CITATION: *Inquest into the death of Emma Jane Claridge* [2011] NTMC 068	
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0172/2009
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HEARING DATE(s):	25 – 29 October 2010
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death in Care, Mental Health treatment, In patient leave, Suicide

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health and Families	Sally Sievers

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0172/2009

In the matter of an Inquest into the death of
EMMA JANE CLARIDGE
ON 26 SEPTEMBER 2009
AT 9 GRIFFE STREET, NAKARA,
IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Emma Jane Claridge ("Ms Claridge") was a Caucasian female born on 27 February 1990 in Geelong, Victoria. The body of Ms Claridge was found by police in the bedroom of her residence at 9 Griffe Street, Nakara in the Northern Territory at approximately 10.59pm on Saturday 26 September 2009.

2. Ms Claridge had apparently hung herself using a scarf which was tied to the curtain rail in her bedroom and then wrapped tightly around her neck, utilising her body weight to hang herself.

3. This death was reportable to me because at the time of her death, Ms Claridge was admitted as a voluntary patient at the Cowdy Ward of the Royal Darwin Hospital. As a result she was a "person held in care" pursuant to the definition contained in s12 of the *Coroners Act* ("the Act") which includes:

   "A patient who, pursuant to the Mental Health and Related Services Act *is in custody whether in a hospital or temporarily removed from a hospital"*

   Therefore, pursuant to s15(1) of the Act, this inquest is mandatory.

4. In addition there is evidence, later referred to in these reasons, which satisfies me to the required standard that Ms Claridge took her own life. Her death was therefore also reportable to me as it was an *unexpected* and *unnatural* death.

5. Pursuant to s34 of the Act, I am required to make the following findings if possible:

> "(1) A Coroner investigating:
>
> a. A death shall, if possible, find:
>
> (i) The identity of the deceased person.
>
> (ii) The time and place of death.
>
> (iii) The cause of death.
>
> (iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*".

6. Section 34(2) of the Act operates to extend my function such that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.

(3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

7. Counsel assisting me at this inquest was Ms Jodi Truman. Ms Sally Sievers was granted leave to appear on behalf of the Department of Health and Families. I thank each Counsel for their extremely helpful assistance in this matter. It is noted that Ms Melissa Claridge, the mother of the deceased, and Mr Glynn Williams, the step-father of the deceased, were in attendance at the inquest, together with other extended family members and friends. I was informed at the commencement of this inquest by Counsel assisting that the circumstances of this death have caused significant distress to the family who believed that by virtue of the deceased having been admitted into the care of the Cowdy Ward, she would be safer than if she remained in their care.

8. Thirteen (13) witnesses were called to give evidence at the inquest. Those persons were:

a. Detective Senior Constable Julie Frost, the officer in charge of the coronial investigation;

b. Melissa Claridge, the mother of the deceased;

c. Michelle Press, a Registered Nurse ("RN") at Cowdy Ward at the relevant time;

d. Dr Ussman Khalid, a Doctor at the Cowdy Ward at the relevant time;

e. Dr Maria San Pedro, a Doctor at the Cowdy Ward at the relevant time;

f. Makiko Noto, a RN at Cowdy Ward at the relevant time;

g. Valerie Kullack, a RN at Cowdy Ward at the relevant time;

h. Tatjana Butler, a RN at Cowdy Ward at the relevant time;

i. Melody Charles, a RN at Cowdy Ward at the relevant time;

j. Senior Sergeant Gary Smith, Watch Commander of Police Communications (COMMS) at the relevant time;

k. Dr Sharon Crabbe, a Doctor at the Cowdy Ward at the relevant time;

l. Fran Pagdin, General Manager of Top End Mental Health Services; and

m. Bronwyn Hendry, Director of Northern Territory Mental Health Services.

9. A brief of evidence containing 35 civilian statements, 21 statements from medical and nursing staff, 16 police statements, together with numerous other reports, photographs and police documentation was tendered at the inquest (exhibit 1). Public confidence in coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I would like to thank Detective Senior Constable Julie Frost for the quality and thoroughness of her investigation.

10. A number of files in the deceased name were seized from medical clinics, the hospital and other mental health services and these were also tendered in evidence (exhibit 2).

