CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of [redacted] AB
Hearing dates:	13 to 16 March 2017 and 1 May 2017
Date of findings:	7 August 2017
Place of findings:	Coroners Court – Wagga Wagga
Findings of:	Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – Suicide, borderline personality disorder, whether treatment was appropriate by general practitioners, whether response at hospital was appropriate, whether policy and procedure was followed on presentation at hospital and on discharge
File number:	2015/165854
Representation:	Mr Ian Fraser (Counsel Assisting) instructed by Ms E Wells (Crown Solicitor's Office) Mr J Brock instructed by the Coronial Inquest Unit, Legal Aid NSW for the family Mr S Woods instructed by Curwoods Lawyers for Murrumbidgee Local Health District Ms K Burke instructed by Avant Mutual for Dr Azab and Dr Edwards Mr H Pintos-Lopez instructed by Kennedys for Dr Woodhouse Mr M Newton instructed by HWL Ebsworth for Dr Davies

Findings:	I find that AB died between 2 and 3 June 2015 at [redacted] Wagga Wagga due to hanging, which was self-inflicted with the intention of taking her own life.
Publication restriction:	Pursuant to s. 75(2)(b), the publication of the name and any matter identifying the deceased and any relative of the deceased is prohibited.

Table of Contents

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of AB *.*

Introduction

1. AB was a 27 year old woman who died within hours of being discharged from the Wagga Wagga Base Hospital (WWBH), which has since been renamed the Wagga Wagga Rural Referral Hospital (WWRRH). She suffered from borderline personality disorder and had been managing her mental health issues for many years.

2. AB was supported by her mother and four sisters during her life. Her mother was very active in the treatment of AB 's mental health throughout her life.

3. On 18 April 2015, AB was scheduled at Gissing House, the mental health unit at WWBH. She was discharged into the care of the Community Mental Health team, which is also part of the Local Health District. They managed her for a period, and then discharged her from that service into the care of general practitioners for psychological treatment.

4. As part of this process, on 2 June 2015 AB attended a GP practice called Glenrock Country Practice and saw a psychologist (Dr Woodhouse), to whom she disclosed an intention to self-harm. The psychologist immediately arranged for AB to see a General Practitioner ("GP") in the same practice. She was assessed by two General Practitioners who determined that she should be scheduled pursuant to *the Mental Health Act 2007*. After quite a heated exchange AB left the practice.

5. The GP completed the schedule on the wrong form but nonetheless AB was taken by ambulance, with police assistance, to the then WWBH. AB was treated by staff as an involuntary patient up until the point that she was assessed by the senior emergency specialist on duty at the Emergency Department that night, Dr Grundy. He did not refer her to the Mental Health Emergency Consultation Service (MHECS), which is the mental health team available at the hospital 24 hours a day. Dr Grundy determined that she was not to be detained pursuant to the *Mental Health Act*, and lifted the hold that had been placed on her.

6. AB was released at about 9:45 pm on 2 June 2015. Despite the fact that her mother and a family friend had been at the hospital with AB earlier in the night, no contact was made with them. After being assessed

by Dr Grundy, AB spoke to a nurse in the Emergency Department and asked if she could leave. He offered to call a taxi which she declined and she walked home.

7. AB was found by her mother the following morning, hanging in a wardrobe in her own home.

8. This inquest was convened to examine the adequacy of the care and treatment provided to AB, and to determine whether there were any recommendations that could be made to improve the treatment of people like AB in the future.

9. Much of the inquest related to consideration of the policies and procedures of the Local Health District, however it must be acknowledged from the outset that AB's death has deeply affected her supportive family. On the night preceding AB's death, her mother was with AB at the hospital. She left but waited up until 4.00 am assuming she would hear if AB was released. Sadly she found her the next day, discovering only that morning that the Hospital had released her the night before. AB's mother is understandably confused by the decision of the Hospital to release AB, or at the least as to why she was not notified of that decision to release her, particularly given AB's complex mental health background.

Nature of the inquest

10. As provided by s. 81 of the *Coroners Act 2009*, it is the role of the Coroner to make findings at the conclusion of the inquest as to:

    a. the identity of the deceased;
    b. the date and place of the person's death; and
    c. the manner and cause of the person's death.

11. There is no controversy as to identity, date or place of death, or the physical cause of death. The real questions concern the circumstances surrounding AB's death.

12. Pursuant to s. 82 of the *Coroners Act*, a coroner may make any recommendations considered necessary or desirable in relation to matters connected with the death. In coming to my recommendations, I have benefited from the evidence from family, treating health care practitioners, mental health care practitioners, independent experts and Emergency Department staff.

13. The purpose of the coronial process is not to apportion blame or make judgments on legal liability, guilt or innocence, but rather to uncover facts that contributed to death, and to learn what might prevent such a tragic outcome in the future.

14. In making such findings in some cases it is necessary to identify human errors, and system errors or failures. This is done not with the purpose of casting aspersions on individuals, but rather to look at the bigger picture and mitigate the risk of errors or failures in the future.

The Issues

15. The issues that arose for consideration in this inquest were as follows:

    1. The nature and adequacy of mental health care provided by practitioners at Glenrock Country Practice, particularly:

        a. Whether AB received appropriate treatment from Dr Azab, Dr Vargas and Dr Woodhouse; and

        b. Whether appropriate steps taken by Dr Azab and Dr Vargas to have AB detained under the *Mental Health Act 2007*.

    2. The nature and adequacy of medical care provided by practitioners at Wagga Wagga Base Hospital on 2 June 2015, specifically:

        a. What are the applicable policies and procedures at Wagga Wagga Base Hospital?

        b. Whether AB was appropriately triaged upon arrival at the hospital;

        c. Whether observations, examinations and clinical assessments carried out by nursing staff and doctors were appropriate in the circumstances;

        d. Whether the decision of Dr Grundy to discharge AB was appropriate; and

        e. Whether adequate discharge measures were put in place to ensure AB 's safety.

3. The nature and adequacy of support and treatment provided by the Community Mental Health team in the lead up to AB 's admission to hospital on 2 June 2015.

AB

16. AB was 27 years old at the time of her death. She was born on , an Aboriginal woman who was local to Wagga Wagga. She was the eldest daughter to and one of five sisters.

17. AB attended High School, then Wagga Wagga High School, and finished her HSC at TAFE. After finishing her HSC, AB moved to Lismore for several years with a boyfriend, before returning to Wagga Wagga just after her 21st birthday. She moved in with her mother and worked for a period cleaning motels. AB later started working in home care and in 2015 started studying aged care online.

18. AB was able to study and work in the community, but she also lived with a mental illness. She enjoyed being with her family and her friends. She loved to paint and write, and had talents in both areas. She provided a source of fun and adventure to those around her.

AB 's mental health background

19. Over the years AB had numerous interactions with Wagga Wagga Base Hospital and the Community Mental Health team in relation to her mental health.

20. In August 2001 at age 13, AB presented to the Emergency Department at WWBH following an attempt to slash her wrists. At 15 AB was diagnosed with schizoaffective or schizotypal disorder.

21. In April 2003 at age 15, AB was admitted to WWBH and detained under the *Mental Health Act* following a suicide attempt (drug overdose). She was later discharged and did not participate in any follow up.

22. In January 2005 at 17, AB was again detained at WWBH Emergency Department under the *Mental Health Act*. She was diagnosed with adjustment disorder with depressive features.

23. In April 2006 at age 18, AB presented at WWBH after attempting suicide by drinking nicotine distilled from cigarettes. She was discharged

and referred to Community Mental Health and a General Practitioner, and encouraged to contact Accessline, which provides support to those experiencing mental health difficulties. She was later discharged from Community Mental Health as she declined further assistance.

24. In January 2007 at 19, AB was admitted to Gissing House at WWBH following an attempted suicide by hanging. The attempt was precipitated by the suicide of a friend several days earlier (also by hanging). AB was then diagnosed with borderline personality disorder.

25. In December 2011, AB was admitted to the Mental Health Inpatient Unit with suicidal ideation. She was diagnosed with an adjustment disorder and referred to Community Mental Health.

26. On 18 April 2015, AB presented to the Emergency Department of WWBH accompanied by her mother. She reported that her friend had killed herself the day before and that she was having suicidal thoughts. AB was assessed by two medical practitioners, both of whom found her to be a mentally disordered person under the *Mental Health Act*. AB told one of the assessing doctors that she was "feeling like she's better off dead", and that she "intends being drunk for days".

27. AB reported at that time that she had three friends who had committed suicide in the previous 2 months, and that she had increasing thoughts of hanging herself or driving her car into a tree. After initially self-presenting, she changed her mind and wanted to go home and expressed the view that she did not think that an inpatient stay would help her. The hospital assessed her as a mentally disordered person and detained her against her wishes under the *Mental Health Act*.

