Furlan at 11:16am in his room, and she was not concerned about what she saw of him at that time. If that occurred, her next obligatory observation of Mr Furlan should have been done by 11:31am, and the next by 11:46am, around the time Mr Furlan was discovered hanging in his room. Thus, accepting the evidence of Nurse Foster that she did sight Mr Furlan at 11:16am, although she did not record it, Nurse Foster only missed one obligatory observation of Mr Furlan.

161 Regardless of whether Nurse Foster missed one or two observations that she was required to undertake, the fact that Mr Furlan was not observed for a period of between 30 and 36 minutes gave him ample opportunity to commit the fatal act.

162 I pause here to mention the issue of duress alarms. Nurse Shaw's evidence was that upon finding Mr Furlan hanging in his room after hearing the screams of Nurse Maghsoudi, she stated 'push your button, push your button' to Nurse Maghsoudi, and she also pressed her own duress alarm. However, as the duress alarms at the time were silent, it was not immediately apparent to Nurse Shaw if the pushing of duress buttons had been effective, as there was no noise that emitted from the button itself. The computers in the nurses' station would make a noise if the volume was turned up, but that noise would not be heard from anywhere other than the nurses' station.

163 In fact, what occurred was that four duress pendants were activated by different staff members at 11:47am in response to the situation with Mr Furlan. However, at 11:48am a fire system was activated in room 2G188 due a patient smoking and, accordingly, the nurse call annunciator panel then displayed the location 2G188-2G191, rather than the location of Mr Furlan's room.

164 Nurse Shaw's evidence was that she attempted to call a code blue at the same time via her two-way radio. However, she stated that:

> 'There were certain black spots in the hospital for the two-way radio systems that had been identified earlier. And when I asked around, after the event, if anyone had heard me calling a Code Blue, basically everyone said no, nothing came out over the radio.'

165 A code blue was called from the nurses' station at 11:49am. The medical emergency team (MET) arrived at 11:51am. Accordingly, there was a four-minute delay between the pressing of the duress buttons and the attendance of the MET. The impact that any delay

caused by the ineffective duress system and two-way radios, in terms of the delay in providing potentially lifesaving treatment to Mr Furlan, is unknown.

166 Nurse Foster could not explain with any certainty why she had missed an observation. The Court heard evidence about the impracticalities of close observations in 2G acute due to the layout of the ward. Nurse Charlesworth's evidence was:

> '… the layout of the 2G acute was impractical … for close observations and there was also a lack of visibility of the patient rooms from the nurses' station.'

Through discussions with other nurses, she was aware this was also the view of other nurses. Nurse Pinto raised in his affidavit that the main corridor is quite long which makes it difficult to allocate patients in an even way. Although the plan was apparently for patients to be out and about and not in their rooms, and for the nurses to be on the floor intermingling with patients, Nurse Charlesworth explained that:

> '… the work draws you into the office with case note writing and visual observations and admissions and discharges. So sometimes you are drawn away from your core business attending to length of stay and admissions and discharges.' [24]

167 There is a lack of visibility of the patient rooms from the nurses' station. During the view undertaken by the Court as part of the inquest, it was observed that Mr Furlan's room was not visible from the nurses' station. Nurse Foster's evidence was that the lack of visibility of Mr Furlan's room from the nurses' station did impact her ability to undertake observations of Mr Furlan because when she was sitting there, she could not see him. Furthermore, there were no viewing windows in 2G acute rooms, meaning there was no possibility of incidental sightings if walking past or stationed nearby.

168 The evidence revealed a number of possible factors which either on their own or in combination contributed to Nurse Foster missing the observations she was required to undertake of Mr Furlan; Nurse Foster's distress on that day following the death of a person close to her, the number of patients she was caring for, the distance between the rooms of the patients she was caring for, the lack of visibility of Mr Furlan's room from the other locations she was working from (room 6 and the nurses' station) when Mr Furlan engaged in the fatal act, and the complications of the discharge of the patient with OCD.

169 As stated by Dr Naso, the criticism is an obvious one; if Nurse Foster was unable to complete the observations at the required intervals, she should have handed that task over to someone else. Nonetheless, Dr Naso also pointed out that Nurse Foster's inability to do the checks at the requisite intervals highlighted the ineffectiveness of close observations and that, prior to the critical event, Mr Furlan had earlier opportunities to self-harm when observations had not been undertaken at the requisite intervals.

170 It must also be observed that the time at which Mr Furlan commenced the fatal act of suspending himself from the ensuite door is unknown. Indeed, even if the observations had been performed as per the prescribed observation regime, that may not have prevented Mr Furlan's death. As is obvious, the evidence was that 15 minutes is long enough for somebody to take their own life.

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[24] Transcript, page 215

Was Mr Furlan's death preventable?

171 Dr Naso's evidence was that if Mr Furlan was under continuous observations his death at the time would have been prevented. Though not specifically extrapolated in her evidence, that conclusion must have assumed that this would have been so if continuous observations were performed in the manner they are to be performed (that is, there was no opportunity for him to have ended his life under continuous observations, where there obviously should not be). Accordingly, I find that if Mr Furlan had been under continuous observations performed in the manner required, his death on 25 February 2018 would have been prevented.

172 In her report, Dr Naso provided some insight into Mr Furlan's potential long-term prognosis had his suicide been prevented. She highlighted that the treatment of psychotic depression typically involves a combination of antidepressants and antipsychotics. When there is limited response to this combination therapy, electroconvulsive therapy (ECT) should be considered. ECT is primarily indicated for patients with psychotic depression. Generally, if a patient shows improvement with combination therapy, the antidepressant should be continued for at least twelve months, and the antipsychotic for at least six months. In practice, many patients may require treatment on a lifelong basis.

Mr Richard Miller

Background

173 Mr Miller's family provided a number of statements to the Court providing background information and clear insight into how loved he was by his family and the devastating impact his death has had on them. The statements were written by Mr Miller's mother Regina, his sister Delise, and his niece Isabella. I am grateful for those statements and have carefully considered them.

174 Mr Miller was Richard John Miller Junior, named after his father. He was also known as 'Budda'. His mother shared stories of many happy and memorable times during his childhood years in Port Lincoln, including camping trips, trips to the beach, and fishing. He had close connections with his family members including his siblings, aunts and uncles, cousins and grandparents.

175 He was blessed to have two children despite being told in his younger years that it may not have been possible. His children were described as the apples of his eye.

176 Mr Miller had been diagnosed with a psychotic disorder that was sometimes described as schizophrenia and at others schizoaffective disorder, traumatic brain injury, intellectual impairment and substance misuse. His mother reports he had experienced a relapsing psychotic illness since the age of 17 with relapses precipitated by stopping depot medication and using cannabis and methamphetamine.

177 In relation to Mr Miller, the Court had the benefit of evidence from two independent experts; firstly, Dr Lynette Rose, whom the Court had engaged to provide an expert overview. Dr Rose works in private practice and as a senior consultant psychiatrist at Flinders Medical Centre within community mental health. She has previously been on the Examinations Committee of the Royal Australian and New Zealand College of Psychiatry (RANZCP) for seven years, Deputy Chair of the Committee for Specialist

International Medical Graduate Education with the RANZCP, and Chair of the Substantial Comparability Assessment Panel of the RANZCP. She has an active role in the assessment and training of psychiatrists across Australia and New Zealand and with binational committees of the RANZCP.

178 Sometime after receiving Dr Rose's report, it became known to the Court that the Office of the Chief Psychiatrist had engaged Dr Sophie Davison to undertake an independent review of the circumstances of Mr Miller's death, and that report was provided to the Court and tendered at inquest. Dr Davison was also called to give oral evidence.

179 The inquest primarily focused on the period when Mr Miller was under an ITO at the RAH just before his death. The adequacy of the treatment he received during prior mental health inpatient admissions and in the community was not scrutinised in great detail. However, both Dr Rose and Dr Davison provided a valuable overview and assessment of the care Mr Miller received in the years leading up to his final inpatient admission. I will summarise that information below, as it offers important contextual background for Mr Miller's admission to the RAH in June 2021.

Mr Miller's mental health history

180 Mr Miller first became known to services in 2004 and had 23 admissions prior to his last admission, along with multiple ED attendances in relation to relapse of his psychotic illness. He was well-known to community mental health services. His CBIS records show that over the years he had been a patient of the Murray Mallee, Eyre Regional, Whyalla, Eastern, and Western Adelaide mental health teams. He had variable levels of engagement with the teams looking after him and was non-compliant with oral medication and intermittently compliant with depot medication.

181 In 2017 he was hit by a truck as a pedestrian causing multiple injuries, including a severe brain injury by way of a compound skull fracture and extradural haematoma. It is reported that following the brain injury his levels of distress increased, his memory worsened, and his thinking was slower.

182 Mr Miller was released from Yatala Prison in June 2020 and was subject to a Community Treatment Order (CTO) which had commenced in custody and involved zuclopenthixol[25] depot injection. There is an entry in CBIS saying that on 12 June 2020 the prison consultation liaison mental health service were told that Mr Miller had been released. They made a referral to the Western community mental health team (CMHT) but were not able to ascertain Mr Miller's release address or with whom he was planning to live. He was not subject to a DCS licence. The Western CMHT sent an email on the same day to the Forensic Court Assessment Service asking if they had any contact details for Mr Miller. They responded that they did not and advised Western CMHT to contact the Aboriginal Liaison Officer (ALO) at Yatala. There is no mention of the CTO in either of the CBIS entries. It appears that the referral was not accepted by the community team because of the lack of a contact address.

183 On 17 June 2020 Mr Miller was brought to the RAH by SAPOL and SAAS. His mother reported that he was agitated, confused, and unable to sleep. His depot medication was

[25] Antipsychotic medication

due, and she mentioned that his speech was loud and bizarre, his mood was labile, and he had been using methamphetamine and cannabis. A diagnosis of drug-induced psychosis was made, and he was admitted under an ITO. The records indicate that Mr Miller was discharged on 19 June 2020 to his mother's house, with the ITO lifted, though he remained under the CTO initiated while he was still in prison, which expired on 17 July 2020. There is no evidence in the records of a clear discharge plan or an active referral to a CMHT, despite him still being subject to a CTO. Attempts to follow-up with Mr Miller by phone on 22, 23, and 27 June 2020 were unsuccessful, as noted in the CBIS.

184 On 23 September 2020 SAPOL contacted the Eastern CMHT to inquire about Mr Miller's next depot appointment, but they were informed that he was no longer a patient of the public mental health system. Mr Miller's mother later confirmed that he voluntarily attended the Port Adelaide Aboriginal Health Service for his depot medication. His next contact with public mental health services occurred on 6 October 2020 when his mother called SAAS expressing concern that Mr Miller had attempted to gouge his eye out. The SAAS co-responder service attended to him at home. Mr Miller denied attempting self-harm, explaining he injured his eye in a shed. He also reported using cannabis and methamphetamine. The service noted a possible early relapse of schizophrenia and referred him to the Western Adelaide CMHT.