Formal Findings

11. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings in relation to the death of Ms Emma Jane Claridge, as required by the Act:

i. The identity of the deceased person was Emma Jane Claridge who was born on 27 February 1990 in Geelong, Victoria.

ii. The time and place of her death was some time between 9 and 10pm, but closer to 10pm, on Saturday 26 September 2009 at the deceased's residence at 9 Griffe Street, Nakara in the Northern Territory.

iii. The cause of death was neck compression due to hanging.

iv. Particulars required to register the death:

1. The deceased was a female.
2. The deceased's name was Emma Jane Claridge.
3. The deceased was of Caucasian descent.
4. The death was reported to the Coroner.
5. The cause of death was confirmed by post mortem examination carried out by Dr Jane Vuletic.
6. The deceased's mother was Melissa Claridge.
7. The deceased lived at 9 Griffe Street, Nakara in the Northern Territory of Australia.
8. The deceased was not employed at the time of her death.

Circumstances Surrounding the Death

Background

12. Emma Jane Claridge was the only child to Melissa Claridge. She was born in Geelong, Victoria and initially lived with her mother at the residence of her maternal grandparents in Geelong. A few short months after her birth her mother commenced a relationship with Mr Glynn Williams and Mr

Williams took on the role of father to the deceased. He was the only father that the deceased ever knew. In 1999 the family moved to Darwin. I heard evidence from Mrs Claridge that the deceased was a "good girl", who was "well behaved and artistic". It also appears on the materials however that from an early age close family members noted extreme changes in the deceased's behaviour sometimes going from happy to angry "in the blink of an eye" and on occasions becoming violent.

13. I heard evidence that when the family initially moved to Darwin the deceased coped reasonably well with the change. In 2003 the deceased enrolled at St Johns College and appeared happy and was described as having many friends. In 2005 the deceased's mother and father separated and this appeared to have an effect upon the deceased, causing for a time a rift between the deceased and her mother. Sometime thereafter however, things improved between the deceased and her mother and when the deceased's mother formed a new relationship with her current partner, Mr Carl Peulen, things became more settled.

14. In 2006 the deceased enrolled herself at Casuarina Secondary College. This change in schooling arrangements came about as a result of the deceased wanting to be closer to a friend also attending at the College. Within a short time however the deceased's friend left the school and the deceased was on her own. It appears that during 2006 the deceased's mental health actively began to decline. At this time the deceased was approximately 16 years of age.

Mental Health Intervention

15. On the materials tendered before me it appears that the deceased began displaying a great deal of anger around this time. The deceased also became somewhat obsessed with motivational books placing significant and intense pressure upon herself. Around this time the deceased also discovered that Mr Williams was not her biological father; but it appears that the deceased

took this news relatively well and was able to maintain a strong, close and loving relationship with Mr Williams. Because of the deterioration in her behaviour, in 2006 the deceased also began seeing a counsellor at Casuarina Secondary College; although it appears that she did not attend regularly.

16. In about August 2007, the deceased also had contact with Casuarina Night and Day Medical Centre where she requested assessment and was provided with a mental health plan. The deceased had presented to the surgery describing herself as feeling depressed and anxious and believing that she was "over thinking" and "over analysing" things. Initially the deceased was diagnosed as suffering depression and potentially a personality disorder.

17. Towards the end of 2007 the deceased began part time work at Hungry Jacks and Coles. Around this time she formed a relationship with a young man and it appears from all accounts that this relationship was extremely intense and caused a rift for a time between the deceased and her mother. In about April 2008 the deceased moved in with her boyfriend and his father; however it appears that this arrangement did not last long. For a period, the deceased moved between living with her mother, living with Mr Williams and on occasions with her aunt. Towards the end of 2008 the relationship between the deceased and her boyfriend broke down, and in early December 2008 the deceased moved back in for a period with her mother.

18. The records tendered before me show that in about December 2008 the deceased attended at the Arafura Medical Centre requesting counselling for ongoing feelings of anxiety. As a result of that attendance a plan was prepared and referral made to the service known as "Head Space NT". From this time, the deceased's attendance upon various services became more regular. In February 2009 the deceased presented to the Farrar Medical Centre and is described as suffering from emotional issues and anxiety. It is noted in the records that she had self harmed in the previous week by scratching her arms with glass. As a result a referral was made to

psychologist, Ms Louise McKenna, for counselling and the deceased was commenced on antidepressant medication.

