JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	8-9 AUGUST 2023
DELIVERED	**:**	17 APRIL 2024
FILE NO/S	**:**	CORC 136 OF 2021
DECEASED	**:**	BOROS, RICHARD ANTHONY

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S. Tyler assisted the Coroner
Ms K. Dias (State Solicitor's Office) appearing on behalf of Fiona Stanley Hospital and the South Metropolitan Health Service
Ms J. Lee (Australian Nursing Federation) appearing on behalf of nurse Sofia Espina

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Richard Anthony BOROS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 8 - 9 August 2023 find that the identity of the deceased person was* ***Richard Anthony BOROS*** *and that death occurred on 14 January 2021 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from an upper airway obstruction (choking) in the following circumstances:*

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LIST OF ABBREVIATIONS & ACRONYMS

Abbreviation	Meaning
the ***Briginshaw*** principle	The accepted standard of proof the Court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
the Court	the Coroner's Court
CPR	cardio-pulmonary resuscitation
CT	computerised tomography
CTO	Community Treatment Order
ECG	electrocardiogram
ED	Emergency Department
FSH	Fiona Stanley Hospital
MET	Medical Emergency Team
MHAU	Mental Health Assessment Unit
observation chart	Patient Observation Chart
PLN	Psychiatric Liaison Nurse
RPH	Royal Perth Hospital
SAC1	Clinical Incident Investigation Report
SMHS	South Metropolitan Health Service

INTRODUCTION

"To the paranoid, facts seem like threats."
F.C. Yee, author

1 The deceased (Mr Boros) died on 14 January 2021 in a mental health ward at Fiona Stanley Hospital (FSH), from an upper airway obstruction (choking). He was 50 years old.

2 At the time of his death, Mr Boros was an involuntary patient under the *Mental Health Act 2014* (WA). Accordingly, he was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[1]

3 In such circumstances, a coronial inquest is mandatory as Mr Boros, "*was immediately before death a person held in care*".[2] Where the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care that person received while in that care.[3]

4 I held an inquest into Mr Boros' death at Perth on 8 - 9 August 2023. The following witnesses gave oral evidence:

(i) Dr Daniela Vecchio (Consultant Psychiatrist at FSH);
(ii) Yolanda Clark-Bell (Enrolled Nurse at FSH);
(iii) Sofia Espina (Registered Nurse at FSH); and
(iv) Sharon Delahunty (Nurse Director of Mental Health at FSH)

5 The documentary evidence comprised of two volumes of material which was tendered by counsel assisting at the commencement of the inquest and became exhibit 1. During the course of the inquest two CCTV clips from the Mental Health Assessment Unit (MHAU) at FSH were also tendered and they became exhibits 2 and 3.

6 After the inquest, Dr Trinity Alfonsi (Dr Alfonsi), who was Mr Boros' treating psychiatry registrar at City Community Mental Health, provided an email to the Coroner's Court (the Court) on 8 September 2023. At the Court's invitation, Dr Alfonsi sent another email dated 3 November 2023 which outlined the care provided to Mr Boros by Dr Alfonsi, including the difficulties the doctor encountered in treating him. This email became exhibit 4. I thank Dr Alfonsi for taking the time to contact the

[1] *Coroners Act 1996* (WA) s 3
[2] *Coroners Act 1996* (WA) s 22(1)(c)
[3] *Coroners Act 1996* (WA) s 25(3)

Court and providing an insight into the care of Mr Boros in the time leading up to his admission at FSH.

7 My primary function at the inquest was to investigate the quality of Mr Boros' supervision, treatment and care that was provided to him from 14 January 2021 when he was taken to the ED of FSH until his death at the MHAU that evening.

8 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle)

9 I am also mindful not to insert hindsight bias into my assessment of the actions taken by Mr Boros' health service providers in their treatment of him. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[4]

MR BOROS

Background [5]

10 Mr Boros was born in Perth on 12 May 1970. He had two sisters and a brother. Sadly, one of his sisters died in a car crash when he was 12 years old. This had a significant impact upon Mr Boros.

11 After completing school, Mr Boros studied graphic art; however, he found it hard to maintain regular employment as he did not like being told what to do.

12 When he was in his mid-thirties, Mr Boros lived in Japan. Although he had a partner over there, the partner's family did not approve of him and the relationship ended. This effected Mr Boros greatly.

13 By 2013, Mr Boros had returned to Western Australia and his family noted he had become anxious and delusional, and often behaved in a psychotic and paranoid manner. He believed people were after him and that he received messages through radio and newspapers. Mr Boros refused to acknowledge that he had any mental health issues.

[4] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[5] Exhibit 1, Volume 1, Tab 7, Statement of Wendy Boros dated 11 August 2021

Psychiatric history [6]

14 On 27 December 2019, Mr Boros was involuntarily admitted to Graylands Hospital following his first reported episode of psychosis. He was diagnosed with paranoid schizophrenia and remained an involuntary patient in Graylands Hospital for five months.

15 Mr Boros was eventually discharged to assisted living accommodation on 28 May 2020. His discharge medications were two anti-psychotic medications, being a four-weekly depot injection of 100 mg paliperidone and a low oral dose of olanzapine. Mr Boros was not placed under a Community Treatment Order (CTO) as he was willing to engage with community mental health services following his discharge.

16 For several months, Mr Boros made very good progress with his mental health. However, on 25 September 2020, he was voluntarily admitted to Bentley Hospital after he was assessed by his community psychiatry registrar as having a significant increase in paranoia and agitation. On 29 September 2020, he left Bentley Hospital's inpatient mental health unit before he had been discharged.

17 On 1 October 2020, police apprehended Mr Boros after he refused to drop a knife he was holding. Mr Boros was taken to Royal Perth Hospital (RPH) where he was admitted on a referral for an examination by a psychiatrist under the *Mental Health Act 2014* (WA) (known as a Form 1A). On 7 October 2020, he was discharged back to his assisted living accommodation on oral paliperidone with the additional medications, diazepam and quetiapine. Mr Boros continued to self-manage his medications under the management of his treating mental health team in the community.

18 It is apparent from the material before me that Mr Boros had an expectation, he would be able to persuade his treating mental health team to change his diagnosis, as he did not accept that he had paranoid schizophrenia. It also appears that he became non-compliant with his medication by the end of 2020.

19 On 11 January 2021, Mr Boros told staff at his assisted living accommodation that he was going backpacking down south. He said he had been feeling more stressed, with heightened thoughts of being unsafe. Although he briefly returned the following day, Mr Boros again left the assisted living accommodation that same day.

