MAGISTRATES COURT
TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, and family by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995

I, Olivia McTaggart, Coroner, having investigated the death of FG

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is FG, date of birth, 30 July 1963;

b) FG died by suicide in the circumstances set out in this finding;

c) FG's cause of death was partially suspended hanging; and

d) FG died on 30 September 2020 at the Royal Hobart Hospital, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into FG's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavits of Dr Christopher Lawrence, forensic pathologist;
- Toxicology report of Forensic Science Service Tasmania;
- The Tasmanian Health Service Death Report to Coroner;
- Medical records of the Royal Hobart Hospital;
- Medical records from Augusta Road Medical Centre;
- Affidavit of AB, wife of FG;
- Affidavit of RM, son of FG;
- Affidavit of VT, sister of FG;
- Affidavits of Leigh Cripps, Sharon Gibson, Robert Gill and Vincenzo Sorrentino- friends of FG;
- Affidavit of the Royal Hobart Hospital Patient Safety Officer (PSO);

- Affidavits of three police officers, including a forensics officer, who attended the scene of death;
- Scene photographs;
- Tasmanian Health Service RCA Report on the treatment, management and circumstances surrounding the death of FG;
- Report from Dr Stephane Auchincloss, independent consultant psychiatrist, concerning the treatment and management of FG;
- Report to the Coroner from Dr Martin Morrissey, old age psychiatrist within Tasmanian Health Service who assessed FG;
- Instrument appointing an Enduring Guardian for FG;
- Report to the Coroner from Dr Stephen Ayre, Executive Director of Medical Services of the Royal Hobart Hospital, regarding implementation of RCA recommendations;
- Report to the Coroner from Professor Kate Burbury, Executive Director of Medical Services and Research Hospitals South, regarding implementation of RCA recommendations; and
- Tasmanian Health Service Protocol *Individual Patient Search* December 2023.

Background

FG was 57 years of age, was married and lived in West Hobart. He has two adult sons with his wife, AB. FG held qualifications as a financial planner and stockbroker and, for 27 years, worked as a financial advisor with Shadforths Financial Group, of which he was also a shareholder. In 2017 Shadforths was sold to another very large company and, for a time, FG remained working as an employee in the company. He subsequently engaged in other enterprises but was not working at the time of his death, apart from managing his own affairs. He had been financially very successful in his career.

As a young man, FG was a talented sportsman who excelled at Australian Rules Football. He played for Geelong but did not play at senior level. Upon his return to Hobart, he played for Sandy Bay in the Tasmanian Football League, where he was a key player. In later life, he enjoyed outdoor adventures with his friends.

As a young adult, FG engaged in regular binge drinking and, from about 2002, he sought counselling and regular treatments for excessive alcohol consumption.

From about 2017, FG began to experience anxiety as a result of changes in his work situation. His alcohol consumption became uncontrolled and involved episodes of heavy binge drinking. His alcoholism exacerbated his anxiety and caused significant tension within his marriage. He

was prescribed medication to assist with his anxiety, but he could not abstain from consuming alcohol.

On 27 April 2018 FG was admitted to the Royal Hobart Hospital (RHH) as a result of experiencing suicidal ideation, seemingly for the first time in his life. From that time onwards, he frequently experienced suicidal intentions and also attempted suicide.

In September 2018, FG had a three-week admission to a private rehabilitation clinic in Essendon. He subsequently returned to the clinic, initially every fortnight and then monthly.

However, in early 2019, FG's mental state deteriorated and his alcohol consumption and suicidality increased. On at least two occasions, he took an electrical cord and told AB that he intended to hang himself from a balustrade at his home. AB was able to persuade him otherwise on these occasions.

On 1 May 2019, FG returned to the Essendon Clinic for a further two weeks. In late May 2019, FG's family arranged for him to be admitted to a clinic in Queensland. Following an inpatient stay for one month, he returned to Hobart with a greatly improved mood. He was not taking prescribed medication, but his psychologist emphasised the importance of abstaining from alcohol for 12 months to two years to ensure he did not relapse.

By August 2019, FG had resumed drinking socially as he said that it alleviated his anxiety.

In October 2019, FG engaged in a three-day binge drinking episode which caused an escalation in his suicidal thoughts and plans. He attempted to hang himself with an electrical cord on two occasions, but again, AB was able to stop him.

Subsequently, on 10 October 2019, he jumped from the top story of his Sandy Bay home. He was then immediately admitted to the RHH for four days and became subject to an involuntary assessment order under the *Mental Health Act* 2013. Following his admission, FG returned to the Essendon clinic for six days. He remained agitated and anxious with low mood. He did not want to take his medication as he did not like the way it made him feel. He remained in regular contact with his general practitioner who encouraged him to comply with the prescription. AB also made considerable efforts to source treatment and counselling options, as well as arranging marriage counselling and holidays.

On 24 December 2019, AB found FG hanging from the rafters in the garage of his home with an electrical cord around his neck. She cut him down with the help of their son. An ambulance was called and FG was admitted to the psychiatric ward of the RHH for several days. Again, he became subject to an involuntary assessment order. He returned to the Essendon Clinic from 27 December 2019 to 10 January 2020.

Between March and June 2020, during the Covid-19 pandemic, FG and AB self-isolated in their holiday home at Orford. AB stated in her affidavit that during this period her husband could be seen "pacing", signifying that he was experiencing suicidal thoughts. On some occasions he held his head, shouted and expressed that he was in pain. He tried to keep busy by cycling and playing golf to minimise his anxiety.

On 9 June 2020, FG called AB saying he wanted to jump off a cliff at Orford. Police were called and took FG to the RHH where he stayed overnight. Two days later, he went back to his Sandy Bay home and commenced drinking heavily. Efforts were made at this time by FG's close friends to supervise and help him.

On 14 June 2020, FG jumped from the balcony of his home in a highly intoxicated state and suffered serious injuries. It was a fall of approximately four metres. One of his friends was present but could not prevent FG jumping. An ambulance was called and FG was transported to the RHH Emergency Department. There is a suggestion upon the evidence that FG may have, in an intoxicated state, jumped from the balcony in order to buy more alcohol because the door was deadlocked. However, the more plausible explanation in light of his past behaviour was that it was an impulsive attempt to end his life.

