[2021] WACOR 38

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	29 - 30 APRIL 2021
DELIVERED	**:**	22 OCTOBER 2021
FILE NO/S	**:**	CORC 15 of 2019
DECEASED	**:**	BROCKLISS, RUSSELL DAVID

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Collins assisted the Coroner.
Ms A Barter (ALS) appeared for the family.
Ms Burke (ANF) appeared for Nurse Girling.
Mr B Nelson and Mr C Mofflin (SSO) appeared on behalf of the WACHS.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Russell David BROCKLISS*** *with an inquest held at Broome Courthouse on 29 - 30 April 2021, find that the identity of the deceased person was* ***Russell David BROCKLISS*** *and that death occurred on 8 June 2019 at Broome Regional Hospital and was consistent with acute cardiac arrhythmia in a man with cardiomegaly, focal coronary atherosclerosis and elevated body mass index (obesity) in the following circumstances:*

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INTRODUCTION

1. Russell Brockliss was an Aboriginal man from the Broome region of Western Australia. He had been a happy child but as a young adult Russell developed a severe and longstanding mental illness precipitated by illicit drug use. He was supported by his parents, with the help of mental health services. His family had a long history of health advocacy in the Broome Aboriginal community, and his parents were strong advocates for Russell throughout his life.

2. Russell's most recent recorded diagnosis, prior to his death, was schizoaffective disorder. Russell's mental illness was treatment resistant and complicated by his drug use and non-compliance with his medications. He was single, with no children, and lived with his parents in Broome. When unwell he could be aggressive. Despite their strong love and support for Russell, at times his parents had trouble managing his behaviour and recognised he needed more intensive treatment in hospital. Police officers were often required to transport Russell to hospital at these times, and he was frequently managed for periods as an involuntary patient under the *Mental Health Act 2014* (WA) (*Mental Health Act*).

3. As well as his mental health diagnosis, Russell had also been recognised as at high cardiovascular/metabolic risk, but he refused examination, investigations and treatment.

4. On 7 June 2019, Russell was taken to Broome Hospital by police after a relapse. He was initially calm but then became aggressive towards staff. He was made an involuntary patient and admitted to the High Dependency Unit of the Mabu Liyan Mental Health Unit. Russell was supposed to be kept under close observation by nursing staff, with visual checks every fifteen minutes. Russell was discovered by a nurse performing such a check just before 8.40 am on 8 June 2019 in a lifeless state. Attempts to revive him were unsuccessful. Despite purportedly being checked regularly, the evidence suggests Russell had actually been deceased for some time before he was discovered.

5. As Russell was an involuntary patient, he was a person held in care at the time he died, and an inquest is mandatory. I held an inquest in Broome on 29 and 30 April 2021. I am required to comment on the quality of Russell's supervision, treatment and care leading up to his death. That task has been made more difficult by important information that is missing from the time leading up to the discovery of Russell unresponsive in his bed, which I will discuss further in this finding.

BACKGROUND

6. Russell was born on 13 April 1981 at King Edward Memorial Hospital in Perth. His parents and sister came to Perth from Broome for his birth, then returned to Broome, where Russell lived the rest of his life.[1]

[1] T 7.

7. Russell was a happy child who was good at school and sport. He went to St Mary's Primary School and then Broome High School. During his childhood Russell had spent a lot of time with his grandparents, with whom he was very close. His maternal grandparents were integral in starting the Broome Aboriginal Medical Service and the Broome Mental Health Unit, and his grandfather received an Order of Australia medal and Aboriginal of the Year award in 1988 for his service to the community, so Russell was raised with wonderful role models.[2]

8. After leaving school, Russell did an apprenticeship and completed his trade certificate in 2004 to become a welder. However, that same year, Russell became mentally unwell for the first time. His parents worked closely with his medical team from that time to try to help him get well.[3]

9. Russell's mother had worked as an Aboriginal health worker for the Department of Health, but she had to stop working to care for Russell. His father, who had worked as a mining supervisor, also stopped work to provide care and support for Russell. They were recognised by medical staff as his primary carers and they played a significant role in helping Russell to determine what care he required, as well as helping him to accept care when he needed it.[4]

10. On 28 October 2004, Russell had a psychiatric admission to Broome Hospital under the *Mental Health Act* with a two day history of feeling paranoid, hearing voices and getting ideas of reference from the television and radio. It was noted he had multiple stressors, including the deaths of two friends, and he had a head injury and had been using drugs.[5]

11. Russell reportedly relapsed in 2005, but then appears to have gone into remission and remained well without medication until a further relapse in 2007. He was admitted to Graylands Hospital in July 2007 and diagnosed with schizophrenia.[6]

12. From this time, he had multiple hospital admissions, including a number of prolonged admissions to Graylands Hospital in late 2010 and 2011. He was often transferred to Graylands from Broome Hospital for containment of his risk of aggression, as he could be aggressive to nursing staff. Russell eventually was diagnosed with paranoid schizophrenia, which was later changed to undifferentiated schizophrenia, and prior to his death was altered again to schizoaffective disorder. All of these diagnoses are similar in effect.[7]

13. Schizophrenia is a severe and lifelong psychiatric illness. It is characterised by 'positive' symptoms, such as delusions, hallucinations and disorganised speech and behaviour, as well as 'negative' symptoms such as social withdrawal, underactivity, emotional flattening and poor self-care. In addition to the core symptoms of

[2] T 7.
[3] T 7; Exhibit 1, Tab 9, p. 3.
[4] T 7.
[5] Exhibit 1, Tab 15.
[6] Exhibit 1, Tab 15.
[7] Exhibit 1, Tab 15.

schizophrenia, schizoaffective disorder has prominent mood symptoms, including episodes of elevated mood and/or depression.

14. Russell's condition was characterised by longstanding positive and negative symptoms. He had recurring delusions of grandeur (being royalty) and paranoia about bikie gangs and sexual assault. His functional ability was poor, as was his self-care and hygiene. When unwell he could be aggressive and at times his parents had trouble managing his behaviour and required assistance, which often led Russell to be admitted to hospital. Some of the hospital admissions were precipitated by non-compliance with his medication and illicit drug use and others were required for respite and carer fatigue. Russell's illness was noted to be 'treatment resistant', requiring changes to his medication regime. By January 2015 Russell had also been noted to be obese with associated health issues.[8]

15. Russell's mental illness was managed by the Kimberley Mental Health and Drug Service (KMHDS) when he was in the community. He was regularly reviewed by psychiatrists and his case manager, Mr Matthew Williams, who visited him at home regularly. There were frequent contacts between Russell's parents and staff from KMHDS. It appears that attempts by the service to attend to Russell's physical health issues and attempts to engage him with other health service providers were largely unsuccessful, so KMHDS was his main service provider.

16. On 1 September 2016 a letter was sent to Russell's medical team by his community psychiatrist noting that they had an open and honest discussion with Russell and his parents about Russell's physical health, particularly his cardiac/metabolic risk in view of his obesity, smoking, sedentary lifestyle and medications. It was identified he was at risk of potential life-threatening complications such as heart attack or stroke. Russell's parents reportedly acknowledged these and admitted they had prepared themselves for the possibility that Russell might die suddenly from a heart attack but recognised his lack of motivation to make changes to his lifestyle. On a risk/benefit analysis, it was agreed to continue his current medications at that time, with a plan to attempt some tapering when he was more stable.[9]

17. On 20 February 2017 the community psychiatrist wrote to Russell's GP suggesting shared care with the GP to optimise Russell's physical health care and address his cardiac/metabolic risk factors, but it was also noted that it would most likely have to be done opportunistically, "due to the established difficulty in engaging Russell with follow-up."[10] A note was made in the BRAMS records on 29 June 2017 that a discussion should be had with Russell to try to take metabolic bloods when he was next in the clinic, but it does not seem he ever attended after that date, although staff from BRAMS did have contact with Russell's mother.[11]

18. Dr Nicola Lauterwein was Russell's community psychiatrist from October 2018. Dr Lauterwein noted that Russell's parents were his primary carers and identified as his guardians. They were very involved in all aspects of his care and were generally

[8] Exhibit 1, Tab 15.
[9] Exhibit 1, Tab 15.
[10] Exhibit 1, Tab 15.
[11] Exhibit 1, Tab 16.

present during community follow-up, and meeting were had with Russell's parents separately, as well as in company with Russell, in order to best manage his care and support them.[12]

19. At a home visit on 24 October 2018 Russell's mother declined NDIS support and both Russell and his parents declined the offer to arrange an appointment at Broome Regional Aboriginal Medical Service (BRAMS) for a health check. Also in October 2018, attempts by BOAB Health Service to contact Russell for a podiatry appointment were unsuccessful.

20. On 4 December 2018 Russell was reviewed by Dr Lauterwein. It was noted he had reasonable stability while on Risperidone depot at a dose of 50mg every three weeks. However, his parents reported that towards the end of every three week period there was a notable deterioration in his mental state before he received his next depot. As a result, a decision was made to administer the Risperidone depot every two weeks.

21. On 7 January 2019 Dr Lauterwein spoke to Russell's mother on the phone and she indicated she had noticed an improvement in her son since changing the risperidone depot.

22. Russell had an admission at Mabu Liyan on 24 January 2019 to give his parents some respite as they were struggling to manage him at home. Russell initially recognised the need for admission as his parents were tired, but then became hostile and had to be made an involuntary patient. Russell's community case manager spoke to Russell's parents regularly during the admission and they indicated they wanted him to return home but agreed that they might need ongoing planned respite admissions to help them cope. There was documentation about whether clozapine had ever been considered. Russell was discharged on 6 February 2019 after a two week admission. The discharge diagnosis was schizoaffective disorder.[13]

23. Russell's case manager, Mr Williams, attended home visits until 28 February 2019, over which time Russell condition fluctuated. A family meeting was held with Mr Williams, Dr Lauterwein and Russell's parents to discuss Russell' ongoing care needs and family respite options. Russell's mother raised concerns about changes to his medications that had occurred during his hospital admission and the need to now wean him from the benzodiazepine lorazepam at home. It was planned to discuss all future medication changes with Russell's mother prior to his discharge from hospital. It was also noted that for his parents' welfare, more frequent respite care would be required for Russell.[14]

24. The goal of Russell's community client management plan around this time was to promote his physical health and encourage him to attend for physical health assessments. However, it was noted that he usually refused this intervention.[15]

[12] Exhibit 1, Tab 21.
[13] Exhibit 2, Third Admission, Discharge Summary, 6 February 2019.
[14] Exhibit 1, Tab 15.
[15] Exhibit 1, Tab 15.

HOSPITAL ADMISSION 4 APRIL – 1 MAY 2019

25. Russell was taken to Broome Hospital by police on 4 April 2019 after he threatened his parents with a knife and was aggressive towards police. He was relatively calm when he presented at the hospital but had delusions about being royalty, bikies and being sexually assaulted. He had possibly been non-compliant with his oral medications for a few days prior to admission. Russell was admitted as an involuntary patient to the high dependency unit due to his risk of aggression to others and recommenced on his regular medication. He also required frequent 'as needed' sedation for his agitation and aggression. He was given graduated access to the open ward, but his mental state fluctuated, and he had multiple re-admissions to the HDU due to his ongoing aggression.[16]

26. The discharge summary noted that Russell's admission was prolonged, and his management was difficult. His mother did not wish the treating team to make any changes to his medication regime without her consent, but she would not attend a family meeting without Russell's case manager and previous psychiatrist in attendance, both of whom were on leave at different times.[17]

27. The family meeting eventually took place on 1 May 2019. It was discussed that in the future Russell might require a prolonged stay at Graylands Hospital for long term rehabilitation, or commencing the antipsychotic clozapine was to be considered. Clozapine is an antipsychotic reserved for treatment resistant schizophrenia. It has a number of serious side effects and requires frequent monitoring, including blood tests, so it had previously been considered unsuitable for Russell as he had refused to have blood tests. In the meantime, Russell was to stay on his current medication regime, as requested by his parents.[18]

28. During the admission Russell's oxygen saturations were noted to be intermittently low, at times in the high 80's and low 90's. A medical assessment during the admission noted that he most likely had chronic obstructive pulmonary disease (COPD) due to heavy smoking. A chest x-ray was reported as normal and examination of his chest was clear.[19]

29. The hospital discharge summary suggested that Russell's GP should consider pulmonary function tests due to his heavy smoking history and low oxygen levels during his admission.[20] A copy of the discharge summary was sent to BRAMS although as noted before, Russell did not regularly attend the service.[21]

30. Russell was also commenced on the diabetic medication metformin due to his blood sugar levels, that were borderline for a diagnosis of diabetes, and his ongoing risk of metabolic syndrome.[22]

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[16] Exhibit 1, Tab 15.
[17] Exhibit 1, Tab 15; Exhibit 2, Fourth Admission, Discharge Summary, 1 May 2019.
[18] Exhibit 1, Tab 15; Exhibit 2, Fourth Admission, Discharge Summary, 1 May 2019.
[19] Exhibit 1, Tab 15; Exhibit 2, Fourth Admission, Discharge Summary, 1 May 2019.
[20] Exhibit 2, Fourth Admission, Discharge Summary, 1 May 2019.
[21] Exhibit 1, Tab 16.
[22] Exhibit 1, Tab 15.

DISCHARGE HOME MAY – JUNE 2019

31. Russell's case manager, Mr Williams, returned Russell home with his medications after his discharge from hospital on 1 May 2019. The medication changes were explained to Russell's mother. Russell appeared excited to go home and was pleasant and in a good mood.