[6] Exhibit 1, Volume 1, Tab 19, SAC1 – Clinical Incident Investigation Report

Incident at the Canning Train Station Bridge [7]

20 At 3.52 am on 14 January 2021, police were notified of a man on the bridge at Canning Train Station who appeared he might jump from the bridge. Two uniformed police officers arrived at the scene about five minutes later.

21 This man was Mr Boros. Initially, he was sitting on the bridge over the southbound lanes of Kwinana Freeway. When he saw the police officers he climbed over the railings and threatened to jump. The police officers noted that Mr Boros was extremely paranoid, stating that people were out to get him. After about 30 minutes, the police officers were able to manoeuvre themselves next to Mr Boros whilst maintaining a conversation with him. They were then able to grab his arms and pull him back over the railings. Mr Boros was in possession of a large amount of cash, a rope and a Stanley knife.

22 Having viewed the body worn camera footage of the police officers during this incident, I commend their actions in being able to communicate with Mr Boros and then thwart his clear intentions to jump from the bridge.

23 At 4.42 am, Mr Boros was conveyed by ambulance to FSH for a mental health assessment.

OVERVIEW OF MR BOROS' TREATMENT AND CARE AT FSH [8]

Attendance at the ED of FSH

24 At 4.49 am on 14 January 2021, Mr Boros arrived at the ED at FSH. He was triaged at 4.56 am.

25 At 8.10 am, he was given a dose of olanzapine, after he was observed to be physically distressed and difficult to settle. Mr Boros was reviewed by an ED registrar who determined he was having a relapse of his schizophrenia. Mr Boros was then referred for a psychiatric review.

26 At that review by the psychiatry registrar and consultant psychiatrist, Mr Boros expressed he had a clear intention to end his life by jumping

[7] Exhibit 1, Volume 1, Tab 2.1, Coronial Investigation Squad Report of Senior Constable Dempsey dated 10 June 2022

[8] Exhibit 1, Volume 1, Tab 15.14, Timeline - CCTV Footage, Exhibit 1, Volume 1, Tab 18, Fiona Stanley Hospital Record Extracts, Exhibit 1, Volume 1, Tab 19, SAC1- Clinical Incident Investigation Report, Exhibit 1, Volume 1, Tabs 20.1 and 20.2, Form 1A - Referral for Examination by Psychiatrist dated 14 January 2021 and Form 6A - Inpatient Treatment Order in Authorised Hospital dated 14 January 2021, Exhibit 1, Volume 2, Tab 1.1, Report of Sharon Delahunty dated 2 August 2023

from the bridge. He reported that he had been targeted by a group that had given him a choice to end his life in accordance with their commands. Mr Boros said that this same group had targeted him for some time, listening to his telephone conversations, watching him and inserting thoughts into his head. He expressed remorse that his suicide plan did not eventuate and asked to leave the ED in order to carry out that plan. He reported feeling intermittently suicidal over the past year, and for the past two weeks it had become "*unavoidable*".

27 Mr Boros was assessed as having poor insight and judgment, with no capacity to make decisions and with few protective factors identified. He was assessed as high risk and the decision was made that he required an involuntary inpatient admission. Mr Boros was subsequently placed under a Form 1A. The requirement for an involuntary treatment order was specified on the Form 1A as a relapse of psychosis on a background of paranoid schizophrenia with a risk of self-harm.

28 Arrangements were made for Mr Boros to be allocated a bed in the MHAU at FSH. The MHAU is a secure ward with eight beds for patients. It is designed to provide a therapeutic environment for patients requiring short term admission for stabilisation and/or monitoring for up to 72 hours.

29 As he waited for a bed at the MHAU, Mr Boros was placed on a one to one constant supervision in the ED and prescribed oral anti-psychotic medication. He was also reviewed by the psychiatric liaison nurse (PLN) at the ED. During this review he did not accept he had a mental health illness and denied any current suicidal thoughts or intent to self-harm. He said he would inform nursing staff if that changed.

30 At about 1.10 pm, Mr Boros was taken to the MHAU by the PLN with an escort by two security officers without incident. He was handed over to staff at the MHAU who were informed by the PLN that there should be visual observations of Mr Boros every 30 minutes until he was reviewed by the MHAU psychiatrist.

Admission to the MHAU at FSH

31 Mr Boros was admitted to the MHAU under the care of senior consultant psychiatrist, Dr Daniela Vecchio (Dr Vecchio) and placed in Room 4. This was a one-bed room located at the end of a corridor (the corridor). Although Room 4 was the furthest room from the nurses' station, there was still a direct line of sight from the nurses' station to the doorway of Room 4.

32 At 1.40 pm, nurses completed physiological observations and an admission electrocardiogram (ECG) for Mr Boros. All observations were recorded as being within normal ranges.

33 At 2.48 pm, Mr Boros was reviewed by Dr Vecchio, who was accompanied by the MHAU psychiatry registrar and two nurses. The relevant CCTV footage shows this review was completed at 3.05 pm. Mr Boros was difficult to interview with perplexed and distressed expressions. He displayed clear paranoia with delusions of a conspiracy targeting him and reported not feeling safe either inside or outside of the ward. Mr Boros expressed concern that there were only two secured doors between him and the "outside" world and he was worried someone would break in. He maintained there was a large group of unidentified people who were trying to harm him. Although Mr Boros said he was not intending to kill himself, he admitted it was a possibility.

34 Not surprisingly, Dr Vecchio was satisfied Mr Boros was clearly psychotic and required treatment, noting there had been a relapse of schizophrenia in the context of non-compliance with his medications.

35 Consideration was given to a one to one constant supervision that had existed for Mr Boros when he was in the ED. However, it was determined that as he was cooperative, and was agreeable to remain in the MHAU and recommence his medications, such an arrangement could have a negative impact on his paranoia. It was therefore determined this highest level of observation was not necessary. However, following this review, observations for Mr Boros were increased from every 30 minutes to every 15 minutes.

36 One of the nurses present during Dr Vecchio's review was Registered Nurse Sophia Espina (Ms Espina). Mr Boros' was one of two patients whose nursing care had been allocated to Ms Espina.

37 At 3.28 pm, Dr Vecchio completed an inpatient treatment order in an authorised hospital under the *Mental Health Act 2014* (WA) (known as a Form 6A). This form permitted the continued detention of Mr Boros in an authorised hospital for up to 21 days for the purposes of further assessment and treatment of his mental illness. It was Dr Vecchio's intention to continue treatment with oral paliperidone overnight.