185 On 8 October 2020 the CMHT attempted to contact Mr Miller's mother but received no response. They visited his sister's home and spoke to her, though Mr Miller was not there. They liaised with the Wonggangga Turtpandi Primary Health Care Service and confirmed that Mr Miller was attending for his depot medication. The CMHT kept the referral open for two weeks but closed it on 13 October 2020 after they were unable to engage with Mr Miller. Based on information from Wonggangga Turtpandi and Mr Miller's sister, they concluded that Mr Miller had suffered an acute episode of psychosis, likely due to drug use, which had since resolved. They discharged him into the care of Wonggangga Turtpandi, having confirmed with them that they would continue his care.

186 It appears Mr Miller spent four months in Mobilong Prison from November 2020 to 1 March 2021. Upon his release, he was referred to the Western Adelaide CMHT. However, the referral was discussed at their allocation meeting on 1 March 2021 and was not accepted, as Mr Miller had been receiving care from Wonggangga Turtpandi prior to his incarceration. The team determined there were no acute concerns warranting CMHT involvement and decided that he could continue receiving care from Wonggangga Turtpandi after his release. A plan was made to inform Mr Miller's mother of this decision and to send his depot chart from prison to Wonggangga Turtpandi.

187 According to the Forensic Court Assessment Service, Mr Miller was arrested and bailed on 12 March 2021 and 29 April 2021. In April 2021, Wonggangga Turtpandi referred Mr Miller to the Western Adelaide CMHT due to concerns about non-compliance with his depot medication and increasing drug use. Over the next three weeks, the CMHT made several attempts to engage with him but were unsuccessful. Attempts to contact Mr Miller's sister, mother, and father were also unsuccessful. It was noted that Mr Miller was in breach of his parole conditions, and although the team spoke to DCS, they were hesitant to initiate proceedings for breach. A letter was sent to both Mr Miller and his sister, as well as to Wonggangga Turtpandi, informing them of his discharge and providing contact details in case they wished to re-engage.

188 Dr Rose commented in her report that treatment in the community was challenging as Mr Miller was difficult to locate, living between several addresses and the streets. When located, staff often felt at significant risk due to the numbers of drug affected people around, putting them at risk in attempting to administer depot medication. Mr Miller frequently failed to attend appointments and did not engage with supports offered in the community. Alcohol, methamphetamine and cannabis were used daily when he had access.

189 Dr Davison opined that throughout this period of time, Mr Miller's care does not appear to comply with the OCP's Standard for continuity of mental health care for people exiting prison, particularly in relation to his release from prison in 2020 when he was subject to a CTO. No mental health clinician appears to have been identified to have ongoing responsibility for monitoring and reporting. She noted that, on looking through Mr Miller's past records, there were times previously where CMHTs have proactively coordinated his care in order to monitor his mental state, maximise his chances of remaining well and safe in the community and mitigate the risks as far as possible. In the year prior to Mr Miller's death he was not provided with that continuity and active care coordination and each referral appears to have been treated in isolation.

Arrest in June 2021

190 Mr Miller was arrested and remanded at the ARC on 2 June 2021 on charges of assaulting his defacto, hindering police and failure to comply with his bail agreement.

191 Prior to this arrest, he was on a disability pension. His defacto partner had an intervention order against him and their two children were in the care of Family Services. He was living between his mother's house and his sister's house.

192 Once in custody at the ARC, Mr Miller had daily assessments by the High Risk Action Team (HRAT). He was muttering under his breath, guarded, and obviously psychotic when assessed by a mental health nurse on 3 June 2021. A social worker noted he was flat and tired, polite and softly spoken, engaging in conversation, denying any mental health diagnosis, and did not appear to be psychotic. Heidi McConnell documented that he gave a good account of social issues, said he had been sleeping rough and asked for support with housing. He reported daily use of methamphetamine and that he was experiencing withdrawals. He told her his mental health was good, that he was not taking medication, and that he had cut his wrists two years earlier due to family stress. Dr Rose asserts that at this time:

> 'I suspect he was psychotic, but that it was not florid, not obvious without detailed assessment by a psychiatrist, and he was able to conceal it – not wanting treatment. There would also have been a drug induced component early in his stay in the ARC.'

193 On 7 June 2021 Mr Miller was seen by Dr Burgess, forensic psychiatrist. Dr Burgess noted that Mr Miller appeared healthy, had not cooperated with the CMHT, was no longer on depot, and lacked any overt signs of psychosis. Seroquel and mirtazapine were started orally for methamphetamine withdrawal. According to assessments conducted by the HRAT, Mr Miller was uninterested but cooperative, wishing for home detention, complaining of physical ailments, and had a stable and reactive mood as well as stable mental health. He was also courteous, engaging, future-focused and denied having psychotic symptoms.

194 Mr Miller was seen again by Dr Burgess on 11 June 2021. He told Dr Burgess it was better to be homeless due to family stressing him out too much, and that his mental health was 'heaps better' without 'white' medication and without mental health and psychiatrists 'playing with my head'. Dr Burgess documented that he was intense, seething with anger about psychiatric medication, family, and other things. He was thought disordered with bizarre delusions, likely to be responding to hallucinations, and irritable. Dr Burgess felt that Mr Miller had deteriorated since the last consultation, that he was experiencing a relapse of schizophrenia, that he was refusing voluntary treatment, and was at risk of aggression and sexualised behaviours when unwell. The only medication Mr Miller was willing to accept was quetiapine 200mg bd. The plan was to review him on 15 June 2021 for consideration of a CTO Level 1 and recommencement of depot zuclopenthixol.

195 Dr Jaqueline Condon, forensic psychiatrist, assessed Mr Miller on 15 June 2021 and placed him on a CTO Level 1. He was guarded and assessed as experiencing auditory hallucinations and persecutory delusions. He was described as severely thought disordered and difficult to understand, incoherent, with perseveration. Depot was commenced (paliperidone, rather than the zuclopenthixol he had previously been prescribed) with an intramuscular loading dose given. This CTO Level 1 was reviewed by Dr Burgess the next day, when he documented Mr Miller as floridly psychotic, admitting non-compliance with oral quetiapine.

196 Dr Rose expressed her opinion that:

> 'When seen by Dr Burgess on June 11th as a matter of routine due to his failure to comply with psychiatric follow up in the community, Mr Miller was becoming unwell and needed to recommence depot medication. I am uncertain why Dr Burgess did not initiate a CTO Level 1 and depot medication at this time with a decline in mental state noted and the risks to others when unwell known to Dr Burgess, though it is clear he considered it as potentially required. I note that there were no immediate risks to self and others and Mr Miller was continued on low dose oral antipsychotic medication, with involuntary treatment and depot medication (paliperidone) under a CTO deferred for a further 4 days. Although known to respond to high dose depot zuclopenthixol, a trial of paliperidone, in a safe and supervised setting, was appropriate – with the reasoning of less frequent injections and less difficulty achieving this in the community.'

197 Dr Davison was asked to comment upon the view expressed by Dr Rose that the depot injections could have been commenced four days earlier than it ultimately was on 15 June 2021, and her evidence was that the decision not to initiate the CTO at that time was a reasonable one, trying to develop a therapeutic alliance and seeing whether he would agree to take some oral medication if he was refusing the depot. Her evidence as to what impact it may have had on him if Mr Miller had commenced the depot on 11 June 2021, rather than 15 June 2021, was that:

> 'It may have prevented him deteriorating quite so badly that he needed admission, but depots take 10 days to two weeks to start really taking effect once you've restarted them, if you haven't been on them for a while. So it's not clear whether he was already going down a path where he was relapsing so badly he needed to go into hospital. But it may have made it a less severe relapse and it might have reduced the need to transfer him acutely to inpatient care. But four days wouldn't have made an enormous difference.'

198 On 19 June 2021 Mr Miller is documented as disoriented, quarrelling with other prisoners prior to cell inspection, and not feeling safe. On 21 June 2021 he is documented as

agitated, irritable, crying uncontrollably, guarded and appearing to be responding to hallucinations. He was thought disordered, chanting, and his behaviour was unpredictable with intimidation of staff and making 'threatening gestures'. He was also described as volatile, displaying odd behaviour and yelling. He was given the second dose of intramuscular paliperidone 150mg.

199 On 22 June 2021 Dr Condon detained Mr Miller on a Level 1 ITO. He was labile, smiling and crying, unable to answer questions, responding to hallucinations and unable to be distracted, unpredictable and aroused. He was talking to himself, had 'homicidal ideation' and there were reports he was 'barking like a dog'. Of the decision to place Mr Miller under an ITO at this time, Dr Rose stated that:

> 'It was essential that Mr Miller be placed under an ITO as he did not have capacity to consent to treatment. He required closed ward treatment for the safety of others and himself, and this cannot be done without an ITO.'

200 Overall, Dr Rose and Dr Davison shared the view that whilst the depot medication could potentially have been commenced four days earlier, the psychiatric treatment provided to Mr Miller in custody was appropriate.

Admission through RAH ED

201 According to Dr Rose, it was clear that by the time of Mr Miller's admission to the RAH ED he had lost contact with reality. He was extremely disinhibited and delusional and thus required physical and chemical restraint for his safety and that of others. His behaviour was extremely agitated and escalating despite him receiving large doses of sedating medications including lorazepam, olanzapine, midazolam, droperidol and clonazepam. It was observed that medication controlled his behaviour for about 20 to 30 minutes only, and there was also evidence of short periods of repeated apnoea (difficulty breathing). He was in three-point shackles, which was later changed to six-point shackles due to his disturbed behaviour.

202 Dr Davison opined that management of Mr Miller in the ED was particularly challenging and I accept that was the case. It was recommended by psychiatrists that Mr Miller be admitted to the PICU rather than James Nash House in the first instance, as Mr Miller's airways needed monitoring and the PICU was much closer to medical intervention. Dr Davison's view was that this was an appropriate decision at that time.

Time in PICU

203 Mr Miller was admitted to PICU on 23 June 2021. During this time Mr Miller was under the care of a treating team which included consultant psychiatrist Dr Reece Bretag-Norris and registered medical officer Dr Andrew King. An affidavit was provided from Dr Bretag-Norris and Dr King gave evidence at the inquest.

204 Dr King first reviewed Mr Miller on 24 June 2021. He described that Mr Miller was one of the most unwell people he had ever seen, and during their first meeting Mr Miller was unable to meaningfully communicate. Dr King stated that over the following few weeks the most significant change was that Mr Miller demonstrated a significantly improved ability to communicate more clearly and became less thought disordered. Dr King opined that Mr Miller was psychotic the entire time he looked after him, and that while the

treatment did improve aspects of his psychosis, a level of thought disorder was always there.