RHH admission from 14 June 2020 until death

In his jump from the balcony on 14 June 2020, FG fractured both patellae and his left wrist, and had a right frontal scalp haematoma and left posterior thoracic bruising. At his admission, he was clearly intoxicated, did not follow staff directions and his behaviour prevented a CT scan being performed at that time. At this time, he was diagnosed with a complex delirium, secondary to alcohol and a possible traumatic brain injury.

On 15 June 2020, FG was transferred to the orthopaedics ward and underwent surgery for fixation of the patellae and wrist fractures.

Over the following days, FG was assessed by the Consultation Liaison Psychiatry team (CLP team) and geriatrics specialists. His decision-making capacity was also considered, with reference to the need for a guardian. FG's behaviour was aggressive and non-compliant, with a number of Code Blacks being called despite him being treated with diazepam.[1]

He was non-compliant with treatment and his insight and judgement were poor.

[1] A Code Black is a hospital code for a situation where security is needed, a person is unarmed, but is a threat to themselves or others.

Notably, he damaged the fixation of the fracture on one patella and required surgery on 23 June 2020 to correct it.

Further Code Blacks were called as his hospital admission progressed and FG was wandering and falling contrary to his instructions not to weight bear. He was medicated for his delirium and assessed as not having capacity to make medical decisions for himself. He was confused, his memory was poor and he was unkempt.

As his admission progressed, FG was consistently assigned Patient Safety Officers ("PSOs" or "sitters") and hospital staff in repeated attempts to re-orientate and reassure him.

A PSO or sitter is a hospital staff member who is assigned to remain with the patient for a designated time, providing a constant presence for the purpose of providing a safe environment and maintaining patient safety, and the safety of others. A PSO is employed to be with vulnerable patients who require intensive bedside support. The role may be undertaken by a wide variety of staff, including care assistants, security staff and orderlies.

The geriatric team, with the aid of the CT brain radiology, diagnosed FG with delirium caused by a combination of alcohol misuse, previous hypoxic brain injuries and possible head trauma. He was not considered to suffer major depressive disorder but had chronic suicidal ideation in the context of alcohol misuse, psychosocial stressors, and most recently delirium. A multidisciplinary team meeting was convened to plan for his further management.

FG's recovery from his injuries was slow. He continued to be aggressive and non-compliant with post-operative care well into July 2020. However, his delirium resolved to a degree and his mood improved.

The CLP team considered that admission to the psychiatric ward was not appropriate because there was no current major mental health diagnosis and no clear goal of care should he be admitted. Although admission to a rehabilitation unit was considered as an option, such a unit would not be able to manage any re-emergence of aggression. I note that the geriatrics team recommended admission to the psychiatric ward. An underlying diagnosis of dementia was considered possible. In this regard, the multidisciplinary team noted that FG had a family history of early onset dementia and a father who had suffered alcoholism.

Throughout July 2020, FG was uncooperative with the needs of his orthopaedic care. He continued to weight bear and, at the end of the month, developed a significant knee effusion.[2] A PICC line[3] was inserted and the rehabilitation service recommended physiotherapy and

[2] Fluid within the knee.
3 Peripherally inserted central catheter line for administration of medication

ongoing rehabilitation. At this time his mental state was intermittently delirious, demoralised and anxious.

On 21 July 2020, an experienced geriatrician confirmed the presence of a persistent neurocognitive disorder[4] which would require intensive discharge planning.

In a multidisciplinary meeting on 23 July 2020[5] the team agreed that FG did not have the capacity to make medical decisions. However, there was a difference in opinion between family members as to whether he was able to manage his money.

In early August 2020, he had suicidal thoughts and expressed that he did not want to *"be here anymore"* and that he was tired of being in hospital.

On 5 August 2020, FG underwent neuropsychological assessment. Although he performed well in some areas, he had significant difficulty in accessing new and novel information. He also had a decreased processing speed in respect of structured verbal information. His executive function was also decreased in speed. Recommendations from the assessment included the provision of a structured environment, the use of substitute decision makers due to his impaired decision-making capacity, a repeat neuropsychological assessment in six months, an occupational therapist to assess driving ability, community case management to maintain community functioning and safety, and social work to provide practical support services prior to discharge. Orthogeriatrics clinicians reinforced to him that his impairment in cognition might partially improve if he ceased drinking.

FG was given accompanied day leave in early August 2020. This occurred without incident. It is to be noted that FG was a voluntary patient. Earlier in 2020, he had appointed AB (and alternatively, his sons) as his Enduring Guardian to make medical decisions on his behalf but *only* in the situation where he had a terminal illness and it was likely that his death would occur in less than 10 days. During his hospitalisation, he was not subject to any order under the *Mental Health Act* 2013 and he was not subject to any order under the *Guardianship and Administration Act* 1995 permitting others to lawfully restrict his movements or make decisions on his behalf.

By mid-August, he remained frustrated with his long hospital admission, had some suicidal thoughts and catastrophised about his future. Mirtazapine was trialled but FG did not consider that it helped him and the CLP team charted an SSRI antidepressant instead. However, it is

[4] Neurocognitive disorders include delirium, mild cognitive impairment and dementia and are characterised by decline from a previously attained level of cognitive functioning: Dr Auchincloss report page 6
[5] which included orthopaedics, rehabilitation, Ortho geriatrics, occupational therapy, social work, CLP and geriatrics.

clear that the CLP team continued to diagnose FG with a neurocognitive disorder (and alcohol use disorder) and did not consider that he fit the criteria for a depressive disorder.

On 17 August 2020, FG tripped on the base of his bed and re-fractured his left radius. Following this, his mental state further deteriorated. He expressed that he felt like *'taking a pill to end it all'* and that he could not bear to be in hospital any longer. A PSO was again assigned to him to ensure that he would not harm himself.

He returned to the operating theatre for the last time on 22 August 2020 for open reduction and internal fixation of the fracture.

By the end of August 2020, FG's mood was extremely low, exacerbated by his knowledge that AB intended to leave the marriage. He had decreased energy and weight loss. He said he was struggling with crippling anxiety and feeling worthless and demoralised. He spoke to a nurse and PSO about ending his life. However, he did not express that he had any particular plans to do so. Recommendations following psychiatric assessment by the CLP team included a higher dose of sertraline, rehabilitation, ongoing physiotherapy and diversion therapy. FG still participated in accompanied day leave, which appeared to assist his mood.