38 From 4.05 pm, Mr Boros was unsettled. He paced the corridor outside his room and spoke to nursing staff and other patients. At about 5.30 pm, he attended the dining room for his evening meal. At 5.37 pm, he continued to pace the corridor, and several minutes later he removed

some pencils and/or pens from the activity room and returned to his room.

39 At 5.44 pm, Mr Boros asked ward staff for a box of tissues, stating he had the sniffles. He was provided with a box of tissues before he returned to his room. At 5.48 pm, he spoke to a nurse before re-entering his room at 5.49 pm.

EVENTS LEADING TO MR BOROS' DEATH [9]

40 By 6.00 pm, the patient in Room 5, which was opposite Mr Boros' room, was subject to a one to one constant supervision. This meant a nurse was seated on a chair outside the patient's room to maintain a continuous observation. Enrolled Nurse Yolanda Clark-Bell (Ms Clark-Bell) was maintaining these observations from 6.19 pm after she had replaced Ms Espina (who had taken over the observations at 6.05 pm to allow Ms Clark-Bell to have a break).

41 At 6.52 pm, Mr Boros left his room and walked towards the nurses' station where he washed his hands at a basin in the corridor. When Mr Boros walked back to his room at 6.53 pm, Ms Clark-Bell used her swipe card to allow him to re-enter his room as the door had automatically locked. It would appear from the footage of the CCTV camera showing the corridor that Ms Clark-Bell closed the door after Mr Boros had entered. This was the last time he was seen alive.

42 At 8.02 pm, Ms Clark-Bell got up from the chair outside Room 5 to retrieve a portable computer on wheels that is used by nurses to make notes.

43 At 8.04 pm, as Ms Clark-Bell walked back towards Room 5 with the portable computer, she paused outside the door to Mr Boros' room and leant her head towards it briefly. She then returned to her seat outside Room 5. Ms Clark-Bell did not recall hearing anything out of the ordinary from Mr Boros' room when she stopped outside its door.

44 Shortly after 8.22 pm, Ms Espina began conducting visual observations of the patients on the ward. At 8.24 pm, after not seeing Mr Boros through the window of his room, she knocked on the door before partially opening it. Ms Espina saw that Mr Boros was not on his bed. When she called out his name there was no response. Ms Espina then

[9] Exhibit 1, Volume 1, Tab 15.14, Timeline - CCTV Footage, Exhibit 1, Volume 1, Tab 19, SAC1 – Clinical Incident Investigation Report, Exhibit 1, Volume 1, Tab 12, Statement of Yolanda Clark-Bell dated 13 April 2022, Exhibit 1, Volume 1, Tab 25, Statement of Sofia Espina dated 2 August 2023

asked Ms Clark-Bell, who was still seated outside Room 5, if she had seen Mr Boros leave his room. Ms Clark-Bell said she had not.

45 When Ms Espina fully opened the door to Mr Boros' room, she saw him lying on the bathroom floor. Mr Boros was unresponsive and not breathing.

46 Ms Espina ran from the room and called for assistance. She also activated the fixed duress alarm in the corridor, which created an audible alarm in the immediate area. Multiple hospital staff responded, and CPR was commenced. At 8.31 pm, a Code Blue medical emergency call was made and FSH's Medical Emergency Team (MET) arrived two minutes later to assist in the resuscitation.

47 During the resuscitation, a difficulty was encountered when attempts were made to intubate Mr Boros. This was due to a large amount of tissue paper that had been crushed into a dense ball blocking his airway. The ball of tissue paper had created a complete obstruction which, in turn, caused a hypoxic cardiac arrest. The tissue paper was removed by forceps, and the resuscitation efforts continued.

48 Despite intensive resuscitative attempts for over 40 minutes, Mr Boros could not be revived. He was declared deceased at 9.10 pm on 14 January 2021.[10]

CAUSE AND MANNER OF DEATH

Cause of Death [11]

49 Two forensic pathologists, Dr Daniel Moss and Dr Joe Ong, conducted a post mortem examination on Mr Boros' body on 29 January 2021. The forensic pathologists also reviewed Mr Boros' medical record at FSH.

50 The post mortem examination found a thickening and narrowing of the vessels supplying the heart muscle (coronary artery atherosclerosis). The forensic pathologists noted evidence of medical intervention, including changes caused by CPR. A whole-body CT scan was also obtained as part of the post mortem examination.

51 Toxicological analysis detected olanzapine and a very small amount of paracetamol. Alcohol and common illicit drugs were not identified.

[10] Exhibit 1, Volume 1, Tab 3, Death in Hospital Form dated 14 January 2021

[11] Exhibit 1, Volume 1, Tabs 5.1 – 5.3, Supplementary Post Mortem Report, Full Post Mortem Report and Interim Post Mortem Report dated 29 January 2021, Exhibit 1, Volume 1, Tab 6, Toxicology Report dated 13 March 2021

52 At the conclusion of their investigations, the two forensic pathologists expressed the opinion that the cause of death was an upper airway obstruction (choking).

53 I accept and adopt the conclusion expressed by the forensic pathologists as to the cause of Mr Boros' death.

Manner of Death

54 On 14 January 2021, Mr Boros was admitted to the MHAU at FSH after displaying paranoid schizophrenia and psychosis with acute suicidal ideation. I am satisfied that this deterioration in his mental health was due to non-compliance with his medications.

55 I am also satisfied that when Mr Boros was alone in his room at an unknown time between 6.53 pm and 8.24 pm on 14 January 2021, he crushed a quantity of tissue paper into a dense ball, placed it into his mouth and swallowed it with the intention of obstructing his airway in order to end his life.

56 When Mr Boros was discovered by hospital staff in the bathroom of his room at 8.24 pm, he was unresponsive and not breathing.

57 Based on the information available, I find that Mr Boros' death occurred by way of suicide.

THE CLINICAL INCIDENT INVESTIGATION OF MR BOROS' DEATH [12]

58 A clinical incident in a hospital which has caused serious harm or death to a patient that may be attributable to the patient's health care (rather than their underlying condition or illness) is known as a SAC1 clinical incident. Such an incident will always become the subject of an investigation by the hospital in question. The goal of a SAC1 investigation is to find out what happened, why it happened, and what can be done to prevent it from happening again. The investigation focuses on these considerations, rather than the individuals involved, in order to understand the system-level factors that may have contributed to the incident.