28. AB was admitted to the mental health inpatient unit, where she remained for two days. AB requested discharge as she felt that continued admission was not helping. She accepted diazepam, but refused any other psychotropic drugs. On 20 April 2015, following further psychiatric review AB was discharged. AB declined referrals to a social worker, and for drug and alcohol follow up, but accepted referral to a psychologist. She was also referred to her General Practitioner and to Community Mental Health. This was six weeks prior to her death.

Treatment AB received by Community Mental Health and Dr Victoria Edwards

29. Following her discharge, AB attended her regular GP, Dr Edwards, on several occasions, last seeing her on 29 April 2015. Dr Edwards formulated a mental health care plan.

30. Dr Edwards gave evidence. She was appropriately concerned for AB, she recognized that AB 's case was complex, and she wanted her to receive a proper diagnosis before being medicated. Dr Edwards' treatment of AB was very thorough.

31. During that period AB had also commenced attending on the Community Mental Health Team, and in particular, Ebony Cribb, a clinical nurse specialist. AB attended on Ms Cribb on several occasions, often with her mother. There was discussion regarding a change in GP to a practice offering counselling and psychiatric services. Ms Cribb gave evidence. She was involved in a very active way in the community treatment of AB . She was well aware of the support that AB had in her mother, and it seemed appropriate communication was made with Ms [redacted] as well as with AB .

32. Dr Edwards was of the view that AB required psychiatric review and arrangements were made for AB to be seen by a psychiatrist from the Local Health District.

33. Dr Davies is a psychiatrist providing services to Community Mental Health patients in Wagga. He saw AB once on 21 May 2015. Dr Davies gave evidence. His notes recorded that AB described her mood as "not very good", and that she was experiencing chronic sleep issues, frequent fluctuations of mood and poor concentration. AB told Dr Davies that she had constant suicidal thoughts, but no intent to act on them. AB admitted self-medicating with alcohol.

34. Dr Davies did not consider AB to be an acute suicide risk at the time he saw her and diagnosed her with borderline personality disorder, alcohol dependence and an alcohol induced mood disorder. AB did not want a referral to drug and alcohol services, and was not interested in taking medications. Dr Davies recommended that treatment focus on psychotherapy and discharged her back to her GP for this purpose within 28 days. He told AB that she needed to address her alcohol abuse, and would have recommended recommencing anti-depressant medication if cessation of alcohol for a month did not improve her mood.

AB attends Glenrock Medical Practice

35. On 27 May 2015, Ebony Cribb referred AB to Dr Azab at the Glenrock Country Practice for the purpose of obtaining general and psychological counselling.

36. Dr Azab first saw AB that day and again the following day. During both consultations AB reported no suicidal thoughts. There was a discussion about various options for her treatment, and Dr Azab referred AB to a psychologist, Dr Woodhouse, who was part of the same practice.

Events of 2 June 2015

37. On 2 June 2015, AB attended an appointment with the psychologist Dr Woodhouse. Dr Woodhouse had not previously seen AB. Dr Woodhouse gave evidence at the inquest. In the handwritten notes taken during the interview AB was noted to be tearful and in distress, and to have spoken of a plan to commit suicide by hanging. Dr Woodhouse assessed AB as being a very high risk of self-harm. Dr Woodhouse went to Dr Vargas, a GP within the practice, to inform him of her concerns. She suggested antidepressants, and told AB that it was important she saw a medical doctor before leaving the practice.

38. Dr Woodhouse presented as a very experienced and professional psychologist. She spent about 50 minutes with AB. Given the fact that a psychologist cannot schedule a client, she took the most appropriate steps to ensure quick referral to a resident GP.

39. Dr Vargas was a GP practicing at Glenrock Country Practice. He was licensed to work under supervision, and was required to have all his cases reviewed by Dr Azab, who supervised him. Dr Vargas gave evidence. He said that he was informed by Dr Woodhouse about her concerns and as a result went into the consultation with knowledge of the information AB had provided to Dr Woodhouse. Ms [redacted] was present in the consultation with Dr Vargas, although she did not go into the session with Dr Woodhouse.

40. Dr Vargas had concerns for AB. He recorded in his notes that AB said that she had suicidal thoughts and "has had plans although not at the moment". As required by his licence, he called in the senior GP, Dr Azab, who came in to review AB. Dr Vargas' evidence was that things escalated at that point. He said that AB was offered the option of

medication, however she was resistant to the medications suggested by Dr Azab, and wanted a particular medication which is not licensed in Australia for treating depression. He said that AB did not address Dr Azab's questions regarding any thoughts of self harm, that she did not want to take the medications recommended by Dr Azab as she was concerned regarding the side effects, and that AB was also resistant at any suggestion she should go into hospital. He said that AB became hostile, and then left the consultation.

41. Dr Azab gave evidence. She presented as a very caring and concerned local GP. Her evidence was that in her long spanning career she had in fact only scheduled three or four people. She had the advantage of seeing AB on two previous occasions. She said she attempted to interview AB to determine the details of the plan that had been discussed with Dr Woodhouse. She mentioned scheduling and at that point AB became very upset and left.

42. AB 's mother was present at the consultation involving Doctors Vargas and Azab. Ms [redacted] gave evidence. Ms [redacted] recalled that during the initial part of the consultation with Dr Vargas there was discussion regarding antidepressants. When Dr Azab joined the consultation, Dr Azab began demanding whether AB had "a plan", and whether she was going to hurt herself. AB initially said that she was there to get antidepressants, but when pressed, made some reference to hanging. On Ms [redacted] 's account, the matter further escalated with an argument regarding which antidepressants would be appropriate, at which point Dr Azab said that she would "section" AB . AB then walked out of the appointment and the medical centre.

43. Ms [redacted] believed there had been a misunderstanding and that AB was confused about what plan the doctors were asking her about. Ms [redacted] of course was not present for the session with Dr Woodhouse, and was not aware of the details disclosed by AB to Dr Woodhouse. Without the benefit of that knowledge she appeared to witness a sudden confrontation that escalated very quickly.

44. There is some evidence from AB herself about the meeting in the form of a later text message to a friend. AB said in the text that during the appointment with Dr Azab it was discussed which antidepressant would be suitable, and that the doctor said that if she did not take the antidepressants the doctor wanted her to take, and stay with her mother for three weeks, she would have her "sectioned."

45. I am satisfied that the doctors and psychologist at the Glenrock Country Practice were all very concerned for AB 's welfare and took action for her safety.

46. After AB left the surgery, a "Form 1: Medical report as to mental state of a detained person" was completed and signed by Dr Vargas under Dr Azab's guidance. That form stated that AB had been evaluated by a psychologist as being at high risk of suicide and medically evaluated by two doctors. It went on to state that AB "again expressed suicidal thoughts – hanging self – but refused further questioning on this matter". The form also said that she had been offered antidepressants but had declined them, and also declined to attend the hospital.

47. This form was faxed to the NSW Police at approximately 6:15pm and calls were made to Police before and after by the practice. No Schedule 1 form was completed, which was the appropriate form to commence the process for AB to be detained under the *Mental Health Act*. The Form 1 used was a form to be used at a later stage of the process, when the further detention of a person is under consideration. Although the doctors completed an incorrect form, their intention was clear.

<u>Police and ambulance attend to transport AB to Hospital</u>

48. After leaving Glenrock Country Practice AB returned to her mother's home where she spoke with a family friend, [redacted]. After expressing her frustration about what had happened at the appointment she returned to her own flat anticipating the arrival of police.

49. The Form 1 was received by NSW Police and was treated as a Schedule pursuant to the *Mental Health Act*. The role of taking AB to hospital was assigned to Leading Senior Constable Simon Carberry and Constable Brenton Casey. The officers attended AB 's address at [redacted], Wagga Wagga. The officers announced their presence and AB told them to go away. After some discussion, AB let the officers in. They explained why they were there. AB expressed frustration at "the system".

50. An ambulance was called to transport AB to WWBH and AB called her mother asking her to come. While waiting for the ambulance, AB was said to have been argumentative and at one point threw her handbag at LSC Carberry. Her mother then arrived and she tried to explain to officers that there had been something of a misunderstanding. Whilst waiting, Mr [redacted], also attended.

51. After some delay an ambulance and two ambulance officers took AB to the Emergency Department of WWBH, arriving at approximately 8:15pm. During the trip, AB was uncooperative and was swearing at the ambulance officers, and they were unable to conduct a mental health assessment. At the hospital, AB was handed over to nursing staff. Police provided the Form 1 to staff and left shortly afterwards.

AB presents at Wagga Wagga Base Hospital

52. Following her arrival at WWBH, AB was triaged by Registered Nurse ("RN") Rashid Samad. RN Samad also gave evidence at the inquest. He spoke with AB and explained why she was at the hospital. AB told him that there had been a misunderstanding with the GP and denied suicidal thoughts. RN Samad's initial triage assessed AB as requiring treatment and assessment within 30 minutes.

53. RN Samad then contacted the Mental Health Emergency Consultation Service ("MHECS") and spoke with Mr Paul Craft. On the information provided to him, Mr Craft recommended observation of AB at care level 1, meaning visual observation every 10 minutes, and security level 2, which meant security was to be present in the Emergency Department.

54. RN Samad appeared to conduct a mental health clinical risk assessment. He said in evidence said that he relied on the information in the Form 1 completed by the GP's. The document indicates that AB was assessed as having a high risk of suicide, with suicidal ideation and self-harm being noted as present. AB was then placed into a safe assessment room. RN Samad was able to strike up a good rapport with AB, and she seemed to calm down. RN Samad conducted observations of AB until he went on a break. He said in evidence that at that time he told the doctor that AB was ready for assessment.

55. Both AB's mother and Mr [redacted] had also attended the hospital. Initially they were both in the safe assessment room with her. At some point an argument developed between AB and her mother, with AB being very upset towards her mother. Ms [redacted] sought to calm the situation and took herself from the room. Ms [redacted] waited for some time in the waiting room. Meanwhile Mr [redacted] remained for a period with AB. He had a very good relationship with AB and was able to calm her down. He had personal obligations of an urgent nature and so after waiting for some time with her, and only at AB's insistence, he left the hospital.

Assessment by Dr Grundy

56. Dr David Grundy was the supervising consultant on duty in the WWBH Emergency Department on 2 June 2015. Dr Grundy has since returned to the United States and declined to give evidence at the inquest. Due to being outside Australia, he cannot be required to do so. Available to the inquest were the notes of Dr Grundy, together with a statement he provided to Police in November 2015. The notes comprised a contemporaneous handwritten progress note, a contemporaneous entry in the electronic medical record timed at 9:41pm, and a longer entry made in the electronic medical record the following day at 7:35pm.

57. On the basis of the notes and the statement it appears that the assessment of Dr Grundy occurred at some time between 9pm and 9:41pm. However, the last nurses' observation is timed at 9:25pm, which suggested that Dr Grundy's assessment did not start until after that time. Dr Grundy had available to him RN Samad's mental health clinical risk assessment.

58. Dr Grundy's contemporaneous handwritten and electronic notes recorded that AB appeared normally interactive, and established good rapport. He recorded that AB said that whilst she had been feeling depressed, she strongly stated that she was not feeling suicidal at this time. He further noted that AB said that there had been a series of communication failures in respect of her psychiatrist and that she felt she would be able to address her depression in some other way than being on anti-depressants. His notes record that AB indicated she was willing to reengage with her psychiatrist, that she had a support system in the area, and that she contracted for her safety. The contemporaneous notes finally noted that AB was discharged in "a stable condition." The contemporaneous electronic notes stated, "Current hold on this patient has been removed."

59. The later electronic notes gave some further detail regarding the examination, including details of the physical examination conducted by Dr Grundy. These notes referred for the first time to "an invalid mental health hold", and said that she had had an argument with her psychiatrist. They referred to AB as displaying "appropriate insight and judgement", and that she said denied any suicidal ideation or other desire for self-harm on multiple occasions.

60. In his statement, Dr Grundy said he was told by staff that AB had previously presented to WWBH on several occasions for treatment for mental health issues, but did not state any detail of any information

provided to him. The statement indicates that Dr Grundy detected no signs of psychiatric distress, although he noted AB appeared somewhat angry at first. Dr Grundy stated that AB had given a detailed account of a series of misunderstandings with her GP that had led to her being brought to hospital, and accepted that the notes incorrectly referred to an argument with her psychiatrist. He said that she gave a clear account of her support network, and that she said she would immediately make contact with her mother when she was released. He also stated that she told him she would re-engage with her doctors and the community mental health resources the next day. Dr Grundy's statement reiterated that AB clearly denied any suicidal ideation or other thoughts of self-harm, and "contracted" for her own safety. The statement also said that she told him about things that she was looking forward to doing over the next day.

61. In his statement. Dr Grundy said that he formed the opinion that AB 's presentation and statements had provided him "with genuine insight" into her current mental state. Dr Grundy stated has said that he concluded that AB was not a threat to herself or others, and that he could not conclude that she was a mentally ill person or mentally disordered person under the *Mental Health Act*. Therefore she did not meet the criteria for further involuntary detention and he approved her for discharge. Dr Grundy notes that he told AB to immediately return to the Emergency Department if she felt suicidal or had other concerns. By his approach, Dr Grundy appeared to be treating AB as a scheduled patient.

62. Dr Grundy did not contact MHECS to assess AB . Psychiatry support was also available from an on-call psychiatrist, but was not sought. There is no evidence that he participated in or took responsibility for overseeing her actual discharge process, particularly given AB had to enquire with a nurse whether she was free to leave.

Discharge of AB from WWBH

63. Dean Marchioni was the nurse in charge in the Emergency Department on 2 June 2015. Nurse Marchioni gave evidence. AB happened upon him before leaving, and enquired whether she was free to go. He explained to AB that the schedule had been revoked and that she was free to go home. He offered to call AB a taxi but she said she could walk home as it was close.

64. Following her discharge AB made her way home. She sent a number of text messages to friends in which she voiced her distress and frustration at the mental health system. These included the following:

"I got released. One moment of fake sanity. And a 7 block walk home in 3 degree weather in the dark without a jumper."

"The way that mental health works in this country. Forcefully take some from their home under the mental health act. Then release them moments later without any real assessment. With only asking one question. And no care if they are truly safe or not."

"My doctor tried to have me sectioned by force and my psychologist is connected to the same doctor's office. Leaving me. With myself."

65. The last text message sent by AB was at 11:53pm.

66. Meanwhile, Ms [redacted] had left the hospital making her way home. She knew that her contact details had previously been provided to the hospital. Mr [redacted] called in to see her briefly after he left the hospital. Ms [redacted] sat up until about 4 am in case the hospital rang. She did not receive any contact from the hospital. The next day she received a call from Ebony Cribb at the Community Mental Health Team. Ms Cribb had not been notified that AB had presented to the hospital, and only learnt of it from Ms [redacted].

67. Ms [redacted] made her way to AB's flat sometime after 9:30 am. When she got no answer, she broke in and found her hanging in the wardrobe. She cut her down and rang 000 although she could tell that she had already passed away. Police and Ambulance officers attended shortly after.

68. Police officers investigated the scene and found a note from AB to her mother. It read:

"Dear mum,
I am sorry for getting angry at you; it is not for lacking of what you have done. It is purely out of frustration at the system. A system that was suppose to be put in place to help me but has done nothing but let me down, not take me seriously, humiliated me and make me believe that the option I had was this… You have been there with me while I jumped through the hoops."

Summary of the evidence and submissions of Murrumbidgee Local Health District (MLHD)

69. A statement which dealt with the relevant policies and procedures of WWRRH was provided to the inquest by the MLHD. It was signed by Dr Fry, the Co-Director of the Emergency Department of WWRRH.

70. The inquest had the benefit of Dr Fry attending and giving evidence; he was cross examined at length. Given the absence of Dr Grundy from the inquest, the input of Dr Fry was very important to the inquest. He is clearly a leader within the hospital and an extremely experienced practitioner. During his evidence, it became evident that Dr Fry was not fully aware of the basis of some of the detail in the statement. He said that he had received some assistance with the statement, particularly those parts relating to mental health.

71. The statement from the MLHD informed the court of the following:

    a. When a person presents at the Emergency Department with mental health issues, the Emergency Department staff are responsible for the initial triage, assessment and management of all mental health patients presenting. The triage process will include notification to MHECS at the time of arrival.

    b. The MHECS team, in conjunction with the triage nurse, formulate an interim management plan while the patient awaits assessment. This takes place by telephone. The interim plan will specify the patient's current level of risk and visual observation status.

    c. If a person is known to the Emergency Department there will be access to the current management plan.

    d. Any patient brought to the hospital under the provisions of the *Mental Health Act* is assessed by a senior Emergency Department medical officer (such as Dr Grundy). That doctor will conduct a physical examination to exclude any organic causes, as well as a mental health state examination.

e. The senior medical officer makes an assessment as to whether or not the patient is a mentally ill person or a mentally disordered person, and whether the patient in question can be reasonably detained under the *Mental Health Act*. The responsibility for that clinical decision rests with the medical officer. MHECS consultations, assessment, and interim management plans are to be used to assist in that decision making process.

f. A patient who is assessed and considered by the medical officer to have a mental health problem, is referred to the MHECS team for assessment.

g. Before a patient can continue to be detained, an authorised medical officer must be of the opinion that the person is a mentally ill person or a mentally disordered person, and that no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.

h. If the Emergency Department medical officer disagrees with the MHECS assessment, or the patient is deemed high risk and immediate consultation is required, there is an on call psychiatrist available to provide support and direction to the medical officer.

i. On discharge, if a MHECS interview is determined as being not required, the medical officer will advise MHECS and then discharge the patient with an appropriate discharge plan.

72. The fundamental MLHD policies and procedures relevant to AB 's presentation at WWBH are:

a. the district procedure entitled "Mental Health Emergency Consultation Service" ("MHECS procedure");[1]
b. the district policy "Suicide Risk Assessment and Management"[2] ; and
c. the district procedure "Suicide Risk Assessment and Management"[3]. [4]

73. The MHECS procedure sets out the Emergency Department triage, mental health initial clinical risk assessment, and immediate management of persons presenting with possible mental health issues. Within section 2 of the policy, entitled "ED Medical Assessment", the following is provided:

[1] See Tab 43 of Exhibit 1.
[2] See Tab 42 of Exhibit 1.
[3] See Tab 42 of Exhibit 1.
[4] Consideration is also given to the policies and procedures at Tab 44 and Tab 45 of Exhibit 1.

"3. MO establishes whether MHECS interview (comprehensive mental health assessment) is required, and advises MHECS where required. Consumers presenting with evidence of suicidal behaviour (i.e. suicidal ideation, recent deliberate self-harm, or significant act of deliberate self-harm within the last six months), or at risk of serious harm to self/others, must be referred to MHECS and receive a comprehensive mental health assessment. (Note: Serious harm includes physical harm, harm to reputation and relationships, financial harm, self-neglect or neglect of others e.g. the person's children.)

4. Where no such clinical risks are identified and specialist, emergency MH assessment is not indicated, the patient should be referred to a GP for follow-up. This need not preclude referral to MHECS, however. Patients determined to be low/no foreseeable risk by the ED with a Hospital MH Discharge Plan (Appendix 5) that includes:

- Follow-up arrangements with relevant health professional/s
- Details of the consumer's support person upon discharge
- AccessLine phone number and advise around what to do if symptoms return/worsen"

74. Dr Fry gave evidence that in his view it was not mandatory for the Emergency Department to have referred AB to MHECS. He confirmed that that since this incident, *"EDMOs have been encouraged to discuss all patients presenting with a relevant mental health issue with regardless of whether or not a decision is being made not to continue detention pursuant to the [Mental Health] Act".*

75. Dr Fry distinguished between WWRRH and smaller hospitals within MLHD, in terms of the application of the relevant policies, suggesting that paragraph 3 of the MHECS procedure (set out above) only applied to the smaller hospitals. Dr Fry also interpreted the policy document as mandating MHECS referral only when a patient presents to the Emergency Department with immediate signs of suicidal ideation, placing them at immediate acute risk.

76. Despite this, Dr Fry agreed that best practice would have amounted to a referral to MHECS in AB 's case.

77. The policy statement contained in the district policy "Suicide Risk Assessment and Management" provides:

"Every consumer with possible suicidal behaviour who comes in contact with the MLHD, regardless of facility or setting, must be referred to the Mental Health Service and must have a comprehensive mental health assessment, including a detailed suicide risk assessment, psychosocial assessment and management plan."

78. Further, paragraph 7 of the district procedure "Suicide Risk Assessment and Management", which is headed "Corroborative History", outlines what additional information is to be considered by mental health clinicians to assist with the risk assessment. It provides as follows:

    a. "The assessing MH clinicians should actively seek further corroborative information to assist with the risk assessment, with careful consideration given the consumer's privacy.

    b. Sources of information include:

        - Communication with other clinicians and officials directly involved e.g. ED staff, ambulance officers, Police;
        - Interview of any persons accompanying the consumer;
        - Interview or phone contact with other relevant people e.g. GP, primary care team, family, friends, Primary Carer, treating psychiatrist, school counsellors;
        - Access to previous health care records.

    c. Consider cultural issues which may influence families' or carers' willingness to reveal the extent of the consumer's problems.
    d. Assess the family/carer beliefs about the consumer's current presentation and determine their response to the situation (e.g. worried, angry).
    e. Assess the family/carer's willingness and capacity to facilitate a protective environment for the consumer when they are discharged."

79. Paragraph 10 of the same procedure is headed "Management in the Emergency Department (ED)", and includes the following statement:

    "Arrange for consultation and assessment of suicide risk by MH clinician/MHECSC as soon as practicable. Ensure the MHECSC is aware of the consumer's presentation."

80. In relation to the discharging of patients, in 2015 New South Wales Health issued a policy directive called "Suicidal Behaviour - Management of

patients with Possible Suicidal Behaviour".[5] This policy includes the following guidelines for Emergency Departments at paragraph 3.4.

"Discharge and follow-up protocol

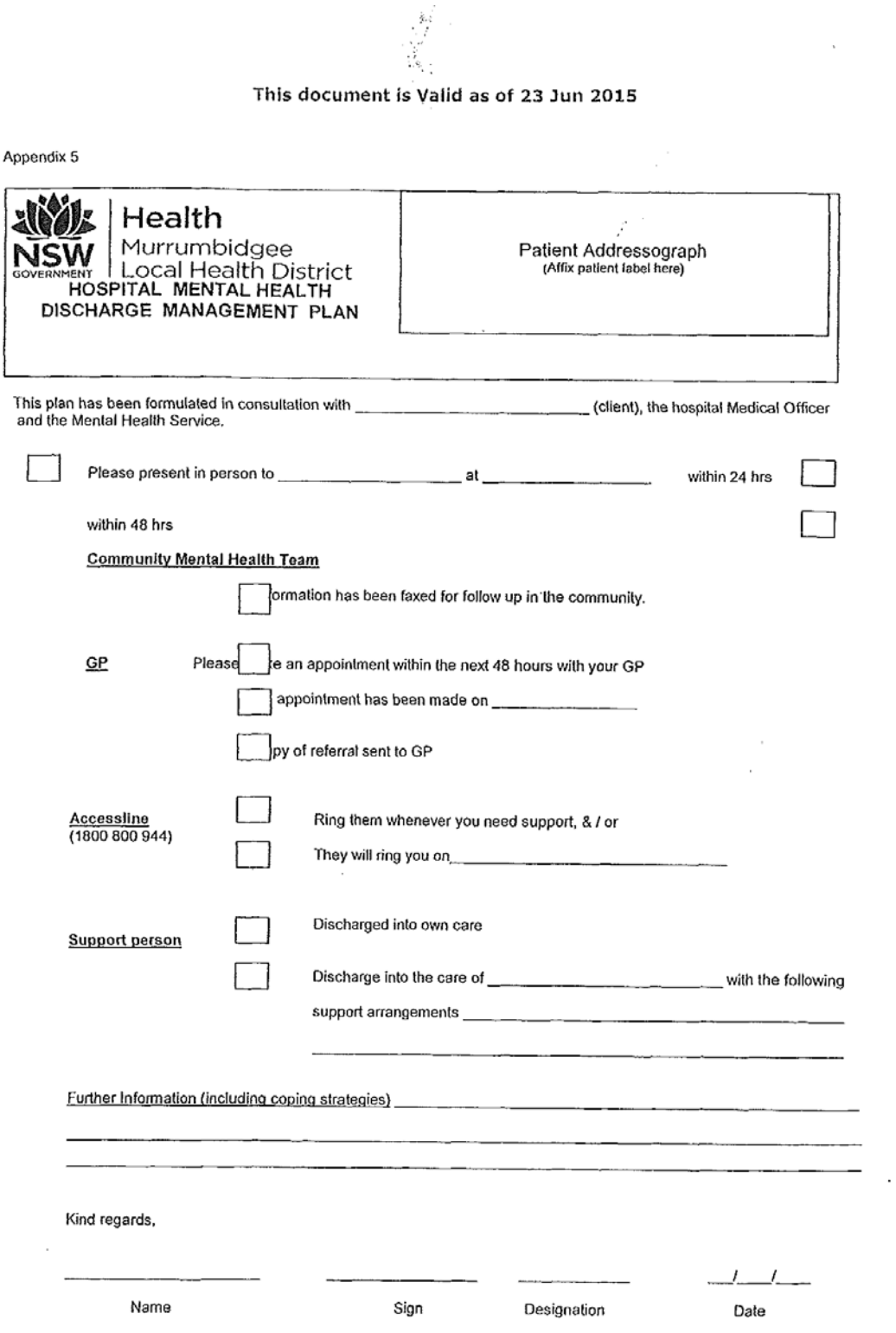
The first few weeks following discharge is a period of greatly increased risk for most patients with mental health problems or patients with suicidal behaviour.
When a decision is made to discharge a patient or not to admit the patient who presented to the health service with suicidal behaviour or suicide risk factors, staff of the health service must take the following steps:

- If a patient with intermediate or high risk of suicide is not admitted, an appointment for **follow-up within 24 hours following discharge** must be made with the relevant health providers (case manager, local mental health service, general practitioner, psychologist/therapist or private psychiatrist). The rationale and reasons for not admitting the patient must be documented. For a patient at low risk an appointment must be made within 24-48 hours.
- Subject to the patient's agreement, it is strongly recommended that the patient's partner, carer or nominated next of kin be fully informed of the risk, advised of the appointment and be invited to accompany the patient on discharge.
- If the patient is under 16 years, the carer **must** be contacted prior to discharge. If no carer is available a suitable advocate for the young person must be contacted.
- The relevant health provider … must receive a verbal report at discharge, or an interim summary within a day of discharge. Written advice should then follow within 3 days of discharge. The DOCFACS system must be used whenever available for this purpose.
- Before the patient leaves the hospital/facility, they should be given a treatment plan including written information on how to seek further help, including a 24 hour telephone number and the name of a contact person.
- Documentation of discharge and follow-up plans in medical records.
- Where a patient has attempted suicide and is believed to be at continuing risk but does not attend an initial follow-up appointment, the relevant health provider who the appointment has been made with, must contact the patient immediately and assess his/her risk of suicide or self-harm."

[5] (PD2005_121) Tab 46 of Exhibit 1.

81. These matters are essentially replicated in the MLHD district procedure "Suicide Risk Assessment and Management". [6]

82. The MLHD MHECS procedure contains a discharge form, which appears below:



This document is Valid as of 23 Jun 2015

Appendix 5

NSW GOVERNMENT Health
Murrumbidgee Local Health District
HOSPITAL MENTAL HEALTH DISCHARGE MANAGEMENT PLAN

Patient Addressograph
(Affix patient label here)

This plan has been formulated in consultation with _____ (client), the hospital Medical Officer and the Mental Health Service.

☐ Please present in person to _____ at _____. within 24 hrs ☐

within 48 hrs ☐

Community Mental Health Team

☐ ormation has been faxed for follow up in the community.

GP Please ☐ e an appointment within the next 48 hours with your GP

☐ appointment has been made on _____

☐ py of referral sent to GP

Accessline (1800 800 944)

☐ Ring them whenever you need support, & / or

☐ They will ring you on _____

Support person

☐ Discharged into own care

☐ Discharge into the care of _____ with the following support arrangements _____

_____

Further Information (including coping strategies) _____

_____

_____

Kind regards,

_____ _____ _____ ___/___/___

Name Sign Designation Date

[6] See in particular section 14 entitled "Transfer of care/Discharge and Follow-up Protocol"

83. The MLHD provided extensive submissions. It accepted that the decision to complete a comprehensive mental health assessment should have been made in consultation with MHECS.

84. The MLHD also accepted that the documentation of Dr Grundy was unsatisfactory. Dr Fry said as follows in his statement:

> *"The initial physical and the mental health state examination were not initially well documented by the senior ED MO in the eMR [electronic medical record] but rather in handwritten and later appended to previous notes after the patient presented deceased the following evening."*

85. The MLHD accepted that a discharge plan was not given to AB as required. Dr Fry's statement included the following:

> *"Ms* AB *was allowed to leave the ED on her own given she was assessed as not being at risk. This was a breach of local Procedure. In Ms* AB *'s circumstances such a plan would have set out a continuation of the existing plan, being consultation in the community with the GP and Psychologist. The plan could have been discussed with family members given there had been documented concern from other medical personnel (GP, psychologist) that Ms* AB *was at risk*."

86. However, Counsel for the MLHD argued that AB 's discharge did not involve non-compliance with its procedures. It was acknowledged that Emergency Department medical officers have now been encouraged to discuss all patients presenting with a relevant mental health issue with the MHECS team. That is encouraged regardless of whether or not a decision is made not to continue detention pursuant to the *Mental Health Act*.

87. The MLHD submitted that it has introduced a number of improvements since this incident. These include:

    a) Education has been offered to staff addressing triage.
    b) Quarterly audits have been introduced. Education is conducted addressing the documentation to be used for mental health

presentations. This included the MLHD Hospital Discharge Management Form.

c) Fortnightly sessions are conducted by the Mental Health Drug and Alcohol Educator.
d) A multi-disciplinary working party has been formed to review engagement with MHECS.
e) Renovations have meant changes and improvements to the service. There is a Mental Health Drug and Alcohol specific work station located opposite the Safe Assessment Room.
f) A multi-disciplinary meeting is held between ED Management Team and the Mental Health Drug and Alcohol Mental Health Inpatient Unit every month.
g) MHECS has one staff member who identifies as being Aboriginal.

Submissions on Behalf of the Family

88. The submissions of the family direct the court to the question of whether the evidence has disclosed missed opportunities that would have promoted AB 's survival prospects.

89. The central concern of the family is whether there was a sufficiently detailed assessment of AB 's presentation, and whether further assessment may have led to responses that would have minimised her risk of self-harm.

90. It was submitted by the family that Dr Grundy was only with AB for a short period of around 15 minutes to complete a physical and mental health assessment. It is also submitted that his notes were substandard, and that the later notes of Dr Grundy were made after he was aware that AB was deceased, and as such should and must be treated with care. The submissions also raise the issue that the notes fail to provide specific information as to the details of support networks that were nominated, but include a reference to her "psychiatrist" when she did not have one. The notes talk about contracting for safety, but it was submitted that was not an appropriate approach.

91. The concept of contracting for safety is one where the patient makes a promise in effect to follow instructions and not to self-harm. One of the independent psychiatrists who gave evidence to the inquest, Dr Ellis, counsels against this practice. This position is supported by the NSW Health Policy Directives "Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour", and "Clinical Care of People Who May Be Suicidal".

92. It is also submitted on behalf of the family that a MHECS assessment would have provided a comprehensive picture of AB at the time of presentation. It seems it would also have changed the discharge process.

93. The relevant policies use language such as “vital” and “highly desirable” in relation to engagement with carers and family in the assessment and discharge processes. The family’s submissions raised the failure of Dr Grundy and the MLHD to attempt to engage with Ms [redacted] at either stage as a significant issue.

94. The submissions also highlight concerns of a failure to consider other alternatives, such as exploring voluntary admission.

95. AB was presenting with an inconsistent account of an incident compared to the account provided on the Form 1 by treating doctors. Both experts agreed that exploring an inconsistency like this is important. Furthermore, any suggestion that AB was merely to return to her treating doctor and psychologist in a situation where AB was asserting they improperly scheduled her due to a misunderstanding, was of concern in itself.

96. It was submitted by the family that there were many breaches of the Hospital’s own policies, including:
    a) AB should have been referred for assessment by MHECS.
    b) A carer or member of the family ought to have been consulted in the initial assessment of AB.
    c) There was no attempt made at discharge to contact anyone to have a family member or carer to accompany AB home.
    d) The discharge plan was not in writing.
    e) MHECS was not advised of the discharge.

Expert Evidence

97. Two expert psychiatrists gave evidence at the inquest. Associate Professor Michael Robertson, consultant psychiatrist and Dr Andrew Ellis, forensic psychiatrist. Both experts had expertise in major hospitals, extensive knowledge of emergency departments, and mental health presentations and assessment. The input to the inquest from both was invaluable.

98. The experts were able to inform the court of a number of matters relating to the assessment of AB. In summary AB was considered to be a

person with an incredibly complex mental health diagnosis. Her ultimate diagnosis of borderline personality disorder is one that both experts agree is a very difficult condition to treat.

99. Dr Ellis said this in his oral evidence of borderline personality disorder:

> *"Its primary treatment is psychotherapy and that requires the person's engagement and motivation to participate with that. Some of the characteristics of the disorder are difficulties in interpersonal relationships, and psychotherapy is a form of interpersonal relationship and so rejecting therapy, rejecting therapeutic offers that are made to a person is typical of someone with borderline personality disorder and that's likely seen through the pattern here of engaging in and then rejecting care over time. But it's not to say that it's an untreatable condition and that people do respond and that there are now established effective treatments for borderline personality disorder but they're not universally effective."*

The actions of Glenrock Country Practice

100. The experts both approved of the actions taken by the psychologist and doctors at Glenrock Country Practice. In evidence, Dr Ellis said of the situation that occurred when AB was confronted by Dr Azab in the consultation:

> *"I think there's a difficult interaction. Then it would have been difficult for anybody to calm that situation down."*

101. In relation to the scheduling of AB by Dr Azab, Dr Robertson stated:

> *"I think she had little alternative in the circumstances".*

102. The treatment and action taken by the Glenrock practitioners (Dr Woodhouse, Dr Vargas and Dr Azab) was found by the experts to be appropriate. They noted that it is an infrequent event for a GP to take the step of issuing a schedule. Each of the practitioners acted in a way to ensure that AB 's needs were being addressed.

103. Ms [redacted] certainly was distressed by the incident at the practice. Ms [redacted] obviously had many years of experience in managing AB , and would have liked to have seen that situation managed in a different way. She considered at the time that there had been a misunderstanding, but she was unaware of AB 's disclosure to Dr Woodhouse of her

intentions to carry out a plan by hanging herself. At that time Ms [redacted] would have been left very confused by what had unfolded.

104. There can be no question that the incorrect form was completed by the treating doctors. Accordingly, there was no legal scheduling of AB pursuant to the *Mental Health Act*. However, the intention of the doctors was very clear.

105. The inquest was informed that the Glenrock Country Practice has since taken active steps to ensure easy availability of the correct form to all doctors within the practice. There has also been education and training for staff.

106. Those acting on behalf of Dr Azab (Avant Mutual) also indicated that they were taking the step of raising with the Australian General Practice Training Programme the lack of training for new practitioners on the practical aspects of scheduling patients under the *Mental Health Act*, and use of the correct forms.

107. Each of the practitioners from Glenrock presented in evidence as caring, concerned and deeply affected by what later transpired. They acted professionally, and by issuing the schedule acted in a protective way to ensure that AB received further treatment and did not walk away from the practice in a state they had assessed as a high risk of suicide.

Triage at Wagga Wagga Base Hospital

108. Once AB reached the hospital, the triage nurse treated her as a patient who was attending pursuant to a valid schedule. The initial triage by the hospital was appropriate, and contact with MHECS as per policy was made by the nurse. The nurse managed to establish a good rapport with AB, even in a situation where she was angry and distressed. That nurse (RN Samad) ultimately was the nurse to observe her for most of her short stay in the hospital.

109. The hospital procedures and policies were mostly followed in relation to the appropriate triage and treatment of AB upon her arrival at the hospital, and as to the initial notification of MHECS, and implementation of an interim management plan pending assessment. It was however identified that there was no mental health assessment completed initially, and that there was no identification of the incorrect form used by Glenrock.

As such, AB was processed as a scheduled patient (which in any event had been the intent of the practitioners at Glenrock).

Treatment by Dr Grundy

110. The inquest did not have the benefit of oral evidence from Dr Grundy. The initial notes made Dr Grundy during or shortly after consultation were criticized by the experts as being insufficient in detail. He supplemented these notes at a later point when he was aware of AB 's death. Dr Fry agreed that the notes were inadequate. This highlighted the obvious need for appropriately detailed notes to be kept.

111. The issues that arise from the treatment by Dr Grundy are these:

a) Was he the appropriate person to assess AB , as he was not an authorised medical officer under the *Mental Health Act*?
b) Should he have hospitalised AB ?
c) Should he have referred her to MHECS?
d) Did he comply with proper discharge procedures?

<u>Was he an authorised medical officer (AMO)?</u>

112. The *Mental Health Act* provides that a person taken to a declared mental health facility under a schedule issued under the *Mental Health Act* must be examined by an "authorised medical officer" ("AMO"), "as soon as practicable (but not later than 12 hours) after the person arrives at the facility" (see s. 27(1)(a)).

113. The NSW Health "Guidelines for Nomination of Authorised Medical Officers under the Mental Health Act (NSW) 2007"[7], provide for the process for nomination of such an officer. These guidelines provide for a register to be kept by the medical superintendent of each declared mental health facility ("DMHF") of those successfully nominated. They state (at p. 1 under the heading "Key Principles"):

> "The key features of the guidelines are that the medical superintendent of the DMHF is responsible for ensuring that:
>
> a. The medical officer they wish to nominate as an AMO has the relevant level of knowledge, skills and experience to undertake this role.

[7] Exhibit 4.

b. The AMO has an understanding of their responsibilities under the Act.

c. The AMO has access to psychiatrist consultation regarding the assessment and care of patients and decision-making regarding the admission and discharge of patients.

114. Dr Grundy was not an authorised medical officer for the purposes of the *Mental Health Act*. He was not nominated nor was he on the register. He was not a person, in relation to a person brought to the Emergency Department under a valid schedule, that was empowered to make a determination as to whether the hold should continue. Even though he sought to raise the invalidity of the form in his later notes, it is clear from his language in the original notes that he sought to release the hold.

115. Clearly, AB was in fact not the subject of a valid schedule under the *Mental Health Act*. It was the contention of the MLHD that even where there was a valid schedule, an AMO was only required in the event that the hold was to be continued, and that there was a practice whereby an Emergency Department medical officer would first make an assessment. If that medical officer concluded that the hold should not continue, the person would be discharged. If the officer concluded that it should continue, an AMO would then assess the patient and make the appropriate determination.

116. This interpretation is not reflected in any policy of MLHD, and appears inconsistent with the language of s. 27 the *Mental Health Act* and the excerpts tendered at the inquest from the Mental Health Act 2007 guidebook, issued by NSW Health. Ultimately, this is an issue that is relevant across NSW, and no submissions on the issue were sought from the NSW Ministry of Health. In the circumstances, it is unnecessary for me to resolve the issue, however, I intend to forward a copy of these findings to the Ministry of Health, to ensure that they are aware of it.

117. It cannot be ignored that regardless of the validity of the form used in AB 's case, there was an attempt to schedule her, and that for a number of purposes AB was treated as if she had been scheduled. In those circumstances, it is concerning that AB was not assessed by anybody with any specific mental health accreditation, be it an AMO, MHECS clinician, or a psychiatrist. I will consider the issue of referral to MHECS further below.

Was his decision not to hospitalise AB appropriate?

118. The appropriateness of the decision to release AB that night is difficult to comment on given that Dr Grundy was not available to explain his decision more fully.

119. The issue of whether or not AB ought to have been hospitalised that night was the subject of discussion by the experts. They outlined the very real problem that is created by hospitalisation. The experts spoke about the fact that patients who have been hospitalised are in fact then at increased risk of self-harm following discharge. Dr Ellis stated in evidence:

> *"I think that a decision to hospitalise is one that's made carefully after you've evaluated the information that's available."*

120. When asked about admission to hospital, both experts agreed that you would not look to just the question of admission or not. Dr Ellis said in evidence:

> *"You're looking for a management plan to address this patient's unique set of circumstances. Hospitalisation might be a part of that even if a person is low risk or assessed as low risk. It's about determining whether hospitalisation will be of benefit to the patient or not."*

121. The question of the decision to not continue to detain AB under the *Mental Health Act* is not the central issue. The main question raised by Dr Grundy's treatment of her is much more about the steps he did not take in her treatment.

122. The ultimate decision must of course be in the hands of the appropriate medical officer. It was raised on behalf of the family that one option that could have been explored was one of voluntary admission to the hospital, or a deferral of the decision to release her, to allow further enquires to be made to have a more complete picture of AB. The experts agreed that these were things that could have been done in this case.

123. Dr Grundy's contemporaneous notes are limited. Without provision of greater detail of what actually took place during Dr Grundy's assessment, and what Dr Grundy considered, it remains difficult to comment on the overall decision to release AB. The experts noted competing questions and factors to be taken into account when making that decision. They discussed the issue of making a decision to release a patient at that time of night, the possibility of deferring a decision until a time when a fuller picture could be gained from the treating doctors or mental health

services, the effect on a person's mental health when detaining them against their will, and the detriment that can flow from such a decision.

124. What seems clear from the evidence is that Dr Grundy spent a limited time with AB and did not take steps to consult notes regarding AB 's previous admissions to WWBH, other health professionals or any family members. Given her complex issues, the conflicting information from medical practitioners in the Form 1 from hours before, and the time of night, these are steps he should have taken before making the decision to release her.

Was his decision to not refer AB to MHECS in accordance with policy?

125. The terms of the MLHD MHECS procedure have been referred to above. The experts stated that the procedure required that people presenting with a risk of suicide must be referred to MHECS for a comprehensive mental health assessment. That accords with the plain meaning of the policy. Submissions were made by MLHD that the procedure did not apply in this case. I reject that submission.

126. It is clear from its wording that the MHECS procedure mandates referral to MHECS of a person presenting with evidence of suicidal behaviour. This should be read in its broadest terms consistent with the expert evidence. Evidence of suicidal behaviour is not only to be found in the words said by the person at the time of presentation, but in all of the surrounding information. In this case, there was clear evidence in the Form 1 document, provided by two GPs and after consultation with a psychologist.

127. AB should have been referred to MHECS in accordance with the policy. She was presenting as a complex mental health patient who had been scheduled against her wishes only 6 weeks prior. Two GPs attempted to schedule her under the *Mental Health Act*, and provided evidence that she had voiced live suicidal thoughts with a plan. Even if Dr Grundy assessed her immediate suicide risk at the time he saw her as low, she was clearly not a low risk patient generally.

128. AB 's own words of "One moment of fake sanity" help explain why the policy of referral to MHECS is necessary.

129. MHECS provide an essential service within the region. The MHECS clinician who gave evidence stated that they are available 24 hours a day. The assessment can take from 1 to 3 hours. They have easy access to an external on-call psychiatrist. They have links to services within the

community that can ensure effective transfer of care. They have significant experience in the formulation of discharge management plans.

130. If the policy is not clear to those working within the hospital then a plain English version ought to be created to ensure that the NSW Health policy guidelines are being uniformly followed within all of the MLHD, including WWRRH and its outlying hospitals.

131. There was evidence that communications between WWRRH Emergency Department and the MHECS has now greatly improved and a more integrated service is provided. That is very positive.

Was Dr Grundy's method of discharge in keeping with policy

132. The experts reviewed the policy documentation of the hospital relating to the discharge of patients, and agreed it was appropriate and in keeping with the Ministry of Health guidelines.

133. The experts also agreed that the proper discharge procedures were not followed on this occasion.

134. It seemed clear also from the statement of Dr Fry that the policies were not followed. He agreed that all patients, whether mental health patients or not, should leave the Emergency Department with a written discharge plan. That did not occur here.

135. The discharge document set out earlier, is a simple and easy document to complete which ensures that people leaving with mental health issues have a plan for future treatment. It provides for a future appointment, and both experts agreed that the handing over of such a document itself has value in the treatment of a person.

136. All agree that it is for the treating doctor in emergency to oversee the arrangement of this plan. If MHECS is involved it seems a matter of course that this will be done. However in cases where the doctor does not utilise the services of MHECS the responsibility lies with them to ensure the form is completed as per policy.

137. Dr Robertson said in evidence:

> *"There is a standard of care established by the Department of Health, now Ministry of Health, for the management of suicidal patients in the community, which has a number of requirements, including delay, the time to subsequent engagement, the type of communication between*

care providers, the involvement of family in the decision, all of these sorts of things. So, yes, you don't just say, "All right, you're not going into hospital. Off you go, then." The process of non-admission then should trigger the standard of care established by the Ministry of Health about discharge planning and communication of discharge plans, involvement of various decision-makers, or stakeholders, dare I say, in the process".

138. Dr Ellis added:

"…in fact the patient that is not admitted and merely assessed is, in some ways, one of higher concern because you know much less about them than someone who has been admitted to your ward for several weeks and discharged in that manner."

139. The experts agree that this document provides the minimum standard for discharge, and is in keeping with the Ministry of Health policies and guidelines. . They indicated that the policy was applicable to AB . Dr Ellis opined in evidence:

"Even if his assessment is that she's low risk, she still presents with some risk and she still presents with distress, and so treatment should be offered to her, and that treatment should be delineated, and this document sets the minimum standard for that."

140. The nursing care that AB received was excellent. The staff however did not appear to have a sound knowledge of these policies, and the Co-Director of the Emergency Department did not consider them strictly applicable in this case.

Consideration of submissions made on behalf of MLHD

141. The submissions by MLHD that the WWBH was actively managing AB 's case after her discharge were not correct. It was submitted that Ms Cribb's attempted to contact AB the next morning was evidence of this active management. This was not the evidence. Whilst Ms Cribb was contacting AB 's mother, this was coincidence only. This is no criticism of Ms Cribb or Community Mental Health. Ms Cribb and Community Mental Health were not even aware at that time that AB had presented at hospital. When AB was released she was released with no plan whatsoever in place. The submission made by MLHD that it would have been preferable if steps had been taken to make appointments for AB

within 48 hours misses the point of MLHD's own policy. It was required to take those steps.

142. A submission was made by MLHD that in effect there was no point of contact being made with Ms [redacted] upon discharge of AB, because *"there is simply no reason to infer or to assume that had Ms [redacted] been contacted she would have sought to do anything differently"* is unhelpful. The point of the policy is to ensure everything that should be done is in fact done. Discharge procedure is not optional. It is a direction to staff and it exists to give each mental health patient the best chance of survival upon discharge. In accordance with its own policy the hospital failed to enquire with AB whether she wanted a support person notified, failed to enquire whether they could make contact with Ms [redacted], and failed to provide Ms [redacted] the opportunity to support her daughter. No written discharge plan was provided to AB. She left the hospital with no documentation at all.

143. The submission made that Dr Grundy was not in effect technically "discharging" AB because she was not at law scheduled, and therefore not an involuntary patient is a submission contrary to the policy documents of the hospital in relation to emergency mental health presentations, and is rejected. The language of the policy makes it clear what must be done. The experts have supported this position.

144. The evidence of Dr Fry highlighted a need for a simple and straightforward policy to be in place. He is an extremely experienced emergency physician, and although his experience may lead him to act in a certain way, this will not be the case for all attending physicians within the hospital. A policy that is mandated and simple to understand will ensure that uniformity exists within the Local Health District.

Conclusion

145. Mental health diagnoses within the community are ever increasing. Mental health patients are complex, and the pressure on emergency departments to meet this demand is very real. The work undertaken by its staff is constant, demanding and unpredictable.

146. WWRRH is the only provider of emergency treatment in Wagga Wagga. It is the major hospital for the region, and an asset for the community. It has recently undergone transformation on a major scale. The hospital opened its doors to the inquiry and provided it with a tour of its impressive facilities.

147. Mental health patients comprise 10-12% of all presentations to the emergency department - over 1100 such patients a year. That is similar to the number of people with mental health issues presenting to the emergency departments of major hospitals in Sydney such as Royal Prince Alfred.

148. For those who live locally, there is no alternative emergency department to Wagga hospital. The community is dependent upon it. Equally there are no options for WWRRH to divert ambulances or patients elsewhere when it is busy. It is expected to cope with all presentations.

149. There is no ignoring the fact that mental health treatment in the emergency department is fraught with difficulty. The supervising doctor and nurse manager have responsibility for all patients. They are required to deal with patients with major physical injuries or illnesses that may be life-threatening. They are also dealing with a significant percentage of patients on a daily basis who may face similar life-threatening mental illness. The concept of a busy emergency department taking in patients with mental health concerns who require time and patience is one that is difficult to reconcile with the pressures to treat patients within restricted time frames.

150. Patients with mental illness are complex, time consuming and can be difficult to diagnose and treat. Some mental health patients present in alcohol or drug affected states, and the process to properly diagnose their condition cannot commence until they are able to communicate effectively. For some, just being in an emergency department environment can aggravate their condition, which in turn has a detrimental effect on other presenting emergency patients. These patients need health practitioners who can sit down and talk to them in a calm and re-assuring manner. These are most often the patients who are at highest risk given they are at a point in their mental illness of self-referring or being forced by a schedule to attend.

151. The experts provided evidence that some of the major city hospitals have the benefit of a dedicated clinical nurse specialist or clinical nurse consultant to deal immediately with mental health presentations. This is obviously a matter of budget, but in a hospital with a large number of presentations per year it would seem a very good funding option to have such a person undertake the initial assessment, freeing up the emergency doctors and reducing the time they need to spend with such patients.

152. At present, the mental health team is available 24 hours at the hospital, MHECS, is the best resource available to specifically address patients presenting with a mental illness. They provide a service that is trained in mental health and can assist by conducting robust, detailed assessments. They must be funded and resourced in a way that allows the Emergency Department to call on them regularly.

153. Not every person presenting with a possible mental health issue will require the services of MHECS. The emergency doctor must make an assessment of the patient and direct the use of those resources where appropriate. That involves considering whether the presentation is indeed genuine, for example not the result of substance abuse alone, and warrants further intervention. However, given the complexity of many diagnoses, the doctor ought never be hesitant as a result of resources to refer the patient to MHECS.

154. This inquest confirms that every staff member of the Emergency Department should know that when a patient presents with evidence of a risk of suicide, the hospital policy should be followed strictly, in that such people will be referred to MHECS for assessment, and will be provided with proper care and a discharge plan. Wherever possible, family or carers should be involved in both the assessment and discharge stages.

155. This was a busy night in the Emergency Department at WWBH. AB presented late at night against her wishes with complex mental health problems. She had been scheduled only 6 weeks prior. Three health care professionals attested to her expressed suicidal intentions only hours earlier. She left the hospital without a MHECS assessment, without contact being made or even attempted with her family, and without a discharge plan of any sort. She was offered a taxi only because she made a simple enquiry of a nurse as to whether she could leave. Her mother was not offered the chance to provide support for her that night upon her release.

156. AB 's experience has highlighted the need to reconsider the wording of the current policy (as some staff think it is ambiguous), and to ensure that policies are not simply words on a page, but have a meaning that is implemented by all staff within the Hospital so people being treated in the Emergency Department for mental health issues are given the care that promotes the greatest opportunity for their survival.

Consideration of Proposed District Procedure – Clinical care of people who may be suicidal

157. The delivery of these findings was postponed pending consideration of two pieces of additional material from MLHD. The first was a summary statement document indicating proposed changes made to improve care for mental health clients in the Emergency Department, the second is a new proposed district procedure entitled, "MLHD Clinical Care of people who may be Suicidal". It should be noted that this latter document referred to other revised policy documentation, not all of which is before the inquest. Parties have had the opportunity of commenting on this latest proposed policy.

158. The MLHD has demonstrated a serious intention to make changes to address issues raised by this inquest. It is however clear that the process is not yet complete.

159. The summary statement sets out in short form a number of changes said to be either made or intended within the Emergency Department of WWRRH. The majority of matters in the summary statement may be said to be statements of intent. With the exception of the draft proposed policy, those matters were either yet to be reflected in policy documentation, or reflected a restatement of current policies and procedures. That being said, some tangible stated changes should be noted, in particular:

1. Changes to medical records such that the notes of the Community Mental Health team are now kept electronically and can be accessed by Emergency Department staff. This should facilitate better information for those making assessments of patients in the Emergency Department.
2. The insertion of an alert on the electronic medical record notifying staff of the previous nomination of a designated carer. This should assist in involving carers in the assessment and/or discharge process.
3. Additional training of staff on discharging patients into the community.

160. In addition, the summary statement refers to a number of liaison meetings, and meetings within the Emergency Department, regarding issues facing mental health clients in the Local Health District.

161. In relation to the proposed procedure "Clinical Care of people who may be Suicidal", the matters set out on page 4 under the heading "Common

Guiding Principles for all MLHD staff" provides a very comprehensive outline for all staff. In particular at c):

> *"Every person identified with possible suicidal behaviour including those presenting with self-harm who comes into contact with the MLHD, regardless of the facility or setting,* ***must*** *be referred to the Mental Health Service, and must have a comprehensive mental health assessment, including a detailed suicide risk assessment, psychological assessment and management plan."*

162. However, as was identified during the inquest, ambiguity and complexity is to be avoided, to ensure that there are not differences in interpretation. At page 7 of the proposed procedure, immediately under the heading, "Care of people who may be suicidal within a MLHD Facility or ED", the following is stated:

> "ED and MLHD Facility clinicians have a responsibility to ensure the following groups receive a comprehensive mental health assessment prior to discharge:
> - Referrals to ED for suicidal ideation/behaviour (Including those presenting with self-harm) or;
> - at risk of serious harm to self or others and/or;
> - presenting under the auspice of the Mental Health Act."

163. This is a significant change from the current policy. However, the full effect of this statement cannot be assessed. Immediately following this paragraph at a), it is stated that in relation to persons presenting to the Emergency Department "with possible suicidal ideation or behaviour", Emergency Department clinicians are required to follow the MLHD Mental Health Emergency Consultation Service Procedure 2017. This procedure has not been provided. I also noted that this expression of mandatory referral for comprehensive mental health assessment, has not been incorporated into the flow chart on p. 3 of the proposed procedure.

164. I also note that paragraph d) on page 8 still appears ambiguous in its wording, which states:

> *"where a person is identified as having suicidal ideation and/or behaviours whilst admitted to a MLHD facility the clinician must follow the MHECS policy and procedure and ensure that the consumer is reviewed by medical officer where available, assessed by MHECS as soon as possible and referred to the community Mental Health Team for daily follow-up and/or as part of discharge planning"*

165. A problem highlighted in the evidence at the inquest was the ambiguity perceived by those working in the hospital about the need to refer to MHECS in emergency where there is any risk of suicide. The procedure to be followed in emergency should be simple, clear and unambiguous in keeping with the MLHD's own words at page 4, paragraph (c) of the proposed procedure, which are set out at [161] above.

166. Sub section (e) on page 8 again provides clear description of what process needs to happen upon leaving ED but the policy must be explicit as to whom this subsection applies, i.e. persons at any risk of suicide.

167. The new policy is general, and not specific to emergency. It seems clear that the emergency department should have its own simple, clear policy, given the emergency department is such a unique department within the hospital. It appears that the policy should be being simplified, rather than becoming more complex.

168. There has been a revision of Appendix 5 (discharge form, extracted above). The new document "Mental health Discharge Plan" is simple and clear to read. It still suggests the plan is one made in conjunction with the hospital medical officer and MHECS, which may suggest it is only for use in MHECS referrals which assumption was part of the difficulty in this instance. The form has also removed the section providing space for "further information and coping strategies" which given the complexity of each case may detract from its value. I assume that this is the new proposed form and is not yet in use, although there is no evidence before the inquest on this issue.

169. Also absent from the proposed procedure is a clear expression of who has ultimate responsibility to ensure that required steps (such as those relating to discharge) have been completed. The need for such clear processes was made apparent in AB 's case.

170. The purpose of a policy is that all staff are aware of it, and there is a simple procedure to be followed. That provides for maximum opportunity for any errors to be corrected if all staff are involved. For instance, in AB 's case when she asked to leave the unit the staff should now be in a position to ask a few simple questions, such as where is your discharge plan do you have one? Is anyone here with you? Why don't you wait while we call someone for you?

Recommendations

171. Whilst some changes have been made to practice at the WWRRH, and significant changes to relevant policies are clearly in train, it is my view that there remains a need for recommendations.

172. Current policies are not being implemented in relation to assessment of patients at risk of suicide. The policy of MLHD in relation to the assessment of patients presenting to an emergency department with any risk of suicide provides that a referral to MHECS should occur as part of the assessment process. Staff should be trained to ensure this is occurring.

173. There also appears to be ambiguity in the interpretation of the policy in relation to mandatory referral to MHECS, where a risk of suicide is identified. The policy ought to be written in plain language to reflect that individuals presenting to an emergency department with any risk of suicide should be referred to MHECS for assessment.

174. Further, when a patient presents to an emergency department on a Schedule pursuant to the *Mental Health Act*, they should also receive a referral to MHECS for assessment. A policy should be developed in plain language to reflect this.

175. Current policy is also not being followed in relation to discharge of mental health patients in the emergency department. In accordance with current policy it must be ensured that discharge management plans for future care are formulated in writing and provided to the patient at the time of discharge (in terms of Appendix 5 or the equivalent), regardless of whether or not they are assessed by MHECS. Any revised policy should make this clear.

176. The discharge management plan requires in certain cases for future appointments to be made for the patient and follow up to occur. Procedures should be put in place to ensure these appointments are being made when required.

177. Discharge policy for any mental health patient with any risk of suicide should include an attempt to arrange family or other support at the time of discharge. This should include a request to any patient who is being discharged as to whether a support person can be contacted on their behalf. The discharge policy should be amended to clearly reflect this.

178. Finally, the current policies have no clear delineation of whose ultimate responsibility it is to ensure that processes, in particular those relating to discharge, have been followed. This should be addressed in any revised policy.

179. Whilst the draft revised policy seeks to address these matters in part, in my view it has not achieved clarity, and further work in this regard is needed. I also note that the draft policy is yet to be implemented, and at this time other revised policies referred to have not been provided.

180. For these reasons, pursuant to s. 82 of the *Coroners Act* 2009, I make the following recommendations to the Chief Executive Officer, Murrumbidgee Local Health District:

1. The policies and procedures relating to persons presenting at the Emergency Department with a risk of suicide be reviewed, in particular to provide for the following:

    i. Any persons presenting to the Emergency Department with any risk of suicide, or under the auspices of the *Mental Health Act,* must be referred to MHECS for comprehensive mental health assessment.

    ii. Discharge management plans must be formulated and documented prior to discharge.

    iii. Discharge management plans for future care must be formulated in writing and provided to the patient at the time of discharge (in terms of Appendix 5 or the equivalent), regardless of whether or not they are assessed by MHECS.

    iv. Procedures should be put in place to ensure that appointments required by discharge management plans are made for the patient, and that appropriate follow up occurs.

    v. Any patient who is being discharged (or not admitted) must be asked whether a support person can be contacted on their behalf.

    vi. Simple and clear direction be included outlining the steps required to be followed in i – v above, including who is responsible for undertaking those steps and who is responsible for ensuring that all required steps have been followed prior to the patient's discharge.

2. All emergency staff be given training and support to understand the applicable polices, and steps taken to ensure that they are being implemented.

Closing remarks

181. AB was clearly a bright articulate young lady. AB 's own evidence in the form of her note and the text messages assisted the inquest in understanding the nature of her distress at the system which she experienced. Dr Ellis spoke in evidence a great deal about the need to work to alleviate distress in a patient, and it was distress that was evident in AB 's words.

182. AB 's family were present and participated in the inquest in an involved, quiet and dignified manner. They were a huge to support to AB in life, and she to them. Her sister provided the following words on behalf of the family about her:

> '*AB to me was the definition of a free spirit. She was eccentric and a free thinker, basically a flower child. She expressed herself through her poetry. Her words could change the way you see your darkest days. She was an artist. Her paintings and drawings brought beauty to every room.*
>
> *I'd give anything to go back and take away all the hurt that AB was feeling, to see her smile, to hear her laugh and to just merely be in her presence one more time."*

My deepest condolences extend to the family and friends of AB .

Findings

AB died between 2 June and 3 June 2015 at [redacted], Wagga Wagga, in the State of New South Wales, as a result of hanging, which was self-inflicted with the intention of taking her own life.

I close this inquest.

E C Kennedy

Coroner
Wagga Wagga

Date
7 August 2017