By 8 September 2020, FG was able to perform his activities of daily living and to mobilise independently. His orthopaedic and general medical care had therefore been completed. In ordinary circumstances, he would then have been discharged from the orthopaedic ward. However, discharge from the hospital was not appropriate, having regard to his cognitive state, mental health issues and lack of capacity. Further, no other RHH ward was identified as suitable for transfer.

On accompanied day leave, FG visited his new home in West Hobart as AB had moved him out of their house in Sandy Bay. The discharge plan at that time was for FG to move into the West Hobart home with potential for an inpatient stay at St John's Hospital.

A discharge date was not set and discharge options continued to be considered. Given FG's neurocognitive disorder and level of risk, the CLP team indicated that ideally he needed a long stay rehabilitation placement suited for his type of need. However, there is no evidence that such an option was available. The Roy Fagan centre was considered but not thought by family members to be acceptable.

On 9 September 2020, a good friend of FG, Leigh Cripps, who visited him regularly, told staff that FG had walked to the top of Argyle Street Car Park on day leave with the intention of jumping but could not go through with it. Further, Mr Cripps said that he believed that FG had purchased alcohol and was intoxicated. There is no reason to doubt this account.

Following this event, a PSO was assigned to FG from 8.00am to 3.00 pm and day-leave was revoked. The Drug and Alcohol Service was asked to see him.

On 10 September 2020 FG was assessed by two experienced experts, Dr Anila Rao and Dr Martin Morrissey, with a view to discharge planning.

Dr Anila Rao was Acting Head of the Department of Psychiatry. FG, consistently with information provided to other specialists, told Dr Rao that he had no zest for life and felt empty and numb. He said that he mourned the consequences of his alcohol use, especially the loss of his marriage and the fall from his balcony. He denied being suicidal. Dr Rao indicated that FG lacked rationality and was not confident that he had the capacity to live independently, particularly relating to his continuing risk of alcohol use and suicidality.

On that same day, FG was also assessed by old age psychiatrist Dr Martin Morrissey. Dr Morrissey, consistent with other specialists, did not consider that FG had depression and that antidepressant treatment should not be the primary focus of his management. Dr Morrissey emphasised that alcohol was the contributing factor to FG's poor mental state. Dr Morrissey agreed with the CLP team that FG did not have a formal mental health diagnosis but rather neurocognitive issues.

Dr Morrissey recommended various discharge options for FG. Primarily, he considered that FG should be transferred to a long stay alcohol rehabilitation facility but, if this could not occur, then he required full-time support in his own home due to his very high risk of misadventure or suicide. Dr Morrissey was of the view that discharge to his home should only occur as a gradual process, potentially achieved from an inpatient psychiatric setting, either in the public or private sphere.

On 14 September 2020, one of FG's friends indicated that FG had again been drinking and a nurse formed the view that he was stockpiling diazepam.

Between 16 and 22 September 2020, repeated psychiatry reviews continued to emphasise FG's diagnosis of an irreversible neurocognitive disorder and high risk of continued alcohol misuse and self-harm. These problems were still not considered to fulfil the criteria for admission to an acute psychiatry inpatient ward. However, Orthopaedics wished to discharge him from the orthopaedic ward. The option of a private facility in Queensland, as suggested by FG's family, was not feasible due to Covid-19 restrictions. NDIS services were rejected by the family in favour of arranging private services for him. FG did not wish to undergo inpatient drug and alcohol rehabilitation.

A multidisciplinary team meeting on 17 September 2020 focused upon arrangements for FG's discharge strategies assuming FG and the need for appointment of a guardian as he lacked capacity to manage his affairs. The social work team became involved in organising community mental health services, supports for his activities of daily living, psychological support and transportation services.

On 22 September 2020, an occupational therapy assessment noted the significant difficulties in finding a suitable destination for FG given his high risk of self-harm and continued need for intensive support. The social work team questioned whether the family understood that he had an irreversible neurocognitive disorder, being dementia. Family members were still requesting FG to be transferred to a Queensland facility. There was consideration that if the family could not make a decision in his best interests, then an application to the Guardianship and Administration Board for appointment of a substitute decision-maker may be required.

On 23 September 2020, a family meeting with treating clinicians took place relating to discharge. A family member suggested that FG might suffer chronic traumatic encephalopathy with increasingly abnormal behaviour in the last few years and especially in the previous 12 months. Family members considered that his private treating and assisting team should be reengaged. This included his psychiatrist, psychologist, life coach and personal assistants. FG rejected the suggestion of 24-hour care and did not commit to taking his Antabuse. It is apparent from the records that FG's discharge home plan involved the coordination of extensive supports and was extremely time-consuming for the staff involved. If the supports were unsuitable or inadequate, FG was at high risk of death by suicide. This process was therefore critically important.

Aside from his cognitive issues, at this stage FG required minimal care with his physical injuries. Appropriately, he was having accompanied leave from hospital for up to 2 hours per day. He expressed frustration at the fact he was still in hospital and did not have sufficient insight to understand why he required support at home.

On 24 September 2020, FG denied suicidal thoughts to hospital staff. There is no evidence between that time and his death on 30 September 2020 that he was considering suicide.

Circumstances Surrounding FG's Death

On the 30 September 2020, the assigned PSO for FG arrived for his shift at 7.55am.

On that morning, the PSO entered FG's room and saw that he was in the toilet. Assuming that FG was on the toilet, the PSO exited the room.

The PSO re-entered the room at 8.04am and went into the toilet. He discovered FG hanging by a white electrical cord which was wrapped around his neck and secured to the clothes hook on the back of the toilet door. He called out to the nurses. Two nurses responded and helped the PSO lift FG up and remove the cord off the hook. The emergency button was activated and the resuscitation team arrived at 8.10 am. The resuscitation team found that FG was in asystole and commenced CPR.