59 Included in the SAC1 investigation into Mr Boros' death were the following findings:[13]

[12] Exhibit 1, Volume 1, Tab 19, SAC1-Clinical Incident Investigation Report
[13] Exhibit 1, Volume 1, Tab 19, SAC1-Clinical Incident Investigation Report, pp.14-18

- With hindsight, a "line of sight specialling"[14] may have been appropriate for Mr Boros.
- Processes for ensuring nursing staff were informed of the change to increased observations for Mr Boros were not in place.
- The responsibility for completing visual observations of patients in the MHAU was not allocated to a specific nurse. Instead, it was a shared responsibility.
- CCTV footage established there was no direct visual observation of Mr Boros by nursing staff from 6.53 pm until 8.24 pm.
- The high level of activity/acuity at the MHAU at the relevant time impacted upon the ability of nursing staff to document observations in a timely manner.
- In the previous six years since FSH had opened, there had been no reported clinical incidents that items such as tissues and toilet paper being provided to MHAU patients had been used to self-harm by swallowing. In a broader setting, such occurrences are extremely rare. The investigating panel acknowledged that it is not possible to remove all risks of self-harm or suicide in a hospital setting.

60 The SAC1 investigation found that organisational systems and processes contributed to the death of Mr Boros, and a number of recommendations were made to prevent the circumstances relating to his death from occurring again.[15]

ISSUES RAISED BY THE EVIDENCE

Was it appropriate not to place Mr Boros on a one to one constant supervision in the MHAU?

61 As already noted above, Mr Boros was placed on a one to one constant supervision in the ED. However, once he was admitted to the MHAU, that level of supervision was not maintained. I am satisfied with the following explanations for not placing Mr Boros on this highest level of supervision.

62 After her review of Mr Boros, Dr Vecchio held the following view:[16]

[14] Also known as a one to one constant supervision.
[15] Exhibit 1, Volume 1, Tab 19, SAC1-Clinical Incident Investigation Report, pp.23-26
[16] Exhibit 1, Volume 2, Tab 3.1, Statement of Dr Daniela Vecchio dated 4 August 2023, p.12

> I did not feel that he was at immediate high risk of harming himself and there was no evidence of risk to others. He was cooperative, agreeable to stay in hospital and agreeable to restart medication. For those reasons I felt that he did not need a 1:1 special[17] but needed close observations.

63 At the inquest, Dr Vecchio also outlined the potential negative impact of a one to one constant supervision of a patient with paranoid thoughts:[18]

> It also triggers further anxiety, particularly in a patient who is paranoid – in a patient who is believing that police and other agencies are involved. There is a conspiracy and what we have seen many times is that they start then believing that us doctors and nursing staff and the staff on the ward are now … part of this conspiracy. So it's a balance between keeping the patient safe but also making sure that we don't increase the paranoid thoughts. We are not incorporated into the paranoid thoughts, so we don't increase the anxiety and the distress of the patient.

64 Sharon Delahunty (Ms Delahunty), Nurse Director of Mental Health at FSH, also noted that Mr Boros required one to one constant supervision in the ED as he was at risk to himself if he absconded. In contrast to the MHAU, the ED is not a secure ward and has several access points. Ms Delahunty observed that it is not unusual for a patient requiring one to one constant supervision when in the ED to be reduced to a lower level of observations once they are transferred to a secure ward such as the MHAU.[19]

65 In those circumstances, I am satisfied that Mr Boros did not require one to one constant supervision once he was admitted to the MHAU. To find otherwise would be inserting impermissible hindsight bias.

66 However, questions arose at the inquest as to whether Mr Boros received the "*close observations"* from nursing staff that Dr Vecchio had identified he required.

Were the assessed levels of visual observations for Mr Boros appropriate?

67 Following Dr Vecchio's review of Mr Boros, the decision was made to increase his observations from every 30 minutes to every 15 minutes.[20] This meant that a member of the nursing staff at the MHAU was required to make a visual observation of Mr Boros every 15 minutes.

[17] Also known as a one to one constant supervision.
[18] Ts 8.8.23 (Dr Vecchio), p.23
[19] Exhibit 1, Volume 2, Tab 1.1, Sharon Delahunty dated 2 August 2023, p.7
[20] Exhibit 1, Volume 2, Tab 3.1, Statement of Dr Daniela Vecchio dated 4 August 2023, p.13

68 Following a visual observation, a record of the time the observation was made and Mr Boros' location and mental state is to be entered onto his Patient Observation Chart (observation chart) by the nurse. This nurse is also required to identify themselves on the observation chart.[21] The expected process at the MHAU in place at the time of Mr Boros' death was for a nurse to take the clipboard file with the patients' observation charts and complete the required visual observations for each patient, contemporaneously recording what they have observed on the patient's observation chart.

69 However, there was a conflict in the oral evidence at the inquest as to how the decision to increase Mr Boros' observations to every 15 minutes was made.

70 It was Dr Vecchio's evidence that it was her role to decide the level of visual observations for a patient and it was her decision to change Mr Boros' level of visual observations to every 15 minutes.[22] It was also Dr Vecchio's evidence that this change should have been documented in the progress note of her review made by the psychiatry registrar.[23]

71 Ms Espina's recollection of how the change to Mr Boros' visual observations came about is different. Ms Espina stated that following a discussion between her and the nursing shift coordinator, it was decided to observe Mr Boros more frequently at 15 minute intervals.[24]

72 Jojo Moonumackal was the nursing shift coordinator at the relevant time. However, he did not remember having a discussion with Ms Espina about changing the frequency of Mr Boros' visual observations.[25]

73 The documentary evidence is either inconsistent or incomplete regarding how, when and by whom the change to the visual observations were made. As conceded by Dr Vecchio, the progress note of her review does not record the change.[26]

74 The details on the Mr Boros' observation chart do not provide any assistance. The handwritten entries as to the time the observations were

[21] Exhibit 1, Volume 1, Tab 18.8 Patient Observation Chart – Mental Health for Mr Boros dated 14 January 2021
[22] Ts 8.8.23 (Dr Vecchio), pp.37-38
[23] Ts 8.8.23 (Dr Vecchio), p.30
[24] Exhibit 1, Volume 1, Tab 25, Statement of Sofia Espina dated 2 August 2023, p.7
[25] Exhibit 1, Volume 2, Tab 2.1, Statement of Jojo Moonumackal dated 4 August 2023, p.3
[26] Exhibit 1, Volume 1, Tab 18.11, Progress Note dated 14 January 2021 at 4.11pm

to be conducted following Dr Vecchio's review state they were to be every 30 minutes.[27]

75 The discharge summary for Mr Boros indicates that the change in the visual observations occurred at or about the time of Dr Vecchio's review.[28] However, an entry made at 4.15 pm by Ms Espina located in the Nursing Handover History for Mr Boros supports her contention as to when and how the level of visual observations changed.[29]

76 I am satisfied it was appropriate to increase Mr Boros' visual observations from every 30 minutes to every 15 minutes. Unfortunately, the recordkeeping for that change was less than adequate and I am not able to determine how, when and by whom the change was made.