205 During his time in PICU Mr Miller had various outbursts. He made threats and displayed risks of self-harm, usually in response to conflict with others, his needs not being immediately met, and his frustration. Episodes in PICU included:

- On 26 June 2021 he was found putting paperclips into a power point and told staff his girlfriend wanted him dead;
- On 1 July 2021 he was found with a metal screw in his mouth, taken from the bed, and a broken tooth;
- On 3 July 2021, following a telephone conversation with his father, he became very aggressive and agitated, kicking, punching and head-butting walls, windows and furniture out of frustration;
- At a psychology review on 5 July 2021 Mr Miller said he was becoming sadder and sadder. In the evening he told staff, 'I don't want to wake up in the morning';
- On 6 July 2021 he pulled out a loose molar tooth;
- On 7 July 2021 he expressed suicidal ideation after an adjourned court hearing;
- On 8 July 2021 he was banging his head in the shower, distressed and wanting his mother;
- On 10 July 2021 he became irritated and threatening with the security guard when out in the courtyard;
- On 12 July 2021 he was yelling and screaming in the courtyard, 'Who do I have to hit to get out of here'; and
- On 13 July 2021 a plastic knife with a sharp piece was found hidden in his nicotine inhaler.

206 Mr Miller's time in the PICU was characterised by a noticeable lack of contact with his family. While phone calls were arranged with his mother and occasionally his father, he did not have any visits from his family. It was revealed that there may have been a miscommunication as the family was waiting to be invited to visit, while staff were waiting for the family to request a visit. Although a document listing approved visitors from DCS should have been provided to Ward 2G, Ms Legg confirmed that she has searched for this document but could not find it in relation to Mr Miller. The lack of contact was deeply distressing for Mr Miller and his family.

207 Furthermore, Mr Miller did not have the benefit of regular engagement with an ALO or an Aboriginal mental health worker (AMHW) during his time in 2G. Mr Miller asked on

several occasions to see an ALO.[26] Staff made several attempts to contact the ALO following these requests, but there is no evidence of any response from an ALO. Mr Miller was not seen by an ALO until he had been in hospital for two weeks.

208 There were seven roles for ALOs or AMHWs in SA Health at the time of Mr Miller's death. These positions were to service the Glenside Campus, The Queen Elizabeth and Repatriation General Hospitals and the Hampstead Rehabilitation Centre. Mr Brenton Wilson, who was the ALO that visited Mr Miller in 2021, stated that it was difficult to fill the ALO roles and that at times he was the only ALO or AMHW although there were six other roles to fill.[27]

209 Mr Wilson was able to see Mr Miller on 6 July 2021 and stated that 'when he saw me, he lit up and was smiling'. Mr Wilson also recalled that Mr Miller was 'easy to talk to and he engaged well during [their] session together', that '[h]e was open and forthcoming as to what was going on in his life' and that he gave him a hug when he left. He also noted that Mr Miller was in 'pretty good spirits' when he saw him.[28]

210 On 12 July 2021, Mr Wilson made a note about his attendance on Mr Miller on 6 July 2021.[29] Although he made steps for a cultural healer to attend, that did not eventuate before Mr Miller's death. Mr Wilson said that he would have liked to have seen Mr Miller every two days, but due to 'capacity and staffing issues' he was unable to. He was next to see Mr Miller on the day that he died.[30] There is no evidence that Mr Miller knew that Mr Wilson was going to see him on 15 July 2021.

211 Ms Legg's evidence was that it is difficult to find staff to fill these roles. In July 2021, only two ALOs or AMHWs were employed to cover the seven sites. Management was aware that the ALOs were understaffed and overwhelmed but stated that there was little they could do about that.[31]

212 According to Dr Davison, ALOs and AMHWs play a crucial role in the care of Aboriginal people. They act as bridges in communication between the clinical team, families, and the community. They help navigate complex cultural, historical, familial and societal issues while offering direct culturally responsive support to consumers. Had Mr Miller been able to meet regularly with an ALO during his stay, it might have contributed to creating a support plan that included his family in a culturally safe manner. This could have helped reduce Mr Miller's distress, fostered the development of a trusting therapeutic relationship, and improved communication with staff, provided the ALO worked closely with both the treating team and Mr Miller's family.[32]

213 Dr King's last review of Mr Miller was the day before his death, 14 July 2021. Dr King described on this occasion that Mr Miller was still quite unwell. He was still in a psychotic state, but there was nothing that separated this review from the reviews leading

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[26] On 1 July 2021 Mr Miller asked to speak with an ALO (Exhibit C66, page 396) and Dr King noted that Mr Miller 'brightened when offered an ALO again' (Exhibit C66, page 400). On 2 July 2021 Nurse Taylor noted that she filled out a referral for Mr Miller and attempted to call an ALO twice to activate the consult but that no one answered.
[27] Exhibit C87
[28] Exhibit C87
[29] Exhibit C66
[30] Exhibit C87
[31] Exhibit C87
[32] Exhibit C74

up to this date. He stated in the notes from that day that Mr Miller denied suicidal ideation, homicidal thoughts, or that he was hearing voices. Dr King's evidence was that following the review on 14 July 2021 he had no interaction with Mr Miller, nor was he contacted and made aware of any concerns about Mr Miller, until he set about seeking to review Mr Miller on 15 July 2021.

Comments to Nurse Taylor on the evening of 14 July 2021

214 Ms Jamie Taylor commenced working in the RAH on Ward 2G in approximately May 2021. Her role on 2G was as a primary nurse. Her tasks included visual observations on patients, administering medications, attending medical reviews, transfers in and out of the ward, and various other tasks. Nurse Taylor was assigned to care for Mr Miller on a number of occasions. The last of those was 14 July 2021, the day before Mr Miller's death. She had also been his primary carer the previous day.

215 Her notes from her interactions with Mr Miller on 14 July 2021 are contained in one CBIS entry. The note includes a 'mental state examination' which stated that Mr Miller denied any thoughts of self-harm. That was not correct. Towards the end of Nurse Taylor's shift on 14 July 2021, Mr Miller had approached the nurses' station requesting to make a phone call and to use the DVD player. He was unable to make a phone call because the dining room where the phone was located was being cleaned, and the DVD player was being used by another patient. Nurse Taylor described, upon being advised of that, he became upset and stated that he did not want to be alive anymore and he wanted to die.

216 Clearly, Nurse Taylor's note at the conclusion of her shift on 14 July 2021 that Mr Miller denied any thoughts of self-harm was not accurate. Nurse Taylor's evidence was that she had copied and pasted this mental state examination from the previous day and had neglected to update it at the end of the shift. The use of copy and paste in this manner is a risky and unacceptable practice that should not occur, as it may lead to errors such as this critical oversight.

217 Nurse Taylor's clinical note recorded that the statement was made in the context of being denied access to DVDs and a telephone call. However, her affidavit tendered at the inquest stated the comments were made in the context of not wanting to be in 2G anymore and wanting a bed at James Nash House. In her evidence, Nurse Taylor stated this comment was made by Mr Miller in the context of both of these things (refusal of DVD access and not wanting to be in 2G but wanting to be in James Nash House).

218 Nurse Taylor gave evidence that she was of the understanding that Mr Miller had made a similar comment on at least one other occasion[33] and that this was information she was told verbally by anther staff member. The CBIS documents do record another occasion[34] when Mr Miller had made a similar comment.

219 Dr Davison's evidence was that the comment needed to be explored in some detail with Mr Miller and that the full and proper context in which the comment was made needed to be recorded in the medical notes. There is no evidence to suggest the comments were explored in adequate detail with Mr Miller. Nurse Taylor stated she could not recall

[33] Transcript, page 1177
[34] Exhibit C66 page 342

having a 'complete conversation' inquiring of him into what sat around those concerns,[35] and agreed there is no record of a complete conversation occurring. Indeed, Nurse Taylor's evidence of her exchange with Mr Miller following this comment could hardly be regarded as a proper exploration of the comment.

220 It was explored with Dr Davison whether the comment was more concerning as being an indicator of Mr Miller being at risk of self-harm, with the additional context of not wanting to be in 2G but wanting a bed in James Nash House, rather than only being made in response to being denied access to DVDs and a phone call. Dr Davison was of the view that a comment of that nature could change his level of suicide risk and:

> '… that's why it's important to really try and clarify with the person what they mean by that, how distressed they are, whether it's a throwaway comment in the context of feeling very frustrated, but they have no intention, or whether it's associated with serious hopelessness and a feeling that they've got no other option or way out.'

221 Nurse Taylor appropriately conceded that she neglected to record in her CBIS note that the comment was made in the context of not wanting to be on 2G anymore and wanting a bed in James Nash House. However, her evidence was that she verbally handed over this information – including the context about wanting to be in James Nash House – to nightshift nurses and to her supervisor Nurse Chan, simply to make him aware that it had occurred. Nurse Taylor did not consider taking any further action other than notifying Nurse Chan.

222 In oral evidence Nurse Taylor could not recall the exact words used when she spoke to Nurse Chan, and she could not recall his response. Nurse Taylor's own view was that nobody needed to explore the comment with Mr Miller at that time unless there were further concerns, and therefore she would not have advised anybody as part of the handover that that should occur. She stated that it was up to others who became aware of this information to make their own judgment about what further action, if any, needed to be taken in response to that. She wanted to make Nurse Chan aware that Mr Miller had made these statements so that if he was still upset it could be acted upon at that time.

223 Nurse Chan's evidence was that he does not recall a conversation to this effect with Nurse Taylor, but it may have occurred. Nurse Taylor did not consider Mr Miller's statements to be an expression of clear intent to seriously harm himself. It can be inferred from that, that if there was a conversation between Nurse Taylor and Nurse Chan about what had taken place when Mr Miller made these comments, Nurse Taylor would have her opinion conveyed, expressly or implicitly, that she did not consider it to be an expression of clear intent to seriously harm himself.

224 Nurse Chan explained what he would have done had Nurse Taylor provided this information to him; that is, he would have undertaken a mental health assessment and made his own assessment of how acute Mr Miller's suicidal ideation was. That would have involved him gathering more information from Nurse Taylor about whether there had been any changes in Mr Miller's static or dynamic risk and speaking to Mr Miller himself. Depending on the outcome of that exploration, he would have decided whether it was necessary to arrange a nurse special to continuously observe Mr Miller until his next medical examination. Whilst expressing that if, upon exploration, Mr Miller's risk

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[35] Transcript, page 1169

profile had changed, he may have arranged a nurse special, he considered it likely that this would not have occurred based on the information known to him.