At 8.37am, CPR was ceased and FG was declared deceased. At 9.26am the RHH called police and, at 9.51am, police officers arrived at the scene. A forensics unit attended as well as CIB officers. Although I am satisfied a thorough investigation occurred, the origin of the electrical cord used by FG remains unclear. At the scene, RHH staff told police that the cord did not belong to the hospital as it did not appear to have an electrical test tag attached. Further, the RHH Root Cause Analysis investigation report (RCA report) also specified that the electrical cord was not the property of the RHH and had been brought in by FG.

It appears likely from the evidence that FG procured the cord whilst on day leave as a hospital inpatient and returned to the hospital with it, intending to use it to effect suicide. I cannot determine how long the cord had been in his hospital room and whether he had concealed it from staff until that day.

On 1 October 2020 experienced forensic pathologist, Dr Christopher Lawrence, performed an autopsy upon FG. In compiling the conclusions contained in his affidavit, he had regard to toxicological testing results of FG's antemortem and postmortem blood samples. Most relevantly, the postmortem blood sample indicated that there was no alcohol in FG's system at the time he ended his life. There was only a range of his therapeutic medications at expected levels. Dr Lawrence determined that FG died as a result of a partially suspended hanging, a conclusion I accept.

Additionally, Dr Lawrence noted that FG's family, after the autopsy, raised concerns regarding the possibility of FG suffering chronic traumatic encephalopathy (CTE) as a result of sustaining multiple knocks to the head during his football career. Dr Lawrence indicated that testing for CTE usually requires fixing the brain and examination by a specialist neuropathologist with access to special immunoperoxidase stains to detect an accumulation of a protein known as "p-tau".

However, Dr Lawrence reported that the brain at autopsy did not show obvious CTE. He stated that his cut sections of the brain looked *"normal and the subtle changes present probably relate to a combination of high blood pressure and excessive alcohol use with possible hypoxic damage from his previous hanging +/- head strike when he jumped off the balcony".*

Dr Lawrence said that the few cases he has seen which appear to have the diagnosis of CTE *"appear much more atrophic than this brain"*. Dr Lawrence also had regard to the antemortem brain MRI finding indicating subjective mild bilateral temporal lobe atrophy and moderate burden of presumed chronic small vessel ischaemic disease, but nothing else of note.

Having regard to Dr Lawrence's opinion, I am satisfied that FG did not suffer CTE.

As a result of the autopsy and police investigation, I am satisfied that there were no suspicious circumstances surrounding FG's death. I am further satisfied that FG took the action of hanging himself alone and with the specific intention of ending his life.

Issues raised in the investigation

Understandably, the fact of a hospital inpatient ending their own life should result in detailed scrutiny of any hospital procedures and processes that may be connected to the death. I am satisfied that such scrutiny has occurred and I outline below the ways in which particular concerns and issues have been brought to my attention in the investigation.

Firstly, with the assistance of their legal representatives, FG's family members raised particular concerns about his diagnosis, care and management at the RHH. The concerns mainly relate to an alleged failure by the RHH to provide him with adequate psychiatric care in the face of many "red flags" signalling risk. Specifically, his family members were of the view that FG should have been transferred into the care of the Department of Psychiatry and placed on that ward once he no longer required acute orthopaedic care. They thought that this would not only have improved the treatment of his mental state but would have greatly reduced his ability utilise items such as an electrical cord to assist him in ending his life.

Secondly, the RHH referred the circumstances of FG's care and death for consideration by an independent panel of experts, who produced the RCA Report on 8 December 2020.

The RCA Report summarised the events as follows and, in this summary, the main issues considered by the panel are identified:

> *"FG a 57 year old man hung himself with an electrical cord in his bathroom on K9 East*
>
> *Orthopaedic ward. FG had been on the acute orthopaedic ward for 108 days. He presented to hospital after purposefully jumping from a balcony and sustaining multiple fractures (broken bones). He had a protracted period of acute delirium (confusion) and non-compliance with his orthopaedic requirements resulting in further surgical interventions. The acute orthopaedic injuries resolved, however he continued to stay on the ward for over 29 days requiring no further*

acute surgical intervention. He had a Patient Safety Observer (PSO) outside his room for the majority of shifts and there was a PSO present on the day of his hanging.

During his inpatient stay his care involved interventions or clinical opinions from Orthopaedics, Orthogeriatrics, Geriatrics, Consultation-Liaison Psychiatry, In-Patient Psychiatry, Infectious Diseases, Drug and Alcohol Services, In-Reach Rehabilitation, Older Persons Mental Health, General Medicine and multiple allied health practitioners. There appeared to be no single team looking at FG from a holistic perspective. While each area reviewed him from their clinical viewpoint, there was confusion regarding which clinical team was responsible for driving discharge planning. FG was also reviewed at the Long Stay committee, discussed with the Executive Director of Medical Services and had several multidisciplined team meetings focused on the discharge, but no firm plan was put into place for discharge until just prior to his hanging. His family were actively engaged in trying to find step-down programs/facilities/home assistance.

After FG's acute delirium resolved the clinical staff believed there was a significant neurocognitive disorder and/or a mental health disorder contributing to his behaviours, poor memory, reduced executive function processes and lack of capacity. The consensus was that the neurocognitive disorder and/or mental health disorder was chronic and unlikely to improve. This differed from family who believed FG could improve in these areas with additional care and support. This meant there were differences between what FG, his family and the clinicians believed was the best discharge plan.

FG had accompanied and unaccompanied day leave. He appeared to have procured the electrical cord while on day-leave but this cannot be confirmed. The intention of FG's hanging (self-harm, impulsive action, wish to end his life) was not for this panel to determine. At the time of his death the clinical teams were aiming to discharge FG to his own home with social supports, Drug and Alcohol Services and Community Mental Health services. These supports were still being coordinated at the time of his death."

As highlighted in the above summary, the issues identified for analysis by the RCA panel included: difficulties and delays with multiple teams providing care and opinions; issues with communication and agreement between clinicians regarding FG's diagnosis; issues with escalation of his care to the Heads of Department and Executive Director of Medical Services; and FG's mood decline while awaiting discharge on a ward that did not have protective measures in place to reduce the likelihood of self-harm or suicide.