32. Russell's mother administered his oral medications as directed and he was administered a depot antipsychotic every two weeks during home visits by a mental health worker. Russell's parents had noticed that a few days before his depot medication was due, he would become agitated and aggressive but not violent. His mother had noted this had happened again prior to his depot being administered on 27 May 2019, and his mood had improved after the injection.

33. On 6 May 2019 Mr Williams visited Russell at home to assist with confusion about his additional medications that had been put in his medication Webster Pak. Russell was reportedly paranoid when medications were given to him in a Webster Pak, so the remaining medications in the Webster Pak were exchanged for boxed medications and given to Russell's mother to administer. Education was provided to Russell's mother about what needed to be done.

34. On 9 May 2019 Mr Williams visited Russell at home again and administered his depot antipsychotic medication. Russell appeared settled and there were no acute concerns.

35. On 27 May 2019, a different mental health worker, Mr Ben Laycock (who had visited Russell before) visited Russell at home and administered his depot antipsychotic. It had been due on or about 23 May 2019. No psychotic symptoms were observed, and Russell's father did not voice any concerns. The next depot was recorded to be due on 10 June 2019.

36. On 4 June 2019 Russell's mother phoned KMHDS and voiced frustration that Russell was given his last depot antipsychotic several days late. She felt it may have had a negative impact on his mental state. She requested that his depot return to the usual week of administration, which was in line with his other medications. Russell's mother was very firm on this point and advised that if the depot administration did not return to how it was, she would be handing over full care of Russell to the service. Dr Lauterwein advised that the depot could be administered two days early, on 7 June 2019, which would help realign the schedule.

37. Russell's mother indicated in her statement that in the few days before his depot injection, Russell's family would see a change in his behaviour and he would become aggressive. He was not violent, but she described him swearing and it seems he was agitated. He would improve in the days after his depot medication was administered, which was why she was keen to reduce the interval between his injections back to the usual time period.[23]

[23] T 7 – 8.

FINAL HOSPITAL ADMISSION – 7 JUNE 2019

38. In the early hours of the morning on 7 June 2019, before the next depot injection could be administered, Russell had a relapse. He was shouting and swearing and directing his anger at the neighbours. Mrs Brockliss called the police and asked them to attend. Police attended and took Russell, who was calm and compliant at that time, to Broome Hospital.[24]

39. Russell was brought into the Emergency Department at 4.50 am on 7 June 2019. The triage note records that Russell's parents had called police as he had threatened self-harm and was increasingly agitated, with delusions of grandeur. He was one week overdue for his depot injection of the antipsychotic risperidone.[25]

40. The triage note also records Russell's temperature at 36.1 degrees, a pulse of 96 beats per minute, respiratory rate of 17 breaths per minute, blood pressure of 140/88 and oxygen saturations of 92%. All of these observations are normal except for the oxygen saturations, which are low. This was a recognised long-term problem for Russell due to his obesity and chronic tobacco smoking, but would generally require increased surveillance.[26]

41. The Adult Observation and Response Chart records a single set of observations at 4.55 am on 6 June 2019. This would appear to be a typographical error in relation to the date, and it should read 7 June 2019. The observations recorded are the same as the observations recorded on the triage form, suggesting they were taken from that document.

42. Russell was reviewed by an Emergency Doctor, Dr David Hailes. Russell was noted to be agitated and claimed to be royalty. He reported being persecuted and requested a lawyer. He was keen to have his depot medication and was wanting to go home. On examination, Dr Hailes recorded that Russell was obese, dishevelled and had a tremor. He smelt strongly of tobacco. The physical observations were said to have no abnormality recorded. A physical examination did not note anything of significance. Dr Hailes noted that Russell was initially restless and agitated on arrival. Russell was given a dose of oral olanzapine at 5.20 am and doses of olanzapine and clonazepam orally at 6.10 am after Dr Hailes spoke with the on-call psychiatrist, Dr Renée Bauer.[27]

43. Dr Bauer is the Clinical Director of the KMHDS and was in that role at the time of Russell's death. She was not Russell's treating psychiatrist and had not met him before, but was aware of him as a long-term client of KMHDS who had been discussed regularly in multidisciplinary meetings.[28]

44. Dr Bauer recalled that Dr Hailes informed her that Russell was highly agitated, and Dr Hailes was concerned about attempting to manage him in the ED setting,

[24] Exhibit 1, Tab 15.
[25] Exhibit 1, Tabs 15, 18 and 19A.
[26] Exhibit 1, Tabs 15, 18 and 19A.
[27] Exhibit 1, Tabs 13B, 15, 18 and 19A.
[28] Exhibit 1, Tab 13B.

particularly given the risks of over-sedation due to his high-risk cardiac factors. Dr Hailes informed Dr Bauer that Russell had received initial physical observations which were normal. Dr Bauer did not recall discussing Russell's oxygen saturation, which on later review was low, but she was aware that this was a long-term health issue for Russell so it was unlikely to have caused concern. Dr Bauer and Dr Hailes agreed that there was a need for blood tests and a cardiograph, but Russell was too agitated for these to be done at that stage. It was hoped that the sedative medications would help to calm him and allow some history taking.[29]

45. They agreed that, if possible, Russell would be kept in the ED to await assessment by the psychiatric liaison nurse (PLN) (who was due to start their shift at 7.00 am), with the expectation that Russell would need an inpatient bed in the MHU if he was medically fit to be transferred. Dr Hailes noted that Russell did settle after the doses of olanzapine and clonazepam and made a note that Russell should be monitored while sleeping.[30] Dr Bauer spoke with staff on the MHU to facilitate Russell's anticipated transfer, with the expectation that from a mental health point of view the safest place for him would probably be in the HDU as he wouldn't need to be restrained, which can cause its own problems.[31]

46. Russell woke up at about 8.55 am and was aggressive towards staff. He was escorted by security outside so he could have a cigarette. He returned in a much more cooperative state.[32]

47. The PLN, Clinical Nurse Specialist Ben Laycock, who had previously visited Russell at home in late May, reviewed Russell at 9.00 am. Nurse Laycock noted Russell's long history of schizoaffective disorder and that he was case managed by the Community Mental Health team and his regular case manager was away. Russell was recorded as stating that he was experiencing spirits inside his body, which were sexually assaulting him, and he reported that these feelings were making him feel suicidal. There were reports of increased verbal aggression towards his parents and they were struggling to manage Russell at home, particularly given his parents' own health issues. It was noted that Russell had required sedation in the ED. Nurse Laycock noted that Russell's parents felt he required further treatment in hospital and on discharge they wanted to talk about alternative care options.[33]

48. Russell was given his missed risperidone depot dose at 9.20 am, while still in the ED.[34] Russell was apparently initially agreeable to a mental health admission, but when he was reviewed by Consultant Psychiatrist Dr Lauterwein at 9.30 am he became threatening and voiced delusional thoughts, so it was determined he should be scheduled under the *Mental Health Act*.[35]

[29] T 186; Exhibit 1, Tab 13B.
[30] Exhibit 1, Tab 18, ED Continuation Notes, Dr Hailes, 7.6.2019, 7.07 am.
[31] T 186 - 187; Exhibit 1, Tab 13B and Tab 19A.
[32] Exhibit 1, Tab 18.
[33] Exhibit 1, Tab 18, Mental Health Assessment, 7.6.2019.
[34] Exhibit 1, Tab 18, Mental Health Assessment, 7.6.2019 and Tab 19A.
[35] T 85; Exhibit 1, Tab 11 and Tab 18, Mental Health Assessment 7.6.2019.

49. At 9.48 am on 7 June 2019 Mental Health Practitioner Kym Bates completed a Form 1A, being a referral for examination by a psychiatrist. Nurse Bates had noted that Russell refused to have an ECG or blood tests but that his observations were normal. No further physical observations were recorded. A further note made by a nurse indicated that at the PLN's request they had asked Russell, in the presence of security, if they could do an ECG and bloods, but he refused any investigations and said he "had it all done last month."[36] The nurse went and asked a doctor to speak to Russell about the investigations, but it seems he was not able to be convinced.

50. Russell was medically cleared for transfer by ED staff (based on the limited physical examinations that had been able to be done), and at approximately 10.30 am Russell was admitted to the Mabu Liyan Mental Health Unit by Nurse Anthony (Tony) Wishart. Nurse Wishart had cared for Russell during previous admissions to hospital. On this day, Russell was highly aroused and agitated when admitted and was hostile towards nursing staff and verbally threatening towards Nurse Wishart.[37]

51. Russell remained agitated and verbally aggressive towards staff, even after being given some chlorpromazine medication (designed to reduce his level of arousal and agitation) and sodium valproate at 1.00 pm. Nurse Wishart recalled Russell banging on the window of the nurses' office, punching it with his hand, in the early afternoon.[38]

52. At 2.30 pm Russell was seen by specialist psychiatrist Dr Bernard Hickey. Dr Bauer recalled that she spoke to Dr Hickey prior to this time to discuss Russell's admission and progress.[39] Dr Hickey was working as a locum psychiatrist at Broome Hospital at that time and had not treated Russell before.[40] Dr Hickey was aware from Russell's medical record that he had a history of schizophrenia dating back to 2004 and had been admitted to Broome Hospital as an involuntary patient previously due to his lack of insight and compliance. During his review of Russell, Dr Hickey noted Russell was very agitated and aggressive and he was wary of getting too close to him due to his threatening behaviour. Dr Hickey assessed Russell as having an exacerbation of his psychosis. He needed to be detained and treated for his own safety and the safety of others.[41]

53. Dr Hickey had noted that Russell was an obese man who smoked cigarettes and was therefore at risk of adverse health events. Despite his health risks, his previous ECG and pathology were not concerning and his observations in the ED that morning were in within normal limits. At the time of Dr Hickey's assessment, Russell was refusing physical examination. The performance of blood tests or another ECG at that time, when he was uncooperative, would have put Russell at risk, due to the restraint required, and put the staff at unnecessary risk. Dr Hickey noted that Russell had multiple previous similar admissions and that he usually settled down relatively quickly with reinstation of his usual medications and with some extra tranquilizing

[36] Exhibit 1, Tab 18, ED Triage Form Notes.
[37] T 186; Exhibit 1, Tab 18.
[38] T 85; Exhibit 1, Tab 11.
[39] Exhibit 1, Tab 13B.
[40] T 48; Exhibit 1, Tab 19A.
[41] Exhibit 1, Tab 19A.

medications. Therefore, Dr Hickey directed that staff should perform routine observations including pulse, blood pressure, temperature, and oxygen saturation, if possible, with a plan to do further investigations such as ECG and bloods as soon as possible the following morning. It was anticipated that Russell would be cooperative by then, based on his previous admission history. As a result, the Physical Examination form was not completed at this time.[42]

54. On Dr Hickey's instruction, Nurse Wishart gave Russell a dose of haloperidol at 2.45 pm, which he understood has more of a sedating effect than chlorpromazine, but this medication also appeared to have no effect on Russell and he continued with the same behaviour he had been displaying since his admission.[43]

55. At 2.50 pm Dr Hickey completed a Form 6A, which directed that Russell was to be held as an involuntary patient, with an expiry date of 28 June 2019. Dr Hickey noted on the form that Russell was hyper-aroused, believed he was royalty and was sexually assaulted by evil spirits last night. He still wanted to leave hospital, so he could not be held as a voluntary patient.[44] Russell was commenced on his usual medications and also prescribed 'as needed' (PRN) medications for agitation and arousal. Dr Hickey considered that Russell needed extra tranquilising medication to calm him as there was a risk he would harm himself or another person and his usual medications would not be adequate in the situation to calm him down to a safe level quickly enough.[45]

56. Dr Hickey clarified that he was aware of the risk of respiratory depression for Russell, given he was a tobacco smoker and morbidly obese, so he was cautious with the medication he prescribed to Russell to calm him. The medications he prescribed (haloperidol, olanzapine and lorazepam) had all been used in previous admissions without any concerning side effects so he prescribed them at the same dose as before. However, as the level of sedation associated with the medication was not fully predictable, Russell was to be observed every 15 minutes. Given he was in the HDU, these regular visual observations were required as standard practice in any event.[46]

57. Dr Hickey was asked about Russell's low oxygen saturations on admission. He commented that this was Russell's chronic state, based on previous admissions, so by itself, it did not warrant more active monitoring of his physical state when weighed against his agitation and risk to himself and others. Dr Hickey gave evidence that he would have liked the nursing staff to have done physical observations of Russell that evening, if it was safely possible without making him agitated. He agreed in questioning by counsel on behalf of Russell's family that there may have been an opportunity to attempt to do so from about 7.00 pm on the evening of 7 June 2019, based on the HDU Interaction Chart. Dr Hickey indicated he expected, at the very least, that they would be done the next the morning, which was the intended plan of the nursing staff until Russell was discovered unresponsive.[47]

[42] Exhibit 1, Tab 18, Mental Health Physical Examination Form, 10.6.2019 and Tab 19A.
[43] T 86; Exhibit 1, Tab 11.
[44] Exhibit 1, Tab 18.
[45] T 51 - 53; Exhibit 1, Tab 19A - B.
[46] T 54, 68; Exhibit 1, Tab 19B.
[47] T 55 – 57, 66.

58. A nursing note at 5.00 pm records that Russell had been unsettled on the ward during the day shift. His mood was labile and his affect blunted. He had been verbally abusive and aggressive towards staff and was verbalising various paranoid, persecutory and grandiose delusions. Chlorpromazine and sodium valproate had been given at 1.00 pm and haloperidol at 2.45 pm and 4.40 pm for agitated and escalating behaviours. Russell had accepted the oral haloperidol as he was familiar with their appearance. He refused any other care or intervention, although he did accept cigarettes, drinks of water and cups of tea.[48]

59. Nurse Wishart had been involved in giving Russell the additional dose of haloperidol at 4.40 pm, which was given with the hope it would have an eventual settling effect, which it did. Russell began to calm down and at 5.00 pm he had dinner. The staff were able to enter the HDU to give him his meal without any hostility.[49]

60. Dr Hickey left the ward at 5.00 pm at the end of his shift and had no further involvement with Russell. Dr Hickey recalled that at the time he left, Russell was still highly aroused but had accepted his medication and was gradually becoming calmer. Dr Bauer, who was already aware of Russell's admission, was the 'on call' psychiatrist overnight. Dr Hickey gave a handover to Dr Bauer before he left the hospital. He did not have a clear memory of what was discussed in the handover, but his usual practice was to confirm the situation, which in Russell's case was that he was highly aggressive and agitated but accepting oral medication. Dr Bauer recalled there were no physical concerns in relation to Russell at that stage but Dr Hickey conveyed to her that Russell was still agitated and aggressive and needed to be managed in the HDU.[50]

61. Dr Bauer gave evidence that there was nothing to indicate Russell had an experienced an acute deterioration in his physical state at that time, so she didn't expect him to have his physical assessment undertaken until the next day, when it was expected that he would have settled. Dr Bauer recalled she discussed this with Dr Hickey during the handover. Dr Bauer agreed with Dr Hickey that, in retrospect, it would have been better if an attempt had been made to take Russell's physical observations that evening, when he had settled, particularly the ECG and blood tests that were outstanding. However, it was not a direction she had made to staff and it was quite possible he would not have cooperated in any event, as even at the best of times he did not like having any investigations. Dr Bauer made it clear she would not, at any stage, have considered over-sedating Russell in order to conduct such investigations, as the risks of over-sedating him were much greater than the risk from not having the observations.[51]

62. As Russell was in the HDU, he was automatically required to be observed no less than every 15 minutes, so this would, in any event, provide an opportunity for

[48] T 56; Exhibit 1, Tab 18, Integrated Progress Notes, 7.6.19, 17.00 hrs and Tab 19A.
[49] T 86 - 87; Exhibit 1, Tab 11.
[50] T 190 – 191; Exhibit 1, Tab 13B and Tab 19A-B.
[51] T 195 - 196.

nursing staff to note if he became breathless or exhibited signs of chest pain or any other signs that might suggest a worsening physical state.[52]

63. Nurse Wishart remained on shift until 7.00 pm. He noted that Russell had been having cigarettes every hour from admission, as per the smoking policy. Russell had his cigarettes at 7.00 pm and showed diminished agitation and irritability. Nurse Wishart then did a handover to the nurse coming onto the night shift and ceased duty. Nurse Wishart recalled that Russell had not appeared to be experiencing any overt psychotic phenomena or delusions, but had been extremely angry, which he would have covered in the handover.[53]

64. Nurse Wishart recalled that he handed over to Nurse Adrian Hepi, Nurse Jade Mumford and another nurse. Nurse Hepi was the shift coordinator for the night shift, so Nurse Hepi would have been in charge of allocating staff to perform the ongoing 15 minute observations of Russell, but Nurse Wishart was not aware who Nurse Hepi allocated the task.[54]

65. Nurse Wishart gave evidence that until he finished his shift he had been unable to take Russell's physical observations, given his agitated presentation, without compromising his safety or the safety of his colleagues. Nurse Wishart gave evidence he had asked Russell if he could take his observations and Russell, "in no uncertain terms, told me where to go."[55] Nurse Wishart described the incident as "quite scary"[56] and said there was no chance he could take them in those circumstances. Nurse Wishart gave evidence he had tried to approach the subject with Russell a number of times before finishing his shift, with the same response, although he did not believe he asked Russell after 5.00 pm, when Russell had begun to calm down, before he finished his shift.[57] Nurse Wishart explained that he had a couple of other patients to care for, and had to prepare his notes for handover, so he did not get an opportunity to do so.[58] Nurse Wishart agreed in his evidence that, in hindsight, it would have been beneficial to attempt to do so given he had settled by that time, but unfortunately this did not occur on the night.[59]

66. Nurse Wishart did not know whether Nurse Hepi or the other nurses commencing the night shift tried to take Russell's physical observations after he commenced his shift, but he suggested this would have been a prime time for them to have attempted to do so.[60]

67. The Mabu Liyan High Dependency Unit Interaction Chart records patient status and interaction at 15 minute intervals. These interactions are signed off by staff. If the patient is asleep, their respiratory rate is recorded. Russell's HDU Interaction Chart is available from his admission into the unit at 10.00 am until midnight on 7 June

[52] T 190 – 191; Exhibit 1, Tab 13B and Tab 19A-B.
[53] T 90; Exhibit 1, Tab 11.
[54] T 92.
[55] T 89.
[56] T 89.
[57] T 89.
[58] T 110 – 111.
[59] T 111.
[60] T 92.

2019, with the last entry made at 11.45 pm. Although there should be entries every 15 minutes, there are no recordings made between 6.15 and 7.45 pm. The nurse responsible for making those entries, Nurse Wishart, gave evidence he was tending to other patients and missed approximately an hour of observations. There was general evidence that it could sometimes occur that staff would be drawn away to do other tasks as they cared for more than one patient.[61]

68. From 7.45 pm the entries for Russell generally record him as asleep with a respiratory rate of between 18 and 22 breaths per minute. At 11.00 pm he was apparently knocking on the nursing station window but was back in bed asleep again by 11.15 pm and remained asleep, with a respiratory rate of 20 breaths per minute until 11.45 pm, when the last note is recorded.

69. The HDU interaction chart for 8 June 2019 is missing. I set out below more information about what is known about what happened to the chart, but it is sufficient at this stage to say that no one has been able to locate it. I am satisfied it existed, but it is unclear what happened to it following Russell's death.

70. To add to the complexity of this issue, the nurse who was tasked with recording many of those observation notes, Nurse Hepi, is unavailable to give evidence as sadly he passed away in 2020. No statement was taken from him about these events prior to his death. This was obviously a missed opportunity to clarify events with a key witness.

71. Another nurse who had made entries in Russell's HDU Interaction Chart prior to midnight, Nurse Mumford, provided a statement dated 22 June 2021. Nurse Mumford confirmed that from viewing the HDU Interaction Chart that ended at 23.45 on 7 June 2019, she had made 15 minute entries from 22.45 until 23.45. She recorded his respirations when he was asleep and also recorded that he was knocking on the nursing station window at one stage but seemed settled. Nurse Mumford did not know what happened to the HDU Interaction Chart that would have commenced at midnight on 8 June 2017, and given the lapse of time between events and providing her statement, she could not now recall whether she did further observations on Russell from midnight onwards.[62]

72. The only documentation that is available in this case after midnight is the nursing note authored by Nurse Hepi at 5.00 am on 8 June 2019, which records that at 7.30 pm the night before, Russell was still asleep after being admitted that day quite aggressive, unsettled, and with labile, blunted mood. Nurse Hepi recorded that Russell had PRN medications but was still quite demanding before he slept. He was up at 2.00 am and was then redirected back to sleep. No smokes or coffee were taken.[63] This note would have been made in preparation for the handover to the day shift.

73. Registered Nurse Sherylee Girling was the Nurse Coordinator for the day shift on 8 June 2019. Her shift commenced at 7.00 am that morning. Nurse Girling had been

[61] T 24 – 25, 94.
[62] Exhibit 3.
[63] Exhibit 1, Tab 18, Integrated Progress Notes, 7.6.19, 5.00 am.

aware of Russell's admission the previous day, when he was cared for by Nurse Wishart, and had been involved in treating Russell when he had been admitted to Mabu Liyan on previous occasions. Nurse Girling was aware from those previous admissions that Russell was often agitated and angry in the early stages due to his mental health symptoms and needed to be nursed in the High Dependency Uni for safety reasons and to reduce his exposure to stimuli. Nurse Girling was also aware that Russell was at higher risk of a cardiac event than most patients.[64]

74. Nurse Girling's only recollection of Russell's behaviour on 7 June 2019 was seeing him through the nursing station window walking around the HDU lounge appearing quite agitated and angry.[65]

75. On the morning of 8 June 2019, when Nurse Girling commenced her shift, clinical handover from the night shift began. The handover can take between 20 and 40 minutes, depending on the acuity of the patients. Nurse Girling was allocated Russell as one of her patients, so she would have received a handover from his allocated nurse, Nurse Hepi, but she did not recall the detail of the handover. I note that the Mabu Liyan Patient Observation Procedure at the time required that at the shift change, both staff were to make their first and last observation together, so if this was done, then Nurse Girling and Nurse Hepi should have observed Russell together at around 7.00 am.[66] There was no evidence about whether this did, in fact, occur that morning.

76. Nurse Wishart gave evidence that he also commenced his shift at 7.00 am on 8 June 2019 and he recalled receiving a handover from Nurse Hepi, the clinical nurse who had been caring for Russell on the night shift. Nurse Wishart had a vague recollection of the handover, recalling that Nurse Hepi said that Russell had been up for four or five hours just waiting in the lounge area for his cigarettes to come every hour, and asking for his cigarettes in the meantime. Nurse Wishart understood that Nurse Hepi was referring to the period of hours after he had finished his shift the night before, which is consistent with the HDU chart for 7 June 2019, but not necessarily consistent with Nurse Hepi's note in the medical records.[67]

77. Nurse Wishart was not allocated to care for Russell for this shift, as that task had been allocated to Nurse Girling, so he did not interact with Russell until later in the morning. He also did not recall seeing the HDU visual observation chart for 8 June 2019 and said he had absolutely no idea what had happened to it. Nurse Wishart expressed great surprise that the chart had gone missing. He gave evidence that he had never heard of that happening before and he was aware that the staff take the HDU interaction chart very seriously, so he found it remarkable that it wasn't in the medical records.[68]

78. Nurse Girling recalled seeing the HDU interaction chart for the time from midnight on 8 June 2019, although she could not recall at the time of the inquest if it had any

[64] T 20 – 21, 38; Exhibit 1, Tab 12B.
[65] T 20 – 21; Exhibit 1, Tab 12B.
[66] Exhibit 1, Tab 13B, RB1, Procedure 2.3.3.
[67] T 91 – 93, 110.
[68] T 90 – 94, 114; Exhibit 1, Tab 11.

entries written on it. Nurse Girling did, however, give evidence it is likely she would have noticed if the chart was blank and made a note of it or discussed it with her nurse manager.[69]

79. Dr Bauer had an independent recollection of seeing the missing HDU interaction chart used for the period from midnight on 8 June 2019. Dr Bauer recalled seeing the chart immediately after Russell was declared life extinct. Dr Bauer remembered seeing it where it was normally located on the desk in the nurses' station below the CCTV, and recalled looking at it for about five minutes. Dr Bauer is confident the chart she perused was the chart for 8 June 2019 and not the early chart ending at midnight on 7 June 2019. At the time of signing her second statement in February 2021, Dr Bauer could say she thought there were checks recorded every 15 minutes, as she was fairly sure if there were any gaps she would have investigated it and asked the staff for an explanation as to why there were gaps. Dr Bauer did recall there was an entry for 8.15 am, which indicated that Russell was breathing. This accorded with what Nurse Girling had told Dr Bauer in the HDU. Dr Bauer did not take the chart out of the nurses' station after looking at it and she did not know what happened to it after that time. She confirmed the hospital staff had searched for it without success. Dr Bauer also confirmed that, although a copy was supposed to be taken of the chart by hospital staff before it was given to police, no copy of the relevant chart had been found. The lack of a copy in the hospitals records does point towards it going missing before the records were copied and provided to police.[70]

80. Given Russell was required to have 15 minute observations, there should have been a number of checks, and corresponding entries, made from 7.00 am, although this may have been delayed by handover. Nurse Girling could not recall if she did any checks of Russell prior to 8.15 am, although she indicated it was possible that she did. Nurse Girling could only distinctly recall conducting a visual observation at 8.15 am.[71]

81. There was in 2019, as there is now, a policy that required that staff could only enter the HDU in pairs, for safety reasons. Therefore, in order to conduct the full physical observations generally required every 24 hours, two staff would enter the HDU together to perform that task. Although two staff could also enter the unit together to conduct visual observations, in mid-2019 staff were not required to enter the HDU to conduct visual observations. Given the observations could be required every 15 minutes, as they were for Russell during this last admission, it was felt it was not always viable to wait for another nurse to be available. Therefore, if they could observe the patient from outside the unit, it was often the case at that time that only a single nurse conducted the regular visual observations. That policy has since changed, and I discuss the new policy later, but at the time a single nurse would usually observe the patient in HDU through a window and if the patient was asleep, they would record the respiration rate by observing the patient's chest rising and falling. Other indications for visual observation were if the patient was seen moving or heard snoring.[72]

[69] T 30.
[70] T 199 - 201; Exhibit 1, Tab 13B.
[71] T 31; Exhibit 1, Tab 12B.
[72] T 23 – 24; Exhibit 1, Tab 12B.