19. On 14 February 2009 the deceased made her first contact with "Kids Help Line". Between 14 February and 26 September 2009 the deceased is recorded as in fact making 89 phone calls to "Kids Help Line" with the last recorded contact being at approximately 2pm on 26 September 2009, being the day of her death. The records indicate that on occasions the deceased would contact "Kids Help Line" up to eight or nine times per day. Calls were also recorded as having been made from the deceased's mobile phone to "Lifeline" over this period.

20. Despite the deceased's regular access to numerous mental health services, on 20 March 2009 the deceased presented herself to the Accident and Emergency Department ("A & E") at the Royal Darwin Hospital ("RDH"). She told staff that she had ingested 10 multi-vitamin tablets and approximately 20mls of floor cleaner 2 days earlier. As a result, and for the first time, the deceased was admitted to Cowdy ward as a voluntary patient under s25 of the *Mental Health and Related Services Act* ("MHRS Act"). The deceased remained in the care of the Cowdy ward until 3 April 2009. In that time the deceased had also been placed on involuntary status under s39 of the MHRS Act but was subsequently returned to voluntary status.

21. During this first admission the diagnosis being considered was "first episode of psychosis", with a differential diagnosis of "Personality Disorder". Upon her discharge on 3 April 2009 the deceased was provided with various medications; however on 15 May 2009 the deceased contacted the police seeking their assistance after ingesting a number of tablets with the intention of committing self harm. As a result the deceased was conveyed to the A & E Department of RDH and was admitted for the second time as a voluntary patient to the Cowdy ward. The deceased was discharged 2 days later on 17 May 2009.

22. During this time the deceased also had contact with the Tamarind Centre and was receiving treatment and medication. On 16 July 2009 the deceased was once again admitted to the A & E Department at RDH after an overdose of medication. The records make clear that the deceased told hospital staff that she wished to kill herself. On this third admission, the deceased was admitted to Cowdy ward under voluntary status and at this time it appears that the general impression being formed in relation to the deceased's condition is that perhaps she was suffering from a schizophrenic type illness, or depression with psychotic features. According to the records, throughout this admission the deceased continued to express suicidal ideation; however she was eventually discharged on 28 July 2009.

Events leading to the final admission to Cowdy ward

23. On 10 September 2009 the deceased had an appointment with her counsellor at Head Space NT. The deceased's mother had woken the deceased for the appointment. In her statement to the police, Mrs Melissa Claridge stated that when she did this, the deceased became extremely angry and used a blunt knife to cut her arm. Eventually Mrs Claridge was able to persuade the deceased to attend the appointment. The Head Space records indicate that when the deceased attended, she appeared dishevelled and "down" in her mood.

24. It appears on the evidence that things did improve during that day. The deceased in fact went to a local bar with a close friend, namely Bryce Walshe, and participated in karaoke. Mr Walshe sets out in his statutory declaration that the deceased appeared to have a "good time". At around midnight he and the deceased left the bar, intending to go to the Casino to meet with the deceased's mother and continue their evening. Unfortunately it appears that the deceased's mood changed on the way to the Casino and the deceased began to cry, telling Mr Walshe that she considered she had nothing to live for. As a result Mr Walshe and the deceased drove to

Casuarina and sat and talked for some time. Mr Walshe sets out in his declaration that the deceased said to him "I want to explain to you everything that is going around in my head, but I don't want to scare you off or anything like that". Unfortunately the deceased did not go on to explain to Mr Walshe what was happening. It appears that the friends continued to talk together, eventually parting company at around 5am on Friday 11 September 2009 because Mr Walshe had to get ready for work.

25. At approximately 5.38am on 11 September 2009 the deceased once again presented to the A & E Department. This time the deceased had taken herself to the hospital and told staff that she was having thoughts of self harm. The deceased was admitted for the fourth and final time to the Cowdy ward. She told staff that she had placed a rope around her neck that morning but it had hurt and as a result she had placed a plastic bag over her head. The deceased was admitted initially as an involuntary patient and continued on her regular medication regime.

26. Between 11 and 15 September 2009 the deceased remained an involuntary patient at Cowdy ward. On 15 September 2009 the deceased's status changed to voluntary and from that time she was granted overnight leave with her mother on a number of occasions. On about 17 September 2009 an alternative diagnosis of "hebephrenic/disorganized schizophrenia" was being considered by the deceased's treating psychiatrist, Dr Sharon Crabbe. As a result the deceased's medication was changed and she commenced on Risperidone, an antipsychotic medication. I received evidence that this form of schizophrenia commonly starts between the ages of 15 and 25 years and tends to have a poor prognosis because of the rapid development of negative symptoms, particularly flattening of affect and loss of volition.

27. Because of the deceased's previous history of poor compliance with medication a decision was made that she would commence on Risperidone via an intramuscular injection each fortnight. The deceased was

administered her first intramuscular injection at approximately 1.30pm on 22 September 2009. The following morning she began to display signs of suffering a serious reaction to this medication. By lunch she reported feeling dizzy and appeared vague. As a result, the deceased was commenced on medication to offset the side effects of Risperidone; however it appears that she suffered from these side effects up until her death. During this time the deceased continued to have overnight leave with her mother. The last occurring on 24 September 2009.

28. On Thursday 24 September 2009 the deceased was seen by her consultant, Dr Crabbe, and a number of other medical staff during the course of a ward round. Dr Crabbe gave evidence that during the course of this attendance she spoke at length with the deceased and also discussed her diagnosis and treatment. Dr Crabbe gave evidence that as a result of that consultation a "treatment plan" was entered into with the consent of the deceased. Part of that plan was that the deceased could have leave but that such leave was to be with her mother. This was recorded in the notes related to the deceased.

29. On Friday, 25 September 2009, the deceased returned to Cowdy ward after having overnight leave with her mother. Plans had also been made for the deceased to have overnight weekend leave with her mother, so that the deceased could participate in family plans to celebrate the AFL Grand Final. It appears that when the deceased spoke with her mother she expressed excitement to be part of these plans. Agreement was reached that the deceased's mother would return to collect the deceased from the Cowdy ward later that evening.

30. In terms of events that took place upon her return to the ward, I received evidence from Registered Nurse, Michelle Press. Nurse Press was an impressive witness with 15 years experience as a registered nurse and particularly at the Cowdy ward. Nurse Press indicated that she worked a double shift on 25 September 2009 and recalled seeing the deceased shortly

after she returned to the ward. Nurse Press stated that the deceased appeared nicely dressed and relaxed upon her return, but that during the day the deceased "unravelled" and became "demanding" and "a little bit histrionic".

31. At about 3.30pm the deceased went for a walk outside Cowdy with a fellow patient. In order to protect that other patient's privacy I will refer to her as "Z" within these reasons. Nurse Press stated that the pair were not gone for long and when they returned the deceased appeared "calm, relaxed, nothing untoward that I could pick up". At around 6pm the deceased's mother arrived at Cowdy ward to collect the deceased for her overnight weekend leave. The deceased was collecting her various items for leave when Z approached RN Michelle Press and advised that during their walk, the deceased had been "talking about euthanasia and was talking about having suicidal thoughts or something to that effect".

32. As to be expected, this information caused Nurse Press to be concerned for the welfare of the deceased and she approached the deceased and asked whether she intended to hurt herself. Nurse Press gave evidence that the deceased became angry and said words to the effect of

> "Well I'm just going to go home and kill myself". Nurse Press stated that the deceased "rambled for a little bit and I just couldn't follow the, you know, the form of the – or the flow of the conversation. In a very short space of time she's turned around to sort of saying, 'Well I wouldn't do that, I haven't read the euthanasia book yet".

33. Nurse Press also spoke with Melissa Claridge and advised her as to what had occurred. Mrs Claridge gave evidence before me that she specifically recalled that the nurse she spoke to that day said words to the effect that the deceased would require "24/7 care" and that if this could not be provided by Mrs Claridge then it was best if the deceased remained at the ward. Nurse Press stated in her evidence that she could not recall saying anything specific as to the level of care necessary if the deceased were to go home on

weekend leave, but she recalled Mrs Claridge appearing to be "uncomfortable and uneasy" about caring for the deceased given her expressed thoughts of suicide. I heard evidence from Mrs Claridge that upon being informed of her daughter's comments, she became extremely concerned for her daughter's welfare and did not believe that she would be able to provide the care she thought was said to be necessary, ie 24 hour care. Agreement was then subsequently reached between Nurse Press and Mrs Claridge that overnight leave should be cancelled that evening with a review to occur the following day.

34. Nurse Press then spoke with the senior nurse in charge of that shift who contacted the on call doctor, Dr Ussman Khalid. Dr Khalid gave evidence before me that he conducted an interview and review of the deceased. Dr Khalid gave evidence that during that review the deceased denied that she had said anything about suicide. Dr Khalid observed that the deceased appeared nervous during the review and made no eye contact with anyone in the room. In terms of the decision he reached as a result of that review, Dr Khalid stated

> "Because Emma just had thought of suicide ideation and was she was a bit ambivalent about her plan or about her ideation. She wasn't speaking to me openly or – it was difficult to understand or to know what was going through her mind, and it was for her safety to deny that leave on that night".

35. As a result overnight leave was refused.

36. Dr Khalid stated that when he told the deceased of his decision, the deceased became "irritable". Dr Khalid stated that he explained to the deceased that he had made this decision as he was concerned for her safety. Both Dr Khalid and Nurse Press recalled the deceased made mention of the fact that she was a voluntary patient. Nurse Press recalled that when this was said, she told the deceased that her status could be changed if they thought that she was "unsafe". Dr Khalid stated that he recalled

acknowledging with the deceased that she was a voluntary patient but this could change depending upon changes in her mental status.

37. I note that within his statement to the police, Dr Khalid recalled that when mention was made by the deceased of her voluntary status, he advised the deceased that if she did try and abscond, one of the possibilities was that the doctors could make a decision to "section her", ie make her an involuntary patient. In his statement, Dr Khalid said this was not his desire, and was not intended as a threat, however he wished to make clear that he did not want the deceased to leave the ward and wanted to make clear what the options were if she chose to leave. I also note that within the records tendered from the Cowdy Office Dr Khalid set out the plan for the deceased as follows:

> "Plan – leave if the doctor on call feels safe to send her – section her if she tries to abscond"

38. Dr Khalid stated that he made clear to the deceased that he was not refusing leave on a permanent basis but simply for that evening because he did not consider it safe for the deceased to leave. Dr Khalid stated that whilst the deceased did appear "irritable", "she wasn't protesting or she wasn't saying anything against the plan". Dr Khalid stated that he reassured the deceased that a review would take place the following day to assess when the deceased could next go on leave. Dr Khalid then left the deceased with her mother.

39. Melissa Claridge then spoke with the deceased about the decision. She told the deceased that she would come back the following day to collect her following the review. She stated that when she left, the deceased appeared to have come to terms with the decision about her leave, although she was still clearly unhappy. Prior to leaving the ward, Mrs Claridge was advised by staff that the deceased would be reviewed the following morning and that she should call to be advised of the decision regarding future leave. Nurse Press recalled seeing the deceased after she had finished speaking with her

mother and at that time the deceased appeared to be "calmer". Nurse Press stated that she reassured the deceased that the decision cancelling her leave was "just for tonight" and that they would review her the following day.

40. Tendered in evidence was the roster of persons on duty at the Cowdy Ward and the Joan Ridley Unit for the three shifts occurring on 25 and 26 September 2009. According to those records RN Valerie Kullack was also working the "PM" shift on 25 September 2009. Nurse Press gave evidence that as a result of the interactions between herself and the deceased, and the decision made by Dr Khalid regarding leave for that evening with a review in the morning, she made a decision to discover what staff were going to be on shift the next day and provide to them as much information as possible as to what had occurred in relation to the deceased.

41. Nurse Press stated that she discovered one of those persons was going to be Nurse Kullack who was also on shift on the evening of 25 September 2009. As a result she went and spoke directly to Nurse Kullack, telling her what had happened and what was planned to occur the following day. Nurse Press stated that she did this to ensure there was a "continuity of care" for the deceased. In addition, Nurse Press gave evidence that she also documented the incident in the patient notes for the deceased and marked those notes with a stamp entitled "Clinical Incident" so as to highlight that there had been a significant change in the deceased's status. She stated that she did this so that anyone reading the notes would see the incident and understand what had occurred. Nurse Press stated this was in accordance with the usual procedure at the ward at that time.