Thirdly, in light of the issues raised, I requested a review and opinion from an independent consulting psychiatrist. After significant difficulties and delays in locating a suitable independent expert, experienced consultant psychiatrist Dr Stephane Auchincloss agreed to provide an opinion. In providing her report, Dr Auchincloss was provided with the critical evidentiary

exhibits. These included three comprehensive affidavits from family members, the RCA Report, historical Drug and Alcohol Service records, RHH medical records, and correspondence from Dr Martin Morrissey, old-age psychiatrist.

In her report, Dr Auchincloss analysed FG's history and provided a detailed chronology of his inpatient admission at the RHH. Dr Auchincloss addressed the issues of FG's psychiatric diagnosis, communication of the diagnosis to his family, adequacy of neurocognitive testing, the location of his care, discharge planning, the roles of his treating doctors and definition between teams. I will deal with her conclusions shortly.

Findings on the identified issues

Below, I set out under various headings the main issues for findings and comment emerging from the evidence. In making these comments, I accept the facts and opinions expressed by Dr Auchincloss, Dr Morrissey and, in general terms, within the RCA Report.

(a) Diagnosis

The CLP team diagnosed FG as having a multifactorial neurocognitive disorder, alcohol use disorder, episodic suicidal attempts and deliberate self-harm when intoxicated. The CLP team did not consider that FG met the criteria for Major Depressive Disorder or a mood disorder.

Dr Auchincloss, in her report, stated that he had delirium with mixed aetiology, alcohol use disorder and early dementia. Dr Auchincloss also formed the view that FG had personality traits consistent with borderline personality disorder. These included difficulties in personal relationships, emptiness, fears of abandonment and rejection, emotional dysregulation and narcissistic traits. She was of the view, which I accept, that the loss of his work role in the preceding years and imminent loss of his marriage may have exacerbated some of these traits.

However, Dr Auchincloss was of the view that FG *did not* suffer a depressive disorder, stating in her report:

> *"The presence of depressive symptoms, such as low mood, tearfulness or lack of enjoyment, is not sufficient to diagnose a depressive disorder. Similarly, the presence of anxiety symptoms is not sufficient to diagnose a disorder. People developing dementia can experience anxiety, low mood, demoralisation, confusion, perplexity, dysphoria and a lack of enjoyment as a result of the underlying decline in cognitive function.*
>
> *A diagnosis of depression requires the presence of at least five of nine symptoms, which must include a depressed mood and loss of interest or pleasure. Other symptoms can include*

significant weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death which may include recurrent suicidal ideation. The symptoms must have been present for at least two weeks and represent a change from previous functioning.

While FG expressed some of these symptoms, the psychiatrists who provided repeated assessments did not judge that they fulfilled the criteria for a diagnosis of major depressive disorder. It appears from the notes that his symptoms fluctuated, for example his mood apparently improved in response to activities or being diverted.

FG's mood, and the assessment of it, would have been complicated by the presence of delirium, his prior alcohol use and withdrawal from it, the possible use of alcohol while in hospital, the hypothesised presence of early dementia, and medications including benzodiazepines and antipsychotics administered during his admission. He was also experiencing major psychosocial stressors, including the strained relationship with his wife and an understanding that he would not be able to return to the family home, which he may have interpreted as rejection and abandonment."

As already noted, Dr Morrissey considered that FG had significant alcohol-related executive cognitive impairment and ongoing alcohol misuse. He commented in his report that, in interviewing FG and considering his interactions with staff on the ward, FG had difficulty with planning and reasoning. He did not consider that FG had a depressive syndrome nor that treatment for depression should be a primary focus of his management. He stated in his report that FG did have some long-standing depressive and anxiety symptoms complicated by alcohol abuse which made it appropriate to trial antidepressant medication.

I have ruled out CTE as a likely diagnosis for the reasons given above. I find that FG suffered permanent cognitive impairment, which was in severe decline associated with dementia and alcohol misuse. I also accept the evidence of Dr Auchincloss that his diagnosis was also complicated by personality features and psychosocial stressors.

(b) Suicidality and risk assessment

Dr Auchincloss said of FG *"it appears that his risk of suicide fluctuated markedly throughout his admission. He sometimes expressed thoughts of suicide by highly lethal methods, but at other times he denied any suicidal thoughts. On occasions he denied suicidal thoughts despite having recently expressed them to a sitter or family. The inconsistency in his statements made it very challenging to assess his true immediate risk, as discussed above. In addition, prior suicide attempts had been impulsive and unpredictable."*

Dr Auchincloss also commented that the fluctuating nature of FG's suicidality was problematic to treat, even in a psychiatric unit, stating *"Minute-by-minute supervision would have been required to ensure that suicide could be prevented."* She commented that such was the fluctuating and inconsistent nature of his suicidality, his actual suicide occurred despite a sitter (PSO) being assigned to his care. She also emphasised that FG's suicide risk was partly generated by unmodifiable factors (cognitive impairment associated with dementia and alcohol use). She was of the view that his future risk of suicide would have greatly increased with continued alcohol use.

Dr Morrissey was also of the opinion that, though FG did not have a depressive syndrome, he was at high risk of suicide. This was due to FG's previous history, loss of social and occupational structure, his cognitive impairment (with impulsivity) and increased chance that he would continue drinking upon being discharged.

Dr Morrissey reported that, in his view, FG's prognosis was extremely poor in terms of addressing ongoing alcohol abuse and associated further brain injury, and risk of completed suicide. Dr Morrissey was particularly concerned about the risk presented by FG's ongoing minimisation and denial of active suicidal ideation, and his minimisation of previous hospital admissions and previous alcohol intake.

I conclude that FG was permanently at a high suicide risk, caused by irreversible neurocognitive issues combined with personality features and stressors. His risk fluctuated greatly from time to time during his lengthy admission. His mood and suicidal ideation (including suicide plans) were constantly monitored whilst an inpatient and his treatment adjusted in an attempt to alleviate his distress and lower his risk. It was recognised by the CLP team that FG's mood fluctuated greatly and he was emotionally labile. It was also recognised that his previous suicide attempts were impulsive and not always preceded by known plans. The CLP team obtained FG's agreement to discuss any thoughts or plans of self-harm with staff and to stay sober, thus minimising risk. A PSO was assigned for his safety when his mood deteriorated or when he had thoughts of self-harm.