225 Nurse Taylor's evidence was that at the time the comments were made, and based on her interaction with Mr Miller, she did not form the view that his level of observation needed to change. Though she was aware of the policy in relation to continuous observations at the time, which dictated that anybody who expressed a clear intent to seriously self-harm should be specialled or under continuous observations, she did not consider Mr Miller to be expressing a clear intent to seriously self-harm when he made this statement.

226 Nurse Taylor's evidence was that, in her view, those comments did not change Mr Miller's level of risk. Dr Davison stated that she probably would have changed it to medium but noted that she does not think those categories of risk are particularly helpful. The fact that Nurse Taylor did not update Mr Miller's risk at that time to either medium or high was of little consequence. The evidence was that if she had updated his risk at that time to medium, 'that would have been a discussion within the team whether we could continue 15-minutely observations or if he required a nurse special'. If his risk was updated to 'high' at the time, then he would have been allocated a nurse special, though it was noted by Dr Rose that even if Mr Miller had been placed on continuous observations overnight due to that outburst, it most likely would have been lifted as he reportedly had settled and slept well all night. Dr Rose's evidence was that there was nothing untoward noted on the morning of 15 July 2021 that indicated he was suicidal and needed continuous observations on that morning, and that at that time, close observations in the PICU setting were appropriate.

227 In relation to the comments made to Nurse Taylor on the evening of 14 July 2021, Nurse Taylor should have delved deeper into these comments and made more detailed notes about the conversation, including the context in which the threat was made and a thorough exploration of the remarks. However, considering the events that occurred on the morning of 15 July 2021, when no concerns were reportedly raised, any potential changes implemented as a result of heightened concern on the afternoon of 14 July 2021 had the comments been properly explored - namely continuous observations - would likely not have remained in place by the time of Mr Miller's death on 15 July 2021.

228 I also note the conclusion of Dr Davison that the wish to die expressed the night before Mr Miller's death does not of itself mean he planned to take his own life when he did. Dr Davison observed that his death was a tragic and unforeseen event. She stated that it is not clear what his intention was when he placed the ligature around his neck.[36]

Events of 15 July 2021

229 Mr Prakash Veluchamy started working at the RAH in March 2021 as a registered mental health nurse.

230 Nurse Veluchamy completed his nursing studies in India in 2004 and then worked as an intensive care nurse in India between 2005 and 2007. He worked a further two years as a nurse in Abu Dhabi before relocating to Australia in 2009. Upon arrival in Australia, he completed a six-month bridging course through the University of South Australia in

[36] Exhibit C74

order to become qualified and registered as a nurse in Australia. He then worked as a nurse in an aged care setting for nine years (between 2009 and 2018). He completed a Graduate Diploma in Mental Health through the University of South Australia in 2018 and began working as a mental health registered nurse at the Lyell McEwin Hospital. He worked at the Lyell McEwin Hospital for three years in a similar setting to ward 2G at the RAH, that is, a mental health ward with both open and closed wards.

231 In March 2021 Nurse Veluchamy transferred to work at the RAH in the mental health ward on a full-time basis. He worked in both the acute mental health ward and the PICU.

232 Nurse Veluchamy described that upon his commencement at the RAH in March 2021 he was provided with an online orientation module of approximately one hour in length, and an on-site ward orientation which he said consisted essentially of following a 'buddy' nurse around while they completed their duties. His evidence was that the onsite ward orientation was usually meant to occur for two days, however he only did this for one day as the ward was short staffed at that time.

233 Nurse Veluchamy gave evidence that he was not given any specific instructions during his online orientation or his buddy orientation as to how to perform clinical nursing duties such as taking vital signs and performing visual observations. Nor was he given copies of any written policies throughout the orientation process or directed to read any particular policies before he started working. He was aware as a matter of general knowledge that policies are usually available online and seemed to recall that hard copy policies were available in the nurses' station when he started working there.

234 Nurse Veluchamy was on duty on 11 occasions throughout the course of Mr Miller's 23 days in the PICU. On various occasions prior to 15 July 2021, Nurse Veluchamy cosigned and/or administered medication to Mr Miller and performed visual observations of him when relieving other staff. On 5 July 2021, Nurse Veluchamy assisted Mr Miller's primary nurse in de-escalating a situation and spent some time talking with Mr Miller. However, prior to 15 July 2021, Nurse Veluchamy had not been specifically allocated to care for Mr Miller.

235 Nurse Veluchamy commenced his shift at 7am on 15 July 2021. It is noted that there were no observations recorded as having occurred between 6am and 7:15am that day, however, there has been no evidence as to why that was the case.

236 As to staffing during this day shift, one of the nursing staff was not allocated patients so that they could support breaks and be of assistance to other nurses for the shift. However, the result of this was that Nurse Veluchamy was allocated two patients in addition to Mr Miller, when he should have only been allocated one patient other than Mr Miller. An obvious consequence of this is that Nurse Veluchamy may have had less interaction and less opportunity for interaction with Mr Miller due to the fact he was caring for two other patients rather than the one he should have been. Accordingly, events that transpired during this shift with Mr Miller occurred in the context of Nurse Veluchamy being allocated more patients than policy dictated.

237 Nurse Veluchamy's evidence was that he is confident that he would have read Nurse Taylor's CBIS note of the day prior because this is his general practice. He could not

recall whether it was communicated to him, either verbally or through the journey board,[37] any different context for those remarks other than what was in the notes. He did say that if he was aware of the comments in the context of being in a sense of despair or helplessness about being stuck in hospital and wanting to go to James Nash House, it is very hard to say if he would have changed anything about the way he went about his duties that morning.

238 At 8:02am Nurse Veluchamy went to call Mr Miller for breakfast. Mr Miller said he wanted to sleep and refused breakfast.

239 Nurse Veluchamy administered medication to Mr Miller at 10:18am and 10:19am.

240 At some point during the morning Mr Miller went to the nurses' station and asked Nurse Veluchamy to make a phone call to his mother. Nurse Veluchamy's evidence was that he made this call but there was no answer. His evidence was that he did not see Mr Miller upset once he advised him that the call was unsuccessful.

241 Nurse Veluchamy also recalled seeing Mr Miller again in the dining room, sitting alone eating morning tea. The evidence was that morning tea is usually between 10:15am and 10:30am. According to the observation chart, Nurse Veluchamy sighted Mr Miller at 10:16am and 10:36am but he could not recall on which of these occasions he sighted Mr Miller eating morning tea.

242 Nurse Veluchamy's evidence was that the next occasion he saw Mr Miller was when he went to his room and the guards reported to him that Mr Miller had just had a shower. His evidence was at this time the bedroom door was shut. He looked through the window and saw 'the rolling of Mr Miller' which he elaborated was 'movement from this side to that side'. He could not recall what Mr Miller was wearing or whether he was under the bedsheets or on top of them. Nurse Veluchamy was adamant in his evidence that what he described seeing is what he has recorded as the 10:42am observation.

243 Nurse Veluchamy's recollection as to the timing of the phone call to Mr Miller's mother was that it was proximate to the timing of the medication administration. However, a table tendered by CALHN as apparently generated from internal RAH telephone records,[38] indicated that a telephone call was made from within the PICU nursing station to Ms Miller's mother on 15 July 2021 at 10:46am for 21 seconds.

244 Mr Miller's mother's telephone records[39] indicate that her mobile was being used to make a series of calls that morning shortly prior to 11am: at 10:41am for one minute (ie. until 10:42am), at 10:42am for one minute, a further call at 10:42am for six minutes (ie. until approximately 10:48am), at 10:48am for one minute (ie. until approximately 10:49am), at 10:49am for one minute (ie. until approximately 10:50am) and at 10:51am for one minute (ie. until approximately 10:52am).

245 On the evidence it is likely that the telephone call from the PICU nurses' station at 10:46am went unanswered by Mr Miller's mother (or was diverted to voicemail) because

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[37] The journey board was a tool used by the team leader to handover for the next day. It had the names and room numbers of patients. They write information on it. There is no hardcopy, but it can be printed out (transcript, page 1230).
[38] Exhibit C90
[39] Exhibit C90a

Mr Miller's mother's mobile was in use at the time. It also appeared from that evidence that Nurse Veluchamy made that phone call at 10:46am, rather than earlier in time, shortly after administering medication, as he thought.

246 As the timing of the phone calls was not known at the time Nurse Veluchamy gave his evidence, it was not put to Nurse Veluchamy in the course of his evidence that he might be mistaken about the timing of the call that he made to Mr Miller's mother. However, it seems that is a reasonable possibility. Any inaccuracy on Nurse Veluchamy's part as to the timing of that appears to have been merely confusion which is hardly surprising given the lapse in time between this event and him being asked questions when giving evidence at the inquest.

247 The evidence from the forensic guards supported the conclusion that the phone call took place at 10:46am. Mr Rafiq indicates that Mr Miller left his room at approximately 10:45am and knocked on the nurses' station and asked the nursing manager for a phone call. Mr Rafiq stated he did not hear any conservation that occurred with the nursing manager. Mr Kumar, the other guard present at that time, also stated that Mr Miller went and knocked on the window of the nurses' station at 10:45am.[40]

248 The affidavits from all the guards involved in caring for Mr Miller that morning indicated only one occasion upon which Mr Miller approached the nurses' station and asked for a phone call while they followed behind him. Nurse Veluchamy reported that when Mr Miller approached the nurses' station asking for a phone call, the guards followed him. It is likely that there was only one occasion upon which Mr Miller approached the nurses' station asking to make a call. Nurse Veluchamy must have been there at the time that request was made, in addition to the nurse manager David, and Nurse Veluchamy must have made the one and only call that was made to Mrs Betts on 15 July 2021 before Mr Miller's death at 10:46am.

249 Of note is that the observation record indicated that there was a period of 20 minutes between 10:42am and 11:02am where Nurse Veluchamy did not observe Mr Miller, which would indicate there was five minutes longer than there should have been between those observations. However, the evidence suggested that Nurse Veluchamy did in fact sight Mr Miller at 10:46am when he made the phone call, and thus he would have next been required to observe Mr Miller at approximately 11:02am.

250 The next observation, according to the observation chart, is recorded to have occurred at 11:02am. Nurse Veluchamy had no independent recollection of that observation though was confident he would not have recorded that observation if it did not occur.

251 Counsel for Nurse Veluchamy has submitted that he gave his oral evidence in a careful, considered and detailed manner. It was submitted that Nurse Veluchamy made appropriate concessions and did not purport to stray inappropriately beyond matters within his own knowledge or recollection. He was careful to distinguish between things that he could picture in his mind's eye and those which he could not recall and would

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[40] Though he stated he thinks the nurse manager that Mr Miller spoke to told him his nurse, Nurse Veluchamy, was on a break, Nurse Veluchamy stated he was not on a break at that time. Despite Mr Kumar thinking that may have been said, it seems unlikely that it was.

otherwise be reconstructing. I agree with that assessment, and I accept his evidence that he performed the 11:02am observations which he recorded.