Failure to conduct visual observations for Mr Boros every 15 minutes

77 Although I am not able to determine precisely when Mr Boros' visual observations changed to every 15 minutes, the documentation establishes that by 4.15 pm this change had been made.[30]

78 As at the date of Mr Boros' admission to the MHAU, each nurse was allocated one to two patients for each shift. However, that nurse was not necessarily required to conduct the visual observations of their patient.[31] As explained by Ms Delahunty:[32]

> At that time, there was no policy in place to provide clear guidelines to nursing staff on this point and it was a shared responsibility. All patient observation charts were placed in a clipboard in the nursing base. Any nursing staff member could complete the observations by taking the clipboard and completing the observations for each patient.
>
> At the relevant time of 14 January 2021, patients would be allocated to different responsible nurses, but the observation forms would be on clipboard and one nurse would go and do all the observations for the patients at the same time.

79 Being an acute ward, it was very rare for the MHAU not to have any patients on close observations.[33]

[27] Exhibit 1, Volume 1, Tab 18.8 Patient Observation Chart – Mental Health for Mr Boros dated 14 January 2021
[28] Exhibit 1, Volume 1, Tab 22, FSH Full Medical Record, Discharge Summary dated 14 January 2021, p.2
[29] Exhibit 1, Volume 2, Tab 1.2, Nursing Handover History, p.2
[30] Exhibit 1, Volume 2, Tab 1.2, Nursing Handover History, p.2
[31] Exhibit 1, Volume 2, Tab 1.1, Sharon Delahunty dated 2 August 2023, p.4
[32] Exhibit 1, Volume 2, Tab 1.1, Sharon Delahunty dated 2 August 2023, p.10
[33] Ts 9.8.23 (Ms Delahunty), p.164

80 I was somewhat alarmed to find out this was the procedure for conducting visual observations at the time of Mr Boros' death. Ms Espina's evidence at the inquest was that the shared responsibility amongst nurses for visual observations was "*flawed*".[34] After Ms Espina gave that evidence, counsel assisting succinctly explained it in this way: "*In a team approach, everyone is responsible, but no one is actually responsible.*"[35] Ms Espina agreed with that assessment.[36]

81 I am satisfied that the system in place at the time of Mr Boros' death for conducting visual observations could lead to the very real risk of observations of patients not taking place when required. In Mr Boros' case it was compounded further by the fact that his observation chart had not been amended to reflect the change in his visual observations to every 15 minutes.

82 However, that error almost pales into insignificance after the relevant CCTV footage of the corridor is viewed. This footage shows that Mr Boros was not even visually observed every 30 minutes from 4.15 pm.[37] This is dealt with in more detail below.

Pre-populating the scheduled times on Mr Boros' observation chart

83 The observation charts used in the MHAU had a column titled "Time (Observation Conducted)". With respect to Mr Boros' observation chart, Ms Espina had inserted pre-populated[38] times at 30 minute intervals from 4.30 pm until 9.00 pm. Ms Espina could not recall exactly when she inserted these times.[39] However, I am satisfied it most likely took place at or about 4.30 pm.

84 Ms Delahunty was of the view that observation charts should not have been pre-populated. She noted that: "*Pre-populating the form may result in inaccurate information being recorded and may not demonstrate the real time the patient was observed.*"[40] This statement is hardly controversial. In my view, it is a simple statement of fact.

[34] Ts 9.8.23 (Ms Espina), p.115
[35] Ts 9.8.23 (counsel assisting), p.115
[36] Ts 9.8.23 (Ms Espina), p.115
[37] Exhibit 1, Volume 1, Tab 18.8, Patient Observation Chart – Mental Health for Mr Boros dated 14 January 2021
[38] That is, pre-filling
[39] Ts 9.8.23 (Ms Espina), p.98
[40] Exhibit 1, Volume 2, Tab 1.1, Report from Sharon Delahunty 2 August 2023, p.10

85 Nevertheless, Ms Espina's evidence at the inquest was that it was not uncommon for observation charts to be pre-populated in this manner. As she explained:[41]

> That was the ward practice I entered in, and that was the ward practice that I was shown by the nurses that were on the ward. So that's the work that I've picked up.

86 In contrast, Ms Clark-Bell's evidence at the inquest was that she would only write the time on the observation chart when she actually came into contact with the patient for the purpose of a visual observation.[42] As to the time frames being pre-filled on observation charts, Ms Clark-Bell stated: "*It's not the norm. It's not what we do*".[43]

87 I am satisfied, for the reasons stated by Ms Delahunty, that it was not appropriate to pre-populate the time when visual observations were to be conducted on the observation chart. Ms Espina should not have done that in this instance. Nevertheless, I will accept Ms Espina's explanation that this was a practice she was told she could do.

Entries in Mr Boros' observation chart by Ms Espina

88 As already noted, Ms Espina accepted she had pre-populated the entries for the time visual observations were to be conducted from 4.30 pm until 9.00 pm.[44] Ms Espina also accepted that she wrote the entries on Mr Boros' observation chart indicating she had made the visual observations of Mr Boros at 4.30 pm, 5.00 pm, 5.30 pm and 6.00 pm. The CCTV footage of the corridor shows that no visual observations were made of Mr Boros by any nursing staff at these times.[45] Ms Espina was asked about each of these entries at the inquest.