Thus, there were considerable efforts made on a daily basis by clinicians and staff to monitor FG's foreseeable suicide risk by assessing his condition, mood and behaviour. The assignment of the PSO at times of perceived a higher risk was appropriate. The PSO was assigned to him for significant periods of his inpatient stay, including on a daily basis in the lead-up to his anticipated discharge. His unaccompanied day leave was revoked upon the suspicion of alcohol consumption, and was subsequently limited to short periods of accompanied leave.

Although FG was always at risk of suicide, there was no reason to consider in the week or so before his death that he experienced suicidal thoughts or was consuming alcohol on his accompanied leave periods. There was no reason to consider that his risk was so elevated that he would imminently attempt suicide. I also do not criticise the PSO for stepping out of FG's room briefly to allow him privacy whilst he was in the toilet. There was no warning at all to the PSO that FG would take action to end his life at that time.

I set out below the changes made by the hospital to the vital role of the PSO as a result of this matter. The developments are to be commended so that the role may be maximised in its value. However, there is no criticism to be made of the PSO role or function with regards to FG that can be connected to his death.

However, two considerations arise relating to how FG's suicide might have been prevented.

Firstly, there was no risk assessment of FG's physical hospital environment or ongoing risk assessments throughout his admission to ensure, to the extent possible, that he was safe in his room and he did not have the means to effect suicide. In my view, this was an omission. If he had been a patient within the Department of Psychiatry, access to means of suicide would likely have been greatly restricted.

A system of risk assessment and ongoing monitoring may have been overlooked because of FG's immediate need for orthopaedic treatment due to his serious injuries. He was accommodated in a ward appropriate for such treatment and received a high level of care for a prolonged period. However, there is no evidence that FG was ever searched for items that might be dangerous or used to harm himself.

There was also no evidence of any audit of items in his room, either belonging to FG or the hospital, that might present a risk. In particular, he had a known history of attempting suicide with electrical cords. This fact should have been considered in any monitoring and searching process.

It is most certainly the case upon the evidence that FG's impulsivity and suicide attempts were overwhelmingly associated with consuming high levels of alcohol. I speculate that his treating doctors may have been, to some extent, comforted that FG's risk was sufficiently mitigated whilst he was a sober and closely monitored inpatient in a hospital ward. In hindsight, his poor cognitive state demanded that he receive highest level of protection possible.

(c) Neurocognitive testing

FG underwent a cognitive assessment with a psychologist on 5 August 2020. His family members, particularly his son RM who is a medical practitioner, expressed concern about the

accuracy and frequency of cognitive/neuropsychological assessments of FG. RM, who examined the medical records, expressed the view in his affidavit for this investigation that the raw testing data was incomplete, and that there was mention of unspecified factors that might confound the test results.

Dr Auchincloss stated that the neurocognitive testing occurring on 5 August 2020 identified deficiencies likely associated with FG's long history of alcohol misuse, delirium, early dementia and his medical problems. She stated that repeated or more extensive testing would have been unlikely to have altered the course of his care. She also had regard to FG's antemortem MRI (brain) results demonstrating ischaemic changes consistent with cerebral vascular disease as well as temporal lobe atrophy (associated with significant memory problems).

I agree with her conclusion and do not consider in FG's case that further neuropsychological testing was necessary at that time or would have better informed FG's treatment. The plan to repeat neuropsychological testing in six months was adequate and, if the results were to be accurate, FG would need to have abstained from alcohol for some time beforehand. His history indicates that he would not have been able to achieve such abstinence.

I also observe that, aside from such testing, FG underwent numerous and thorough assessments of his mental state conducted by experienced psychiatrists, all of whom formed consistent views of his diagnosis.

(d) Communication to family of diagnosis of dementia

FG's close family members were not content with the communication to them regarding FG's ongoing condition and hospitalisation. Dr Auchincloss also said that it appeared that communication with family members did not convey the severity and implications of FG's mental health problems.

The evidence is clear that his family members were advised that he had cognitive impairment.

However, Dr Auchincloss stated that *"confusion may have arisen over the terminology used, for example the use of "neurocognitive disorder" to describe what would previously be labelled as dementia"*. Dr Auchincloss noted, for example, that FG's wife believed that he was still capable of managing his financial affairs without issue. She said that dementia has variable effects and long-term skills and activities are often able to be preserved for some time. The actual fact was that FG had been repeatedly assessed as lacking capacity to make decisions.

Dr Auchincloss was also of the view that that communication to family members likely did not emphasise the severity of FG's impairment, his lack of decision-making capacity and his very

poor prognosis for recovery. She said that if these matters been more clearly conveyed, the particularly complex issues surrounding discharge may have been better understood.

The RCA did not specifically examine the adequacy of communication between clinicians and FG's family. It is very difficult without embarking on a further lengthy enquiry to determine which, if any, incidents of communication to FG's family members were inadequate and liable to lead them to erroneously consider that FG's condition and prognosis were significantly better than the reality. There are several reasons why communication to family members may have been sub-optimal. These include the complexity of FG's condition and questions about his diagnosis, his inpatient care being within the orthopaedic ward, and lack of leadership in efficient discharge planning. It is also likely that some family members, consciously or otherwise, did not accept the extent of FG's impairment and did not accept that his condition was largely irreversible. It might be hypothesised that more definitive communication with family members may have shortened the discharge planning phase for FG. However, ultimately, there is no causal nexus between communication with family and FG's suicide.

(f) Who was in charge of FG's care and should he have been transferred to the psychiatric ward before his death?

The central focus of the RCA Report was issues arising and disputes about which medical team was in charge of FG's overall care and discharge destination. The RCA panel was critical of his management in this regard, summarising the situation as follows:

> *"Overall, the reviewing panel found that while there were multiple teams involved in providing care and clinical opinions, no team had or took overall holistic care for FG. However, hospital policy states a patient's final clinical responsibility should be the team who holds the patient's Bed Card. It appeared to the panel that each clinical team looked at and considered care within their own specialty area but not the patient as a whole. If there had been more communication and agreement on FG's diagnosis his care pathway could have been clearer. The panel believed that this could have been achieved if the written communication between teams was clearer. In addition, when it was apparent that the two main teams (Orthopaedics and CL Psychiatry) did not agree on the diagnosis of mental health condition/neurodegenerative disorder the issue of next steps in care should have been escalated to the Heads of Department and the Executive Director of Medical Services to make a decision. This is because at present there is no known group with the authority to make a decision on care pathway or discharge pathway if two clinical areas disagree. This resulted in FG being distraught while on a ward that did not have protective measures in place to reduce the likelihood of self-harm or suicide."*

Dr Auchincloss agreed with the RCA panel that there was a lack of definition among the treating teams about the provision of holistic care and discharge planning. She stated that disagreement between Orthopaedics and the CLP team about the nature and implications of FG's mental health issues was not surprising given the relative expertise of the two disciplines.