252 Nurse Veluchamy has recorded next to the 11:02am observation the number 1, indicating that Mr Miller was asleep at this time. An inference can be drawn, based on the evidence Nurse Veluchamy gave as to his usual practice of observations when a patient was sleeping, that Nurse Veluchamy may have conducted this observation from the outside of Mr Miller's room through the window, or he may have entered the room, but either way, he was satisfied he could see the rise and fall of Mr Miller's chest.

Observations through the window of a sleeping patient

253 Nurse Veluchamy detailed the practices he had witnessed from other nurses on the ward, which he followed for patients undergoing 15-minute observations. He stated that it was not necessary to speak to the patient every 15 minutes, and that clinical judgment was required to assess each case individually. He was of the view that simply seeing a patient walking around the ward could count as an observation for 15-minute check. He further clarified that observing a patient through the window of their bedroom door, seeing them walk around or sit at their desk, was adequate for a visual observation, although he acknowledged that if a patient were agitated or engaging in harmful behaviour, further action would be required.

254 Nurse Veluchamy emphasised that no explicit instructions were given to him regarding the use of the bedroom door window within the PICU for performing observations. He simply mirrored the practices he observed from other nurses and was clear in his testimony that he saw others using the bedroom door window for visual checks. He reaffirmed his understanding of this approach, stating:

> 'The main thing … is if you can't see the patient walk in. If you're unsure, walk in. If you're unsure about breathing, walk in. That's what I've been saying…'

255 Nurse Veluchamy confirmed that he was never directly instructed that observing a patient's neck was important for visual checks, nor was he told that it was inappropriate for patients to sleep with a hood over their head or that such situations required entering the room for a visual inspection. His testimony was consistent: if he could not clearly see the patient through the window, he would enter the room right away.

256 Nurse Veluchamy also explained how he conducted 15-minute checks on sleeping patients, which was based on practices he observed from other staff members. He described checking for the rise and fall of the patient's chest to determine whether they were asleep, noting that if he could observe this movement for six to eight seconds, he would be confident the patient was sleeping. When a patient fell asleep in their room with the door closed, Nurse Veluchamy explained his usual approach:

> 'If the room was dark, I would go in; but if I could see the patient, I would stand there for six to eight seconds, watch the rise and fall of the chest, and document 'asleep.''

If he could not observe the chest movement through the window, he would enter the room and continue the check from within. If he still could not confirm the patient was asleep, he would attempt to wake them by tapping their leg, hand, or face.

257 Nurse Veluchamy acknowledged that factors like room lighting, and the patient's position could impact his ability to observe clearly. However, he stated firmly that if he had any doubts about his observation, he would open the door and enter the room to verify the patient's condition. He also mentioned that the potential noise caused by entering with a swipe card, which had previously upset some patients, would not deter him from entering to confirm the patient's status.

258 Nurse Veluchamy stated that no one at CALHN or the RAH ever told him that his method of performing visual checks through the bedroom door window was wrong or inappropriate. He also confirmed that no one ever suggested this practice was inconsistent with CALHN's expectations or the standard practice on the ward. There was no evidence to suggest he had been told otherwise. Nurse Taylor's testimony aligned with Nurse Veluchamy's account. Nurse Taylor, who started at RAH in May 2021 (shortly after Nurse Veluchamy began in March 2021), did not recall receiving specific orientation or written policies, although she knew policies were available on the intranet. When asked about performing visual checks through the bedroom door window, she said:

> 'That's what I was told, and as long as we could see the rise and fall of the chest, that was acceptable. If I couldn't see it, I would go in there.'

259 Nurse Taylor noted that she had been instructed about this practice during her initial training and through hands-on experience with other nurses. When asked to clarify the training she received regarding visual checks in PICU, she explained that she was referring to general training as part of her enrolled nurse education, rather than specific training for the ward. Nurse Taylor also said that if she could not see the rise and fall of the chest, especially in a dark room, she would enter and 'look and listen for breathing'. However, if she could observe the chest movement through the window, she would consider the observation complete. She agreed that it was ultimately a matter of clinical judgment for the nurse to decide whether they were satisfied with their observation of the chest's rise and fall. Nurse Taylor also stated that during her time working in PICU, no one had told her that her approach to visual checks was incorrect or contrary to the ward's expectations, nor had anyone suggested she should avoid using the bedroom window for such checks.

260 Nurse Charlesworth, the nurse unit manager for Ward 2G before August 2019, agreed that determining whether a patient's chest is rising and falling is a clinical judgment for the nurse conducting the observation. Essentially, it was up to the nurse to be satisfied that they were capable of making the correct observation. The key matter from her perspective was 'seeing the chest rise and fall'. Though she expressed doubt about the ability of nurses to see the rise and fall of a patient's chest from the window, she had never in fact attempted to perform such an observation herself. I accept, based on evidence from Nurses Veluchamy and Taylor, who did in fact perform such observations, that it must have been possible to observe this through the window, at least on some occasions.

261 The most telling suggestion of the existence of widespread and common practice with respect to the use of the bedroom door windows when performing visual observations of

sleeping patients in PICU bedrooms, was contained in an email sent to nursing staff shortly before the commencement of the inquest on 28 April 2023[54] which stated:

> '**Visual observations in PIC**
> PIC unlike Acute has bedroom doors that have a window in them
> While this should be used to ensure that you can safely enter the room, especially at night the viewing window should not be used for the purpose of visual observations and assessing signs of life.
> Even if the bathroom light is on overnight, lighting is not sufficient to ensure adequate assessment during visual observations.
> Like in Acute, overnight visual observations mut occur by opening the bedroom door and viewing the patient directly, not through the window in the bedroom door.

262 Implicit in this email is the fact that there had been a practice, continuing up until two years after Mr Miller's death by the time this email was sent out, of using the bedroom windows 'for the purpose of visual observations and assessing signs of life'. Nurse Veluchamy gave evidence that this email was the first time he was given any direction in relation to the use of the windows when performing visual observations. It is curious that the email says nothing about the performance of visual observations through the bedroom windows during the daytime and thus might imply that such a practice is acceptable during the day.

263 Ms Legg's evidence was that this email would have been sent as a result of preparations for this inquest and that the primary reason for sending this bulletin out was to avoid situations such as Mr Miller's where Nurse Veluchamy looked through the observation window, but did not go into the room. However, based on the evidence of Nurse Veluchamy, it is fair to conclude that even had this communication been in place at the time of Mr Miller's death, he still would not have gone in the room (as it was day time and he could see signs of life through the window).

264 I accept that the way in which Nurse Veluchamy used the bedroom door window on Ward 2G on the morning of 15 July 2021 to perform routine visual observations of Mr Miller, including when he was asleep, was consistent with the common practice of the nursing staff on the ward at the time. It had not been suggested to Nurse Veluchamy as being inappropriate or contrary to expectations or policy at that time.

The next observations due after 11:02

265 Nurse Veluchamy stated that at some time after the 11:02am observation, Dr King asked him to get Mr Miller for his daily review. Accordingly, Nurse Veluchamy went to Mr Miller's room and entered using his swipe card. He said he went in and called 'Richard, Richard' while standing near the bed. He could not recall whether the lights were on or off and whether the blinds were open or closed. He could not recall the position that Mr Miller was in. He stated he patted his leg four or five times and touched his hand. He could not recall seeing the rise and fall of his chest at that time, but he recalls seeing Mr Miller's face and noted 'nothing was significant, alarming for me at that moment'.[41] His evidence was 'I thought that Mr Miller was okay ... that I had in back of my mind that I was thinking Mr Miller was not ready for the review'. His evidence was that at least one of the guards was in the room at this time. He stated he went back to Dr

[41] Transcript, page 1291

King who was in front of the nurses' station and reported to him that Mr Miller was 'playing possum'.

266 Nurse Veluchamy's evidence was consistent with the evidence of Dr King who stated that he asked the nurse to get Mr Miller for his daily review. Dr King reported that the nurse came back less than a minute later:

> '… and said 'He doesn't want to come' and I'm like 'Well, what do you mean? What's, you know, what's going on? Why doesn't he want to come?' and he's like 'He's, you know, he's playing possum' is what he said, 'He's just sort of laying down'…'

267 Dr King said he understood the comment 'playing possum' to mean:

> '…he just wanted to be left alone, he's pretending to not hear you because he doesn't want to come to the review. It's something that some patients might do if they're trying to avoid a review for some reason.'

268 Dr King went back to the room with Nurse Veluchamy. He described his attempts to rouse Mr Miller, and agreed with the proposition that from the steps that he took attempting to rouse Mr Miller, and before he realised he was unresponsive, it was not obvious to him or immediately apparent to him from the position in which Mr Miller was lying that he was not okay. Based on Dr King's evidence it seems it was not unreasonable for Nurse Veluchamy to have not realised that Mr Miller was in a life-threatening predicament when he attempted to wake him for his review, as that fact was also not immediately apparent to Dr King when he entered the room.

269 Dr King gave evidence that once it became apparent to him that Mr Miller was non-responsive, and noted a ligature around his neck, he called a code blue and began CPR. The evidence indicated that the code blue was called at 11:24am. Whilst one document suggested the timing was 11:28am, that appears to be an error, as another document indicated that the code was called at 11:24am and that there was also a code blue from the nurses' station at 11:26am. The formal review concluded that the code was called at 11:24am.

270 The Medical Emergency Team arrival is recorded as occurring at 11:33am. That means Dr King was awaiting the arrival of the MET from 11:24am-11:33am. Dr King stated he remembers feeling concerned about how long it took for the MET to arrive. There was no evidence about any impact that delay may have had on the outcome for Mr Miller. I cannot make any findings in relation to that.

271 CPR was ceased at 11:55am and Mr Miller was declared deceased.

The role of the guards

272 The evidence revealed that, in the lead up to Mr Miller's death and even continuing post Mr Miller's death, there was a misunderstanding amongst some other staff members about the role of the guards that were sitting outside Mr Miller's door.[42] For example, on 6 July 2021, Mr Miller said to Nurse Muraji, 'I don't want to wake up in the morning'. The nurse noted '[a]dvised security guards to continually monitor him while he is in his

[42] Transcript, pages 997, 940, 1361, 1190

room'.[43] Dr Davison also gave evidence that during her visit to the PICU on 6 February 2023 that a nurse in the PICU told her that the patients were under continuous observations by the guards.[44] Dr Davison opined that this may have led staff into a false sense of security that Mr Miller was under constant observations, or that the guards were contributing to the management of Mr Miller's suicide risk, when that was not the case.[45]

273 I do observe that, despite some confusion around the role of the guards which was clearly unsatisfactory and potentially dangerous, at the time of Mr Miller's death Nurse Veluchamy was performing observations at intervals of no more than 15 minutes as required. Thus, it does not appear that this potential confusion around the guards' role had any impact in the moments leading up to Mr Miller's death.