82. Nurse Girling remembered doing the visual observations check of Russell at 8.15 am. She recalled the observation as she still has an image in her mind of Russell and his position in the bed at the time she observed him. That recollection is strengthened from the subsequent events that occurred that morning. Nurse Girling gave evidence that she looked at Russell, who appeared to be asleep in bed, through the narrow window in the door. Nurse Girling has a "visual snapshot of him, lying on his side, facing that window, with the blankets covering his legs."[73] Nurse Girling cannot recall if she was able to assess Russell's respirations at that time. If she had been unable to do so, or count the respirations accurately, she indicated she would have looked for signs of life, such as snoring or movement.[74]

DISCOVERY THAT RUSSELL WAS UNRESPONSIVE

83. After the 8.15 am check, Nurse Girling was dealing with a distressed patient in the HDU. She then realised she was late for her next check of Russell, which should have been done at 8.30 am. Russell was due for his next set of physiological observations around this time, so she asked Nurse Wishart to accompany her into the HDU so they could wake him up, give him breakfast and do some vital and physical observations before the consultant came in to review him that morning. Russell had been reluctant to have his observations done earlier, so it was hoped that he might be a bit more cooperative after being given some food and a chance to have a cigarette.[75] Nurse Girling believed they entered the HDU together at approximately 8.37 am.[76]

84. Nurse Wishart had a slightly different recollection of events. He recalled that they went into the HDU as the phlebotomist was present ready to take Russell's blood samples, and the time was more like 8.00 am to 8.15 am, although he conceded he could not be 100 per cent certain about the time.[77]

85. Irrespective of the exact time, both nurses agreed they entered the HDU and approached Russell, who was still in bed. As they entered the room, Nurse Girling said she noticed that Russell was lying in an unnatural position on his stomach, with his face to the side and his leg hanging off the bed. She believed this was a different position to when Nurse Girling had seen him at 8.15 am. She touched Russell's leg, which was cold, then touched his arm, which was also cold. Nurse Girling tried to get a peripheral pulse of Russell's wrist, but no pulse was there. Nurse Girling wasn't certain at that stage if this was because he was deceased or because he was obese. Nurse Wishart was also trying to obtain a pulse without success. Nurse Girling tried to feel for a pulse around Russell's neck, which she believed felt warm and sweaty, but she couldn't gain access to his neck so she wasn't quite sure if he had any pulse around his neck. Nurse Girling was, however, certain Russell wasn't breathing.[78]

[73] T 30.
[74] T 30.
[75] T 32; Exhibit 1, Tab 12B.
[76] T 32 – 33; Exhibit 1, Tab 12B.
[77] T 95 – 96.
[78] T 32 – 33; Exhibit 1, Tab 12B.

86. Nurse Wishart recalled that as they entered Russell's room, Russell was lying in bed on his right side, facing away from them. Nurse Wishart recalled they tried to wake Russell up but he was unresponsive. Nurse Wishart then checked him and found he was "very, very cold to touch"[79] and had no carotid pulse and no radial pulse.[80] When asked to clarify what he recalled, Nurse Wishart gave evidence Russell's body was "freezing cold"[81] and he appeared to be a shade of blue. Nurse Wishart confirmed that he had checked for a pulse on Russell's neck, as well as Nurse Girling, and he did not notice Russell's neck being hot and sweaty, rather it was cold like the rest of his body. He did not, however, observe any signs of stiffness or rigor mortis.[82]

87. Nurse Wishart said they activated the CPR protocol, which involved checking there was no danger, trying to get a response from Russell and then seeking help. Dr Bauer arrived on the ward around this time as she was preparing to do her regular ward rounds. Dr Bauer explained at the inquest that there were actually two patients in the HDU at that time, Russell and another patient, so there had been a need to "juggle around managing interaction between Russell and the other patient"[83] and she had wanted to look at that issue fairly early on the Saturday morning. Dr Bauer estimated she arrived on the ward between 8.40 and 8.45 am.[84]

88. Dr Bauer asked the student nurse at the nursing station where Nurse Girling was, as she wanted to consult with Nurse Girling. The student nurse advised her that Nurse Girling and Nurse Wishart were in the HDU, so Dr Bauer went in there to find her. As Dr Bauer entered the HDU she saw the two nurses beside Russell's bed and heard Nurse Girling calling for help. Dr Bauer noted Russell was prone and unresponsive, had no pulse or respirations and felt cold to touch. Nurse Girling explained the history of events while Nurse Wishart and Dr Bauer moved Russell from his stomach onto his back in order to commence compressions. This took some time and effort due to Russell's size and the need to move around the bed. Once they had successfully moved him into position, Nurse Wishart and Dr Bauer immediately commenced CPR. Dr Bauer believed good compressions were obtained.[85]

89. At that time, Nurse Girling left the room to go and press the medical emergency team (MET) call button to call a Code Blue. At that time, the closest Code Blue button was in the nursing station, which required Nurse Girling to travel some distance out of the HDU to reach it, before she could return to the HDU and help Nurse Wishart and Dr Bauer.[86]

90. While waiting for the MET staff to arrive, another staff member came in to assist, so Nurse Girling asked them to go and get the air viva from the trolley in anticipation of the MET members arriving. Dr Bauer recalled there were some delays in the ward staff locating the MET trolley and oxy viva apparatus, and she felt it took a long time

[79] T 96.
[80] T 96.
[81] T 97.
[82] T 96 – 98.
[83] T 193.
[84] T 196; Exhibit 1, Tab 13A.
[85] T 196 - 197; Exhibit 1, Tab 13B.
[86] T 33, 96, 98.

to come, but when it arrived she started using the oxy viva to bag and mask Russell before the medical team arrived.[87]

91. After Nurse Girling pressed the call button, the MET team were alerted to the medical emergency in Mabu Liya, although there was evidence it did not identify that the patient was in the HDU. Nurse Wishart gave evidence that the other medical staff arrived quite promptly, within a couple of minutes, and everything that could possibly done to try to save Russell's life was done. He noted that Russell was quite hard to do compressions on because of his size, but all efforts were made. Nurse Girling recalled it seemed like it took the MET team "forever"[88] to arrive, but she conceded it probably felt that way because of the seriousness of the situation.[89]

92. Dr Sasha Saharov works as a GP anaesthetist at Broome Hospital. He had not had any involvement in Russell's care until he heard the MET call alarm at 8.48 am on the morning on 8 June 2019. Dr Saharov and two senior nurses went to Mabu Liyan as quickly as possible to assist. Dr Saharov was working in the emergency department at the time and he estimated it was about a three minute run from there to the mental health unit. When they arrived at the unit, they attended the nurses' station but unfortunately, there was only a student nurse there who was unable to inform them of where the emergency was occurring. Looking through a window at the nurses' station, they could see a nurse being held by a patient, which initially made them think she was being assaulted, but then they established she was not in danger as she gave them a 'thumbs up'. Dr Saharov looked at all the video screens and could not see any resuscitation in progress. He then spoke to the nurse he had seen being held by the patient and she directed him to the HDU.[90]

93. Dr Saharov commented that it was fortunate he went and spoke to the nurse, as they could have simply left at that stage, thinking it was a false alarm. Dr Saharov noted that typical practice, and best practice, is for a MET team to be greeted by someone who is familiar with the layout of the unit and direct the team to where they need to go, but that did not occur in this case. In hindsight, he realised that it was because all of the available staff except the student nurse were caught up in the HDU, but he did not know that at the time.[91]

94. Dr Saharov gave evidence that he felt that, due to these issues, it took him longer than he would have liked to reach Russell, and estimated overall it would have taken him up to five minutes from the time he saw the alarm until he entered the room where CPR was in progress, allowing for three minutes to run to Mabu Liyan from the ED.[92]

95. Dr Saharov said he entered the HDU through the airlock and started looking around the general living area and the courtyard then went to the bedroom and found Dr Bauer and other staff performing resuscitation on Russell. He could see they were

[87] T 96, 100, 197; Exhibit 1, Tabs 11 and 13B.
[88] T 35.
[89] T 100, 112.
[90] T 116 - 117; Exhibit 1, Tab 14.
[91] T 117 – 119.
[92] T 146 – 147.

doing compressions and considered they seemed adequate, so he went back outside to get the nursing team, who had waited outside the HDU until Dr Saharov established that it was safe for them to enter. They followed Dr Saharov back into the HDU with the equipment, although there was apparently a short delay while they located the MET trolley in the mental health unit.[93]

96. Being the only GP anaesthetist in the room, Dr Saharov said he went straight to the airway and took over the bag and mask, while also simultaneously taking over leadership of the situation after a handover from Dr Bauer. He was trying to optimise the ventilation while also listening to Dr Bauer and looking at the patient and checking for signs of life.[94]

97. Dr Saharov recalled that Russell was pale to blue, cold to touch, had a large beard and an extremely large body habitus. He wasn't able to get adequate ventilation with a bag and mask, so rather than continuing to try and push air into a closed tube, he then assessed Russell's airway and his face. Dr Saharov explained that there can be a number of reasons why you might not be able to ventilate a patient, including that the mask doesn't fit or a large beard might make it difficult to get a seal. He tried to optimise the placement of the mask, but found it difficult because of Russell's position. Dr Saharov said normally he would get behind the patient, but because the bed was fixed on the floor and Russell was right up against the wall, it was difficult. As well as that, Russell had a large beard.[95]

98. Dr Saharov explained that one of the manoeuvres he attempted was to actually put Russell's jaw forward, which pulls the tongue forwards and opens up the airway. However, he was unable to do that because Russell's jaw was so stiff. Dr Saharov couldn't open Russell's mouth more than it was already open. His mouth was open wide enough the Dr Saharov could look inside and he couldn't see any foreign body in there, such as vomit or anything else, but he couldn't open it any further. Dr Saharov checked Russell's eyes at this stage and noted his pupils were a little bit retracted and his pupils were fixed and dilated. Dr Saharov gave evidence that these two features, taken together, suggested to him that Russell was deceased and had been for a longer time than the overall picture with which he had originally been presented. Dr Saharov had been informed in the handover that Russell had been seen breathing relatively recently, but he now questioned whether that was correct.[96]

99. Dr Saharov explained that he has worked in palliative care, as well as in emergency, and so he has seen a lot of people die. He was aware that proximal rigor mortis comes before peripheral rigor mortis, which means the muscles closer to the centre become stiff first, such as the eyelids, jaw and muscles controlling the tongue. Although he considered that Russell's large neck, with a lot of extra tissue around the jaw, would have played a part in why his jaw wouldn't open, based upon his considerable experience in certifying deaths, Dr Saharov believed the tissues had also stiffened due to the commencement of proximal rigor mortis, even though he

[93] T 120 – 121.
[94] T 122.
[95] T 122 – 123.
[96] T 123 – 124.

was still mobile peripherally. This suggested he had been dead for longer than the half an hour he had originally been told.[97]

100. Having also already noted that Russell was cold to the touch and had pallor and cyanosis, these observations prompted Dr Saharov to ask Dr Bauer and the nursing staff whether they were sure they had seen Russell breathing only half an hour before. Dr Saharov explained that the reason he wanted to clarify this issue is that if it was true, then the process of him stopping breathing was more sudden and potentially more reversible, such as an obstruction.[98]

101. Although Dr Saharov had doubts about the accuracy of the information he had been given as to when Russell had stopped breathing, he gave evidence that medical staff give patients the benefit of the doubt when considering whether to continue resuscitation, and they were aware Russell was in the care of the State and was a relatively young patient, so he decided they should continue resuscitation efforts for a further period. During this period a defibrillator had been attached to Russell, which had shown Russell was in complete asystole, with no circulatory activity at all, the whole time. This did not change as resuscitation attempts continued and Russell showed no sign of a return of spontaneous circulation. Dr Saharov advised that generally if someone is in asystole for 10 minutes and/or resuscitation has continued for more than 20 minutes with no signs of life or spontaneous circulation, the person is considered to be irrecoverable.[99]

102. Around this time, Dr Saharov took a tympanic measurement of Russell's temperature, which was recorded as 34.4°C. This was well below what would be expected for someone even when they are asleep in bed in air conditioning, and almost two degrees below what he would expect to be the minimum for a live person. Noting that when a person dies their body temperature cools about a degree an hour, he estimated that Russell had been deceased a couple of hours at that time. Dr Saharov indicated the temperature simply confirmed what he already believed was the case, based on all the other clinical criteria, as he would not rely upon the temperature in isolation.[100]

103. Given the clinical criteria of 10 minutes of asystole and 20 minutes of good quality CPR with no signs of life had both been met, and noting the other signs that suggested Russell had been dead for a considerably longer period of time, CPR was continued but Dr Saharov started the discussion about ceasing resuscitation efforts. He indicated he believed it was futile, as Russell had already died, and Dr Bauer and the nurses present all agreed. At that time another doctor, Dr Michael Murray, entered the room. He had come to see if he could assist with the MET call. Dr Saharov ran the whole situation passed Dr Murray while compressions continued. After being apprised of the situation, Dr Murray agreed that it was reasonable to stop CPR at that stage. Dr Saharov felt comfortable, having consulted his colleagues who had been assisting with the resuscitation, as well as obtaining a second opinion from Dr Murray, that it was appropriate to cease CPR. All resuscitation efforts were

[97] T 124 – 126.
[98] T 126.
[99] T 127 - 133.
[100] T 131 – 133; Exhibit 1, Tab 14.

ceased at 9.03 am and Dr Saharov waited for 4 minutes before checking for any signs of life or return of spontaneous circulation, or which there were none. He therefore certified Russell as deceased at 9.07 am.[101]

104. Russell's father happened to be present at the hospital at the time Russell's death was confirmed, as he had come in to drop off some of Russell's thing. Dr Bauer and Dr Saharov spoke to Russell's father in a quiet area at approximately 9.30 am to inform him of Russell's death. They offered to ring his wife, Russell's mother, to inform her of Russell's death, but Russell's father made it clear he preferred to go home and inform her of their son's death himself, which the doctors respected. Dr Bauer asked him if he could ask Russell's mother to call her when she was ready.[102] Dr Bauer spoke to Russell's mother on the telephone at 11.15 am that morning.[103]

POLICE INVESTIGATION

105. First Class Constable Sacha Mann was one of the first attending officers to the hospital after Russell's death, together with Senior Constable Haxholdt, Sergeant Langthorn and Senior Constable Ferguson. They arrived at the hospital at about 10.30 am and were directed to the Mental Health Unit. They were aware Russell had been an involuntary patient, so the matter was to be investigated as a death in custody.[104]

106. First Class Constable Mann recorded in her report that the attending police were told by the nursing staff that Russell had been checked regularly throughout the night and morning at 15 minute intervals. When he was checked at 8.15 am he was asleep on his back in bed and at the next check, which was completed 7 minutes late at 8.37 am, he was lying face down and was showing no signs of life. First Class Constable Mann recalled she spoke to Nurses Girling and Wishart and Nurse Girling advised of the 15 minute observations and the fact that they were seven minutes overdue for the 8.30 am check.[105]

107. Dr Sascha Saharov, who had responded to the MET call, also later spoke to the police and advised that he had formed the opinion that Russell had been dead longer than suggested by the nursing staff checks.[106] This information cast some doubt on the reliability of the accounts of the nursing staff as to the last time Russell was confirmed to be alive before the MET call was made.

108. The attending police officers did not see the observation charts that had been completed when they attended the MHU that morning, but they did ask for all of the medical notes to be provided. First Class Constable Mann indicated that the nursing staff were cooperative and willing to provide the medical records. However, as the police seize the originals, the hospital staff wanted to take a copy before handing over the originals and they had not yet completed that task on the morning of

[101] T 133 – 134; Exhibit 1, Tab 14 and Tab 23.
[102] T 214 – 215; Exhibit 1, Tab 13A.
[103] T 215; Exhibit 1, Tab 13A.
[104] Exhibit 1, Tab 9.
[105] T 10, 12 – 13, 17.
[106] T 12; Exhibit 1, Tab 9.

Russell's death. Accordingly, the medical records were not provided to the attending police officers that morning.

109. First Class Constable Mann gave evidence the records were handed over to the investigating officer who took over management of the coronial investigation, Sergeant Langthorn, later that day. The records were placed with Russell's body so that they could accompany his body to the State Mortuary for the benefit of the forensic pathologist conducting the post-mortem examination. First Class Constable Mann assumed that all of the relevant medical records were provided.[107]

110. Unfortunately, it became clear in preparing for the inquest that the observation charts from midnight until the time of Russel's death were not in the medical records at the time they were provided to this Court. Further, while the hospital apparently took copies of the records before they were provided to the police, the hospital also did not have copies of the charts. It was confirmed with the State Mortuary staff that they did not have a copy of the chart that they could provide to the Court.

111. It is stating the obvious to observe that this situation is unsatisfactory and makes it extremely difficult to know now how Russell appeared in the hours prior to the discovery of his body later that morning. It is also impossible for me to properly assess the quality of his supervision, treatment and care over that period. I discuss this issue further below.

CAUSE AND MANNER OF DEATH

112. Dr Gerard Cadden, a very experienced forensic pathologist, conducted a post-mortem examination of Russell on 14 June 2019 after his body was transferred from Broome to the State Mortuary. Dr Cadden noted that at the time of the examination Russell's body weight was 160 kg and his BMI was 43, which demonstrates morbid obesity. No gross primary pathology was evident although the heart was noted to be enlarged, which can occur in a person who is considerably overweight. Some minor atherosclerosis was identified during the initial examination, which was found to be more evident and severe microscopically than to naked eye inspection. The very significant hardening and narrowing of the coronary arteries on the surface of the heart was felt by Dr Cadden to have played a role in Russell's death.[108]

113. Neuropathology assessment of the brain did not find anything of note other than post-mortem changes.[109]

114. Toxicology analysis showed various medications, consistent with Russell's known medical treatment.[110]

115. At the conclusion of extensive investigations, Dr Cadden formed the opinion Russell's death was consistent with acute cardiac arrhythmia in a man with focal

[107] T 12, 15.
[108] T 175; Exhibit 1, Tab 5A – B, Tab 6A – C.
[109] T 175; Exhibit 1, Tab 7.
[110] T 175; Exhibit 1, Tab 8.

coronary atherosclerosis and morbid obesity. His history of chronic schizoaffective disorder was also noted as a significant contributing factor, but not the direct cause of death.[111]

116. Dr Cadden was unavailable to give evidence at the time of the inquest, so Dr Clive Cooke, another very experienced forensic pathologist, reviewed the post-mortem examination materials and Dr Cadden's reports and gave evidence at the inquest about the post-mortem findings. Dr Cooke did not take issue with Dr Cadden's conclusions and considered Dr Cadden "gave a very fair cause of death based on what he has found"[112], while noting that the possibility of sleep apnoea or some other contributor could not be excluded entirely, which is why Dr Cadden has prefaced the cause of death with the words 'consistent with'.[113]

117. I accept and adopt Dr Cadden's opinion as to the cause of death.

118. Dr Cooke had sighted the microscopic sections and confirmed for himself the calcified coronary arteriosclerosis, which he noted is a natural process of ageing but the usual risk factors are poor diet, diabetes and cigarette smoking, all of which were known to Russell. Dr Cooke confirmed that it was common for this condition to be unidentified during life if a person does not experience symptoms or does not seek investigation of those symptoms. Dr Cooke also confirmed that it was possible for Russell to have developed coronary arteriosclerosis, but it not be detected on an ECG. If diagnosed, the treatment would generally involve the insertion of stents initially or ultimately cardiac bypass surgery.[114]

119. In terms of a possible diagnosis of COPD, Dr Cooke gave evidence there was only congestion of the lungs identified, which is a very non-specific finding and is a feature of the heart stopping. Dr Cadden did not mention seeing any changes of COPD, like emphysema, asthma or bronchiectasis, but Dr Cooke noted that these features are so commonly seen at the time of post-mortem that forensic pathologists often don't give it much credence in terms of reporting, particularly in someone who has a history of smoking. In Russell's case, there were also issues of decomposition that may have made it difficult to make a proper assessment. Therefore, the absence of reference to such findings does not exclude the possibility that Russell did suffer from COPD.[115]

120. Dr Cooke explained at the inquest that the reason why Dr Cadden included the reference to Russell's schizo affective disorder was because it is a well-known risk factor to sudden cardiac death, with schizophrenics known to be at approximately three times increased risk of sudden cardiac death.[116]

121. Dr Cooke confirmed that an acute cardiac arrhythmia is a sudden event, and someone might appear well and show no signs of deterioration and then have this sudden

[111] T 175; Exhibit 1, Tab 5A - B and Tab 6A - C.
[112] T 181.
[113] T 181.
[114] T 176 - 178.
[115] T 178, 183.
[116] T 180.

cardiac event. In terms of treatment for cardiac arrhythmia, Dr Cooke indicated that if it is detected quickly, attempts may be made at resuscitation, but whether they will be successful or not will depend on a lot of factors.[117]

122. Dr Cooke was asked his opinion on the possibility that Russell had been deceased for a longer period of time than initially believed, based on the known evidence. Dr Cooke indicated that Dr Cadden's findings do not really contribute to that question, as the post-mortem delay was several days. In terms of the body temperature reading recorded by Dr Saharov, Dr Cooke agreed that a tympanic reading does reflect quite closely the core body temperature, and the reading was suggestive that Russell may have been deceased longer than 35 minutes. Similarly, the evidence of established rigor mortis was also suggestive he had been deceased for a couple of hours as rigor mortis normally starts in the jaw an hour or two after death. Although Dr Cooke qualified these comments with a caution that it is easy to over-interpret these estimations, he agreed that it was suggestive that Dr Saharov was probably right that Russell had been deceased for a couple of hours at the time he assessed him.[118]

123. Dr Cadden and Dr Cooke expressed the opinion that Russell's death was consistent with natural causes. I accept and adopt their opinion in relation to the manner of death.[119]

TIME OF DEATH

124. As set out above, Dr Saharov's examination of Russell suggested to him that Russell had been deceased for longer than the half an hour he had originally been told when he attended the MET call. Dr Saharov considered Russell's low body temperature, along with the proximal rigor mortis around his jaw and the other clinical criteria, all suggested that he had been deceased for a period more like two hours.[120]

125. Nurse Wishart indicated that when he had heard Dr Saharov say that Russell's body temperature was 34 degrees, he realised they had been fighting a losing battle and Russell had probably been deceased for some time.[121] Based upon the times that were able to be worked out, and Dr Saharov's estimate from the body temperature, it appeared Russell may have died as early as 7.00 am that morning.[122]

126. Dr Bauer also indicated that, although she had accepted what she had been told about Russell being seen breathing at 8.15 am at the time she was performing CPR, she agreed that Russell's tympanic body temperature of 34.4 degrees suggested that Nurse Girling was mistaken when she thought she saw him breathing at 8.15 am.[123]

[117] T 181 - 182.
[118] T 178 – 179.
[119] T 182.
[120] T 124 – 126, 131 – 133; Exhibit 1, Tab 14.
[121] T 97, 99; Exhibit 1, Tab 11.
[122] T 133.
[123] T 200; Exhibit 1, Tab 13B.

127. While noting the limitations on interpreting the various clinical signs, Dr Cooke agreed that Dr Saharov's observations supported the conclusion that Russell had been deceased for a couple of hours at the time Dr Saharov assessed him.[124]

128. Given the general agreement of the other witnesses, I asked Nurse Girling at the inquest whether she accepted it was possible Russell had already died at least at the time she did the 8.15 am visual check. Nurse Girling was clear in her evidence that, at the time, she believed she had observed signs of life. If she had experienced any doubt at the time that Russell wasn't breathing, she would have taken action immediately, as she did at 8.37 am. However, having had an opportunity to consider the other available evidence, Nurse Girling very reasonably and frankly accepted that it was possible Russell had died at that time. Her ability to view him through the window was limited, she has no recollection of viewing his respirations at the time, and the observation chart is not available to refresh her memory.[125]

129. There was evidence that it could be very difficult to see a patient and be accurate about respirations through the window, particularly if the room was dark.[126] I saw for myself the difficulty of clearly viewing a patient in bed from the window during a viewing of Mabu Liyan prior to the inquest, which would be compounded at night in the dark when the staff have to use a torch to look through the window.

130. Nurse Girling's most compelling reason for believing that Russell was still alive at 8.15 am, is that she thought he had definitely changed position at the time she observed him in a lifeless state at 8.37 am. Nurse Girling had also given evidence that Russell's neck had felt warm and sweaty, although his arm and leg were cold. This also made her think he had only recently stopped breathing.[127]

131. In relation to his neck feeling warm and sweaty, there was other evidence from Nurse Wishart that Russell's neck felt cold, so Nurse Girling may have been mistaken in that regard. Her error may have been caused by the stress of the situation. As to the change in position, while I accept Nurse Girling believed this to be the case, there is no record of this observation and I note she did not enter the HDU, but rather observed Russell through the window at this earlier time, where a full view of the patient could be obscured. When weighed against Dr Saharov's evidence of Russell's signs of early rigor mortis and low body temperature, which both Dr Saharov and Dr Cooke agreed placed a likely time of death at a couple of hours, I am satisfied that Russell died some time prior to the 8.15 am observation, and possibly as early as 7.00 am when Nurse Girling was commencing her day shift.

132. In making that finding, I accept that Nurse Girling was following common procedure in Mabu Liyan by taking visual observations in a way that minimised disruption to a previously agitated patient in HDU who was now sleeping, and if she had seen anything that gave her a concern that Russell was not breathing, she would have taken immediate action. She was an honest and forthright witness who had clearly been affected by these events and wished to participate in the inquest process to

[124] T 178 – 179.
[125] T 36 – 37; Exhibit 1, Tab 12B.
[126] T 200.
[127] T 37 – 38; Exhibit 1, Tab 12B.

ensure that a similar event did not reoccur. She agreed that changes had since been implemented that helped her, and the other nursing staff in the MHU, to do their job better, and she also made suggestions about further improvements that could be made for the future.[128]

EXPERT OPINIONS

Review by Dr Brett – Expert Psychiatrist

133. Dr Adam Brett is a Consultant Psychiatrist who has extensive experience providing expert evidence in coronial cases. Dr Brett was asked to provide an independent expert opinion on the medical treatment and care provided to Russell, to assist me in my task of commenting on his supervision, treatment and care prior to his death. Dr Brett conducted a review of the relevant materials and provided a written report to the Court[129] and also gave evidence at the inquest. The primary focus of Dr Brett's review was the quality of Russell's community and hospital psychiatric care and the adequacy of his physical observations during his final hospital admission.

134. Russell had a well-documented diagnosis of schizophrenia/schizoaffective disorder, that was treatment resistant and complicated by poor compliance and substance use. He was managed by the KMHDS when in the community but his treatment was challenging and he often required admission to hospital under the *Mental Health Act*. Dr Brett observed that the community mental health service that generally managed Russell in the community did an excellent job of communicating with Broome Hospital about Russell's mental health issues and physical health issues. In his report, he described the documentation by the community mental health team as "outstanding."[130]

135. Dr Brett noted that the medication treatment of choice for treatment resistant schizophrenia is clozapine. As detailed above, this had been considered for Russell but not pursued as he refused blood tests regularly and these were necessary in order to undertake clozapine treatment. The medical notes indicate there had been discussion about a long stay admission for Russell in the future, to allow clozapine to be commenced in that controlled setting, but it did not eventuate before his death.[131]

136. In his report, Dr Brett explained that the physical health problems associated with schizophrenia are well documented, including metabolic syndrome, both as a result of some of the effects of his mental illness and the medications used to treat it. Russell was no exception. He had started putting on weight in 2011 and his risk of developing metabolic syndrome had been identified early, but there were difficulties engaging Russell in interventions. Dr Brett noted that there was good discussion with Russell's family about these issues and good documentation about the management decisions. Dr Brett considered Russell's "community management and long term

[128] Submissions filed on behalf of Sherylee Girling, filed 26 May 2021.
[129] Exhibit 1, Tab 15.
[130] Exhibit 1, Tab 15, p. 9.
[131] T 71 - 72; Exhibit 1, Tab 15.

care in this very difficult case was exemplary."[132] However, Dr Brett observed that despite the high standard of care, Russell appeared to have a very poor prognosis for his mental health and physical health issues.[133] Dr Brett commented that he did not think "you can underscore the difficulty and the complexity of mental health management, … particularly in a case like this."[134]

137. Dr Brett noted that Russell had a number of hospital admissions, which were generally quite short. He did not express any concerns about his earlier hospital admissions and considered that Russell's mental health was well managed throughout his journey. In terms of his medications and the family liaison, including during his last admission, Dr Brett expressed the opinion that ideally the family should be involved in discussions about care, provided the patient was agreeable, but it is not a necessary thing, particularly when a person is acutely well causing problems on the ward, as the staff have to act in the client's best interest and delay contacting family wouldn't be appropriate.[135]

138. The only adverse opinion Dr Brett expressed in his review was that Russell's physical observations during his final hospital admission were inadequate. Dr Brett had based his opinion on the absence of any observation chart from midnight. He acknowledged that if the observations were done, but the chart had been lost, that would change his opinion to some degree.[136] However, he also noted that Russell's observations chart was generic, rather than individualised for him to take into account his COPD. Dr Brett considered a more individualised management plan, with better guidance on how he should have been observed and had his oxygen saturations monitored, should have occurred. Dr Brett indicated he did not know whether the course of events could have been altered if Russell had received comprehensive observations. He deferred to the opinion of an appropriately qualified physician in that regard.[137]

139. Dr Brett also commented more generally on the known risks of physical health problems in people with serious mental health issues and expressed the opinion that he does not think they are given the resources in mental health that they require. Dr Brett noted that it can be very difficult to measure and observe someone's respiratory rate through a window, so other options and technology need to be considered. He referenced access to pulse oximetry, although acknowledging patients are not always cooperative with it and he did not think it would have been suitable for Russell, as well as using video surveillance for people who are at high risk, in combination with movement sensors.[138]

140. In addition, Dr Brett commented on the need to try to identify and address issues associated with metabolic syndrome at an early stage, while acknowledging in

[132] Exhibit 1, Tab 15, p. 11.
[133] T 72; Exhibit 1, Tab 15.
[134] T 74; Exhibit 1, Tab 15.
[135] T 74 – 75.
[136] T 79.
[137] T 76 – 78; Exhibit 1, Tab 15.
[138] T 74 – 76.

Russell's case his community team had tried to address this issue but Russell was uncooperative.[139]

141. In conclusion, Dr Brett commented that he was impressed overall with the efforts of everyone to try and manage Russell and care for him as best as they could.[140] Dr Brett also expressed his condolences to Russell's parents, who he acknowledged had tried tirelessly over the years to assist their son.[141]

Review by Dr Martin – Expert Physician

142. Dr Jaye (Jacqueline) Martin is a Consultant Physician who trained in the United Kingdom and later began practising in Australia. Dr Martin has more than 20 years' experience working in both metropolitan and remote regional areas of Western Australia, so she understands what resources are available in a facility such as Broome Hospital. Dr Martin provided a very detailed independent expert report in relation to Russell's physical health care in the community and in hospital for a lengthy period leading up to his last hospital admission, as well as during his last admission at Broome Hospital prior to his death on 8 June 2019. Dr Martin also gave evidence at the inquest. Dr Martin confined her comments to Russell's medical care and made no comment on his psychiatric care, which was addressed by Dr Brett.[142]

143. Dr Martin noted that Russell had multiple chronic medical comorbidities and complex medical and psychiatric issues that contributed to the difficulty managing his care. This was reflected in his admission on 7 June 2019, when he was aggressive to staff, resistant to physical assessment and required sedation to settle him in the ED.[143]

144. Dr Martin commented on Russell's previously recorded low oxygen saturations during his admission from 4 April 2019 to 1 May 2019, which were significantly below normal. At the time, it was thought that the low oxygen saturations might be due to Russell's long history of very heavy smoking and possible development of chronic obstructive airways disease (COAD, also often referred to as COPD), which Dr Martin considered reasonable, although she still thought his recording of 86% was lower than she might expect even in a chronic situation. Dr Martin also considered it was possible Russell was suffering from obesity hypoventilation, which meant that due to his large body mass he could not expand his lungs adequately to get adequate amounts of air into his lungs, which over a long period of time can cause permanent damage and low oxygen concentrations.[144]

145. Dr Martin acknowledged that, on discharge, it was appropriately suggested that Russell be reviewed by his GP to arrange outpatient pulmonary function testing, although this did not eventuate. In that regard, Dr Martin commented that it was well documented in the medical records from previous admissions that it was very hard to

[139] T 54 – 76.
[140] T 77.
[141] Exhibit 1, Tab 15.
[142] Exhibit 1, Tab 24.
[143] Exhibit 1, Tab 24.
[144] T 150 - 151.

engage Russell with medical services in the community, so in retrospect, she suggested it would have been preferable for those types of tests to be performed while he was still in hospital. Dr Martin described this as a missed opportunity to try to work out a diagnosis and see what could be done in terms of treatment that might have potentially improved Russell's low oxygen saturations.[145]

146. Dr Martin agreed that the salbutamol puffer (also often known as a Ventolin inhaler, its trade name) that Russell was offered as acute treatment in hospital, was appropriate in the short term, but if he had been diagnosed with COPD there are other inhaled medications that could have been used on a more long term basis, which are preventers that gradually reduce inflammation in the airways and improve lung function and oxygen levels gradually over time. Dr Martin agreed that this would have required Russell to cooperate with taking the inhaled medication daily at home, which was not necessarily going to occur given he declined the offer of the salbutamol puffer in hospital.[146] Therefore, while arranging for Russell to be tested and diagnosed in hospital, and offered appropriate treatment that Russell then agreed to comply with was the best option, Dr Martin agreed that "with the best will in the world that may not have happened".[147]

147. If the problem was due to obesity hypoventilation, Dr Martin explained that this condition is much more difficult to treat as the only thing that really works is weight loss. Nevertheless, Dr Martin believes it would have been worth at least making the diagnosis.[148]

148. As for Russell's diagnosis of metabolic syndrome with borderline diabetes, this indicated he was at high risk of progressing to overt diabetes, so Dr Martin considered the decision to commence him on the diabetes medication metformin at that stage was appropriate.[149]

149. In relation to his ECG done during the April/May admission, Dr Martin concurred that it was within normal limits and there had been no significant change in appearances from other ECG's done as far back as February 2018. In particular, the corrected QT interval was normal. This was relevant as Russell was prescribed some antipsychotic medications that can alter the QT interval and increase the risk of an abnormal heart rhythm, but there was no evidence of this occurring in Russell's case and his ECG's were reassuring.[150]

150. In relation to Russell's admission to the ED on 7 June 2019, Dr Martin commented that it was "perfectly reasonable"[151] in the circumstances to defer a thorough physical examination until the following morning, given Russell's agitated and aggressive state and the staff's fear for their safety in that situation. Dr Martin considered the medications Russell was given in the ED and HDU to calm him were all necessary

[145] T 151 - 152.
[146] T 153 – 154.
[147] T 154.
[148] T 152.
[149] T 154 – 155.
[150] T 155 - 156; Exhibit 1, Tab 24.
[151] T 156.

and standard medications, and were administered under the guidance of a psychiatrist with an acknowledgment that Russell was a high cardiovascular risk patient and there was a risk of sedation given his reduced oxygen levels. Dr Martin noted they were not abnormally high doses and were given in a careful staged sequential way. Although there could be a theoretical risk in administering them, there was also a risk that Russell's high levels of agitation and arousal could put increased strain on his cardiovascular system if he did not settle, so it was a balancing exercise that was managed appropriately.[152]

151. Similarly to the opinion of Dr Brett, Dr Martin's main area of concern related to the lack of monitoring of Russell in the HDU overnight, given at the time Dr Martin had prepared her report there was no visual observation chart from midnight onwards and she was unclear as to whether any monitoring was done from that time. Prior to giving her evidence, Dr Martin was told that the monitoring had occurred, but the chart had been lost. Based on that information, Dr Martin considered it more likely that Russell had a sudden fatal cardiac arrhythmia and probably nothing could have been done to save him at that point. However, Dr Martin did rely on that opinion to a certain extent on the observation at 8.15 am that Russell was still breathing, which has been cast into doubt. Dr Martin gave evidence that with more regular observations, something might have been picked up a little sooner.[153] That is not, of course, to say that Russell could definitely have been saved, but it reduced the opportunity to identify any changes he might have been experiencing in his breathing.

152. The same can be said for the lack of physiological medical observations, such as regular observations of his temperature, blood pressure, oxygen saturations, respiratory rate, etc. Dr Martin gave evidence that in the medical wards such routine observations are done every six hours, if not more regularly. As noted above, Dr Martin acknowledged that there were valid reasons for not taking those observations when Russell was still agitated, but if they had been done, they might have shown the oxygen levels dropping a little bit more or the pulse rate going up a little more, which on a medical ward might have triggered a call for a review by a medical officer. Dr Martin noted the general MHU policy of observations only every 24 hours, which obviously differs from the six hour general ward policy, and considered that time frame probably didn't allow an opportunity to pick up something going wrong acutely and allow time for intervention.[154]

153. It does raise the question whether more could have been done to take Russell's physical observations on the evening of 7 June 2019, after he had calmed down. Nurse Wishart conceded there was an opportunity to at least attempt to do so after about 5.00 pm, when Russell had become more cooperative and Dr Hickey also gave evidence it would have been appropriate to attempt to do so that evening. Nurse Hepi was, of course, not able to be asked whether he attempted to do so and the request was refused by Russell, but there is nothing in the notes to suggest such a conversation took place, so I make the assumption that it did not occur. Dr Martin agreed that it would have been preferable if the nursing staff had tried a little bit

[152] T 156 – 157.
[153] T 163.
[154] T 164.

harder to take those observations on the evening of 7 June 2019.[155] Nurse Wishart certainly conceded this was the case.[156]

154. However, Dr Martin agreed in evidence that even if Russell had cooperated with physical observations being taken that evening, it is possible that he could have had normal observations at that time and then suffer cardiac arrhythmia without warning during the night. So once again, it falls into the category of a missed opportunity to look for any concerning signs or signs of a deterioration in his condition, if they were present, but it may not have prevented Russell's death occurring.[157]

155. Dr Martin did note that Russell's admission was a purely acute psychiatric presentation, without appearing overtly short of breath, and without complaint of chest pain or dizziness, so there was no indication that there should have been a clinical concern for his physical health at the time he was admitted.[158] This did not appear to change while he was in the MHU, and Nurse Hepi's nursing note and handover suggests when Russell was awake he showed no concerning change in his physical presentation. The problem appears to have arisen when Russell was asleep, and in that regard, Dr Martin gave evidence that it would appear that perhaps the significance of his low oxygen saturations was not properly appreciated. Dr Martin suggested, while Russell obviously needed to be in the HDU, one option could have been for the MHU staff to contact the on-call physician and advise of his likely COPD and generally low oxygen saturations and ask for any suggestions for how they should manage the patient overnight.[159] In that regard, Dr Martin agreed with Dr Brett's suggestion that it would be better to have an individualised plan for the patient, rather than simply going with the general 24 hour physical observations policy.[160]

156. Overall, Dr Martin's primary concern was with the earlier admission in April/May 2019, as there was an opportunity for more testing to be done in hospital to obtain a diagnosis for Russell's abnormally low oxygen saturations, which may have allowed for treatment to be implemented that could have improved his oxygen saturations prior to his admission in June 2019. However, Dr Martin also commented that she had formed the impression the psychiatrists treating Russell for many years were well aware of his high cardiovascular risk and had made attempts to engage him in improving his physical health, without much success.[161] Therefore, there was always the prospect that Russell would not have engaged with a treatment plan, even if a diagnosis had been able to be made.

[155] T 171.
[156] T 111.
[157] T 166; Exhibit 1, Tab 24, p. 7.
[158] T 164 – 165.
[159] T 168.
[160] T 170.
[161] T 168 – 169.

OTHER ISSUES

Medications

157. Russell's parents has raised concerns about a lack of consultation with them during Russell's final admission, particularly in relation to the medication he received. I note, at the outset, that neither Dr Brett nor Dr Martin expressed any adverse opinion about the medications Russell received during this final admission, and it was not suggested by the forensic pathologists that the medications played a role in his death. However, Russell's parents had made it very clear, during earlier admissions, that they wished to be consulted about any changes to his medication, and staff had been respectful of that request in the past, so they wished to know why that consultation did not occur on this occasion.

158. Dr Hickey gave evidence that while it is always important to involve the family as much as possible in general decision-making, his decision to prescribe medication was a medical decision and not an area he considered appropriate to discuss with Russell's parents, at least at that early stage. It was his responsibility to provide safe care for Russell and as part of that, to determine what medication Russell should be prescribed. He undertook that task by prescribing Russell medications he had received during his most recent prior admission, on the basis he had tolerated them before and with the aim was to get him back to the status quo quickly. He also agreed that there was limited time to arrange a family meeting to discuss Russell's treatment on 7 June 2019, and he had acute care needs that had to be addressed quickly.[162]

159. Nurse Wishart, who was involved in administering the medication doses to Russell on 7 June 2019, as prescribed by the doctors, acknowledged that Russell's family could have been contacted by phone to discuss his medication, but it was not a practice that was usually done and, accordingly, it was not something he considered doing that day.[163] Nurse Wishart did speak to Russell's father on 7 June 2019, when he came to the hospital to drop off some of Russell's personal effects. They discussed Russell's behaviour and mental state briefly, but did not discuss his medication.[164] Nurse Wishart gave evidence that on the day, given Russell's agitated state and the risk he might harm himself or others, it was quite important he receive his medications immediately and he did not think it would have been appropriate to delay administering them in order to consult his family.[165]

160. Dr Bauer indicated that she had no concerns about the medications that were prescribed and administered to Russell during his last admission. Dr Bauer gave evidence that they are always cognisant of the risks of medication, but she noted the doses were not high doses, were consistent with doses that had been well tolerated by Russell in the past and, in any event, Russell was heavy-set and had a tolerance to antipsychotic medication.[166]

[162] T 58 – 59, 64, 67.
[163] T 87.
[164] T 104.
[165] T 114.
[166] T 205; Exhibit 1, Tab 13B.

161. I hope that this information better explains to Russell's parents why they were not consulted during this last admission about the medication he received, and that they are reassured that their requests to be consulted had not been ignored by staff.

162. I am satisfied that the staff were dealing with an acute medical situation and their decisions about medications needed to be made quickly and were based around previous care he had received and tolerated in the past. Once Russell had settled, I am confident the mental health staff would have engaged with Russell's parents to discuss a treatment plan moving forward, as they had done in the past. Unfortunately, Russell died before this could take place.

SAC 1 and recommendations from Dr Saharov

163. As noted above, Dr Saharov was not involved in Russell's care prior to the day he died but was the lead physician in relation to the resuscitation efforts. Dr Saharov demonstrated he had given a great deal of thought to Russell's death and what could be learned from these events. He said he had asked for Russell's death to be investigated by the WA Country Health Service as a Severity Assessment Code 1 (SAC 1) clinical incident, and Dr Bauer had indeed reported it as a SAC 1 incident on the day of Russell's death. Dr Saharov provided some suggestions for recommendations to the SAC 1 committee, which he also shared at the inquest. The report of the SAC 1 committee was provided to the Court, as well as updated information on the outcomes from the committees recommendations.[167]

164. A clear initial issue raised by the review was the location of the MET call button. There was evidence that, at the time of this incident, the nearest available button was in the nurse's station, which required Nurse Girling to leave the HDU and run some distance to reach it. Nurse Girling gave evidence that the original position of the MET call button, in the nursing station, was "way too far away"[168] from the HDU when she needed to access it. Since that time, a new button has been installed in the corridor just outside the HDU doors. Nurse Girling agreed that the new location of the button is the best possible solution. This button is in addition to the button in the nurse's station, so there is more than one option available to staff in Mabu Liyan now, as well as duress alarms carried by staff, which could be used in a medical emergency if necessary.[169]

165. One of the main issues raised by Dr Saharov was his belief that the MET alarm system was inadequate on the day as there were other senior ED doctors in the building who could have come to assist with the MET call but they were both in areas in the hospital, one in the medication room in the ED and the other in the doctor's office, where the alarm does not sound. Enquiries established that there are also quite a few other areas in the hospital where the MET call alarm can't be heard. Dr Saharov acknowledged that if his colleagues had heard the alarm and attended, it was unlikely to have changed the outcome in this case, but he did indicate it would

[167] T 135; Exhibit 1, Tab 17 and Tab 13C.
[168] T 34.
[169] T 34, 207.

have made the event much less stressful and traumatic for the staff involved as Dr Saharov gave evidence that at the time, "we felt very, very alone."[170]

166. At the time of the inquest Dr Saharov indicated that no changes had been made to rectify this problem. He had been told that there was a plan to implement a visual cue in areas where the alarm does not sound, but no change was proposed to the areas where the audible alarm can be heard. Dr Saharov advised he had been told there was a technical barrier to changing the audible alarm system, as well as a cost element, and the hospital believed the current paging system for doctors is adequate. However, Dr Saharov gave evidence he believes the paging system does not work in a practical sense and he believes strongly that the audible alarm system is the most effective tool. Dr Saharov also agreed in questioning that messaging to a mobile phone, given all doctors have one, would be more effective at least than the current paging system.[171]

167. Dr Saharov also gave evidence that, in the alternative, there is a process at Broome hospital whereby the phone system can be overridden, and an announcement can then be put over the speaker. He was unaware at the time that it could be done, and he believes many staff are still unaware it is available. Dr Saharov suggested this information could be included in orientation for new staff and training for existing staff.[172]

168. The WA Country Health Service has confirmed in submissions that the pressing of a MET call button activates the hospitals enunciators (overhead alert system) and paging system. There paging system has whole hospital coverage, but Dr Saharov has expressed some reservations about the practicality of these devices, and the enunciators cannot be heard in certain parts of the hospital. WACHS has confirmed that quotes have been obtained for the installation of further enunciators in administration areas and meeting rooms to expand the reach of that system. It also confirmed that the hospital's phone system can be used as a back-up to announce a MET call over the PA system, which can be heard everywhere in the hospital. This response appears to address Dr Saharov's concerns.[173]

169. Another area raised by Dr Saharov was resuscitation simulations for all staff. He advised that junior doctors are given training but not the senior doctors who are generally responsible for MET calls. Dr Saharov suggested it is important for the teams who will provide the emergency care to practice together, in a multi-disciplinary approach, and in different parts of the hospital. This would ensure that all staff know the layout of the different areas and where to access the MET trolleys. This suggestion was supported by a recommendation from the SAC 1 investigation and I am informed regular multidisciplinary simulations in different parts of the hospital is now occurring.[174] Dr Bauer confirmed the work done has ensured that staff are better trained to improve the response time in a future emergency.[175]

[170] T 135.
[171] T 136, 147.
[172] T 137.
[173] Submissions filed on behalf of the WA Country Health Service, filed 3 June 2021.
[174] T 137.
[175] Exhibit 1, Tab 13B.

170. Nurse Girling gave evidence that she had never been in a medical emergency situation before and had never had to perform resuscitation. Whilst this might seem surprising for a nurse of some years' experience, there was evidence that emergency resuscitation situations are quite rare in mental health. Nurse Girling gave evidence that she believed it would have helped her to have practised her resuscitation skills more, prior to this incident, as it would have improved her confidence in her skills, but she indicated she believed this additional practice beyond the annual training was her responsibility.[176]

171. Dr Bauer gave evidence that there has also been an increased focus on basic life support training to the nursing staff in the MHU. This is important as these kinds of medical incidents are rare in the MHU. Dr Bauer indicated that at the time of the inquest, 96% of the MHU nursing staff were compliant with the training. In addition, there are drills to make sure that people know where to go and that someone is present to greet and direct them.[177]

172. Dr Bauer noted that on the morning of Russell's death, there were limited staff on the ward and most of them were in the HDU, but now they have an extra staff member rostered on both the evening nightshift and during the day, which creates a greater likelihood that a staff member would be free to do that necessary 'meet and greet'. In addition, any new staff in the general wards and ED are walked through the mental health unit as part of their orientation, so if they come onto the unit they already have some familiarity of the layout even without direction. The same is done for all wards, as part of the drills, to ensure that staff are familiar with all parts of the hospital in the event of an emergency.[178]

173. Dr Saharov also noted that there were issues with finding the personal protective equipment (PPE) in the HDU, as well as the MET trolley, so that he and the nurses had to perform the whole resuscitation without PPE. Russell's death occurred prior to the COVID-19 pandemic, but he noted that if a similar situation were to occur now, it would create an even greater danger for staff. At the time, Dr Saharov made multiple requests to a hospital orderly to go and obtain PPE, but it was not done, and other staff also did not react. He was hopeful the simulation training might improve the response, but there still needs to be the PPE available to be accessed.[179]

174. Dr Bauer agreed with Dr Saharov that the MET trolley had taken a long time to be retrieved and wasn't fully stocked when it arrived. Since Russell's death, Dr Bauer indicated that it is the duty of the nightshift nurses to make sure that the MET trolley in Mabu Liyan is fully stocked with all necessary equipment (including the PPE). The nature of that equipment is now standardised across the hospital in terms of content, and also where it is located on the trolley.[180]

[176] T 33 – 35.
[177] T 198; Exhibit 1, Tab 13C.
[178] T 198; Exhibit 1, Tab 13C.
[179] T 138, 140 - 141.
[180] T 198.

175. Dr Saharov, who had earlier explained about the difficulties in establishing times as there were three sets of times at the hospital that were not in sync, also suggested that there is a need for the wall clocks, pager system and internet to be synced together, so that staff making decisions about whether to continue resuscitation can really upon accurate timeframes.[181] This does not seem to me to be something that requires the recommendation of a coroner, but is something that the hospital administration can take a practical approach to and consider how it can be addressed, given the importance of accuracy during a medical emergency.

176. Dr Saharov also supported Dr Brett's suggestion of implementing video monitoring of HDU patients' vital signs, which he referred to as video plethysmography, noting it was not supported in the SAC 1 investigation.[182] Dr Bauer also agreed that it was an option "worth [183]exploring."[184] The SAC 1 review recommended that the availability of remote monitoring sensor equipment for the HDU be explored. I was advised that the WACHS evaluation of the SAC 1 recommendations had concluded that remote sensor equipment was not required as the lack of monitoring of Russell's vital signs was because the staff "chose not"[185] to make the observations so that they did not disturb him while he was sleeping. Rather than remote monitoring, it was considered the appropriate step was to change the visual observation policy to require staff to enter the HDU in pairs and physical monitor the patient's breathing when they are sleeping.

177. Dr Bauer gave evidence there is an updated proposed Patient Observation Procedure for Mabu Liyan, which was yet to be implemented at the time of the inquest in April 2021, that set out the new policy requiring two nursing staff to enter the HDU to monitor and record the respiratory rate of a patient in HDU when they are sleeping. In the meantime, Dr Bauer advised the Nurse Unit Manager of Mabu Liyan had already sent a directive to staff requiring observations to be done in this manner in February 2021, in anticipation of the formal endorsement of the amended policy, so the practice is already in place.[186] I queried whether such a procedure is practical, but was informed it has been found to be working thus far, noting that there is an additional staff member now rostered on both the day and night shift to assist with this task.[187]

178. Dr Bauer also advised that, as part of the new procedure, the HDU Interaction Chart will also be updated to clarify that staff are required to record patient respiration and to escalate the case if the respirations fall outside normal parameters.[188]

179. There is the issue that a lot can happen in the other 14 minutes when a patient is not being checked, and I would have thought some form of remote monitoring might

[181] T 132, 137 - 138.
[182] T 138.
[183] T 210.
[184] T 209 - 210.
[185] Exhibit 1, TAB 13C, WACHS Evaluation of Recommendations following SAC 1 investigation.
[186] Exhibit 1, Tab 13B and RB2, Procedure 2.6.3.
[187] T 203 – 204.
[188] Exhibit 1, Tab 13C.

have assisted in that regard, but given it has been explored and rejected by the Mabu Liyan senior staff, I don't propose to take it further in this finding.[189]

180. From a practical perspective, Dr Saharov also raised the issue of the fixed beds as an impediment to resuscitation. He acknowledged that the beds were fixed for safety reasons, but indicated that if you can't move the bed, there needs to be another way to move the patient safely and quickly.[190] I'm not sure whether this issue has been considered by hospital staff, but I note that I have made a recommendation below in relation to a redevelopment of the HDU, and I'm sure this issue could be considered in that context.

181. In addition, Dr Saharov mentioned the unavailability of a venous blood gas machine, which was a five minute walk away from where they were performing the CPR. Dr Sarahov recommended that there needs to be more than one machine in the hospital, so that they can be accessed more easily in a MET call situation.[191] As there is no obvious connection between this issue and Russell's death, noting he was already deceased when the emergency team arrived, I don't consider I can do more than simply record his comments for the benefit of anyone reading this, noting that if in another medical emergency this issue had a negative effect on the success of resuscitation efforts, it will be duly noted that the concern had already been raised in the past.

182. Finally, Dr Saharov suggested that the resuscitation teams would benefit from a formal debrief afterwards, given they have been involved in a traumatic situation. Dr Saharov indicated that he undertook this task himself that day, including all of the relevant staff he could identify, but he believes this should be formally written into the procedures.[192] Again, it is not a matter directly connected with Russell's death, from a coroner's point of view, but it seems to me to be a very sensible, and considerate, suggestion and I simply record it here for the benefit of those responsible for considering the welfare of the Broome Hospital staff.

183. In relation to other matters raised during the SAC 1 investigation, Dr Bauer explained that the concerns in relation to Russell not having his physical assessment before his death has prompted a new protocol to make it more clear that there needs to be an individualised plan made if a patient is admitted to the MHU having refused a physical assessment prior to admission, and the consultant psychiatrist takes responsibility for conveying that plan to staff. If there are ongoing medical problems, they can call the ED doctors into the ward, but otherwise it is for the psychiatrists to identify what needs to be done and ensuring that it is documented as part of the formal risk assessment.[193]

184. Further, in relation to the second recommendation of the SAC 1 investigation, relating to recognising and responding to acute deterioration in patients, compliance audits have indicated there has been good compliance around staff recognising that

[189] Exhibit 1, TAB 13C, WACHS Evaluation of Recommendations following SAC 1 investigation.
[190] T 139.
[191] T 140.
[192] T 141, 144.
[193] T 188 – 189, 193, 221.

issue. The audits have also shown that in high standards of vital signs monitoring have been maintained through 2020 and 2021 and where minor errors have occurred, education has been provided one on one to the staff members involved.[194]

185. Dr Saharov gave evidence that he believed everyone involved did the best that they could, and he believed they did remarkably well in extremely difficult circumstances, but he was keen to ensure that some lessons could be learnt from this sad event and that Russell's family could be reassured that some good might come out of his death.[195] It does seem that some important changes have arisen, some with Dr Saharov's assistance, and I am informed in submissions filed on behalf of Russell's parents that his family hope these changes may improve the quality of care provided to patients in the future.[196]

Design of the HDU

186. Moving forward, Nurse Girling's primary suggestion was that there should be a nursing station located within the HDU, to allow good visibility of HDU patients and quick access to them, rather than having to enter through two doors each time. Nurse Girling gave evidence that observing people through cameras or windows isn't optimal.[197]

187. Given her experience with Russell, Nurse Girling agreed that until such time as a nursing station can be located in the HDU, the present practice of requiring two nurses to enter the HDU to perform the visual observations is necessary and appropriate in order to check sleeping patients.[198] However, she indicated there can often be delays when waiting for another nurse to accompany them into the HDU to do a physical check.[199]

188. Dr Hickey also supported the concept of a specifically staffed nursing station located in the HDU, to allow for closer, uninterrupted nursing care.[200]

189. When this proposal was put to Dr Brett, he agreed, saying it was an "excellent idea"[201] and noting that "particularly this case demonstrates that."[202]

190. Nurse Wishart gave evidence that, in his opinion, it was impossible to do visual observation checks by shining a torch through the window and be sure that the patient was breathing, given the distance and the bedding. He gave evidence that when he worked the night shift, even prior to Russell's death, he always went into the HDU with another nurse to do the checks, but he acknowledged that it was not

[194] Exhibit 1, Tab 13C.
[195] T 136.
[196] Submissions filed on behalf of Frances and Alan Brockliss, filed 12 May 2021.
[197] T 25 – 27.
[198] T 46.
[199] T 25 – 27.
[200] T 62.
[201] T 74.
[202] T 74.

the practice of all the nurses to do so at the time.[203] He agreed the current practice that it is mandatory to enter the HDU with another nurse and do a bedside check when the patient is sleeping is appropriate, and accords with his previous practice.

191. Nurse Wishart was asked his opinion on the suggestion that a nursing station could be located in the HDU, to facilitate these checks being done. Nurse Wishart gave evidence that if he was feeling unsafe, he would usually get security to attend to help him carry out the visual observations, so he was not certain whether he would feel safe actually being located in the HDU in a nursing station the whole time, without security being present. In particular, Nurse Wishart indicated that, based on how Russell had appeared when he was first admitted, he certainly would not have wanted to be located in the HDU with him. However, he agreed that if it was a protected environment within the HDU, so separate to the patients, then he agreed it might be practical.[204]

192. Dr Bauer agreed that a nursing station being located in the HDU would be "an excellent idea"[205] but it would require some modifications to the size of the unit, given the small footprint that it currently occupies. Dr Bauer agreed that really there is a need for a new, larger HDU. Dr Bauer gave evidence that there have been plans in place for a long time, well prior to Russell's death, for changes to the HDU but funds haven't been available to carry out those changes. Dr Bauer believed having a better designed HDU with space to keep patients separate and allow for nurses to be co-located with patients in the area, would not only improve the ability of the nursing staff to closely monitor high risk patients like Russell, but would also improve the staff's ability to respond to the patients, which might alleviate agitation and provide a better experience for the patients, thereby reducing the need for sedation which reduces the risk to the physical health of the patient.[206]

193. Dr Bauer raised in her evidence the problem of managing the interaction between Russell and the other patient in the HDU, which had fortuitously brought her into the HDU early on the Saturday morning. The HDU has two bedrooms, a shared lounge area and a small contained courtyard. While the bedrooms have doors on them, people don't want to always stay in their bedroom and they don't want to shut them in there against their will as that would be a form of seclusion. The communal areas are small, and Dr Bauer explained that the limited space, and inability to manage the patients' interaction, can mean that they are unable to use both beds at the same time, particularly if there are gender issues. Dr Bauer indicated that they can manage it with nursing staff, but in such a small space, this has its own issues.[207]

194. Given there is a known shortage of mental health beds in the health system, and noting Broome Hospital is in a remote area, far from other facilities, it is a significant problem that they are regularly unable to use both beds in the HDU.

[203] T 101.
[204] T 102.
[205] T 205.
[206] T 207 – 208.
[207] T 193.

195. Dr Bauer indicated that funding has been obtained for the building of a 'step-up, step-down' centre in Broome for mental health patients, but there have been issues with identifying an appropriate site for the development in conjunction with the Shire of Broome. I assume that, if funding were to be obtained for redeveloping the HDU, it would not face a similar delay, as the development would occur at the Broome Hospital, where it is currently located. The development of the 'step-up, step down' facility might also have been relevant to Russell's case, as it could have provided an environment where he could have been supported to engage with interventions for his physical health, when not acutely psychiatrically unwell, as well as potential early intervention for those times when his parents could see that his mental health was deteriorating to avert him becoming acutely psychotic.[208][209]

196. In submissions filed on behalf of WACHS, it was accepted that the layout and size of the HDU impacts on the ability of staff to respond to an emergency and to monitor sleeping patients. It was noted that Dr Bauer had referred to design work that has already been undertaken in relation to a new layout for the HDU. However, it remains the case that there is no funding, at present, for any works to be undertaken on the HDU.[210]

197. I have seen the HDU for myself, and I can fully appreciate why all of the staff and experts are supportive of a redevelopment of the unit to better ensure the safety and wellbeing of the patients and staff, and to ensure that maximum use can be made of the beds in the unit. Given Broome Hospital's remote location, it is not a simple case of moving someone to another hospital if there is no capacity in the HDU, and having to over sedate or restrain a mental health patient to keep them calm is obviously to be avoided at all costs. I fully endorse the concept of funding being obtained to redevelop the Mabu Liyan HDU on an urgent basis

[208] T 213 - 215.
[209] Exhibit 2, Tab 13B [21] – [24].
[210] Submissions filed on behalf of the WA County Health Service, filed 3 June 2021.

RECOMMENDATION

I recommend that the Honourable Roger Cook MLA, Deputy Premier and Minister for Health, give urgent consideration to funding a redevelopment of the Broome Hospital Mabu Liyan High Dependency Unit in order to ensure that two patients can be safely, and sensitively, housed and cared for in the HDU at all times, with the ability for the staff to be co-located in a secure area within that unit in order to facilitate regular visual observations, and furnished in such a way that the area is safe for patients and staff but patients are still able to be accessed for appropriate resuscitation in the event of a medical emergency.

COMMENTS ON CARE, TREATMENT AND SUPERVISION

198. Russell had a long history of severe and treatment resistant mental illness. His parents had supported him and cared for him all his life. They were actively involved in managing his medical treatment including ensuring he took his medications and they worked in conjunction with the KMHDS to try and keep him as stable as possible so he could live safely in the community in the least restrictive manner possible. However, as his parents became more elderly, and frail and Russell's management became more difficult, it was becoming increasingly likely he would require treatment in a facility for ongoing care in the future. There had been talk of transferring him to Graylands Hospital in Perth for a longer stay and the possibility of starting a different medication that was recommended for treatment resistant schizophrenia.

199. As well as his significant mental health issues, as he grew older Russell also developed serious physical health issues. Physical illness is common in patients with severe mental illness and management is often less than ideal. The reasons for this are complex and multifactorial, including the medications used and the adverse lifestyle factors, such as smoking and lack of exercise, frequently seen in people with mental illness. This increases the risk of cardiovascular and other diseases.

200. Russell had been identified by staff at the KMHDS as being at high cardiovascular/metabolic risk, but he had refused examination, investigations and treatment. Nevertheless, review of the hospital records reveals that Russell' blood pressure was not significantly elevated, and his cholesterol levels were reasonable, when last checked in 2019. He had also been commenced on diabetic medications for a borderline blood sugar result. This indicated that these cardiovascular risk factors appeared relatively well controlled, although his inability to quit smoking or lose a significant amount of weight remained a risk.

201. During his extended admission to Broome Hospital between 4 April and 1 May 2019, Russell's oxygen saturations were consistently low, and a medical assessment

determined Russell most likely had chronic obstructive pulmonary disease (COPD) due to smoking. The hospital discharge summary suggested Russell's GP should consider pulmonary function tests, but this did not occur, so the underlying cause of his low oxygen levels was not confirmed. Russell's oxygen levels were also low in the ED on the day prior to his death, so it appears the problem was probably ongoing. It is unfortunate more was not done to follow up investigations and try to confirm the cause and consider any treatment options prior to Russell's death, particularly during his last admission in April/May 2019. This was described by Dr Martin as a missed opportunity to explore the issue, and I agree with her opinion. It may have been that establishing a diagnosis may not have altered the course of events, as Russell may not have cooperated with any treatment suggestions, but it would still have been preferable to have made a diagnosis and at least formulated a treatment plan. It is something for mental health staff to consider in the future.

202. When Russell became unwell again on 7 June 2019, it was appropriate for him to be taken to hospital and admitted as an involuntary patient. It was also appropriate to give him some sedative medication to ensure that he did not hurt himself or anyone else while his mental health was stabilised. However, even acknowledging that it can be very difficult to undertake physical assessments and observations on a large, agitated man, in my view the monitoring of Russell's physical health appears to have been less than ideal during this final admission. Only a single set of physical observations were taken on admission, and while most were normal, his oxygen saturations were low. Although this was normal for Russell, it still required extra monitoring.

203. I accept that it would not have been safe to try and take Russell's physical observations while he was actively refusing to cooperate, but there was evidence that between 5.00 pm and 7.00 pm on 7 June 2019 he had calmed and it was agreed there might have been an opportunity at that time for Nurse Wishart to ask him again, or one of the night shift nursing staff to do so after they commenced at 7.00 pm. He may well have refused, once again, but it was a missed opportunity to see if more could be done to assess Russell's physical state as well as his mental state. I accept there is no evidence to suggest he was showing any signs of an acute physical deterioration, and was apparently walking around and knocking on the nurses' window at least on one stage, but if physical observations had been taken, we would have a much clearer picture of how he was presenting physically on the night before he died.

204. The missing HDU Interaction Chart, and the lack of a statement or any evidence from Nurse Hepi, compounds the problem. It is an example of why more should be done to encourage nurses and doctors to make notes or provide statements in situations such as these to coronial investigators at an early stage. It is of benefit to the witnesses as much as it is to the Court, as it is very difficult for people to have to try to recall traumatic events from years before, and is much better done when events are fresh in people's minds. I made my thoughts clear on this point during the inquest, and I encourage the WACHS to consider what support and guidance they can give to health staff who are involved in coronial matters, particular where it is apparent there will be a mandatory inquest, in order to assist them to make early

statements or reports where they are able and willing to do so. The WA Police, as coronial investigators, are always able to assist in that regard.

205. Ultimately, I am satisfied that, while there was a missed opportunity to try to take some additional physical observations from Russell the night before he died, it is not clear whether it would have made any difference to the final event as he may not have cooperated, or if he had he may not have exhibited any signs of a physical deterioration at that stage.

206. Similarly, there is evidence that supports the conclusion that the visual observations being performed on Russell were inadequate, at least from 7.00 am onwards, but it is again unclear whether it would have made any difference to the final outcome, given it has been concluded that he died from a sudden cardiac event. However, it is clear that it was another missed opportunity, as the earlier it was identified that Russell was not breathing, the greater the chance of a successful resuscitation.

207. There is no evidence to suggest any staff in the MHU were derelict in their duty or that any policies or procedures were not complied with in caring for Russell. Instead, it appears that it was generally accepted at that time that physical observations could safely be done every 24 hours, and it was felt that the system of viewing a sleeping patient through the window was generally sufficient to monitor them appropriately.

208. WACHS has acknowledged that lessons must be learnt from Russell's death and a number of changes have been made to relevant policies, including active consideration of a treatment plan by a psychiatrist where a patient has refused physical observations, and a new requirement for two nurses to always enter the HDU to check any sleeping patient and record their respirations. Other changes to improve response times for medical emergencies have also been implemented, and future changes proposed to the HDU to improve care further.

209. I am satisfied that the steps that have been taken by WACHS have properly acknowledged the areas of concern identified as a result of Russell's death, and addressed them. Therefore, other than the recommendation in relation to the redevelopment of the HDU, which is supported by WACHS, I made no other recommendations.

CONCLUSION

210. Russell's parents were understandably shocked and devastated to be told he had died that morning. Even though they were aware he was at risk of a sudden cardiac event, there was nothing that had indicated to them that he would be going to hospital on this occasion and never coming home. This was supported by the medical evidence, which indicated that although Russell was in a high risk category for a sudden death event at any time, there was nothing about his presentation that suggested he might be about to suffer a terminal event. It appears none of the nursing staff experienced any concerns for Russell's physical wellbeing until the moment he was discovered unresponsive in bed, at a time when they were intending to undertake vital and physical observations.

211. Unfortunately, it is not unusual in a sudden cardiac death for no one to appreciate that something is wrong until it is too late. Even people who appear overtly healthy and well can die suddenly and unexpectedly from a cardiac event, and Russell had already been identified as at high risk of sudden cardiac death. The ability to successfully perform resuscitation in such cases varies. In Russell's case, maximum resuscitation attempts were made, but it became clear that these efforts were futile as by the time he was discovered he had been deceased for some time.

212. It is clear from the evidence before me that Russell was deeply loved by his parents, who had devoted much of their lives to caring for him and advocating for him during his years of illness. It must have been very hard for them to have lost him so suddenly. I hope that as a result of this coronial inquest process, they feel that Russell's memory has been respected and that positive change has come out of the investigation into his untimely death.

S H Linton
Deputy State Coroner
22 October 2021