I have also had full regard to RM's understandable concerns as set out in his affidavit, which were clearly expressed and well-reasoned. His examination of his father's medical records highlights the complexity and, at times, confusion, in respect of FG's pathway of care.

RM was particularly concerned about the role of the CLP team, summarising his concerns in his affidavit as follows:

> *"I believe that FG would also have received better care in regard to his mental health concerns and needs on a psychiatric ward. I also believe there were many concerned parties (both medical and non-medical) in regard to FG's ongoing mental health concerns, including his risk of suicidality. I believe the CL psychiatry team were fully aware of his risk of suicidality and had several opportunities to take over his care and transfer him to a psychiatric ward where it would have been far less likely for him to complete suicide, and to ensure his ongoing safety. I believe there was a significant lack of insight from the CL psychiatry team as to the risks of FG being managed on an orthopaedic ward in the context of ongoing evidence of suicidal ideation. I believe a disproportionate amount of pressure was placed on the orthopaedic and allied health teams in regard to enacting FG's CL psychiatry plan and management for his ongoing psychiatric needs. I have concerns the staff in these domains were placed under significant pressure that exceeded their area of expertise and that the CL psychiatry team did not appreciate or ignored limitations in regard to the care that they could provide."*

Upon the evidence, by mid-July 2020 the CLP team considered that FG's diagnosis of cognitive impairment meant that there was no indication for his admission as an inpatient to the psychiatric ward. The CLP team remained of this view throughout FG's admission.

Dr Auchincloss, in her report, emphasised that the primary role of the CLP team is to advise the various medical and surgical teams about the mental health of patients in their particular wards, rather than providing continuing acute care. She did not criticise the decision that FG remain on the orthopaedic ward and not to be transferred to the psychiatric ward. In this regard she said:

> *"The CL psychiatry team, the acting head of psychiatry Dr Anil Reddy and Dr Morrissey all addressed the difficulty of the next stage of care for FG. They faced the difficulty that acute psychiatric inpatient units are focused upon patients requiring acute episodes of care with a clear plan for management, recovery and discharge. FG's multiple long-term needs including*

dementia, alcohol misuse, and social and occupational dislocation, could not have been addressed in a public acute inpatient setting."

Dr Auchincloss's reasoning is sound. It was reasonable, in principle, for FG to remain on the orthopaedic ward with continuing input from the CLP team.

It was recognised by the experienced treating psychiatric and geriatric specialists that inpatient care was required by FG following recovery from his orthopaedic injuries. However, finding the appropriate inpatient setting for that care proved a most difficult task.

The Acute Rehabilitation Unit was considered a possible option but was excluded due to the issues of FG's Code Black calls and suicidality.

On 22 July 2020, following assessment by an experienced geriatrician, the Roy Fagan Centre was suggested by that specialist as an appropriate inpatient facility. This facility is operated by Statewide Mental Health Services and provides care and treatment for older persons with both mental illness and cognitive impairment (dementia). The Roy Fagan Centre would likely have been a suitable facility for FG but his family did not consider that he would wish to be transferred to that facility.

A private facility in Queensland, where he had stayed previously, was suggested as desirable by his family but was not a feasible option because of the risks involved with the Covid-19 restrictions (including an inability of FG to quarantine for 14 days in a hotel). No other private hospital or facility in Tasmania was suitable for FG. It would have been appropriate for FG to be transferred to inpatient drug and alcohol rehabilitation but he was resistant to this option.

Therefore, FG remained in the orthopaedic ward for a prolonged period while a discharge plan was arranged. The RCA panel concluded that there was no ideal environment for FG at that point. The panel held the view that the psychiatric ward was not ideal as there were no acute mental health issues for treatment in such a setting.

In my view, the orthopaedic ward became particularly unsuitable for FG from about 6 September 2020. By this date, his orthopaedic care had finalised and he was only awaiting a discharge plan and arrangements. The complexity of the discharge planning process meant that he spent a further 24 days in in that ward. In hindsight, if it was known that the discharge planning period would be lengthy, the safer physical environment of the psychiatric ward may have been preferable. In accordance with the expert evidence, however, I do not criticise the decision to maintain FG on the orthopaedic ward pending discharge. The more significant issues relate to the length of time taken for discharge planning and the lack of safety processes.

(f) Discharge planning

The formulation of a discharge plan by clinicians and staff is essential after inpatient treatment, and involves identifying and coordinating necessary care and services for the patient's specific needs. Discharge planning was the subject of many discussions between clinicians from an early stage in FG's admission. Towards the end of his admission, and following multidisciplinary meetings, the clinical teams were aiming to discharge FG to his own home with extensive social supports, drug and alcohol services and community mental health services. The coordination involved in these arrangements was considerable. By this time, the options for a suitable further inpatient facility had been exhausted as described above.

As noted above, the RCA panel emphasised that once it became clear that there were difficulties in the direction of care as between the CLP team and orthopaedic team, FG's treatment decisions should have been escalated to the Heads of Department and EDMS in a timely manner. The EDMS would then have had the authority to make efficient decisions upon treatment and, following that, discharge.

In fact, on 14 September 2020 the CLP team did recommend escalation to Heads of Department and EDMS for decision on next steps in care. Both the CLP team senior psychiatrist and Head of Psychiatry recommended that the Orthopaedic Registrar speak to the EDMS. It is unclear whether this occurred, but it does not appear that the matter was escalated or that the EDMS had involvement in the case. This step would likely have been of considerable benefit in deciding on FG's care.

The RCA panel also commented in the report that it was not apparent from the clinical notes whether the medical teams involved in FG's care were aware of the Long Stay Surgical Committee. This committee discussed FG's case but it does not appear to have been actively involved in decision-making. The evidence does not permit further comment on this matter.