Ligature used by Mr Miller

274 Mr Miller was located with a ligature around his neck which was cut off by staff shortly prior to CPR being commenced. The ligature was seized by police. It was later deconstructed by undoing knots to reveal one black sock missing the top cuff, which had been cut, a black sock top cuff, and a piece of cotton-like material. The items were photographed, and the photographs circulated to CALHN and DCS with a view to identifying the origin of the ligature, but no identification could be made by either department. The items were subsequently submitted to the Forensic Science South Australia for examination on 24 February 2022. Forensic scientist Michael Cook examined these items and prepared a full report of his findings following analysis through visual examination and optical microscopy. It was established that the two sections of the black sock were physically different from each other and did not originate from the same single item. The cotton-like material was determined to be a machined cloth item that may have originated from a waist tie of a protective gown or some other similar type of tie. or some unrelated use or purpose. It was determined that the two lengths of this item did not constitute the whole of the original and there is a section between the cut ends that is absent.

275 Although these items of themselves did not appear dangerous to a patient, questions were raised throughout the inquest about how patient safety is ensured by limiting access to items that may be used to self-harm. For example, Mr Miller was found on one occasion to have a sharpened plastic knife hidden in a nicotine inhaler his room. On the day of his death it was noted that he had various pairs of shoes with shoelaces in them in his room.

276 Whether certain items will be taken away from patients will depend on the patient. What is concerning is that no one appeared to turn their mind to what Mr Miller had in his room the night after he stated that he 'did not want to live anymore' and that he 'wanted to die'. Instead, he was left overnight with high-risk items like shoelaces and a plastic knife. I note that he did not end his life using either of these items. It is conceivable, however, that the sharpened plastic knife was used by Mr Miller to cut the material used in the ligature with which he ended his life.

277 In early February 2020, before Mr Miller's death, the shift coordinator commenced to undertake safety checks in PICU at 6pm and 9pm each day. The safety check 'check list'

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[43] Exhibit C66, page 432
[44] Transcript, pages 1008, 1009,1034; Exhibit C74, page 25
[45] Transcript, pages 997, 1007

was tendered.[46] This included ensuring that 'access to ligatures is limited [ie phone cords, hoodie ties, etc]. The evidence indicated that Nurse Taylor and Nurse Chan did the safety check on the evening of 14 July 2021. According to procedure that would have occurred at around 6pm (prior to Mr Miller expressing his wish to die). It is curious that, at the time of his death, Mr Miller was located with three pairs of shoes with shoelaces in his room. I say that is curious, not only because one may think shoelaces are an obvious ligature to consider removing during the process of the daily safety check, but also because those shoelaces ultimately were not used by Mr Miller to end his life. It can be concluded that at least two socks were used as ligatures. The origin of the third component of the ligature remains unidentified. However, this demonstrated that despite best attempts to minimise access to ligatures (which did not occur here given the existence of six shoelaces in his room), a patient may still find the means to create a ligature.

Aftermath

278 The first event that occurred in the aftermath of Mr Miller's death which caused significant distress to his loved ones, and particularly his mother, was a phone call made by Dr King in which he informed Mrs Betts that her son had died. It was apparent that this phone call was not the procedure that should have been followed in the circumstances, though Ms Legg noted that such tragic incidents are rare, and staff are sometimes unsure of what should and should not be done. At the inquest it was evident that Dr King was aware of the harm done, and he expressed sincere regret in relation to that phone call. The impact it had on Mrs Betts was clearly apparent when this topic was discussed in the courtroom. I accept that no malice was intended, but that the trauma this caused was significant and long lasting.

279 The process of open disclosure was not properly followed after Mr Miller's death. Ms Legg had no information about why that did not occur as it should have. Open disclosure after a death can assist the family to navigate complex emotional, practical and sometimes legal aspects of grief. The process should foster trust, accountability, and ultimately contribute to better healthcare outcomes for future patients. The failure to engage in the open disclosure process with the family of Mr Miller meant that for many years they had unanswered questions about the last days and even moments of his life. It was clear that hearing many details about Mr Miller's experiences in PICU for the first time in court was a deeply traumatic experience for his family. Much of the information would have been known to them earlier had the open disclosure process been followed.

280 Mrs Betts also expressed her distress at not being able to see her son after he died. She stated she made a request to do so which was reportedly refused. Mrs Betts addressed the Court as to the cultural significance of saying goodbye, which she was unable to do. I acknowledge the grief this caused to the family.

281 I acknowledge recommendation 25 of the Royal Commission into Aboriginal Deaths in Custody:

> 'That unless the State Coroner or the Coroner appointed to conduct the inquiry, directs otherwise, and in writing, the family of the deceased or their representative should have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorized to be conducted by the Coroner, to engage an independent

[46] Exhibit C71a

> medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report. If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service.'

282 At the inquest, the evidence did not deal with exactly what arrangements were offered to Mrs Betts, if any, at the RAH, or at Forensic Science SA (FSSA), so I shall not make specific observations about what occurred in this case but some general remarks on the topic are appropriate. When a reportable death occurs, the body of a deceased person is under the exclusive control of the State Coroner until the State Coroner considers that the body is not further required for the purposes of an inquest into the death of that person; and, issues an authorisation for the disposal of human remains in respect of the body.[47] If a post mortem examination is authorised by the State Coroner (as occurred in the case of Mr Miller) the body is conveyed to FSSA, where the post mortem examination is undertaken by a specialist forensic pathologist. It is the usual practice that viewing of the body whilst at FSSA is available to the next of kin of a deceased person by arrangement made through a social worker at the Coroner's Office, in conjunction with staff at FSSA. At present this can only occur behind glass, principally due to building design constraints. Within the relatively near future, FSSA will be housed in a new purpose-built building. If an opportunity exists within that design and build project to provide Aboriginal people with opportunities for viewing a deceased other than behind glass, and better accommodating their cultural requirements, that should be considered. I do not intend to make a recommendation to the Attorney-General on this topic as I am aware that those involved in the design of the new building are aware of the issue and consulting appropriately.

Was Mr Miller's death preventable?

283 The expert opinion of both Dr Rose and Dr Davison was that there was nothing about Mr Miller's presentation during the morning of 15 July 2021 which indicated, or which should have indicated, to any staff member that Mr Miller was acutely at risk of self-harm or likely to attempt to take his own life.

284 I also observe that, despite Nurse Veluchamy's evidence about the busyness of the shift on 15 July 2021, and the fact that he was allocated to care for more patients than he should have been on this shift, there is no evidence that the outcome would necessarily have been any different if Nurse Veluchamy had had more opportunities to speak with Mr Miller during the morning.

285 As to the question of whether Mr Miller's death could have been prevented, Dr Davison stated:

> 'On reviewing Mr Miller's care it is clear that his death was a tragic and unforeseen event. Both his family and those caring for him have trouble comprehending how and why he placed a ligature around his neck. It is not clear what his intention was. There does not appear to be any clear evidence of planning or stated intention to actively take his own life. He did express a wish to die the night before his death. Of itself this does not automatically mean he planned to take his own life. On review of Mr Miller's care, I could find no

[47] Section 32 of the Coroners Act 2003

> indication that anyone could have accurately predicted Mr Miller's death, or that any one thing could have been done that would have prevented his death.'

286 Dr Rose concluded in her report that:

> 'It is possible that Mr Miller's death may not have occurred at this time had he been transferred to James Nash House. Similar frustrations, behaviours, emotional dysregulation, and impulsivity would however have been present in James Nash House or in the ARC, with a similar risk of fashioning a ligature out of clothing or bedding. His risk of death, particularly by asphyxiation, had been present for many years in the community in the setting of frustration, distress, or intoxication.'

287 I do not conclude, on the balance of probabilities, that Mr Miller's death was preventable by reason of anything that occurred during the shift on 15 July 2021. However, as concluded by Dr Davison, I agree there were aspects of Mr Miller's care that could have been improved, which would not necessarily have prevented his death, but may have reduced the overall risk, and I so find.

Summary of Findings

In relation to Mr Furlan

288 The care provided by the ECMH was appropriate.

289 The decision made to place Mr Furlan under an ITO and transport him to the RAH was appropriate.

290 As to the diagnosis of Mr Furlan by Dr Staugas, I make the following findings:

- The diagnosis at conclusion of interview, and before the comments were made to Nurse Foster, was appropriate; however
- Adhering to that diagnosis, at least without having a conversation with Mr Furlan after Nurse Foster reported to Dr Staugas the comments that he had made to her, was not appropriate.

291 Once Nurse Foster reported to Dr Staugas the comments that Mr Furlan made, Dr Staugas should have:

- Positively diagnosed Mr Furlan with a psychotic depression; and
- Immediately gone back to speak to Mr Furlan to further probe those comments; and
- Regardless of the outcome of that further conversation, ordered Mr Furlan to be placed under continuous observations.

292 As to the plan by Dr Staugas, I make the following findings:

- The confirmation of the ITO was appropriate;
- The modifications to the medication regime were appropriate;

- The sourcing of further collateral information from the family would have been appropriate, although not specifically required given information already contained in documents;
- The choice of close observations, as chosen by Dr Staugas, was open to Dr Staugas as per the observations policy in place at the time;
- The choice of observations was a decision made by both Dr Staugas and Nurse Foster;
- Close observations (of no more than 15 minutes) are difficult to maintain;
- Mr Furlan should have been under continuous observations;
- Had Dr Staugas been aware of the limitations involved with completing close observations, she may have placed Mr Furlan under continuous observations;
- This decision relating to the observation regime was made some 20 hours before Mr Furlan's suicide.

293 No nurse saw (or at least reported or recorded) any reason to initiate increasing the frequency of observations on Mr Furlan at any time between Dr Staugas' assessment of Mr Furlan and his death.

294 According to the policy in place at the time, Nurse Foster should not have been allocated to care for Mr Furlan on the date of his death.

295 The last recorded observation Nurse Foster performed of Mr Furlan was at 11:10am, at which time he was sighted alive in his room.

296 The last actual observation of Mr Furlan by Nurse Foster was at 11:16am.

297 The reason for Nurse Foster failing to undertake the observations of Mr Furlan at intervals of no more than 15 minutes in accordance with the observation policy is unknown.

298 Even if Nurse Foster had undertaken the observations at intervals of no more than 15 minutes, that would not necessarily have prevented Mr Furlan's death.

In relation to Mr Miller

299 In the year prior to Mr Miller's death he was not provided with continuity of care and active care coordination in the community.

300 The decision to place him under an ITO on 22 June 2021 was appropriate.

301 The decision to admit him to the PICU at the RAH while awaiting a bed at James Nash House was appropriate.

302 On 14 July 2021 Mr Miller stated to Nurse Taylor 'I don't want to live, I want to die' in the context of being refused access to DVDs and a telephone call, and then on further exploration connected these statements with not wanting to be in 2G and wanting a bed at James Nash House.

303 That comment of itself was not a reason to place Mr Miller on continuous observations.

304 That comment required detailed exploration with Mr Miller, and that did not occur.

305 Though Nurse Taylor handed over to nightshift and Nurse Chan information about the comments Mr Miller made, she did not express that she felt the comments needed to be explored further but left that decision up to those staff members.

306 Mr Miller had made similar comments on a previous occasion, and that was known to both Nurse Taylor and Nurse Chan on the evening of 14 July 2021.

307 No other staff member explored these comments with Mr Miller between the time the comments were made to Nurse Taylor and his death the following day.

308 Nurse Taylor should have recorded the entire context in which those comments were made in her CBIS note.

309 There is no evidence that any staff member would have done anything differently if the proper context had been recorded in the note.

310 It is unclear whether these comments made by Mr Miller were in fact connected to his death the following day.

311 Nurse Veluchamy conducted observations at the intervals required of him, given that Mr Miller was under close observations at that time.

312 Nurse Veluchamy was of the view, based on his training and the practices of his coworkers, that it was appropriate to conduct observations of a sleeping patient through the window, provided you could be satisfied there were signs of life.

313 Nurse Veluchamy's observations of Mr Miller were done in a manner which accorded with hospital policy and procedure in place at the time.

314 The policy and practice of conducting observations through the window was insufficient for establishing whether Mr Miller had a ligature around his neck.

315 Mr Miller may have had that ligature around his neck at the time of the 11:02am observation.

316 Nurse Veluchamy was allocated to care for more patients than he should have been during this shift.

317 At the time Nurse Veluchamy entered to rouse Mr Miller for his review by Dr King, it was not immediately obvious that Mr Miller was in a life-threatening predicament.

318 Nurse Veluchamy immediately returned to report his inability to rouse Mr Miller to Dr King, who then returned to the room.

319 It was not immediately apparent or obvious to either Dr King or Nurse Veluchamy upon entering Mr Miller's room, from the position in which Mr Miller was lying, that he was in a compromised state.

320 It was only when Mr Miller's hood was removed from over his head and neck that the ligature around Mr Miller's neck was exposed and it became apparent that Mr Miller was in a compromised state.

321 It is not possible to say for how long Mr Miller had been in a compromised state and, in particular, when he placed the ligature around his neck, but it must have been at some time after 10:46am given the timing of the attempt to contact Mr Miller's mother by telephone.

322 Upon the ligature being observed, steps were immediately and appropriately taken by Dr King and Nurse Veluchamy to perform CPR and raise a duress alarm to seek assistance.

323 Upon Dr King becoming aware that Mr Miller was not breathing properly, a code blue was called, and CPR was commenced.

324 There was some delay in the MET arriving to assist with the emergency situation and, despite attempts by the MET to resuscitate Mr Miller, he was declared deceased.

325 Whether the earlier arrival of the MET may have had any impact on the outcome for Mr Miller is not known.

Recommendations

326 Pursuant to section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of events similar to the events which were the subject of the inquest.

327 The Court received into evidence information from Ms Legg about a number of changes that have been put into place since the deaths of Mr Furlan and Mr Miller in attempt to mitigate the chances of future similar deaths occurring in Ward 2G. Some of those changes I do not need to comment upon further. Those changes are as follows:

- A new direction was put in place from 28 March 2018 that one-to-one nurse specialling (sometimes referred to throughout inquest as 'continuous observations') was required where a patient was considered to be at significant risk to themselves.
- There has been an increase in nursing staff levels each shift. There has also been a significant reduction in the need to use agency nursing staff.
- In the PICU, since 18 March 2023, all nursing staff except the shift co-ordinator are allocated a patient load.
- The role of the security guards in the PICU has been clarified so that they are located at egress locations.
- Since May 2022 partnership meetings have been arranged involving members representing CALHN, Forensic Mental Health Services and DCS to promote better communications between these agencies.

328 I was also advised through counsel for CALHN of some further changes that I do need to comment on further.

329 I was advised that the duress alarm system has been changed so that there are now 47 screens throughout Ward 2G, and the system is now audible. I note however, in relation to Mr Furlan's matter, that the duress alarms were said to have been overridden by a fire alarm initiated in another room at approximately the same time. I was not given enough information to assess whether this is an issue that could occur again in the future, although I hope that the screens indicate exactly where an alarm has been activated from, so that, if multiple alarms are activated at once or in short succession, the screens will display this, and not overwrite previous alarms.

330 There was some evidence at inquest from Nurse Shaw about there being 'black spots' in the hospital. Her evidence related to her attempted use of her radio which she tried to use to call a code blue. I was advised in the closing submissions of CALHN that the duress alarm system has been fully assessed and there are no reported black spots, however it is unclear to me if that was in fact an assessment of the duress alarms only or the two-way radio system also. To the Chief Executive Officer of CALHN I recommend that (if this has not been done) the Royal Adelaide Hospital assess whether there are black spots in coverage of the two-way radio system and, if so, whether they may be practicably resolved.

331 I was advised that that the options for anti-ligature ensuite doors within patient rooms had been explored and at the time of the inquest there were no ensuite doors being used in Ward 2G. In the first week of March 2023, Ms Legg arranged for Hipac Healthcare to further review anti-ligature doors. Ms Legg advised that the vendor had improved the functionality of the doors, which are sturdier, and it is probable that those doors will now be installed as the ensuite doors in each room. Given the active exploration of a resolution to the issue of the ensuite doors I do not make any recommendations in relation to those doors.

332 In relation to the ligature points, I was advised that a colour coded map of Ward 2G is displayed in the nurses' station showing high, medium and low risk areas (in terms of ligature risks). I am not convinced that this necessarily reduces the risks associated with the sheer number of ligature points in the ward. The evidence revealed that a ligature audit was undertaken before Ward 2G opened. A significant number of ligature points were identified, and certainly more than one might expect in a newly constructed mental health unit. That included the ensuite door which Mr Furlan used to end his life. The plan for addressing that ligature point was for it to be 'locally managed', however, clearly in Mr Furlan's case, that had not occurred. Another ligature audit was undertaken in March 2022, shortly before the inquest began. That review identified a significant number of ligature points in Ward 2G, including up to 11 points associated with a number of the 2G acute consumer rooms. Ms Legg's evidence was that the ligature risks are now more appropriately managed due to a colour-coded map of Ward 2G showing high, medium and low risk areas to alert staff to that information. The effectiveness of that measure clearly needs to be questioned given that Nurse Veluchamy stated he had never seen that map, despite working on Ward 2G on countless occasions when that map was allegedly on display in the nurses' station.

333 I was also advised that there been a change in the referral system for ALOs. Ms Legg's evidence was that all people who identify as First Nations People are referred immediately

to ALOs, and an order is put through EPAS (or Sunrise).[48] She mentioned that this information is audited to confirm how often it is occurring and to make sure that it does occur. Counsel for Mr Miller's family asked some questions of Ms Legg about the new process. They raised in their submissions that an audit from early 2023 indicated that only 50% of the Indigenous patients were seen by an ALO. The audit also seemingly indicated that there is a considerable lag for the order of an ALO after the patient has been admitted. Counsel for the Miller family submitted that the information in the audit on its face is concerning, and without a better explanation, I am left to conclude that only 50% of Indigenous patients at the RAH who are referred to see an ALO, actually see one. If correct, that would be an entirely unsatisfactory state of affairs. It was submitted by counsel for the Miller family that CAHLN needs to assess whether this is a true reflection of what is happening in the RAH and, if so, why that is the case, and that strategies must be developed to address it. Directly on this issue, Dr Davison made the following recommendation in her report:

> 'I would recommend that the PICU review its access to ALOs and consider ways of improving access to ALOs and/or AMHWs and develop a model of how they will work with the consumer, their family, the community and the treating team to enhance the social and emotional wellbeing of Aboriginal mental health consumers and the cultural safety of their care on the PICU. They need to be sufficiently resourced to be able to work in this way.'

To the Minister for Health and Wellbeing and the Chief Executive of CALHN I recommend accordingly.

334 I was also advised that more training has been implemented and planned for Ward 2G nursing staff including by forensic mental health services to improve understanding about forensic mental health and in relation to safety planning. I note that counsel for the Miller family urged me to make a recommendation that staff have additional training around how to appropriately deal with any client comments about not wanting to live anymore, or threats to kill themselves. I anticipate that such topics would be covered in training by forensic mental health services, and I expect that such training will continue on a regular basis. I will not make a formal recommendation on this topic.

335 Counsel assisting urged me to make a number of recommendations.

1. That the doors in Ward 2G acute patient rooms should be replaced as a matter of urgency. New doors should be anti-ligature and have a viewing window (similar to that in Ward 2G short stay or PICU). In relation to the viewing window, Dr Naso agreed that there should be a viewing panel on each of the doors. HPU 131, which was not published until March 2018 after Mr Furlan's death, states at 3.7.4 that there should be vision panels in consumer bedrooms in the acute unit. In their written submission, CALHN agreed with the recommendation that there should be a viewing panel in the bedroom doors (similar to that in Ward 2G short stay or PICU). Having attended Ward 2G acute for the purposes of the view, it was clear to me that the doors in those rooms did pose a significant risk due to their ability to be used as a ligature point, and the risk associated with this is even greater in the absence of any way to see into the room from the outside without opening the door.

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[48] Electronic Patient Administration System

336 Accordingly, I recommend that the doors in Ward 2G acute patient rooms should be replaced as a matter of urgency. New doors should be anti-ligature and have a viewing window.

2. That CALHN introduce an electronic observation record for use in all mental health wards that can be transported with nurses undertaking observations. The electronic observation record should record the time the observation was done, the exact time that the entry is made, and also an alert for occasions when an observation due to be completed has not been performed by the required time. In urging this recommendation, counsel assisting pointed to the evidence that most nurses did not carry the observation sheet around with them, but rather, it stayed at the nurses' station. Nurse Charlesworth stated that there would likely be a fair few minutes between conducting that observation and when it was recorded in the observations chart, and that sometimes nurses are distracted between doing the observation and returning to nurses' station. Nurse Charlesworth agreed that in most cases the time that the observation is recorded is significantly after when the observation is done. Furthermore, there was no evidence of there being any method of reminding nurses when observations were due – one could understand how on a busy ward with many competing journeys, and no reminders, observations could inadvertently be missed. It was also pointed out by counsel assisting that there is the ability to manipulate the manual observations records after the time, and the crossed-out entry of 11:38am on Mr Furlan's observation records was a prime example of that. Counsel assisting submitted that a method of recording the observations contemporaneously, and with a built-in reminder system, would be far preferable. CALHN's response to this recommendation was that this should be done using a tablet that is not bulky and could not be used by a patient as a weapon. I agree that this is important.

337 Accordingly, to the Minister for Health and Wellbeing and the Chief Executives of the Local Health Networks, I recommend that all LHNs in South Australia introduce an electronic observation record for use in all mental health wards, which can be transported with nurses undertaking observations. The electronic observation record should record the time the observation was made, the time that the entry is made, and also an alert for occasions when an observation due to be completed has not been performed by the required time.

338 Counsel assisting also urged a recommendation that CALHN implement a number of recommendations made by Dr Davison in her report. A number of the recommendations made by Dr Davison I have already mentioned above. The other recommendations urged by Dr Davison were:

1. That the service review their risk assessment and management policy and start developing risk management safety plans which detail how to address risk factors for self-harm, suicide and violence. These also need to identify specific triggers and circumstances which may compromise safety; identify strategies to reduce risk and enhance safety; and detail agreed actions and roles for the consumer, their family and personal support person and clinicians in implementing these actions. I would recommend the service review how information about risk and its management is collected and shared as a team, and changes in risk are monitored and responded to.

2. That the service review its processes for ensuring that staff understand the visiting rules for DCS patients and there are procedures put in place to automatically obtain an

approved visitors list from DCS, and procedures to get permission to add people to the list. I would also suggest that the service ensure that families and patients are given clear information about the rules and procedures around visits for DCS patients so they understand what to expect. I would also recommend that the service audit their involvement of families in care planning to identify any improvements required.

3. That the PICU work with DCS and with advice from the James Nash House Forensic Service to review the prisoners' procedure in relation to the PICU and clearly agree when DCS officers will be required to be on the unit and the role of the DCS officers on the unit, and how decisions are made about their presence and where they are placed so they are as unobtrusive as possible. There needs to be clarity about whether they are allowed into private consultations with patients and, if so, in what circumstances. There also needs to be clarity about what their role is if there is an incident, and a patient detained under the Mental Health Act 2009 is restrained or secluded. There also needs to be clear procedures to ensure all mental health staff understand the role of the DCS officers and what they can and cannot be expected to do. For example, staff need to understand they are not providing observations to reduce the risk of suicide.

4. That the service work with DCS, the ARC, the forensic mental health service and the SAPHS to ensure there are procedures to ensure a consistently smooth handover of care, transfer of information and of any identified risks when people are transferred from the ARC.

5. There should be enough forensic mental health beds that all DCS patients can be cared for at the same forensic mental health unit and get the specialist care they need. If they are to continue to be outliers on the PICU, I would recommend that staff are sufficiently trained to support DCS patients through the legal process and understand the procedures around DCS patients and that staff have specialist consultation liaison support from the forensic mental health service to the PICU who can advise and assist them in their care for DCS patients.

6. As soon as possible the service arranges to meet with the family to go through the incident review and its findings and ensures it puts in place mechanisms to ensure that there is always an open disclosure meeting following an incident review. I would also recommend that the service clarify the procedures, roles and responsibilities in consultation with DCS in the event of the death of a DCS patient to ensure that the family is informed in as supportive a way as possible and it is clear whether and when they may see their loved one's body.

7. That the service review its procedures for treating patients with very disturbed behaviour in the ED to ensure that pharmacological interventions are as safe as possible and prescribed according to best practice guidelines and that the overall approach and environment are trauma-informed and aimed at minimising restrictive practices.

8. That the SA community and inpatient mental health services and forensic mental health services work together to develop a consistent approach to providing coordinated, assertive, interagency and continuous care that complies with the OCP's standard to the small group of patients with chronic, multiple and complex needs

including homelessness, cycling in and out of prison and hospital who may also present with challenging behaviour and difficulties engaging.

339 CALHN have indicated in their written submissions that nearly all of Dr Davison's recommendations are accepted and a number have already been actioned by the changes already identified above. The recommendation in relation to the SA community and inpatient mental health services and forensic mental health services has been referred to the Mental Health Statewide Leadership Committee as it directly involves other agencies. Given that information, I see no need for me to make any further recommendations in relation to action that should be taken in regard to Dr Davison's recommendations.

340 Counsel for Dr Staugas urged me to make a recommendation for the implementation of treating teams on weekends in Ward 2G to assess new admissions and high acuity patients on Ward 2G on weekends. It was stated that there is no logical reason why psychiatrists should not see their patients on weekends when the practice is that other specialties in medicine do come in on weekends to see their patients. Dr Naso says she has never seen psychiatrists practise in this manner. It would be appropriate to recommend a change to this existing practice. Whilst it is not submitted this would have prevented Mr Furlan's death, such an arrangement would provide an opportunity for treating psychiatrists to promptly form a therapeutic relationship with patients, assess their progress throughout admission (including their response to treatment) and monitor for signs of potential deterioration. It would also provide patients with a continuity of care which would assist in the handover process between shifts, both on weekends and during the week. I note the evidence of Dr Naso on this topic that, in an 'ideal world' there would be a treating team to attend and complete rounds on the weekends as they would in other specialities, however, she has not seen it happen in psychiatry in her many years of experience. Although she expressed that perhaps it was due to staffing issues, she made it clear that the reason for this practice is outside of her area of expertise.[49] There is no doubt that the lack of a treating team during the first 48 hours of admission, a time of high risk of suicide, is not ideal. However, given the evidence from Dr Naso I am reluctant to make a recommendation that may have broader implications that were not explored at the inquest. Dr Naso did refer to the fact that services have tried to mitigate the risks by having on call RMOs, psychiatry registrars and psychiatrists, so as soon as a patient is admitted into an ED, the treatment commences.

341 To the Minister for Health and Wellbeing and the Chief Executive of CALHN I recommend that all LHNs review policies relating to admission of patients to a mental health ward on a Friday evening or over a weekend to ensure that those patients receive adequate psychiatric input in a period of increased suicide risk combined with the absence of a treating team.

342 The family of Mr Miller urged me to make a number of additional recommendations other than those which mirrored or were closely related to those I have already detailed above.

1. That the mental health unit within the RAH conduct an audit to determine the level of family engagement in a patient's care and amend relevant policies to make family involvement a key area to consider within the first 48 hours of a patient's care, and to train and educate staff about the policy. Counsel for CALHN stated in their

[49] Transcript, page 791

supplementary written submissions that the benefits of having family member involvement in the care of a patient will depend upon whether it is clinically appropriate and the particular circumstances of the individual. As such, it was respectfully submitted that a desktop audit to determine the level of family engagement in patient care will not produce meaningful results and will be practically difficult to undertake. Further, the suggestion that there should be family involvement within a set time period of 48 hours does not appear to have been suggested or endorsed by any of the psychiatrists at the hearing. I decline to make this recommendation.

2. That LHNs should implement a policy whereby at least the plastic knives are counted before and after morning tea as well as other meals. If any are missing, clients should be asked if they have them in their room and, if not, an additional search of the rooms should be undertaken if one is not due within an hour of when it has been determined that a plastic knife is missing. This policy should include that patients are not to have plastic knives in their rooms and that they should be confiscated if they are found in a patient's room. In response to this counsel for CALHN, in their supplementary written submissions, stated that the counting of utensils is unnecessary as a matter of general policy. None of the witnesses appear to have suggested that it was necessary. Ward 2G is a therapeutic environment and imposing custodial type conditions as a matter of general policy risks being counter-productive for many patients. The evidence was that where there is particular risk in relation to a patient, consideration will be given to issues such as the presence of utensils within patient rooms. Without further evidence about the appropriateness or otherwise of counting utensils in an attempt to minimise self-harm attempts, I decline to make this recommendation.

3. CALHN should update its visual observation policy to include a reference that sleeping patients' observations should not be conducted through the viewing window when the patient's room is dark. The email to CALHN staff referred to in paragraph 260 has dealt with this but it should be given formal effect in CALHN's visual observation policy. This should extend to all SA Health sites.

343 To the Minister for Health and Wellbeing and the Chief Executive of CALHN I recommend that mental health visual observation policies be amended to provide that overnight visual observations must occur by opening the bedroom door and viewing the patient directly.

4. I was also urged to recommend that CALHN should assess whether the use of a night light, which can be turned on from the outside of a patient's room would assist in checking patient's signs of life when their room is dark. In response to this, counsel for CALHN in their written submissions stated that this was addressed by counsel for Nurse Veluchamy at the hearing on 16 November 2023. Relevantly, nurses can carry torches as necessary to enable checks to be done when patient rooms are dark. It was suggested that this option is considered less intrusive than a night light and achieves the same purpose. I agree.

5. Mr Miller's family endorsed Detective Brevet Sergeant Britta Rivett's suggestion that SA Health should consider a standard operating procedure to address how families are to be advised of unexpected deaths via SAPOL or someone attending at a home. To the Chief Executive of SA Health, I so recommend.

6. That SA community and inpatient mental health services and forensic mental health services work together to develop a consistent approach to providing coordinated, assertive, interagency and continuous care that complies with the Office of the Chief Psychiatrist's standards in relation to a patient with complex needs like Mr Miller.[50] This consideration should include whether it would be helpful to have a clinician who is clearly identified to have responsibility for the care of the patient and that an episode of care should not be closed until care for the individual has been transferred to another provider.

    a. This suggestion mirrors, for practical purposes, the recommendation of Dr Davison referred to in paragraph 335.8 of this finding, which followed Dr Davison's consideration of Mr Miller's lack of continuity of care in the community, particularly upon his release from prison. Dr Davison observed, 'Mr Miller's care does not appear to comply with the OCP standard for continuity of mental health care for people exiting prison, particularly in relation to his release from prison in 2020 when he was subject to a CTO.[51] No mental health clinician appears to have been identified to have ongoing responsibility for monitoring and reporting'.[52] This recommendation of Dr Davison has been referred to the Mental Health Statewide Leadership Committee. I need only comment that the Mental Health Statewide Leadership Committee should also consider the appropriate time for case closure as part of consideration of Dr Davison's recommendation.

344 In conclusion, I express my condolences to the families of Mark Furlan and Richard Miller.

Keywords: *Death in Custody; Inpatient Treatment Order; Psychiatric/Mental Illness; Patient Observations*

[50] Exhibit C75, page 41; Transcript, page 1032
[51] Community treatment order
[52] Exhibit C74, page 40