89 As to her entry of making a visual observation at 4.30 pm, Ms Espina said this entry was written on the basis she had seen Mr Boros when she gave him some medication. The CCTV footage shows this took place at 4.12 pm.[46] When asked whether it was her practice to record that an observation had been made at a time not specific to the one recorded on the observation chart, Ms Espina replied: "*It was common practice back then.*"[47]

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[41] Ts 8.8.23 (Ms Espina), p.98
[42] Ts 8.8.23 (Ms Clark-Bell), p.62
[43] Ts 8.8.23 (Ms Clark-Bell), p.62
[44] Ts 8.8.23 (Ms Espina), p.98
[45] Exhibit 1, Volume 1, Tab 15.14, Timeline - CCTV Footage
[46] Exhibit 1, Volume 1, Tab 15.14, Timeline - CCTV Footage
[47] Ts 9.8.23 (Ms Espina), p.120

90 As to her purported visual observation at 5.00 pm, Ms Espina gave evidence that: "*I do apologise. I did make an error in that, and it would have been filled out retrospectively from memory*".[48] Her entry in the observation chart stated that Mr Boros was resting in bed.[49] However, the CCTV footage shows Mr Boros pacing the corridor at 5.00 pm.[50]

91 Ms Espina's entry for her purported observation of Mr Boros at 5.30 pm was that he was resting in bed and appeared to be sleeping.[51]

92 There is no CCTV footage of the corridor available at exactly 5.30 pm.[52] However, at 5.25 pm, Mr Boros is seen pacing the corridor near the nurses' station before entering the dining room. When the CCTV footage recommences at 5.37 pm, Mr Boros is pacing the corridor.[53] Ms Espina did not unconditionally agree that her entry in the observation chart must have been in error. Her position was that it could not be objectively established from CCTV footage whether Mr Boros had gone back to his room at 5.30 pm and was in bed when Ms Espina had observed him.[54] As she explained: "*It would be hard to – whether I agree or not* [that it was an error]*, if I do not have any footage because I don't remember what was happening through that night.*"[55]

93 As to the observation of Mr Boros recorded by Ms Espina as taking place on 6.00 pm, the CCTV footage of the corridor shows no observation by any nursing staff taking place for Mr Boros at this time. At 6.05 pm, the CCTV footage shows Ms Espina commencing the one to one constant supervision of the patient in Room 5. However, it does not appear from this footage that Ms Espina conducted any visual observations of Mr Boros. At the inquest, Ms Espina accepted that a nurse responsible for a one to one constant supervision should not be undertaking visual observations of other patients.[56]

94 I am satisfied, to the required standard and applying the ***Briginshaw*** principle, that Ms Espina made entries on Mr Boros' observation chart that were either inaccurate or incorrect with respect to her purported

[48] Ts 9.8.23 (Ms Espina), pp.120-121
[49] Abbreviated to "RIB" in Mr Boros' observation chart: Exhibit 1, Volume 1, Tab 18.8, Patient Observation Chart - Mental Health for Mr Boros dated 14 January 2021
[50] Exhibit 1, Volume 1, Tab 15.14, Timeline - CCTV Footage
[51] Exhibit 1, Volume 1, Tab 18.8, Patient Observation Chart - Mental Health for Mr Boros dated 14 January 2021
[52] There is no CCTV footage of the corridor from 5.26 pm until 5.37 pm: Ts 9.8.23 (closing submissions by Ms Dias), p.226
[53] Exhibit 1, Volume 1, Tab 15.14, Timeline - CCTV Footage
[54] Ts 9.8.23 (Ms Espina), p.122
[55] Ts 9.8.23 (Ms Espina), p.122
[56] Ts 9.8.23 (Ms Espina), p.122

observations of Mr Boros at the times between 4.30 pm and 6.00 pm that she had pre-populated on the observation chart. I am satisfied the 4.30 pm entry was not accurate as Ms Espina had made the visual observation at 4.12 pm. As to the entries for 5.00 pm, 5.30 pm and 6.00 pm, I am satisfied these were not only inaccurate but were incorrect. The CCTV footage at or about 5.00 pm and 6.00 pm does not show Ms Espina conducting a visual observation of Mr Boros. I also find that although the CCTV footage at 5.30 pm is not available, the circumstantial evidence of what Mr Boros was doing before and after this time enables me to find that he would not have been resting in bed and appearing to be asleep at 5.30 pm as recorded by Ms Espina on the observation chart.

95 At the inquest, it was disappointing to hear Ms Espina give evidence that she only accepted and apologised for the incorrect entry she acknowledged she made with respect to the 5.00 pm visual observation. It did not reflect well on her that during her testimony she failed to unconditionally accept and apologise for her incorrect entries at 5.30 pm and 6.00 pm.

96 The South Metropolitan Health Service (the SMHS) conducted a disciplinary investigation with respect to the entries made by Ms Espina on the observation chart for Mr Boros. That investigation found that Ms Espina did not observe Mr Boros at the time she signed the observation chart for the visual observations purportedly undertaken at 5.00 pm and 5.30 pm on 14 January 2021 and that her entries were completed retrospectively (and/or falsely). The disciplinary action taken was a reprimand in the form of a warning and counselling in accordance with section 163(3)(b)(i) of the *Health Services Act 2016 (*WA).[57]

97 To her credit, Ms Espina accepted she was responsible for not changing Mr Boros' observation chart to show that his visual observations were to be every 15 minutes.[58] Nevertheless, later in her evidence, Ms Espina said that the nursing shift coordinator could have also made the changes to the observation chart.[59] Evidence that the nursing shift coordinator could make these changes on an observation chart was also given by Ms Delahunty.[60]

[57] Exhibit 1, Volume 1, Tab 15.10, Proposed finding and action letter from Sharon Delahunty to Ms Espina dated 29 June 2021
[58] Ts 9.8.23 (Ms Espina), p.141
[59] Ts 9.8.23 (Ms Espina), p.146
[60] Ts 9.8.23 (Ms Delahunty), p.183

98 Although I accept that either the nurse allocated to the patient or the nursing shift coordinator could make these changes, I am satisfied that the responsibility for ensuring this particular observation chart correctly reflected the change to visual observations every 15 minutes was Ms Espina's. As she had pre-populated the observation times from 4.30 pm onwards, it was incumbent upon her to make the necessary changes to those pre-populated times to ensure the observation chart adequately reflected the change that had been made.

99 Ms Delahunty also provided another reason why in this particular case it was Ms Espina's responsibility. As Ms Espina was the nurse who had noted the change in the visual observations in the nurses' clinical handover, she should have also made the change on Mr Boros' observation chart.[61]

Entries in Mr Boros' observation chart by Ms Clark-Bell

100 The CCTV footage of the corridor also shows that no visual observations were done for Mr Boros at 6.30 pm, 7.00 pm and 7.30 pm. Nevertheless, his observation chart had entries for those times indicating that Mr Boros had been observed resting in bed.