In summary, FG's discharge plan should have involved transfer to a suitable inpatient rehabilitation setting but none were acceptable to him or his family or suitable for his needs. In hindsight, this may have been a case where a Guardianship and Administration Order could have been sought for his medical decisions well before the final weeks of his inpatient stay.

Dr Morrissey considered that the Millbrook Rise Centre was a good option for him but this was not considered in the discharge planning. I comment that it would have been highly unlikely that FG or his family would have accepted this facility in New Norfolk as a rehabilitation option. Therefore, the complex and lengthy process of organising home discharge ensued, during which FG ended his life. The planning was thorough and had primary regard to his risk of suicide. However, this process undesirably extended the hospital stay.

Was FG's death preventable?

For the reasons given, it is possible that FG's suicide in hospital might not have happened if effective searches of his person and room had taken place. His suicide might also not have occurred if he had been discharged at an earlier time. It is possible that his prolonged stay in hospital following resolution of his injuries did contribute to his decision to end his life. However, he did not leave any note explaining the reasons for his actions. I am also not able to determine when he obtained the electrical cord, whether it was "hidden" in his room or the extent to which he may have pre-planned his death.

Unfortunately, FG's lack of insight, the severity of his condition and his entrenched alcoholism meant that it was almost inevitable that he would return to consuming alcohol and end his life. However, in hindsight, a greater appreciation that he was at risk of suicide within the hospital environment may have led to increased vigilance with regards to day leave and searches. More emphatic communication with the family regarding his condition and escalation of his care and discharge to a single decision-maker may have resulted in a more decisive and efficient discharge plan. The unavoidable Covid-19 restrictions also prevented his discharge to a suitable interstate rehabilitation facility.

It should also be acknowledged, notwithstanding the comments I have made, that the medical teams (including the CLP team) and hospital staff treated and cared for FG conscientiously, competently and intensively over his lengthy admission in very difficult circumstances. His suicide no doubt impacted them considerably.

Developments since FG's death

I have received reports, in April 2022 and September 2024 from the Executive Director of Medical Services RHH and the Executive Director of Medical Services and Research Hospitals South respectively. The reports summarise the progress of key developments arising from the recommendations in the RCA report. These are as follows:

1. The Integrated Discharge Team (IDT) commenced a trial for 6 months in about October 2021. The IDT was responsible for supporting and facilitating high-quality discharge practices for patients with complex and high-risk discharge needs. The IDT is now not operational and is currently in an evaluation phase with funding not confirmed for this service. However, a Complex Patient Committee with representatives from many services[6] has been in operation since August 2024 and was set up to address gaps in decision-making and support for clinicians and teams regarding appropriate escalation, approval, and decision-making pathways. Relevantly, the Complex Patient Committee encompasses an

[6] Medical and Cancer services, Subacute, Aged and Community Services, the Integrated Operations Centre, and Allied Health and Nursing.

escalation pathway for clinical barriers, review of patient journeys where barriers to accessing treatment, services or discharge are identified, and a clear escalation pathway to the Executive.

2. Following FG's death, the Department of Health commenced exploring options for an appropriate public setting for patients with acquired brain injury who are aged less than 65 years and who are not so incapacitated that they need nursing home care but cannot be discharged into the community. Currently, however, the EDMS reports that there are no plans underway for a public facility to accommodate such patients. However, the NDIS is one of the options for supported discharge of patients in this category.

3. From October 2021 the protocol *Statewide Mental Health Services Restricted and Prohibited Items Search* became effective and provided guidelines for clinicians to carry out search procedures. Further, in December 2023, Hospitals South introduced a protocol for the searching of individual patients,[7] including upon return from a period of leave where there is a reasonable suspicion that the individual poses a risk or threat to their safety or the safety of workers. This is due for review and implementation on a statewide basis.

4. In relation to suicide risk assessment, the THS and Statewide Mental Health Services updated its relevant protocol, including the assessment of patients who may be at risk to themselves. A wide range of factors are included in the risk assessment process[8] if it is identified that a patient is at risk of self-harm or suicide based on the history and current circumstances, a safety plan and risk mitigation strategies are developed. This plan is to be made in conjunction with the patient and their family/friends (where consent has been provided). When assessing and mitigating risk the aim is for a consensus to be reached on the most appropriate setting for the patient to receive the care, treatment and monitoring required to manage the assessed risk.

5. From September 2021 a Patient Safety Assistant (formerly a Patient Safety Officer or PSO) protocol has been effective, incorporating the requirement of a PSA to follow the directions from clinical staff and to escalate issues of concern to the nurse allocated to the patient's care. A PSA is to now undertake an orientation program including scope of practice, delirium, and behaviour management. There

[7] Tasmanian Health Service protocol *Individual Patient Search,* Review Date June 2024.
[8] Suicidal thinking, suicidal intent, suicidal plans, means of suicide, future life plans, history of suicidal attempts, psychiatric history, physical health, stressors, substance abuse, family history in relation to suicide and psychiatric illness, premorbid personality, social and demographic factors.

was also significant work undertaken to develop a statewide protocol and screening tool for requesting a PSA. In the South, a PSA handover tool was developed regarding handover from the nurse to the PSA and also handovers between PSAs. Currently, a review is underway regarding employment and governance arrangements for the PSA role in the South. This includes review of the way in which the role can be more effectively employed in clinical settings. Other supports for PSAs in education, training and communication have been developed. Further consideration is being given to commencing the shift start times of the PSA to align with nursing staff in order to integrate this role with the nursing team and thus improving communication about patients and their care requirements during the shift.

Recommendations

I **recommend** that the Tasmanian Health Service develops a statewide protocol for the searching of individual patients and their immediate physical environment in order to minimise the risk of harm to that patient and others; and, once completed, take steps to ensure that all relevant staff have a working knowledge of the policy and are able to conduct effective patient searches in the required situations.

I **recommend** that the Tasmanian Health Service regularly reviews the operation of its Complex Patient Committee and other established processes, and takes any necessary steps to ensure, on an ongoing basis, that treating teams are familiar with the circumstances and processes for escalating a patient's treatment, care and discharge planning.

I convey my sincere condolences to the family and loved ones of FG.

Dated: 26 November 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner