
**STATE CORONER'S COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Ahlia Raftery |
| **Hearing dates:** | 29 May to 31 May 2017 |
| **Date of findings:** | 9 June 2017 |
| **Place of findings:** | NSW State Coroner's Court, Glebe |
| **Findings of:** | Magistrate Derek Lee, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – self-inflicted death, adolescent mental health, psychiatric intensive care unit, Mater Mental Health Centre, transfer of care, patient observation levels, risk assessment, handover process, ISBAR, nurse-to-patient ratios, back-to-base pulse oximetry |
| **File number:** | 2015/84416 |
| **Representation:** | Dr P Dwyer, Counsel Assisting, instructed by Ms J Geddes (Crown Solicitor's Office)<br><br>Mr M Byrne (Mr Russell Lilly)<br><br>Mr N Dawson (Ms Chit Chit Than & Ms Loretta Steers)<br><br>Mr M Lynch instructed by Ms K Kumar (Hunter New England Local Health District)<br><br>Ms M Moody (Ms Lainie Drinkwater & Ms M Baxendale) |

**Non-publication orders:** Pursuant to section 74(1)(b) of the *Coroners Act 2009* I direct that the following material is not to be published:

1. The name of the patient referred to as [redacted] referred to in evidence during the inquest on 29 May 2017 and any information (including images) that might identify her.

2. The name of the patient referred to as [redacted] in evidence during the inquest on 31 May 2017 and any information (including images) that might identify him.

**Findings:** I find that Ahlia Raftery died on 19 March 2015 whilst she was a patient in the Psychiatric Intensive Care Unit of the Mater Mental Health Centre in Waratah NSW. The cause of Ahlia's death was neck compression due to hanging. Ahlia died as a consequence of actions taken by her with the intention of ending life.

**Recommendations:** **To the Chief Executive, Hunter New England Local Health District:**

1. *I recommend that the HNELHD amend any procedures and policies regarding the transfer of patients between mental health services and units to include a mandatory requirement that patients are not to be transferred without agreement from a patient's consulting psychiatrist or a member of a patient's medical treating team.*

2. *I recommend that the HNELHD provide specific targeted training to all mental health clinical staff in relation to any changes in patient care policies introduced since March 2015.*

3. *I recommend that the HNELHD provide ongoing periodic training to all mental health clinical staff in relation to the need for a holistic consideration of the needs of a patient in determining the level of observation that is to be afforded to a patient.*

4. *I recommend that the HNELHD provide increased and regular education and training to nursing staff within mental health units regarding completion of patient observation charts to ensure that observations are accurately recorded at the times that they are performed, and to avoid the practice of "block recording" where observations are recorded collectively and subsequent to the time of the actual observations.*

5. *I recommend that the HNELHD amend the Mental Health: Levels of Observation – Psychiatric Intensive Care Unit (PICU) policy issued on 31 July 2015 to ensure that clear instructions are given to nursing staff regarding the performing of observations day and night, and how observations should be performed in order to ensure the safety of patients.*

6. *I recommend that the HNELHD develop policies and procedures to clearly identify the roles and duties of incoming and outgoing nursing staff within mental health units during handover times. In particular, I recommend that any such policies and procedures clearly identify the nurse responsible for performing observations of patients that occur during handover times.*

7. *In the event that the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts is unsuccessful, I recommend that the HNELHD give consideration to independently conducting its own trial to access the acceptability and feasibility of using pulse oximetry units to continuously monitor inpatients in mental health intensive care units within the district.*

**To the NSW Minster for Health:**

1. *I recommend that a copy of these findings be forwarded to the Minister for Health for consideration in conjunction with the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts.*

2. *I recommend that the NSW Minister for Health give consideration to increasing nurse-to-patient ratios within the Psychiatric Intensive Care Unit of the Mater Mental Health Centre, Waratah to ensure that patient safety is not compromised.*

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## Introduction

1. Ahlia Raftery died just over a month after her 18th birthday. For the first 17 years of her life she had been a vibrant, energetic, intelligent girl with a passion for life and adventure and an unbreakable spirit. She had enormous love for her family and many friends and they, in turn, adored her. In the last 11 months of her life a debilitating mental illness cruelly took from Ahlia the things that she loved and cherished the most. Despite her own courage and strength of will, and the support of her family and friends, and the health care professionals who assisted her, Ahlia tragically took her own life on the morning on 19 March 2015. At the time Ahlia was a patient in an intensive care mental health facility where she was meant to have been kept safe from harm.

## Why was an inquest held?

2. A Coroner's function and the purpose of an inquest are provided for by law as set out in the *Coroners Act 2009* (the Act). All reportable deaths must be reported to a Coroner or to a police officer. One type of reportable death is what the Act describes as an unnatural death.[1] Usually an unnatural death means where a person has died from other than natural causes and some external factor has contributed to that person's death.

3. Ahlia did not die from natural causes which means that, according to the Act, her death was unnatural. However, Ahlia's death was unnatural for other reasons as well. Ahlia's death was unnatural because no parent should ever have to endure the anguish of losing a child, and never see them grow up, marry and have children of their own. Ahlia's death was unnatural because no younger brother should ever have to grow up without their loving and nurturing older sister, a sister who taught them how to count, how to write their name, and how to love. Ahlia's death was unnatural because no older brother should ever have to lose the chance to care for and guide their younger sister and to be denied the simple pleasure of being able to buy them their first drink in a bar. And Ahlia's death was unnatural because no 18 year old, with their entire life, aspirations and unfulfilled promise ahead of them, should have it taken away in such heartbreaking circumstances.

4. Once a person's death is reported to a Coroner, the Coroner has an obligation to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to fulfil his or her functions. A Coroner's primary function is to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it.

5. In Ahlia's case, ample evidence was gathered during the investigation following her death to allow the questions about her identity, her cause of death and when and where she died to be answered. The inquest was primarily focused on the manner of Ahlia's death. In other words, what happened in the last months, days and minutes of Ahlia's life and how did these events affect what occurred on 19 March 2015?

[1] *Coroners Act 2009*, section 6(1)(a).

6. In the course of investigating the manner of Ahlia's death several issues were identified. Many of these issues concerned the care and treatment that Ahlia received throughout her contact with a number of different child and adolescent mental health services administered by the Hunter New England New Local Health District (**HNELHD**). The coronial investigation gathered evidence about these issues from various mental health professionals directly involved in Ahlia's care in order to consider whether the care provided to Ahlia was adequate and appropriate. The investigation also reviewed a number of policies created by the HNELHD which governed the way in which treatment was given to Ahlia and how her care was managed. This review was done to also consider whether any aspects of the policies were deficient and, if so, whether they could be improved upon.

**Ahlia's life**

7. Ahlia's death was reported to the Coroner's Court in March 2015. This meant that by the time of the inquest in May 2017 Ahlia's name was well known to the police officers who investigated her death, to the lawyers who appeared at the inquest, and to myself. Despite Ahlia's name being familiar to all of us, and despite having read hundreds of pages in the brief of evidence about events surrounding the last 11 months of her life, none of us truly knew her. It is often the case that, apart from family members and friends, the people who participate in an inquest know very little about the person at the centre of the inquest. What little they do know has been gleaned from snippets of information found in the typically voluminous amounts of paper that are generated by the investigation into a person's death.

8. But this investigation is typically focused on things like times, dates, medical records, policies, reports and other cold and lifeless information. This information is gathered so that we may gain an understanding of the circumstances of a person's death. But it does very little to give us an understanding of that person's life. More significantly it does very little to give us an understanding of what the loss of that person's life means to those who loved that person the most. If we, as a society, value and cherish the preciousness of human life, and aim to ensure that preventable deaths are prevented, then an understanding of what a life lost truly means can only strengthen our resolve to achieve this aim.

9. That is why on the final day of this inquest the persons in the court room who did not truly know Ahlia were privileged to hear some incredibly heartfelt words spoken by Ahlia's parents, Kirstie and Michael, and by Ahlia's older brother, Adam. Their words were at times uplifting and, at other times, almost unbearably painful to hear. But that pain pales into insignificance when compared to the pain that they have experienced, are experiencing, and will continue to experience from Ahlia's loss. The courage which they showed was humbling. The dignity which they showed, in sharing treasured, private and painful memories, was admirable. And the words which they spoke were poignant and profoundly moving.

10. Ahlia's life and what she meant to those who loved her and knew her best cannot be summarised in a few brief paragraphs by someone who never had the honour of meeting her. But the lasting impression left from the words spoken by Kirstie, Michael and Adam is that Ahlia had an adventurous spirit which could not be contained, a sense of selflessness which had no limits, and a love for her family and friends which knew no bounds.

11. Ahlia's sense of adventure began at a young age. She loved camping and had a passion for snowboarding from the time she was introduced to the snow at age 3. That passion culminated

in Ahlia competing in snowboarding at interschool representative level. From there Ahlia also pursued other adventurous activities, such as motorbike riding, so much so that she was known to those closest to her as a daredevil with limitless energy and an infectious zest of life. Ahlia was also a talented sportswoman having played hockey for many years and performed gymnastics so as to attract the attention of high performance centres at the state level. Ahlia had a love for the outdoors and, in particular, the water. She was actively involved in her local surf lifesaving club and loved not only the beach lifestyle that this brought with it, but also the sense of community that it engendered.

12. Apart from her adventurous and sporting pursuits, Ahlia also had an artistic side. She was passionate about music, photography and cake decorating and had a genuine natural talent in these areas despite being self-taught. Adam described Ahlia's remarkable ability to discover and capture beauty in the most mundane of things. No doubt this was a reflection of the beauty of her spirit and soul.

13. Ahlia's sense of adventure and discovery meant that she loved to travel. One of the happiest times in Ahlia's life was in 2005 when her family had the opportunity to live in Cyprus for 6 months due to Michael's work commitments. That experience created many happy and lasting memories, and moments of joy, for Ahlia. Again, what Ahlia held dear was the bonds that she made with the people she met during her travels. It is unsurprising that Ahlia, with her warm and generous nature, was able to leave overwhelmingly positive and lasting impressions on the people that she met.

14. There is no denying that what mattered most to Ahlia were her family and wide group of friends. Many of them were present throughout the inquest: Ahlia's grandparents, her uncles and aunts, and her best friend, Johanna. Ahlia had much love to share with the most important people in her life and much delight to bring to them. But the person who Ahlia had the most love for and who brought the most joy to her life was her younger brother, Liam, who was only 4 years old when Ahlia passed away. Ahlia told Kirstie that she could not imagine loving anyone more than Liam. Ahlia was not only a big sister but a second mother to him. Liam loved Ahlia's cooking and loved watching movies with her, he joined her in many wonderful adventures that she created with the splendor of her imagination, but most of all they simply treasured the moments that they were able to spend with one another.

15. Ahlia was taken all too soon from the people and things she loved the most. She will never have the opportunity to see Liam grow up and to impart her sense of adventure in him; to enjoy university with her friends; to travel to Canada and live in a cabin in the woods as she had dreamed; to attend a music festival in Europe; to give Adam and Michael one last hug; or to simply share a moment with Kirstie, sitting, chatting, and looking out at the snow.

16. Whilst this has been only the briefest of glimpses into the wonderful, loving, kind-hearted and spirited person that Ahlia was, it has left an indelible mark. I am enormously grateful to Ahlia's family for their generosity and courage in sharing their private, beloved and most treasured of memories.

**Ahlia's history of care**

17. The last 12 hours of Ahlia's life were spent in the Psychiatric Intensive Care Unit (**PICU**) of the Mater Mental Health Centre (**the Mater**) in Waratah, near Newcastle. Although several

important events happened in these 12 hours, in order to obtain a full understanding of how Ahlia came to be in such an intensive and, for an 18-year old girl, frightening, setting, it is necessary to describe the previous 11 months of Ahlia's life in some detail.

***April 2014 to May 2014***

18. It is abundantly clear from the above that Ahlia was surrounded by a loving family and a close group of friends. Ahlia's life up until April 2014 had been much like that of any other teenager. She was in the final year of school and contemplating what her enormous future might hold. This makes the events of April 2014 and onwards even more tragic. At that time Kirstie observed what she later came to describe as a major turning point. Kirstie noticed that Ahlia began spending more and more time with her, and withdrawing from her previously active social life. Kirstie also noticed that Ahlia began making comments such as, "*I just don't enjoy anything anymore*", and, "*Nothing makes me happy*".[2] Concerned that Ahlia might be suffering from depression, Kirstie took her to see a local GP.

19. Ahlia saw Dr Joanne Noble, a GP with training in adolescent mental health, for the first time on 16 April 2014. Dr Noble assessed Ahlia and found that she had a number of features of depression (such as pervasive feelings of sadness, and low energy and motivation) and anxiety. Ahlia told Dr Noble that she had harmed herself in the past, and Dr Noble saw that Ahlia had superficial lacerations to her arm. Ahlia also said that she had been having suicidal thoughts, but that these had occurred impulsively and that she had no plans to act on them, and that she could guarantee her own safety. Dr Noble diagnosed Ahlia as suffering from an adjustment disorder with depression and prescribed her some antidepressant medication (Fluoxetine). Dr Noble also referred Ahlia to see a local psychologist at Headspace[3] for an assessment and to continue seeing a school counsellor. At the end of the session Dr Noble made arrangements to follow up with Ahlia on a monthly or bi-monthly basis.

20. In early May 2014 Kirstie received a call from Ahlia's school. They told Kirstie that Ahlia was so distressed that she could not make her way home safely on her own. When Kirstie went to pick up Ahlia a school counsellor recommended that she should take Ahlia to the John Hunter Hospital in Newcastle for a psychiatric assessment. Kirstie immediately took Ahlia to the hospital's emergency department where Ahlia was assessed and later admitted to the Nexus unit, the hospital's child and adolescent mental health inpatient unit. Ahlia spent about 3 weeks in the unit where she was diagnosed with depression and anxiety.

21. Following her discharge from the Nexus unit, Ahlia saw Dr Noble again on 21 May 2014. Ahlia said that she still had suicidal thoughts, but no plans, and said that thinking of her family prevented her from acting on these thoughts. Dr Noble revised her initial diagnosis from adjustment disorder to a diagnosis of mixed depression and anxiety.

22. During this period of time, Kirstie noticed that the quality of Ahlia's schoolwork and her ability to concentrate on her HSC studies declined dramatically. Kirstie discussed with the mental health professionals involved in Ahlia's care and Ahlia's school whether Ahlia should continue with her HSC studies. Despite her personal troubles Ahlia showed her determined nature and strength of character by insisting that she should continue studying. Ahlia's school was greatly

[2] Exhibit 1, page 158.

[3] The National Youth Mental Health Foundation which provides intervention youth mental health services to 12-25 year olds, along with assistance in promoting young peoples' wellbeing.

supportive and created a plan for Ahlia to complete her studies without her workload causing any adverse impact. Kirstie describes that being able to continue with school was of great comfort to Ahlia.

***First contact with the Child and Adolescent Mental Health Service***

23. Due to her recent admission to the Nexus unit Ahlia was referred to the Newcastle Child and Adolescent Mental Health Service (**CAMHS**) on 29 May 2014. This is an acute community-based mental health service available for young persons aged between 3 and 18, and provides both inpatient and outpatient support. As part of the referral process Ahlia met with Angela Becher, a clinical nurse specialist, on 6 June 2014. Ms Becher was Ahlia's allocated care coordinator and part of Ahlia's multidisciplinary team, which also included a clinical psychologist. Ms Becher's role was to provide case management for Ahlia and also therapeutic care when required.

24. Ahlia's parents were both present at her initial appointment with Ms Becher. This first assessment was designed to include a risk assessment for Ahlia, review safety planning for her and, in consultation with the multidisciplinary team, determine what ongoing care Ahlia required. Following the appointment a plan was made for Ahlia to be assessed by a CAMHS appointed psychiatrist to review her medication with a view to returning Ahlia back to the care of Headspace as she had developed a good relationship with one of the counsellors there.

25. On 15 June 2014 Ahlia and her family went through a traumatic and terrifying event. Ahlia drove herself to a nearby beach after having suicidal thoughts which crystallised into a plan to jump off a cliff. Whilst parked at the beach Ahlia called the Kids Helpline[4] and one of her counsellors. Swift intervening action was taken which resulted in Ahlia being taken to the emergency department at John Hunter Hospital where she was assessed but not admitted. This upset Ahlia and she absconded from the emergency department and made her way to a nearby overpass expressing thoughts of wanting to jump down onto the road below. Ahlia eventually returned to the emergency department where she remained until later being discharged into Kirstie's care.

26. Ahlia's next appointment with Dr Noble was on 18 June 2014. She told Dr Noble that Headspace could no longer be involved in her care as she was considered to be too high risk, and that she was waiting to see if CAMHS would take over her care. Ahlia also told Dr Noble that after the incident at the beach three days earlier she continued to have suicidal thoughts but that they were less intense. Ahlia said that she would not act on these thoughts because of the impact that this would have on her family and friends. However, Ahlia also told Dr Noble that her self-harming behaviour, in the form of superficial scratching and hitting herself, had returned and increased. Dr Noble changed the type of Ahlia's antidepressant medication and increased the dosage, and made a plan to review her the following week.

27. Dr Noble saw Ahlia again on 25 June 2014. At this time Ahlia told Dr Noble that her mood was flat and that she had ongoing daily suicidal thoughts. However, Ahlia indicated that these thoughts were less intense than previously and that it was easier for her to ignore them or distract herself from these thoughts. Ahlia also told Dr Nobile that she continued to self-harm.

28. On 15 July 2014 Ahlia met with Dr Wesley Rigg, a child and adolescent psychiatrist, as part of the assessment to determine whether CAMHS would take over Ahlia's care. Dr Rigg formed the view that Ahlia was suffering from Major Depressive Disorder. Although he found that Ahlia was

[4] A phone and online counselling service for young people aged 5 to 25.

severely depressed Dr Rigg did not consider Ahlia was at high immediate risk of suicide because she told Dr Rigg that she had recently been attending school and wanted to continue with her studies. Dr Rigg scheduled a follow up appointment with Ahlia 3 days later.

29. On 18 July 2014 Ahlia returned to see Dr Rigg and told him that she was feeling even more depressed, suicidal, and that she could no longer guarantee her safety.[5] Due to obvious concerns for Ahlia's wellbeing Dr Rigg recommended that Ahlia be urgently admitted to the Nexus unit at John Hunter Hospital for observation, treatment, and risk containment. Ahlia's mother took Ahlia to the Nexus unit where she was admitted and remained for about 3 weeks. During her admission to the unit, Ms Becher continued to be involved with Ahlia's care.

30. Following her discharge Ahlia saw Dr Noble again on 18 August 2014. Ahlia told Dr Noble that she continued to have panic attacks and feelings of sadness. Ahlia also reported that her suicidal thoughts persisted but that she had no plans or intention to act on them, even though her self-harming behaviour continued. Kirstie describes this period of time as being increasingly difficult for Ahlia as she was struggling to keep her anxiety under control. Kirstie found that Ahlia was becoming more and more isolated, having cut ties with many of her friends, and that she found it difficult to leave the house and go out in public.

31. Ahlia saw Dr Noble for a sixth and final time on 17 September 2014. By this time Ahlia's suicidal ideation had intensified but she told Dr Noble that she felt better on this particular day. Ahlia said that she had plans to finish her HSC and start the Newstep program[6] at the University of Newcastle where many of her friends would be. Ahlia also told Dr Noble that she was looking forward to the summer holidays.

***Admission to the Intermediate Stay Mental Health Unit***

32. Unfortunately Ahlia was readmitted to the Nexus unit in late October 2014 just before her HSC exams. She had been experiencing increasing suicidal thoughts and continued to struggle with her depression and anxiety. During this admission one of the registrars suggested a transfer to the Intermediate Stay Mental health Unit (**ISMHU**) located at James Fletcher Hospital in Newcastle. The ISMHU is a non-acute mental health facility which caters to patients with high needs for psychiatric recovery and rehabilitation which cannot be met by other services in the community.

33. Ahlia was later transferred to the ISMHU and, whilst there, Kirstie noticed an improvement in Ahlia's symptoms: she was reconnecting with her friends and didn't struggle as much with her anxiety. Ahlia was also focused on, and determined to finalise, her Newstep application for the following year.

34. On 14 November 2014 Ms Becher referred Ahlia to the Newcastle Mental Health Services - Rehabilitation Team (**NMHS-RT**). As Ahlia's 18th birthday was soon approaching (on 7 February) the intention of CAMHS was to transition Ahlia to an adult mental health service. Michelle Andrews, a psychologist, and Jessica Turnbull, an occupational therapist, met with Ahlia on 1 December 2014 for an initial assessment as part of this referral process. The purpose of the assessment was to see what Ahlia's goals were and to determine whether the NMHS-RT was suitable for her. Ahlia told Ms Andrews that she needed a service where she could talk to

[5] Exhibit 1, page 143.
[6] Newstep is a one-year foundation studies program designed for 19-20 year olds as a pathway between school and undergraduate study.

someone twice a week (and once per week "when things were going OK"[7]) and pointed out that she had not stayed with Headspace because they could only see her once every 3 weeks which was not enough.

35. As the NMHS-RT could not offer twice weekly contact over the long-term, Ahlia decided that they were unsuitable for her. Instead Ms Andrews recommended that Ahlia be engaged by the NMHS acute team and that she be referred to the Centre for Psychotherapy so that her diagnosis could be clarified. However this recommendation was overruled and a decision was made that the NMHS-RT could provide appropriate care for Ahlia. Due to Ahlia being referred late in the year and due to the closure of the NMHS-RT over the Christmas period, Ahlia did not see Ms Andrews again until 19 January 2015. In the meantime, Ahlia remained at the ISMHU and continued to see Ms Becher.

36. Over the Christmas 2014 period it appears that Ahlia's condition improved somewhat. She was given leave from the ISMHU so that she could travel with Kirstie to the Gold Coast to visit family. Although Ahlia had some anxiety beforehand about leaving the ISMHU, where she felt safe, Kirstie recalls that Ahlia enjoyed their holiday time and, in particular, enjoyed spending time with her cousins. When they returned to Newcastle Ahlia also returned to the ISMHU where she remained for several more weeks.

37. During the first half of January 2015 Ahlia was concerned about her financial situation and this was causing her stress and anxiety. However, by January 2015 Ahlia was feeling better. She was discharged from the ISMHU and began the Newstep program shortly afterwards. Kirstie describes Ahlia's demeanour as being much more positive during this time. Ahlia told Kirstie about her plans to finish the program and apply to study nursing, with the goal of eventually specialising in mental health nursing so that she could help other young people.

38. On 19 January 2015 Ahlia met with Ms Andrews so that an assessment could be conducted and a plan put in place to coordinate Ahlia's care. Arrangements were also made for Ahlia to see a doctor specialising in psychiatry so that a mental state and suicidality assessment could be performed. From this point on, Ahlia met with Ms Andrews typically on a weekly basis. During her meetings with Ms Andrews Ahlia spoke of a number of concerns which were adversely impacting her mental health: her multiple changes in care, financial concerns, anxiety about leaving school and getting behind in her university work, and having a close friend move away.

***Thursday 12 March 2015 and admission to the Psychiatric Emergency Care Centre***

39. In the month that followed Ahlia's wellbeing deteriorated considerably. She saw Ms Andrews for the last time on Thursday, 12 March 2015 and on that occasion Ahlia was in enormous distress. She was shaking and crying uncontrollably, hitting her head against a wall, and using her fists to hit her head and body.[8] Ahlia had been harming herself by cutting her leg and told Ms Andrews that she had persistent suicidal thoughts, most recently as the previous night when she thought she would go out and not return home. Ahlia also told Ms Andrews that she didn't know if she could keep herself safe that night, and that she felt the urge to jump off a cliff or lie in front of an oncoming train. Although Ahlia had previously told Ms Andrews about her suicidal thoughts during earlier meetings, this was the first time where had she expressed a plan, could not

[7] Exhibit 1, page 38.
[8] Exhibit 1, page 41.

guarantee her own safety once she left the appointment, and could not identify any strategy to reduce her distress.

40. The extent of Ahlia's distress obviously concerned Ms Andrews greatly and she spoke to Dr Diane Pennington, the Career Medical Officer in psychiatry at NMHS-RT. Ahlia repeated to Dr Pennington that she had recurrent suicidal thoughts and described considering different ways of how to act out these thoughts. Ahlia told Dr Pennington that she was unsure if she could continue to resist these urges and said that she didn't know if she would "be alive at the end of the week".[9]

41. Dr Pennington and Ms Andrews both agreed that Ahlia posed an acute increased risk to herself from self-harm and that she needed urgent hospitalisation. They suggested an acute psychiatric admission to the Mater. Ahlia was initially unsure about this suggestion because she was worried that, based on her past admissions, any improvement in her mental state would only be temporary. However, she eventually agreed that an admission would be helpful and explained that she felt at risk over the next few days as she was expecting to be alone, with her mother working and her brothers away. Ahlia agreed to allow Dr Pennington to call Kirstie who arrived a short time later. Kirstie drove Ahlia to the Mater where she was admitted to the Psychiatric Emergency Care Centre (**PECC**) at about 4:20pm.

42. Ahlia was admitted as a voluntary patient under the care of Dr Rahul Gupta, consultant psychiatrist. Ahlia was initially assessed by Dr Suraiya Moisey who found that there had been a worsening of Ahlia's mental health over a 2-weeek period which had been brought on by a number of psychosocial stressors.

***Friday 13 March 2015***

43. Dr Gupta first saw Ahlia at about 4:00pm on Friday, 13 March 2015. Ahlia reported increasing anxiety and suicidal thoughts and was unable to guarantee her own safety. Dr Gupta formed the impression that Ahlia was suffering from an adjustment disorder with mixed anxiety and depressive symptoms.[10] He decided to increase Ahlia's doses of Quetiapine (antipsychotic medication) and Lorazepam (a benzodiazepine used to treat anxiety disorders). Dr Gupta later spoke with Kirstie with a view to having her visit Ahlia later, and discussed the possibility of discharging Ahlia on Sunday night.

***Saturday 14 March 2015 and admission to the Lake Macquarie Mental Health Unit***

44. However, Ahlia's condition continued to rapidly worsen. At about 9:25am the following day, Saturday 14 March 2015, Ahlia was found by nursing staff hiding under a bedside table in her room and tying a shoelace around her neck. This incident prompted Ahlia's review by a psychiatry registrar and arrangements were made to transfer her to the Lake Macquarie Mental Health Unit (**LMMHU**), a separate ward also located within the Mater. This later occurred at about 2:00pm and Ahlia was admitted under the care of Dr Ashwinder Anand, the Neuropsychiatry Staff Specialist.

45. At about 11:30pm on Sunday 15 March 2015 Ahlia attempted to hang herself using the bed sheets in her room. Another review followed with Ahlia being subsequently seen by Dr Dina

[9] Exhibit 1, page 45.
[10] Exhibit 1, page 48.

Mahmood, the on-call psychiatry registrar, who ordered that Ahlia be placed on close observations. This meant that Ahlia had to be observed at a minimum of 15-minute intervals. Dr Mahmood also changed Ahlia's admission status from voluntary to involuntary and her medications were continued with a plan for Dr Anand and the treating team to review her on Monday morning.

***Monday 16 March 2015 to Tuesday 17 March 2015***

46. This review took place at about 10:00am on Monday, 16 March 2015 with Dr Anand and his team of Dr Heather Collyer (Psychiatry Registrar) and Dr Vanessa Lee (Resident Medical Officer). Due to Ahlia having been admitted to the LMMHU on a Saturday this was the first opportunity for the treating team to see Ahlia. Also part of the treating team but not present at this initial interview was Alyssa Champagne, a social worker. Ahlia was teary and distressed in the interview and Dr Anand described her as having a prominent sense of helplessness and hopelessness. Ahlia acknowledged that she was feeling suicidal but was unable to identify the reason for her feelings. When asked about her attempted hanging and how she felt compared to the previous night Ahlia said that she "feels the same".[11] She described her mood as flat but not particularly anxious, and said that she had last had a panic attack a few weeks ago.

47. Dr Anand and the treating team formed the view that Ahlia had active suicidal ideation and regarded her as a medium risk of self-harm. They decided to continue Ahlia's involuntary admission, restrict her leave, and, importantly, considered whether she should be transferred to the PICU for increased observations; in the meantime Ahlia remained on close observations. The team also made plans to liaise with Ms Andrews and to take further history by speaking to Ahlia's parents. This occurred when Dr Anand and Dr Collyer met with Michael later that day at about 11:05am.

48. The treating team discussed Ahlia during weekly ward rounds the following morning on Tuesday 17 March 2015. They decided on a plan to continue with close observations, take a further history from Kirstie, allow Ahlia to have escorted leave with her family and staff on hospital grounds, and to involve a psychologist to provide support for Ahlia and help her with anxiety management and distress tolerance.

49. Later at about 11:50am on the same day Ms Champagne met Ahlia and Kirstie. Ahlia asked if she could have internet access so that she could keep up with her university studies. Following this meeting, Dr Lee called Kirstie at about 1:30pm to take a history from her.

50. Dr Collyer reviewed Ahlia at 4:40pm later that afternoon. At this time Ahlia was crying and very distressed. She said that she felt helpless and hopeless and as the interview continued her distress worsened. When Dr Collyer left briefly to find a nurse to assist her, Ahlia ran towards the wall of the courtyard where the interview was taking place and punched it. Dr Collyer formed the view that Ahlia remained at the same level of risk (medium) of suicide as the previous day and developed a plan to continue with observations but to allow Ahlia to sleep in the ward lounge so that she could be seen by nursing staff at all times.

51. Following this interview Dr Collyer and Dr Anand again discussed the option of transferring Ahlia to the PICU. However they decided that if the nursing staff felt comfortable monitoring Ahlia in the LMMHU, it would be preferable for Ahlia to stay there as it provided a more

[11] Exhibit 1, page 61.

therapeutic environment for her. They also discussed the medication that could be given to Ahlia in case her level of distress continued to worsen. Up until that time Ahlia had only been given oral antipsychotic medication and medication to treat her anxiety. Dr Anand and Dr Collyer decided on a progressive care plan where if the oral medication failed to control Ahlia's level of distress then the use of intramuscular medication could be considered. If Ahlia continued to remain unsettled and distressed even after the use of the intramuscular medication, then consideration could be given to transferring her to the PICU.

***The morning of Wednesday 18 March 2015***

52. Ahlia woke up at about 7:45am on Wednesday 18 March 2015. She had been sleeping in one of the chairs in the lounge room. One of the nurses (RN Shantal Wells) in the LMMHU asked Ahlia if she could move from the lounge back to her own room because the lounge was a common area which needed to be used by the other patients in the ward. Ahlia returned to her room about 15 minutes later. Ms Wells subsequently checked on Ahlia in her room twice and noticed that each time Ahlia would quickly lie back down in bed. Concerned that something was amiss, Ms Wells asked Ahlia to pull down her bed sheets so that she could check under them. Ahlia refused. Ms Wells pulled the sheets down herself and discovered a bed sheet that had been made into a noose. Ms Wells removed the bed sheet and spoke with Ahlia for a short time to ensure that she was safe.

53. Later in the morning Ahlia went to the dining room for breakfast and Ms Wells saw that she was socialising with another patient. Despite the incident with the noose earlier that morning Ms Wells' felt less concern for Ahlia at this point in time as Ahlia was engaging with, and being reactive towards, other patients. Ahlia later took part in occupational therapy where she continued to engage and socialise with other patients, and mentioned that she was keen to return to the Newstep program and continue with her studies.

54. Dr Anand and the treating team saw Ahlia again at about 10:15am later that morning. Ahlia told them that she continued to express feelings of hopelessness and a desire to self-harm. She also said that the hospital was keeping her safe and that she "*definitely would have killed myself if I wasn't here*".[12] Ahlia also told them that whilst the medication she had been prescribed helped her mood, her suicidal thoughts remained the same. Ahlia asked how long she would be admitted for and said that she wanted to return to university before the mid-semester break.

55. Dr Anand found that Ahlia showed some slight improvement from when he last saw her on Tuesday afternoon even though there was no change to her suicide risk assessment. Dr Anand believed that Ahlia's risk to herself was still high based on her ongoing suicidal ideations and fluctuating levels of distress.[13] The treating team discussed a plan to commence Ahlia on a different type of antidepressant (Venlafaxine) and consider the use of electroconvulsive therapy (ECT) if Ahlia did not show any signs of improvement with the new medication. The team continued Ahlia's close observations and encourage her to take 30-minutes escorted leave on the hospital grounds with her mother. Ahlia was also encouraged to access her university work if possible.

[12] Exhibit 1, page 64.
[13] Exhibit 1, page 58.

***Admission to the Newcastle Mental Health Unit***

56. Approximately 2 hours later at about 12pm on 18 March 2015 Ms Wells was told that Ahlia was being transferred to the Newcastle Mental Health Unit (**NMHU**). This was another different ward in the Mater but on the same floor as the LMMHU. Ahlia was being transferred because hospital policy dictated that the ward that she was in had to match the area that she was from. That is, because Ahlia lived in the Newcastle region, and not the Lake Macquarie Region, this meant she had to be admitted to the NMHU. Neither Dr Anand, nor any member of his treating team, were told about the transfer or consulted about it prior to it occurring.

57. When Ms Wells told Ahlia that she was going to be transferred Ahlia became upset and said that she didn't want to change wards because she had made some friends in the LMMHU and felt comfortable there.[14] Ms Wells attempted to reassure Ahlia that the NMHU staff were nice and that she would make new friends there. Despite Ahlia's unhappiness about the transfer, arrangements were made for it to occur before 1:00pm.

58. Upon being transferred, Ahlia was admitted under the care of Dr Bipin Ravindran, consultant psychiatrist. RN Younwha Jeong, one of the nurses in the NMHU, was assigned to care for Ahlia. Dr Ravindran never saw Ahlia as her condition worsened during the evening of 18 March 2015 and she was transferred to the PICU. Had this not occurred Dr Ravindran would have reviewed Ahlia during ward rounds on the morning of 19 March 2015.

59. Instead, Dr Aryan Arghandrewal, the duty psychiatry registrar, reviewed Ahlia at about 6:21pm on 18 March 2015. Ms Jeong was also present during the review. Dr Arghandrewal found that Ahlia was dismissive and evaded his questions and that she did not engage with eye contact. Ahlia again expressed feelings of hopelessness and said that she had given up on life. Ahlia told Dr Arghandrewal, "*I will do it again, the same way I did it a few days ago, with a towel. There is no meaning left in life for me anymore*".[15] Ahlia rated her intention to kill herself as 8 out of 10 but would not say how she planned to do so or what she was planning.[16]

60. Dr Arghandrewal assessed Ahlia as being at very high risk of suicide and was alarmed at her mental state. He asked Kenneth Graham, the after-hours nurse manager, to make arrangements for Ahlia's immediate transfer to the PICU for close monitoring. Mr Graham informed RN Maria Baxendale, the nurse in change of the PICU of the proposed transfer at about 6:15pm and gave her a brief summary of Ahlia's diagnosis, her history, and recent self-harm attempts.

***Admission to the Psychiatric Intensive Care Unit***

61. The PICU is another ward within the Mater, on the same floor but separate to the LMMHU and NMHU. It is reserved for the most unwell patients requiring a high level of care. The PICU is comprised of 8 patient rooms along 2 corridors branching off from a centrally located nurses' station. The south corridor has 5 bedrooms and the west corridor has 3 bedrooms. Bed 1 in the south corridor is closest to the nurses' station (about 3 metres away) with bed 5 in the south corridor being the furthest away (about 20 metres away). There is also an activity room in the south corridor, and 2 lounges adjacent to the nurses' station along each corridor. Finally, there

[14] Exhibit 1, page 68.
[15] Exhibit 1, page 71.
[16] Exhibit 1, page 71.

are 2 seclusion rooms and a seclusion lounge in the ward. The seclusion rooms are typically reserved for clinical and behavioural emergencies; that is, when a patient's behaviour poses a serious and imminent risk of injury or distress to themselves or others.

62. At about 6:30pm Ms Jeong escorted Ahlia from the NMHU to the PICU. Upon their arrival Ms Baxendale introduced Ahlia to her allocated nurse, RN Loretta Steers, and gave Ahlia a brief orientation of the PICU. Ahlia was initially placed in bed 6 which was the only empty room at the time. Bed 6 is located in the west corridor, being adjacent to the lounge and the closest bedroom in that corridor to the nurses' station. However Ms Baxendale later decided to move Ahlia to Bed 3 in the south corridor which was closer to, and more visible from, the nurses' station. When Ms Baxendale asked Ahlia if she understood why she had been moved Ahlia replied, "*I don't know why. I told the doctor I was suicidal but I'm always suicidal*".[17] When asked if she was feeling more suicidal than previously Ahlia said that she was "*no different than usual*".

63. From the time of her arrival in the PICU until the nursing staff changeover from afternoon to night shift, Ahlia appeared mostly settled. Ms Steers describes Ahlia as appearing calm and that that she was engaging with nursing staff and showed no signs of agitation, anxiety or immediate risk of self-harm. At about 9:00pm Ms Steers spoke to Ahlia who rated her thoughts of self-harm as 7 out of 10.[18]

***Night shift in the Psychiatric Intensive Care Unit***

64. Ahlia arrived in the PICU during the nursing afternoon shift which was due to end at 11:00pm. Shortly before this time the night shift nursing staff began arriving in the PICU. RN Lainie Drinkwater was the nurse in charge of the night shift. Upon her arrival she and Ms Baxendale discussed whether they should move Ahlia from Bed 3 to Bed 2 in order to bring her closer to the nurses' station. However, at the time Bed 2 was occupied by a psychotic patient who had a history of not sleeping well, but who was asleep at that time. Because of this Ms Drinkwater and Ms Baxendale decided not to disturb this patient and instead discussed moving Ahlia's bed into the seclusion area so that she could be more visible. This in itself was not an ideal solution because if a new patient was admitted, or if the seclusion area was required urgently, Ahlia would be disturbed. As neither option was satisfactory they decided to keep Ahlia in Bed 3.

65. During the night, Ahlia was mostly asleep but woke on two occasions. The first time was at about 3:00am when she was woken by Ms Drinkwater when she was performing a routine round check. Ms Drinkwater reassured Ahlia and encouraged her to go back to sleep which she did. Ahlia woke again a short time later at about 3:50am. She went to the patient lounge where she asked RN Linda Garthwaite, one of the night shift nurses, for a drink of water. Ms Garthwaite gave Ahlia a drink and saw that she appeared calm. Ms Garthwaite did not see any signs that Ahlia was considering self-harm, or that she appeared distressed or anxious.[19] Ms Garthwaite asked Ahlia if she could do anything else for her and Ahlia indicated "*just the water*" before returning to her bed.

[17] Exhibit 1, page 80.
[18] Exhibit 1, page 90.
[19] Exhibit 1, page 103.

***The morning of Thursday 19 March 2015***

66. The night shift was scheduled to end at 7:00am on Thursday, 19 March 2015. The routine in the PICU at the time was that the first nurse from the incoming morning shift to arrive was to perform a drug count with one of the nurses from the outgoing night shift.[20] This was to ensure that all the drugs of dependence were properly accounted for. On 19 March 2015 the first nurse from the incoming shift to arrive was RN Chit Chit Than. After arriving in the ward shortly before 6:45am Ms Than performed the drug count with Ms Garthwaite until about 6:50am. RN Stephanie Briggs, another one of the incoming morning shift nurses, arrived in the ward at about 6:45am and saw Ms Than and Ms Garthwaite performing the count.

67. Mr Russell Lilly, the nurse unit manager for the morning shift, arrived in the ward at about 6:50am. He went in to the nurses' station to begin the handover process from the night shift and to assign the morning shift nurses to patients in the ward. RN David Moate, another one of the incoming nurses, also arrived in the ward at about 6:50am. Whilst testing a duress alarm Mr Moate saw Ahlia's silhouette behind the door to Bed 3.

68. The handover began at about 6:55am. During the handover Ms Drinkwater informed the incoming nurses that Ahlia had been transferred from the NMHU. She explained that Ahlia was on close observations after voicing suicidal ideation and that the NMHU staff had formed the view that Ahlia could not be safely managed in that ward.

69. During the handover several of the nurses in the nurses' station could see Ahlia near the door to her bedroom. Ms Drinkwater said that she saw Ahlia standing just beside her bedroom door in the corridor and that Ahlia stood in this position until about 7:00am. Ms Drinkwater said that she then saw Ahlia intermittently move behind the door, and step out again, to check on activity within the nurses' station. At 7:05am Mr Moate saw Ahlia in the same position as when he had last seen her at about 6:50am; to Mr Moate it appeared that Ahlia had not moved. Both Ms Than and Ms Briggs also saw Ahlia standing behind the door to her room during the handover. Ms Briggs recalls that the lights in the patient area had not yet been turned on and that the south corridor was dark because of this and also because of daylight savings. At the end of the handover Mr Lilly allocated Ahlia to Ms Than as one of the two patients she was to care for during her shift. As Ahlia was scheduled to have breakfast soon in the ward's dining area, Ms Than and Ms Briggs discussed a plan to lock Ahlia's door whilst she was at breakfast. This was so that Ahlia could be kept out of her room and kept in the ward's common areas where she could be more closely observed. [21]

70. The handover ended at about 7:05am. Ms Than and Ms Briggs remained in the nurses' station to deal with enquiries from some patients who had been lingering near the station during the handover. Mr Lilly left the station in order to prepare for blood to be collected from patients as a blood collector was due to arrive at 7:10am. As he did so Mr Lilly passed by Ahlia's room and did not see her near the door.[22] However, Ms Than said that when the blood collector arrived at about 7:10am she saw that Ahlia was still standing by her door.[23] Ms Than saw Ahlia again at about 7:15am, as part of the 15-minute close observation intervals, and noticed that she was standing by the door with half of her face and half of her body visible. Mr Lilly took blood from 3 patients, one of whom was in Bed 2 (the room next to Ahlia's), and finished at around 7:20am. As

[20] Exhibit 1, page 117.
[21] Exhibit 1, page 108.
[22] Exhibit 1, page 108.
[23] Exhibit 1, page 117.

he returned to the nurses' station Mr Lilly passed by Ahlia's room again and did not see her there.

71. At about 7:25am, RN Alex Mapika, another one of the morning shift nurses, was in the process of taking a blood pressure machine from the nurses' station to the common area in order to check a patient's vital signs. Mr Lilly, Ms Than, Ms Briggs and Justin Steel, an occupational therapist, were all in, or in the immediate vicinity of, the nurses' station at the time. As Mr Mapika left the station one of his assigned patients ran towards him shouting, "Come and see this quick, quick".[24] Mr Mapika ran to bed 3 where he saw Ahlia hanging from a bed sheet that had been tied around her neck at one end and tied in a knot around the outside door handle at the other.[25]

72. Within seconds Mr Lilly, Ms Briggs, Ms Than and Mr Steel arrived at Ahlia's room. Mr Lilly, Mr Steel and Ms Than helped Mr Mapika lift Ahlia up and placed her on the ground. Mr Lilly untied the bed sheet from around Ahlia's neck and immediately began cardiopulmonary resuscitation (**CPR**). Mr Lilly instructed his staff to initiate a code blue (a medical emergency) and called for a trolley to move Ahlia to the emergency department. Mr Mapika left to retrieve an oxygen tank whilst other staff arranged for the trolley. Ms Than noticed that Ahlia's hands and feet were blue and her arms were a mottled colour. Ms Than felt for a pulse and could not find one. Justin Delaheras, the nurse manager of the PECC unit, who had been made aware of the code blue arrived soon afterwards and took over CPR from Mr Lilly.

73. Once the trolley arrived Ahlia was rapidly taken to the emergency department whilst attempts to revive her continued. Emergency department staff continued with advanced life support measures for more than 40 minutes. However Ahlia did not respond to the resuscitation efforts and did not show any signs of life. Dr Brett Squires, an emergency medicine specialist, examined Ahlia at about 8:00am and found that Ahlia had no pulse or respiration. Dr Squires later pronounced Ahlia to be life extinct at 8:11am.

**What was the cause and manner of Ahlia's death?**

74. Ahlia was taken from the Mater to the Department of Forensic Medicine in Newcastle where Professor Tim Lyons, Clinical Director, performed a postmortem examination on 23 March 2015. Professor Lyons noted that Ahlia had pressure abrasion marks on the front and sides of her neck and concluded that the cause of Ahlia's death was neck compression due to hanging.

75. Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence. Taking into account Ahlia's history of persistent suicidal thought, past self-harming behaviour and attempts at self-harm, as well as the circumstances in which she was discovered on 19 March 2015, I conclude that the evidence is sufficiently clear, cogent and exact[26] to reach the following conclusion: Ahlia died as a consequence of actions taken by her with the intention of ending her life.

[24] Exhibit 1, page 128.
[25] Exhibit 1, page 125.
[26] *Briginshaw v Briginshaw* (1938) 60 CLR 336.

**Issues examined by the inquest and a Coroner's power to make recommendations**

76. It has been necessary to provide a detailed chronology of Ahlia's history of care and her interaction with various mental health care personnel so that the issues which the inquest examined may be properly understood. Despite the fact that Ahlia received a high standard of care at various times during the last 11 months of her life, the coronial investigation identified a number of specific shortcomings in Ahlia's care and areas which suggested that there is scope for improvement in general mental health care.

77. From a Coroner's perspective, the power to make recommendations which might lead to such improvement is an extremely important one. This power is provided for by section 82 of the Act. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

78. The coronial investigation into the death of a person is one that, by its very nature, involves much grief and anguish. The emotional toll that such an investigation, and any resulting inquest, places on families and friends of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings or failures, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify them not to assign blame or fault but, rather, so that lessons can be learnt from mistakes and so that, hopefully, these mistakes are not repeated in the future. The mere assigning of blame or fault rarely produces a positive outcome and often only serves to add to the anguish that a family member may be experiencing. If families of deceased persons must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be some hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

79. In this inquest Dr Josephine Anderson[27], an independent expert specialising in child and adolescent psychiatry, was engaged to examine a number of different aspects of Ahlia's care and provide a report for the Court. Dr Anderson's report raised a number of matters which shaped the issues which the inquest examined. Those issues can be summarised as follows:

    (a) Whether Ahlia received appropriate care and treatment in the community from the CAMHS;

    (b) Whether the various transfers of care between different mental health care wards was appropriate, and whether this adversely impacted Ahlia's wellbeing;

    (c) Whether those responsible for caring for Ahlia during her various admissions did so adequately and appropriately in response to the risk that Ahlia posed to herself;

    (d) Whether any physical and environmental factors in the wards where Ahlia was admitted contributed to her death; and

    (e) Whether any changes and improvements have been made since Ahlia's death to improve patient care and safety.

[27] Conjoint Associate Professor in Psychiatry at the University of New South Wales and Clinical Director of the Black Dog Institute.

80. Prior to the inquest the HNELHD, as the entity responsible for Ahlia's overall care, was invited to consider and address this last issue. A response was provided in the form of two statements prepared by Dr Marcia Fogarty, a consultant psychiatrist and Executive Director for Hunter New England Mental Health. In her statements Dr Fogarty made the forthright concession that the HNELHD had failed Ahlia in a number of respects.[28] The frankness shown by Dr Fogarty and her willingness to use the failings as a catalyst to improve the general care provided to mental health patients within the HNELHD is to be commended.

81. The failures identified by Dr Fogarty, and others, will be discussed in detail below. Where necessary or desirable, recommendations have been made in the hope that these failures are not repeated and so that improvements to patient safety can be made.

**Did Ahlia receive appropriate care from the CAMHS?**

82. The evidence establishes that from the time that Ahlia was referred to CAMHS in May 2014 up until her referral to the NMHS-RT in November 2014 she was provided with supportive care of a high standard. Throughout Ahlia's admissions to the Nexus unit and the ISMHU, Ms Becher maintained continuity of care with Ahlia. As Ms Becher explained in evidence it was important for her to continue building on the rapport she had established with Ahlia even when she was in hospital.

83. Ahlia's parents were present during Ahlia's first meeting with Ms Becher in June 2014. Unfortunately the meeting did not go well and there were no further combined meetings with Ahlia and her parents during Ahlia's time with CAMHS. In her report Dr Anderson noted that "*family therapy is frequently indicated in the work of child and adolescent mental health services and is a core competency for all CAMHS clinicians*".[29] Dr Anderson also noted that a recommendation had been made for family therapy (through an organisation such as Relationships Australia) but this unfortunately never took place.

84. Ms Becher explained in her evidence at the inquest that the degree of involvement that family members have in the care of a young person is typically dictated by the young person's wishes. Some are more desirous of family involvement than others and there is often a difficult balance to be struck between respecting the wishes and privacy of a young person, and informing families of any concerns and risks. Ahlia's case was complicated by the fact that there was initially some disharmony between her parents, and between Ahlia and Michael. This disharmony added to Ahlia's anxiety and was a stressor for her. Furthermore, in the second half of 2014 Ahlia went through various stages of crisis: she was involved in the frightening incident at the beach in June 2016 and she had a number of admissions to both the Nexus unit and the ISMHU. I accept that arranging for family therapy during this period of time would have proved to be challenging.

85. However, since Ahlia's death there has been recognition on the part of CAMHS regarding the benefits of family therapy. Ms Becher explained that since 2016 there has been an even greater emphasis on involving families of young persons as part of the care process. Even if there are difficulties in involving families directly when meeting with young persons, steps can be taken to involve families separately as part of a multidisciplinary approach.

[28] Exhibit 1, page 1325.
[29] Exhibit 1, page 1381.

86. In November 2014 Ms Becher referred Ahlia to the NMHS-RT in anticipation that Ahlia would soon be turning 18 and transitioning to care provided by an adult mental health service. Ahlia was obviously nervous and anxious about the transition but recognised that it was necessary.[30] Ahlia was comforted by the fact that her contact with CAMHS would continue during this period and Ms Becher explained in evidence that if she had been asked to see Ahlia after the transition or even after she was admitted to the Mater, she could have done so.

87. Although there is no evidence to suggest that the transition process had a direct adverse consequence on Ahlia's well-being, there has been recognition by HNELHD that this process can be improved in order to minimise the distress that it might cause to affected young persons. A local procedure[31] was implemented in August 2016 to address some of these issues. Specifically, the new procedure acknowledged a number of factors that should inform the transition process:

    (a) age alone should not be the sole criteria governing transition;

    (b) flexibility is required;

    (c) the timing of transfer should consider developmental, social and education factors;

    (d) transition planning should begin 5 months before transition;

    (e) the young person and their family (where appropriate) will be involved in all stages of planning; and

    (f) there will be a 3-month handover process from child and adolescent to adult services.[32]

88. Taking all of the above into account, the evidence establishes that the care provided to Ahlia by the CAMHS was appropriate. Furthermore, appropriate action has been taken to ensure the wellbeing of patients during the transition process from youth to adult mental health services.

**Were Ahlia's various transfers between different wards in the Mater appropriate?**

89. During her entire admission at the Mater Ahlia was either admitted or transferred 4 times in the span of 5 days. The shortest time she spent in one ward was only some 5½ hours.

90. Most of these transfers were necessary because of rapid and unexpected deteriorations in Ahlia's condition and Dr Anderson considered most of them to be reasonable.[33] However, the evidence establishes that the transfer from the LMMHU to the NMHU on 18 March 2015 was neither necessary nor reasonable. It is clear that this transfer occurred solely because of where Ahlia lived. That is, because Ahlia was from the Newcastle (and not the Lake Macquarie) region, she had to transferred to the ward that matched her geographical region. The decision to transfer was not made by any member of Ahlia's treating team but by a bed manager responsible for the administrative allocation of patients to wards.

[30] Exhibit 1, pages 980-981.
[31] Titled Mental Health: The Transfer of Young People from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS), MH_LP_1.202.01.
[32] Exhibit 1, page 1329-1.
[33] Exhibit 1, page 1370.

91. The policy which necessitated Ahlia's transfer was sound in principle. As Dr Fogarty explained in her evidence doctors perform part of their work in hospital wards and part of their work within the community. The rationale behind matching patients to their geographic location is that doctors who see patients in hospital will be able to follow up with those same patients once they have returned to the community. However rigid adherence to policy should not be permitted to override the welfare of a patient and what, therapeutically, is in their best interests. This was frankly acknowledged by Dr Fogarty in evidence. As Dr Anderson explained, "*Discharging or transferring a patient always has clinical implications and the wellbeing of the patient concerned should be paramount in making this decision*".[34]

92. The transfer from the LMMHU to NMHU was inappropriate for a number of reasons:

(a) By the time of her transfer Ahlia had spent almost 4 days in the LMMHU. This was by far her longest admission to any ward in the Mater, with the combined total time of her admissions to the other 3 wards being only some 1½ days. During this period Dr Anand and the treating team had spent considerable time building a rapport with Ahlia, taking a comprehensive history from her and her family, and had carefully considered various options about how to best manage her care. Ahlia's transfer to the NMHU effectively meant that the encouraging progress made by Dr Anand and his team was eroded.

(b) Ahlia required time to build trust with a treating team and engage with them. Dr Anderson explained that this engagement and trust "*was a vital component of effective treatment of a young woman with Ahlia's history and diagnoses*".[35] Ahlia's transfer eliminated the trust that she had built with Dr Anand and his team and Ahlia never again had the opportunity to build a similar trust with another team.

(c) When Ahlia was told about the transfer she became visibly upset and said that she wanted to stay in the LMMHU where she had made friends and felt comfortable.

(d) Ahlia's condition rapidly deteriorated following the transfer, resulting in her admission to the PICU. This admission occurred after Ahlia had spent only about 5½ hours in the NMHU. This is significant because Dr Anand and his team had already, on the morning of 16 March 2015 and the morning of 18 March 2015 (only a matter of some 2 hours before Ahlia's transfer), considered a possible transfer to the PICU and decided that it was not warranted.

(e) Dr Anand and his team had already put in place a progressive plan of care for Ahlia so that, effectively, admission to the PICU was only considered as a last resort in the event that all other treatment was unsuccessful.

(f) The PICU itself was not a therapeutic environment for Ahlia. Dr Anderson noted that it was "*likely to be a scary place for a young person new to the adult mental health system*".[36] Although Ms Baxendale explained in evidence that it was common to have patients of Ahlia's age and younger in the PICU Ms Baxendale also said that she would not want her own child to be there, describing it as an "*intimidating environment*" where many patients are psychotic, aggressive, and drug affected. At the time of Ahlia's admission to the PICU there were 7 other patients in the ward. Two of the patients were described as being psychotic

[34] Exhibit 1, page 1379.
[35] Exhibit 1, page 1362.
[36] Exhibit 1, page 1371.

with a history of aggression with one having a criminal history involving a charge of manslaughter. A third patient was described as suffering from schizophrenia with a history of extreme aggression.

(g) During her time in both the LMMHU and PICU Ahlia was placed on the same observation level category, that is, at a minimum of 15 minute intervals. However, it appears that the observation level within the LMMHU was in practice higher because Ahlia slept on the couch in view of the nurses' station, a place where she had identified that she felt safe.[37]

(h) Finally, neither Dr Anand nor any member of his treating team were told of, or consulted about, the proposed transfer prior to it occurring. Given the need to ensure that the wellbeing of a patient should be paramount in any decision to transfer Dr Anderson argues that the patient's consultant psychiatrist should be informed of, and approve, the transfer.

93. In January 2017 the HNELHD introduced a new policy[38] which provided that a patient's geographic location will no longer be the sole determining factor governing their transfer between different inpatient units. The new policy now specifically provides that factors such as a patient's engagement with their current treating team and the proximity of their discharge may suggest that it would not be in the best interests of the patient to be transferred solely for geographic reasons.[39]

94. Whilst this is obviously an important improvement, Dr Fogarty agreed in evidence that Dr Anderson's argument has merit. That is, as Dr Anderson noted in her report, "*it is not good practice for patients to be transferred without the knowledge or indeed the agreement of the consultant psychiatrist who is responsible for the patient's care*"[40] The policy introduced in January 2017 referred to above does not yet provide for such a requirement. It seems clear that a patient's consultant psychiatrist (or a member of the patient's treating medical team) will be the person best placed to determine whether a transfer is in the best interests of the patient and their wellbeing. In my view, the transfer policy should be amended to reflect this.

95. **RECOMMENDATION 1:** *I recommend that the HNELHD amend any procedures and policies regarding the transfer of patients between mental health services and units to include a mandatory requirement that patients are not to be transferred without agreement from a patient's consulting psychiatrist or a member of a patient's medical treating team.*

**Were there any deficiencies in the communication of relevant information about Ahlia between nursing staff?**

96. Generally speaking, ISBAR is a mnemonic created as a communication tool to improve safety in the transfer of critical information in clinical handovers. It refers to Identification, Situation, Background, Assessment and Request. It is used widely in health care settings to ensure that relevant information about a patient and their history is communicated when there is a handover of care from one care provider to another.

97. At the time of her transfer to the PICU Ahlia had been involved in 3 significant self-harm attempts: she was found tying a shoelace around her neck on 14 March 2015 (**the shoelace**

[37] Exhibit 1, page 1363.
[38] Mental Health: Transfer of Care – Into, Within and From Mental Health Services, PD 2016_056: PCP 1.
[39] Exhibit 1, page 1329-2.
[40] Exhibit 1, page 1362.

**incident**), she attempted to hang herself using her bed sheet on 15 March 2015 (**the attempted hanging**), and she was found to be secretly making a noose from a bed sheet on 18 March 2015 (**the noose incident**). Although each of the incidents were recorded in Ahlia's progress notes, none of them were recorded on any of the ISBAR Handover Transfer Forms that accompanied each of Ahlia's 3 subsequent transfers after 14 March 2015.[41]

98. When Ahlia was transferred to the PICU Ms Jeong told Ms Steers about the noose incident but made no mention of the shoelace incident.[42] Despite all 3 incidents being recorded in Ahlia's progress notes, the evidence indicated that Ms Baxendale was only aware of the noose incident (having been told about it by Mr Graham) and that it was only possible that she was aware of the shoelace incident.

99. After Ahlia's arrival in the PICU, Ms Baxendale entered Ahlia's details on a handover sheet. This is an electronic summary of relevant matters relating to a patient that can be updated by nursing staff throughout the course of a shift. At the conclusion of shift it can be printed so that the information entered onto it can inform the handover process to the incoming shift. None of Ahlia's 3 previous self-harm attempts were recorded on the handover sheet.[43]

100. On one view it is therefore not surprising that no mention of the 3 previous self-harm attempts was made during the handover from afternoon to night shift. Ms Drinkwater, the nurse in charge of the night shift, explained in evidence that she was aware of both the attempted hanging and the noose incident, but not the shoelace incident. However, she only gathered this information after having an opportunity to review Ahlia's progress notes during the course of the night.

101. Although Ms Drinkwater acquired this information it appears that it was inconsistently conveyed to other nursing staff. Both Ms Garthwaite and RN Graeme Davies[44], another one of the night shift nurses, said that they were aware of the shoelace incident and the attempted hanging, but were unaware of the noose incident. During the handover from night to morning shift Ms Than said that she was unaware of the attempted hanging and noose incident but that it was possible she was told about the shoelace incident.

102. All of the nurses who gave evidence at the inquest (Ms Baxendale, Ms Steers, Ms Drinkwater, and Ms Than) agreed that a comprehensive history of any previous self-harm attempts by a patient was important and that such information should have been conveyed during each handover. They all also agreed that having such information would have heightened their awareness and concern regarding the risk that Ahlia posed to herself. However, the clear picture that emerged from the evidence is that no individual nurse was armed with the significant and highly relevant information about all of Ahlia's 3 previous self-harm attempts. Even more concerning is that this meant that complete information relevant to Ahlia's care was not communicated during each handover.

103. As part of the new transfer of care policy introduced in January 2017 new ISBAR transfer forms have been created.[45] These new forms have been revised to include different categories relevant to each part of the mnemonic to prompt the recording of relevant information on the form. Whilst this must be recognised as a policy improvement it became evident during the course of

[41] Exhibit 1, pages 222 to 225.
[42] Exhibit 1, page 88.
[43] Exhibit 1, page 351.
[44] Exhibit 1, page 95.
[45] Exhibit 1, pages 1329-32 to 1329-35.

the inquest that despite the policy being implemented some 5 months before the inquest, its practical application had not yet been effectively communicated to nursing staff. Mr Lilly gave evidence that he was unaware that there were any new ISBAR forms and Ms Baxendale said that she had only received informal training about them. Furthermore, Dr Fogarty agreed in evidence that whilst the policy had been released and staff had been told about it no specific targeted training had been provided to staff regarding the new policy. The evidence suggested that nursing staff have simply been asked to acknowledge online that they have read the policy. Given the evidence of Mr Lilly it seems that this has not even occurred. Clearly, changes in policy are rendered meaningless if the people who are to put them into practice are either unaware of them or not specifically trained in their practical application.

104. **RECOMMENDATION 2:** *I recommend that the HNELHD provide specific targeted training to all mental health clinical staff in relation to any changes in patient care policies introduced since March 2015.*

**Was adequate and appropriate care provided by the PICU staff in response to the risk that Ahlia posed to herself?**

105. Only two hours before her transfer to the PICU Dr Arghandrewal regarded Ahlia as being a high risk of harm to herself. This was clearly recorded on the ISBAR handover form that accompanied Ahlia to the PICU.[46] However, on the PICU handover sheet Ahlia was recorded as being a medium risk of harm to herself. This designation did not change for the entirety of Ahlia's admission to the PICU.

106. The assessment of Ahlia being at medium risk of harm to herself was created by Ms Baxendale. In evidence Ms Baxendale said that she was unaware that Ahlia had been assessed as being a high risk prior to her admission to the PICU. Ms Baxendale explained that the classification of Ahlia as a medium risk was based on 3 factors: her own assessment based on the contact that she had had with Ahlia, confirmation from Ms Steers that Ahlia was a medium risk as Ms Steers read Ahlia's progress notes, and a general assumption that a patient's risk level is reduced by virtue of the mere fact of transfer from the NMHU to the PICU alone. In relation to this third factor Ms Baxendale elaborated in evidence that because the NMHU is a 22-bed unit with a 1-to-5 nurse-to-patient ratio whereas the PICU is an 8 bed unit with a 1-to-2 nurse-to-patient any risk to a patient is automatically mitigated by the transfer.

107. Dr Fogarty indicated in her evidence that Ahlia clearly was a high risk of harm to herself. Furthermore, Dr Fogarty acknowledged that it was inappropriate for a nurse to downgrade a risk level that had been previously assigned to a patient by a doctor. Although it is clear that this occurred in Ahlia's case, and was therefore inappropriate, it should be clarified that Ms Baxendale did not do so knowingly. As has already been indicated the downgrading of Ahlia's risk level was done in the absence of complete information about Ahlia's relevant history, most importantly her 3 previous attempts at self-harm.

108. In her report Dr Anderson raises some thought-provoking questions in relation to the concept of risk assessment, particularly where it relates to the level of observation afforded to a patient. Dr Anderson expressed the view that clinical decisions about observation levels "*should not be made on level of risk, but rather upon a holistic consideration of the needs of the patient*

[46] Exhibit 1, page 222.

*(necessarily taking some account of the available resourcing)*".[47] Rather than basing a decision about observation on what she describes as "*essentially meaningless statements about Ahlia's level of risk*"[48], there should have instead been a detailed consideration of the pros and cons of different levels of observation which could have been afforded to Ahlia. Such a consideration should have been clearly documented, and based on Ahlia's recent behaviours, her responses to psychological interventions, and the emotional impact of her previous ward transfers.[49] However, this type of consideration required both time and careful examination of the available information. Ms Baxendale acknowledged that this did not occur given how busy the PICU was on the night of 18 March 2015.

109. The flaws in simply basing patient observation levels on labels of low, medium or high risk are clearly demonstrated by two pieces of evidence. Firstly, the handover sheet recorded Ahlia as being not only a medium risk of harm to herself, but also a medium risk of harm to others. There is simply no evidence in the entirety of Ahlia's medical records to establish that she was a risk of harm to others, at any level. Secondly, the handover sheet records 7 out of the 8 patients (including Ahlia) in the PICU during the night of 18 March 2015 as being both a medium risk of harm to self, and a medium risk of harm to others. Such a generalisation of risk levels only serves to reinforce Dr Anderson's views about the utility of such labels.

110. Despite the errors made in the classification of Ahlia's risk level it does appear that some consideration was given to increasing the level of observation given to Ahlia. Ms Baxendale moved Ahlia to a room closer to the nurses' station and considered moving her into the seclusion lounge. Ms Drinkwater said that she had read in Ahlia's progress notes that she had previously rated herself as 8 out of 10 in terms of potential self-harm and that this suggested that Ahlia was at a high risk. Ms Than said that Ahlia's self-rating of 7 out of 10 in terms of potential self-harm and her previous reference to using bed sheets was enough for her to be considered at high risk. This led to a discussion between Ms Than and Ms Garthwaite about keeping Ahlia in the ward's common areas where she would be more visible and away from the isolation of her room.

111. However, despite such consideration being given there were no actual meaningful changes to the manner in which Ahlia was observed during her admission to the PICU. The difficult question to answer is whether any changes can be made so that clinical staff more readily and easily put into practice the type of holistic consideration of a patient's needs advocated by Dr Anderson. Dr Fogarty acknowledged in evidence that this created a dilemma because whilst labels such as low, medium, or high risk are a useful baseline or guide, such labels should not encourage blinkered thinking. As Dr Fogarty put it simply in her evidence: it is difficult to know how to instruct people to think. Whilst it is acknowledged that there is no simple solution, it seems that ongoing periodic training of clinical staff regarding the approach encouraged for by Dr Anderson is a positive step in the right direction.

112. **RECOMMENDATION 3:** *I recommend that the HNELHD provide ongoing periodic training to all mental health clinical staff in relation to the need for a holistic consideration of the needs of a patient in determining the level of observation that is to be afforded to a patient.*

[47] Exhibit 1, page 1373.
[48] Exhibit 1, page 1375.
[49] Exhibit 1, page 1375.

**How was Ahlia observed during her admission to the PICU and were these observations effective in ensuring her safety?**

113. The evidence established that during Ahlia's admission to the PICU she was under close observations. According to the form used to record observations this meant that Ahlia had to be "*sighted at intervals of no more than 15 minutes*"[50] (emphasis added). Therefore, although Ahlia had to be sighted at a minimum of every 15 minutes, there was nothing preventing more frequent observations if Ahlia's care warranted it. However a mere glance at Ahlia's observation form for 18 March 2015 shows an entry made at *exactly* every 15 minutes beginning at 6:30pm on 18 March 2015 and ending at 6:45am on 17 March 2015.

114. Given the evidence regarding how busy the PICU was on 18 March 2015 it is difficult to accept that Ahlia was observed at exactly 15 minute intervals over the span of some 12 hours. If Ahlia's observation chart is therefore inaccurate, this in turn suggests that she may not have been effectively observed during her admission. Indeed, so much is true for the period when Ahlia most needed observation, that is, during the morning handover on 19 March 2015.

115. Various accounts have been given from the nurses from both the night and morning shift about seeing Ahlia near her door before, during and after the handover process. Ms Than said in evidence that she first saw Ahlia by her door when she arrived in the ward at about 6:45am and that she believed that Ahlia was already hanging by this time. With the exception of the evidence from Ms Drinkwater (who said that during the morning handover she saw Ahlia intermittently moving from behind the door to the front of it), the evidence given by the other nurses tends to support this conclusion. Most of the nurses involved in the handover saw Ahlia standing by her door during the handover which went from about 6:55am until about 7:05am. Importantly Mr Moate said that at 7:05am he saw Ahlia in the same position as he had seen her at 6:50am and it appeared that she had not moved. The combined weight of this evidence suggests that by as early as about 6:45am, and by at least 6:50am, Ahlia had already hanged herself.

116. Part of the ineffectiveness in the observations made of Ahlia stemmed from a number of inconsistences in the way in which the observations were recorded. Ms Steers said that her practice was to record an observation at the time that it was made and that recording a group of observations in blocks was inappropriate. However, Ms Drinkwater said that her practice was to sometimes record an observation at the time it was made, and at other times she would record it at some later stage. Ms Drinkwater said that she would sometimes write up observations in a block of 30 to 45 minutes and indicated that staff had not been provided specific training regarding how observations were to be recorded. Most importantly, Ms Than said that whilst she observed Ahlia at 7:00am and again at 7:15am these observations were not recorded as the handover was taking place during this time.[51] Ms Than said in evidence that the established practice was for the observation form to be completed at the time of the observation if there is time to record it but if there is not then the observation could be recorded at some later time.

117. When these inconsistencies in practice were put to Dr Fogarty she sought to clarify the situation by explaining that it was inappropriate for observations to be recorded in a block and that observations should be recorded at the time that they are made. Given the disparity in the way in which observations were performed in the PICU, and the obvious adverse impact this could

[50] Exhibit 1, page 302.
[51] Exhibit 1, page 118.

have on patient safety, a recommendation for increased and regular training is, in my view, both necessary and desirable.

118. **RECOMMENDATION 4:** *I recommend that the HNELHD provide increased and regular education and training to nursing staff within mental health units regarding completion of patient observation charts to ensure that observations are accurately recorded at the times that they are performed, and to avoid the practice of "block recording" where observations are recorded collectively and subsequent to the time of the actual observations.*

119. Another issue that arose during the inquest concerned exactly how observations are performed. As already noted the close observation form only stipulates that a patient must be *sighted*. In evidence Ms Baxendale said that her understanding of an observation involved making sure that a patient was safe and that this would usually involve some contact with the patient, often verbal but not always. Ms Drinkwater explained that when a patient is asleep observations meant counting the number of respirations made by a patient, usually over the course of a minute.

120. The observations made of Ahlia at 6:45am, 7:00am and 7:15am were clearly ineffective. They did not, in accordance with Ms Baxendale's understanding of what an effective observation involved, ensure that Ahlia was safe. To address this deficiency the HNELHD in July 2015 introduced a new policy[52] which sought to clearly define what an effective observation involved. The policy provides: "*Sighting alone may not always be sufficient to determine the patient's level of safety and wellbeing. The nurse who conducts the observations must do so in a manner as to be satisfied that the safety and wellbeing of the patient is maintained. This is most effectively done through interaction and therapeutic engagement with the patient*".[53]

121. This is obviously a much-needed improvement. However, there is one aspect of the policy which creates the potential for misunderstanding. Page 4 of the policy provides that a patient must be *sighted* at intervals relevant to their level of observation (no more than 15 minute intervals for Level 2 observations and no more than 30 minutes for Level 3 observations). Despite the clarification earlier in the policy regarding how an observation must ensure that a patient is safe and well, the specific reference to mere sighting (as it was referred to on Ahlia's observation form) has the potential to cause confusion and lead to ineffective observations.

122. Furthermore there are also inconsistences in the descriptions of the Level 2 and Level 3 observation requirements. The policy stipulates that Level 3 observations are to be performed *day and night*. However the Level 2 observation contains no such stipulation, only indicating that observations are to be performed at intervals of no more than 15 minutes. Instead, the Level 2 observations only indicate that patients are to be checked for signs of life at intervals *throughout the night*.

123. Whilst repeated reading of the policy seems to suggest that a consistent message is being conveyed, the language of it leaves open the possibility for misinterpretation. This is particularly so given that the specific Level 2 and Level 3 observation descriptions contain only a reference to *sighting* a patient. The potential for misinterpretation which may lead to observations that do not ensure the safety of a patient obviously should be avoided.

[52] Mental Health: Levels of Observation – Psychiatric Intensive Care Unit (PICU), MH_LP_1.201.01.
[53] Exhibit 2, page 3.

124. **RECOMMENDATION 5:** *I recommend that the HNELHD amend the Mental Health: Levels of Observation – Psychiatric Intensive Care Unit (PICU) policy issued on 31 July 2015 to ensure that clear instructions are given to nursing staff regarding the performing of observations day and night, and how observations should be performed in order to ensure the safety of patients.*

**Were patient handovers in the PICU conducted in a way that ensured patient safety?**

125. As already noted it seemed to be established practice that the first nurse from the incoming shift to arrive in the PICU would perform a drug count with one of the outgoing nurses. The second nurse from the incoming shift to arrive would perform a ward round. However this practice was not always followed and was not followed on the morning of 19 March 2015. Ms Briggs, who appears to have been the second nurse from the morning shift to arrive, said that a ward round was not performed shortly prior to handover. Ms Briggs explained that this was because Ms Drinkwater indicated that a ward round was unnecessary as one had just been completed by the night shift.[54] Exactly when this ward round was performed is unclear on the available evidence.

126. Since Ahlia's death two important changes have been made to the handover process. Firstly, nursing staff are now paid during handover times. This allows incoming staff to arrive before the outgoing shift ends so that staff can remain to ensure that a proper handover takes place and all relevant information about patients is communicated in a comprehensive manner. Secondly, during the handover process one nurse is always allocated to be on the ward floor to ensure that patients are safe and well.

127. However, the evidence indicated that there was one further aspect regarding the handover process which required clarification. Again it seemed to be established practice that the nurse responsible for making the observation during handover times was the incoming nurse who was assigned to a particular patient. In Ahlia's case on the morning of 19 March 2015 that was Ms Than. However, the evidence established that Ms Than was not allocated to Ahlia until the end of the handover which occurred at 7:05am. Two things are apparent. Firstly, if, according to the observation form, Ahlia had been observed at 6:45am and was due to be observed again by 7:00am at the latest, this occurred when Ms Than had not yet been assigned to Ahlia's care. Secondly, if Ahlia had in fact been observed by Ms Than at 7:00am then the observation, having occurred during the handover, would not have been recorded on Ahlia's observation form at the time it was made.

128. There appears to be ongoing uncertainty regarding whether it is the responsibility of an incoming nurse or an outgoing nurse to perform observations during handover times. This has the potential to compromise patient safety and is need of clarification.

129. **RECOMMENDATION 6:** *I recommend that the HNELHD develop policies and procedures to clearly identify the roles and duties of incoming and outgoing nursing staff within mental health units during handover times. In particular, I recommend that any such policies and procedures clearly identify the nurse responsible for performing observations of patients that occur during handover times.*

[54] Exhibit 1, page 122.

**Have the environmental factors which contributed to Ahlia's death been adequately addressed?**

130. It is clear that some of the environmental factors within the PICU in March 2015 contributed both to Ahlia's ability to hang herself and the failure by nursing staff to notice that this had in fact occurred. These factors have been investigated by HNELHD and measures have been taken to address them.[55]

131. Firstly the level of lighting in the ward, in combination with it still being daylight savings time and therefore darker in the morning, meant that Ahlia was not easily visible on 19 March 2015. Since Ahlia's death the HNELHD has taken steps to ensure that there is sufficient lighting to ensure that patients can be clearly seen so that nurses can perform effective observations, whilst at the same time ensuring that the lighting is not overly bright so as to disturb patients. Dr Fogarty gave evidence that testing is still currently underway, including the use of dimmable lights, to ensure that an appropriate balance is struck between patient safety and patient comfort.

132. Secondly, it appears that the main contributing factor to the failure to notice that had Ahlia had already hung herself was that the white bed sheet which she used was difficult to see against the similarly white-coloured room door. In order to rectify this issue all room doors within the PICU have now been painted in a darker colour in contrast to the white bed sheets.

133. Thirdly, since Ahlia's death the HNELHD have trialled a tear proof bed sheet in order to reduce the risk that patients might use bed sheets to manufacture a noose. It should be noted that Ahlia did not tear her bed sheet in order to make a noose on 15 March, 18 March or 19 March. Following its assessment the HNELHD concluded that using tear proof sheets did not negate the potential for hanging. Instead, the PICU now has a stock of thermal quilts which can be given to patients as a substitute for bed sheets. The quilts make it more difficult for a noose to be created compared with a bed sheet.

134. Finally, handles which could be used as ligature hanging points have been removed from cupboards and the HNELHD is currently engaged in the process of replacing room door handles to also eliminate the possibility of them being used as ligature hanging points.

135. I commend the HNELHD for their past, and ongoing, work with respect to each of these areas of improvement.

**Back-to-base pulse oximetry**

136. In her report Dr Anderson drew attention to a letter published in an academic journal in 2016[56] in which two experienced public sector psychiatrists argued that what is required to most effectively ensure that suicide attempts by high dependency mental health inpatients are detected and responded to is the use of real-time, back-to-base monitors that measure pulse oximetry (blood oxygen saturation). Unlike current pulse oximetry monitors that are clipped to the end of a finger and are used widely in hospitals, new types of monitors that are wireless and can be worn on the wrist have recently become available.

[55] Exhibit 1, page 1329.
[56] Australasian Psychiatry 2016, Vol 24(2) 204-207.

137. These wireless monitors are less intrusive and allow for continuous monitoring of a person's oxygen level. If this oxygen was to drop below a certain level (or if the monitor is removed, or if the patient moves outside the wireless reception range) an alarm will activate to alert nursing staff so that, in the event of a suicide attempt, there could be a more rapid response to provide potentially life-saving treatment.

138. Dr Anderson points out: "*A wrist monitor, equivalent to a watch in size, is unlikely to be seen as intrusive by most patients and many will be reassured that despite their distressing urges to suicide or indeed abscond, they will be unable to do so. This arguably least intrusive method of observation would also enable patients' greater freedom to engage therapeutically with ward programs*".[57]

139. Dr Anderson advised that the Black Dog Institute recently submitted an application as part of the Health Ministry's Mental Health Reform Innovation scheme for funding to conduct a proof of concept trial. Four Local Health Districts (Hunter New England, Mid North Coast, Sydney and Illawarra Shoalhaven) as well as Justice Health & Forensic Mental Health Network have agreed to participate in the trial if the project is funded. Applications for funding closed on 9 May 2017 and no final determination has yet been made.

140. Although the Black Dog Institute's trial is aimed at youth suicide prevention, the potential use of such a device could obviously have broader application and benefit not only those within the public health sector but also within non-government organisations and in the private sector.

141. The HNELHD has indicated that in the event that funding is not granted to the Black Dog institute it will undertake its own trial of back-to-base pulse oximetry devices as a suicide prevention tool.[58]Dr Fogarty gave evidence that this has already been agreed to in principle by the Chief Executive of HNELHD. However given the important role that such a trial could potentially have to improve public safety and reduce the number of self-inflicted deaths in mental health care, and other, settings, I consider it to be both necessary and desirable to make a formal recommendation regarding it.

142. **RECOMMENDATION 7:** *In the event that the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts is unsuccessful, I recommend that the HNELHD give consideration to independently conducting its own trial to access the acceptability and feasibility of using pulse oximetry units to continuously monitor inpatients in mental health intensive care units within the district.*

143. **RECOMMENDATION 8:** *I recommend that a copy of these findings be forwarded to the Minister for Health for consideration in conjunction with the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts.*

**Nurse-to-patient ratios**

144. At the conclusion of the evidence in the inquest I circulated to counsel a draft list of recommendations and invited submissions from them. One of the recommendations included a recommendation to the Minister of Health that consideration be given to increasing nurse-to-

[57] Exhibit 1, page 1383.
[58] Exhibit 1, page 1329-47.2.

patient ratios within mental health intensive care units to align with the suggested 1-to-1 nursing ratios that are in existence in other intensive care units.

145. Evidence in the inquest established that the nurse-to-patient ratio in the PICU was (and still is) 1-to-2 during the morning and afternoon shifts and 3-to-8 during the night shift. Counsel for Ms Than and Ms Steers suggested to Dr Fogarty that the nurse-to-patient ratio in physical health intensive care units is 1-to-1 and asked why mental health intensive care units should not be staffed in an identical manner. In response Dr Fogarty explained that physical needs of patients in other intensive care units are often greater and require more constant and intensive monitoring. She also explained that if the need arose for a higher nurse-to-patient ratio in the PICU that nursing staff could be drawn from other wards, although this would obviously have a flow-on detrimental effect on the ward from which a nurse might be drawn.

146. Counsel for HNELHD urged me not to make such a recommendation for two reasons. Firstly he drew my attention to *Waller's Coronial Law and Practice in New South Wales* (2010) Fourth Edition in which the authors wrote: "*A coronial recommendation will ordinarily be made to a person or entity interested in the subject matter of the inquest or inquiry who has appeared or been represented. In the ordinary course of discussion and submissions, a coroner will have given those persons an opportunity to be heard on the question whether recommendations ought to be made and, if so, in what form. This process is helpful in the development and refinement of useful recommendations*" [59] (emphasis added).

147. Counsel for HNELHD pointed out that he did not appear for the Ministry of Health and that in fact the Ministry was not represented at the inquest as they had not been sent a notification advising that they may have sufficient interest in the proceedings. This is correct. However in my view there is nothing from the extract from *Waller's* quoted above which precludes a recommendation being made to a person or entity who has not appeared or been represented at an inquest. The authors in *Waller's* simply point out that this will occur in the *ordinary*, but not every, course of events. Furthermore, the authors conclude that affording a person or entity to whom a recommendation is being considered an opportunity to be heard is helpful to develop and refine any such recommendation. Whilst that again is true in the ordinary course of events, in my view there is no requirement for it be so in every case particularly where the issues may be so clear that there is no need for assistance in development or refinement. Further I note that the authors in *Waller's* themselves suggest that "*specific recipients, usually government minsters, officials or agencies but sometimes others, be identified by coroners as the correct recipients for recommendations. The suitable persons or bodies are those identified as having power to respond to and, if appropriate, implement the recommendations*".[60] In this case it is clear that the Minister for Health has the appropriate power to respond to and, if appropriate, implement the recommendation which I propose to make.

148. Secondly, counsel for HNELHD submitted that it was not established during the inquest that there is always a 1-to-1 nurse-to-patient ratio in physical health intensive care units. I agree with this submission and propose to modify my draft recommendation accordingly.

149. Finally, counsel for HNELHD submitted that there was no evidentiary basis to conclude that a 1-to-1 ratio was justified. I respectfully disagree with this submission in part. I accept that the inquest did not receive evidence about the nurse-to-patient ratios in other mental health

[59] Paragraph 82.14.
[60] Paragraph 82.13.

intensive care units outside of HNELHD. However in my view the inquest did receive ample evidence which allows a conclusion to be reached that an increase in nurse-to-patient ratios within the Mater PICU is justified, and that it is necessary and desirable to make a recommendation in this regard.

150. As has been mentioned a number of times already, the evidence consistently given during the inquest was that the PICU was particularly busy during the evening of 18 March 2015. There had been 5 new admissions earlier that day and soon after Ahlia's admission a new patient was admitted before another patient could be transferred out of the unit. This meant that for a time there were 9 patients in the 8-bed ward. At the time of Ahlia's transfer Ms Baxendale describes the ward as being at capacity. Furthermore, in order to facilitate Ahlia's transfer to the PICU another patient, who had only been transferred to the PICU 5 hours earlier, was returned to the NMHU. Ms Baxendale describes this as being a less than ideal situation for both the patient and the NMHU but says that there was no other alternative available.[61]

151. The demands place on the PICU on 18 March 2015 meant that the nursing staff, who were already performing a difficult and challenging role, were stretched to the extent that patient safety was compromised. Ms Baxendale stated that due to the demands placed on her prior to the night shift starting she had not had an opportunity to adequately review Ahlia's progress notes. This resulted in an inaccurate and effectively meaningless risk classification and an inability to perform a holistic assessment of the kind advocated for by Dr Anderson, which in turn led to an inadequate assessment of the type of observation that Ahlia required. The inability to identify this during the afternoon shift meant that during the night handover, the incoming staff were provided with inadequate and incomplete information about the degree of Ahlia's suicidality.

152. Furthermore it is clear that the demands placed on the morning shift staff prevented effective observations of Ahlia which ensured her safety. Ms Briggs states that the morning handover on 19 March 2015 took longer than usual due to interruptions from patients who were lingering by the window of the nurses' station.[62] This in turn meant that nurses were delayed from completing the handover and attending to patients. Further, after the handover was completed both Ms Briggs and Ms Than were occupied dealing with patients at the nurses' station and prevented from adequately performing observations. Whilst Ms Than may have sighted Ahlia from the nurses' station at 7:15am whilst she was attending to another patient, if Ahlia had been the only patient under her care she may have had the opportunity to directly observe Ahlia and notice that Ahlia had already hanged herself.

153. In all the circumstances I am of the view that any increase in the nurse-to-patient ratio in the PICU could only lead to an improvement in patient safety.

154. **RECOMMENDATION 9:** *I recommend that the NSW Minister for Health give consideration to increasing nurse-to-patient ratios within the Psychiatric Intensive Care Unit of the Mater Mental Health Centre, Waratah to ensure that patient safety is not compromised.*

[61] Exhibit 1, page 80.
[62] Exhibit 1, page 123.

## Findings

155. Before turning to the findings that I am required to make, I would like to acknowledge and thank Dr Peggy Dwyer, Counsel Assisting and Ms Johanna Geddes, instructing solicitor from the NSW Crown Solicitor's Office. I am grateful not only their valuable assistance and significant contributions both before, and during, the inquest, but also for the compassion that they have shown in what has been a genuinely tragic matter. At the beginning of the inquest I told Ahlia's family that I aimed to conduct the inquest in a way that would be respectful to, and dignify, Ahlia's memory. I would like to acknowledge the assistance of counsel for all the interested parties in, hopefully, achieving that aim. Finally, I would like to thank, and express my appreciation for the efforts of the police officer-in-charge of the investigation, Detective Senior Constable Daniel Palmer, and his team of investigators.

156. The findings I make under section 81(1) of the Act are:

***Identity***
The person who died was Ahlia Raftery.

***Date of death***
Ahlia died on 19 March 2015.

***Place of death***
Ahlia died whilst she was an inpatient in the Psychiatric Intensive Care Unit of the Mater Mental Health Centre in Waratah, NSW.

***Cause of death***
The cause of Ahlia's death was neck compression due to hanging.

***Manner of death***
Ahlia died as a consequence of actions taken by her with the intention of ending life.

## Epilogue

157. At the end of the inquest Adam told the court that Ahlia's story is not over. His intention is to become an advocate for, and help, other young people who face the same struggles that Ahlia faced. I commend him and wish him every success in his endeavours which will be invaluable. Protecting our children and young people, and ensuring their safety and wellbeing, is one of the most important goals that we can achieve as a society.

158. Inquests and the coronial process in general are traumatic experiences for bereaved families. Coroners often cannot provide the answers which families most want to know. But lessons can be learned and improvements to public health and safety can be made to potentially ensure that other families need not experience such trauma or be burdened with such unanswerable questions. Ahlia herself wanted to become a nurse so that she could help others and hopefully make a difference. If any of the recommendations made lead to systemic changes that help and protect others, Ahlia's hope will be fulfilled.

159. On behalf of the coronial team and the Coroner's Court I would like to offer my sincere and respectful condolences to Kirstie, Michael, Adam and Liam; to the other members of Ahlia's family; and to her friends.

160. When Ahlia was asked how much love she had for Liam, she would say, "To the moon and back". The inspiring love that Ahlia's family have for her is no less, and will never be any less.

161. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
9 June 2017
NSW State Coroner's Court, Glebe