101 Ms Clark-Bell accepted that she completed those entries retrospectively which she acknowledged was "*totally wrong*". She also accepted full responsibility for doing that.[62]

102 Ms Clark-Bell said she made those entries after Ms Espina had asked her to retrospectively write them on the observation chart.[63] At the inquest, Ms Clark-Bell was shown CCTV footage of the corridor from 8.52 pm to 8.54 pm (exhibit 2). This footage shows Ms Espina and Ms Clark-Bell speaking to each other whilst Ms Clark-Bell held the clipboard file with the patients' observation charts.[64]

103 In her evidence Ms Espina did not accept she had asked Ms Clark-Bell to retrospectively complete the observation chart for Mr Boros for these three times.[65] When the relevant footage was played to her at the inquest, Ms Espina accepted that she approached Ms Clark-Bell in the corridor without Ms Clark-Bell calling her over, and she also accepted

[61] Exhibit 1, Volume 2, Tab 1.2, Nursing Handover History, Ts 9.8.23 (Ms Delahunty), p.183
[62] Ts 8.8.23 (Ms Clark-Bell), pp.62-63
[63] Ts 8.8.23 (Ms Clark-Bell), p.63
[64] Exhibit 2, CCTV footage of the corridor from 20.52.23 secs to 20.54.12 secs
[65] Ts 9.8.23 (Ms Espina), p.125

Ms Clark-Bell was holding the clipboard that contained the patients' observation charts.[66]

104 Following the inquest, I carefully examined exhibit 2. I am satisfied to the required standard that the interactions in the corridor between Ms Espina and Ms Clark-Bell corroborates Ms Clark-Bell's version. Using the times from the 24-hour clock displayed at the top of the screen in exhibit 2, I noted the following:

- At 20.52.31: After Ms Espina approaches Ms Clark-Bell, it is Ms Espina who does most of the talking.
- At 20.52.50: Ms Espina turns over one or two pages on the clipboard file that Ms Clark-Bell is holding to show another observation chart and a further conversation take place.
- At 20.53.04: Ms Clark-Bell begins to write on that observation chart as Ms Espina watches what she is writing. It is evident that Ms Clark-Bell is writing on the bottom half of the page which is consistent with the positioning of the entries for 6.30 pm, 7.00 pm and 7.30 pm on Mr Boros' observation chart.
- At 20.53.13: Another nurse calls out to Ms Espina, and she then goes off camera to retrieve a piece of equipment for the resuscitation efforts on Mr Boros which are still taking place. As this occurs, Ms Clark-Bell continues to write on the same observation chart that Ms Espina had turned to.
- At 20.53.46: Ms Clark-Bell finishes writing on this observation chart and turns over to the next observation chart.
- At 20.53.51: Ms Espina returns to stand next to Ms Clark-Bell and starts to walk away, but comes back as Ms Clark-Bell turns back to the observation chart that she had been writing on.
- At 20.53.58: Ms Clark-Bell shows this observation chart to Ms Espina who looks at it for about three seconds before walking away.

105 I also note that Ms Espina was not able to give an account of these conversations she had with Ms Clark-Bell in the corridor aside from saying it was not about retrospectively completing the entries on Mr Boros' observation chart.[67]

[66] Ts 9.8.23 (Ms Espina), p.127
[67] Ts 9.8.23 (Ms Espina), p.126

106 I found Ms Clark-Bell to be a reliable and credible witness. She made no attempt to deflect blame on Ms Espina for the incorrect entries she had completed at Ms Espina's request, accepting full responsibility for doing so with respect to every entry. This unconditional acceptance of her incorrect entries was commendable. In contrast, Ms Espina did not accept that level of responsibility for all the incorrect entries she had made, only doing so when there was uncontroverted CCTV footage to verify that a particular entry was incorrect.

107 Once the evidence from the CCTV footage in exhibit 2 is taken into account, I am satisfied (to the required standard) that the account given by Ms Clark-Bell is accurate and that Ms Espina inappropriately asked her to retrospectively complete the three entries. Accordingly, and applying the ***Briginshaw*** principle, I reject Ms Espina's denial that she asked Ms Clark-Bell to retrospectively complete incorrect entries for the purported visual observations of Mr Boros at 6.30 pm, 7.00 pm and 7.30 pm. Having already retrospectively completed one inaccurate entry and three incorrect entries for purported visual observations of Mr Boros, to then request Ms Clark-Bell to do the same does not reflect well on Ms Espina.

108 The SMHS also conducted an investigation into Ms Clark-Bell regarding the entries made by her. At the completion of the investigation, findings were made that she had retrospectively completed three entries on Mr Boros' observation chart without observing him at these times. As in the case of Ms Espina, the disciplinary action was by way of a reprimand in the form of a warning and counselling pursuant to section 163(3)(b)(i) of the *Health Services Act 2016 (*WA).[68]

Could the procedure for conducting visual observations be improved?

109 The evidence I heard at the inquest regarding the failure to properly supervise Mr Boros caused me a considerable level of concern. I am satisfied that one of the reasons for this was the procedure in place for conducting visual observations.

110 It was reassuring to hear that there had been changes made to this procedure in the aftermath of Mr Boros' death. These changes are detailed below.

[68] Exhibit 1, Volume 14.5, Proposed finding and action letter from Sharon Delahunty to Ms Clark-Bell dated 29 June 2021

CHANGES SINCE MR BOROS' DEATH

111 As would be expected of all organisations, FSH is always on pathways of continual improvement with respect to its operations.

112 There is frequently a gap of some duration between the date of the death requiring a mandatory inquest and the date of the inquest. In those circumstances, an entity connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

113 In this case, there had already been changes made by FSH with respect to the recommendations made by the SAC1 investigation. One of those changes concerned visual observations of patients in the mental health wards at FSH. These changes are designed to reduce the risk of the shortcomings that were identified in Mr Boros' visual observations from occurring again.

Policy changes to the way visual observations are conducted

114 At the inquest, Ms Delahunty explained that the system in place for visual observations on 14 January 2021 had existed since FSH opened.[69]

115 As to the "*team responsibility*" in place for performing visual observations by nursing staff, Ms Delahunty accepted that this approach "*fell down*" regarding the observations that should have been undertaken for Mr Boros.[70] That concession was properly made.

116 Ms Delahunty said that observation charts should not have been pre-populated in January 2021. She explained: "*Pre-populating the form may result in inaccurate information being recorded and may not demonstrate the real time the patient was observed.*"[71] However, it was Ms Espina's evidence that this was not an uncommon practice.

117 The current policy, which was not in place at the time of Mr Boros' death, now makes it clear that observation times must not be written in advance (i.e. pre-populated) on observation charts, and must be accurate and contemporaneous. In addition, observations must never be recorded retrospectively.[72]

[69] Ts 9.8.23 (Ms Delahunty), p.166
[70] Ts 9.8.23 (Ms Delahunty), p.170
[71] Exhibit 1, Volume 2, Tab 1.1 Report of Sharon Delahunty dated 2 August 2023 p.10
[72] Exhibit 1, Volume 2, Tab 1.5, Patient Observation – Specialling and Close Observations: FSFH-MENH-POL-0023, p.2

118 The nursing responsibilities for visual observations have been more clearly defined since Mr Boro's death. The relevant policy introduced by the SMHS now states:[73]

> The Shift Coordinator in charge of the shift will:
>
> - allocate the nurse/s caring for the patient on special or close observations to the most appropriate registered nurse (RN)/ enrolled nurse (EN)/AIN.
> - ensure that increased observations are handed over shift to shift.
> - regularly review engagement and/or other risks between the clinician and the patient, and ensure that the necessary observations are completed during the shift.
>
> It is the responsibility of the member of staff allocated to carry out the patient visual observations to document observations on the Patient Observation Chart.
>
> Observations will be documented on the Patient Observation Chart at the time the observation was taken according to the timed intervals required e.g. 15 minutely.
>
> In the event observations cannot be completed at the required time intervals due to ward acuity, this is to be escalated to the Senior Nurse immediately.
>
> If the allocated nurse is required in another ward activity or to go on a break, they must hand over their patient to another nurse and sign the "co-sign handover" on the Patient Observation Chart.
>
> …
>
> If nursing staff assess that current risks require an increase in the level of observation, nurse initiated observations will be instituted and the Senior Nurse and medical team are to be notified immediately.

119 Ms Clark-Bell endorsed the changes that have now been made. She explained at the inquest that there is now a chart placed in the nurses station at the start of each shift, that designated, on an hourly basis, which nurse is allocated the task of visual observations for all patients in the ward.[74]

120 I am satisfied the changes to the way in which visual observations of patients are to be conducted will lower the risk of a patient not being visually observed at the appropriate times. If these changes are complied

[73] Exhibit 1, Volume 2, Tab 1.5, Patient Observation – Specialling and Close Observations: FSFH-MENH-POL-0023, pp.5-6
[74] Ts 8.8.23 (Ms Clark-Bell), p.56

with, then the risk of a patient not being visually observed for the length of time that Mr Boros was, should be significantly reduced.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF MR BOROS

121 After careful consideration of the documentary evidence and closing submissions from the interested parties at the inquest, and having heard the oral evidence of the inquest's witnesses, I am satisfied that the standard of the treatment and care provided to Mr Boros at the ED and MHAU at FSH was appropriate. This included the resuscitation attempts to revive Mr Boros once he was found unresponsive. And although I am also satisfied that the standard of the supervision of Mr Boros at the ED was appropriate, his supervision at the MHAU was definitely not appropriate. The recordkeeping for that supervision on Mr Boros' observation chart was also manifestly misleading.

122 As I've outlined above, I am satisfied to the required standard that the visual observations of Mr Boros in the MHAU were sadly lacking for a prolonged period of time. I am also satisfied to the required standard that Mr Boros was not made the subject of a visual observation for the specific purpose of completing his observation chart after 4.00 pm. Put another way, after 4.00 pm and until he was found unresponsive, Mr Boros was not visually observed by a member of the nursing staff who was holding the clipboard file with the observation charts and who then contemporaneously completed the required entries into Mr Boros' observation chart. After 4.00 pm, Mr Boros was supposed to be the subject of these visual observations every 15 minutes.

123 Although he was seen on several occasions by nursing staff in the MHAU between 4.00 pm and 6.53 pm, Mr Boros was not sighted by anyone from 6.53 pm until he was discovered unresponsive in the bathroom of his room at 8.24 pm. I cannot be satisfied to the required standard that had Mr Boros been visually observed at the required times during this period, his death may have been preventable. However, I am satisfied that this extended period without any visual observations was a significant oversight.

124 The situation was made worse by the fact the entries in his observation chart indicate that from 4.30 pm, Mr Boros was purportedly being visually observed in accordance with the times specified on his observation chart every half hour. CCTV footage clearly establishes that this was not the case.

125 I am satisfied that the two nurses responsible for those misleading entries have learnt from their mistakes. I do not expect that either of them will ever make this type of mistake again.

126 I should add that it can be readily gleaned from my findings that I am satisfied that with respect to these two nurses, Ms Espina's conduct was more serious than Ms Clark-Bell's. It has not escaped my attention that Ms Espina had graduated from her university nursing course in September 2020. Consequently, she had only been employed in the mental health wards at FSH for four months before Mr Boros' death.

127 I sincerely hope that the mistakes Ms Espina personally made and then had Ms Clark-Bell make with respect to the misleading entries in Mr Boros' observation chart, were a result of her inexperience and a naïve attempt to cover up the inadequate number of visual observations by nursing staff for Mr Boros.

CONCLUSION

128 Mr Boros had a significant mental health condition. Notwithstanding, he was described by his outpatient psychiatry registrar as "*an intelligent and caring man and had a lot to offer if his illness was able to be controlled.*"[75] Sadly, Mr Boros spent the final days of his life tormented by unfounded fears he was being stalked and persecuted, and that his life and the lives of those he loved were in danger.[76]

129 In the early hours of 14 January 2021, Mr Boros had a severe lapse of his paranoid schizophrenia. Police officers were able to prevent him from jumping off the bridge at Canning Train Station and he was taken by ambulance to the ED at FSH. That same day he was transferred from the ED to the MHAU at FSH, and an inpatient treatment order was made which permitted the continued detention of Mr Boros at the MHAU for the purposes of further assessment and treatment of his mental illness.

130 Despite the appropriate decision to have him visually observed by nursing staff at the MHAU every 15 minutes, Mr Boros was in his room behind a closed door without a visual observation for over 90 minutes. When a visual observation was eventually undertaken at 8.24 pm, he was found unresponsive in his bathroom with a wad of tissue paper obstructing his airway. Despite extensive resuscitative efforts, Mr Boros could not be revived.

[75] Exhibit 4, Email to the Court from Dr Trinity Alfonsi dated 3 November 2023
[76] Exhibit 4, Email to the Court from Dr Trinity Alfonsi dated 3 November 2023

131 I am satisfied that the visual observations of Mr Boros were inadequate for considerable periods of time after 4.00 pm until he was found over four hours later.

132 I am also satisfied that changes have been made in the mental health wards at FSH (including the MHAU) that are designed to overcome the deficiencies that existed for the visual observations of Mr Boros. Accordingly, it has not been necessary for me to make any recommendations for improvements in this area.

133 As I did at the conclusion of the inquest and on behalf of the Court, I extend my sincere condolences to Mr Boros' family and loved ones for their sad loss.

P J Urquhart
Coroner
17 May 2024