42. Nurse Kullack gave evidence that on 25 September 2009 she became aware of an "incident" involving the deceased and had been told by Nurse Press that the deceased had been "reading about euthanasia and was contemplating … being part of that and that she had talked about suicide". Nurse Kullack appeared to not readily recall this conversation and was quite vague in her

recollections. Nurse Kullack stated that when this conversation occurred there were a number of other people around and "there was a fair bit of noise". She stated that she could not recall being made aware of any decisions concerning leave. Nurse Kullack stated that she was not aware of a critical incident having been recorded in the notes for the deceased as she did not look at the notes either during the course of that shift or the shift for the following day. Nurse Kullack stated it was her "usual practice" to consider the notes but she had not done so on this occasion.

43. Having considered the evidence before me I find that Nurse Kullack was advised by Nurse Press of the incident on 25 September 2009 and was spoken to directly and specifically about the change in circumstances for the deceased. I found Nurse Press to be an impressive witness and I accept that she told Nurse Kullack about the change in circumstances for the deceased.

44. Nurse Kullack gave evidence that she recalled having five occasions of direct interaction with the deceased during the course of her shift the following day, ie on 26 September 2009, and made the following observations:

a. When she provided the deceased with her medication at the commencement of her shift that morning. Nurse Kullack described the deceased as sitting in her room in the dark watching a DVD. She spoke with the deceased and asked her how she was and she responded that she was "fine";

b. When the deceased approached her asking if she could go for a walk with patient "Z" on the hospital grounds. Nurse Kullack the deceased's "aspect was pleasant" and "she was appropriate" affect and "there was no sign that … she was in any distress at all";

c. When the deceased asked if she could have a "chat" with her. Nurse Kullack stated that the deceased appeared initially "hesitant" to

speak, but when she did commence speaking she was "a little bit distressed" and spoke about her "inability to move forward in life". She described the deceased as "negative … in everything she talked about" and stating that "she felt very hopeless". By the end of that conversation however Nurse Kullack stated that it did appear to her that the deceased had "listened" and she felt that the deceased "had understood some things that – she was thinking about working through some of her problems". Nurse Kullack stated that she "felt that … there was some positive interaction there and she felt better than how the conversation started";

d. When the deceased was undertaking her review with Dr San Pedro;

e. When the deceased asked if she could go to Casuarina shops.

I will detail Nurse Kullack's observations about these final 2 occasions below.

45. Turning to the review on 26 September 2009, I note that this was conducted by Dr San Pedro. Dr San Pedro gave evidence that prior to commencing her review she was made aware of the incident the night before and of the decision by Dr Khalid to refuse overnight leave. Dr San Pedro gave evidence that she was informed of those circumstances by the nurse in charge of the ward, namely RN Makiko Noto and she also looked at the patient notes for the deceased and then arranged to conduct the scheduled review of the deceased. Dr San Pedro recalled that just prior to her undertaking her review, Nurse Kullack approached her and was "enthusiastic" about a conversation she had just had with the deceased. Dr San Pedro recalled Nurse Kullack

> "feeling positive that there were some things that they were getting through to Emma and how she seemed to be doing well and stuff".

46. Dr San Pedro recalled meeting with the deceased and taking her to the interview room. Dr San Pedro gave evidence that when she met the deceased on that day she appeared "quite cheerful", and "quite positive", and they had a joke together. Dr San Pedro recalled Nurse Kullack being in attendance whilst that review was conducted, however she accepted that it could have already commenced when Nurse Kullack arrived in the room.

47. Nurse Kullack stated she recalled attending the review but it had already commenced by the time she arrived. Nurse Kullack stated that she noted that the deceased appeared "neutral" in her body language and was "attentive and listening" to what Dr San Pedro was saying. Nurse Kullack recalled that the deceased indicated that she was "fearful about going on overnight leave and she felt safe about staying on the ward" and "fearful of going home that night". It appeared to Nurse Kullack that the deceased did not want to go on overnight leave. Nurse Kullack stated that by the end of the interview the deceased appeared "quite bright" and that "her spirits had lifted". Nurse Kullack stated it appeared to her that the deceased "was very pleased" about the decision that she was not to permitted to go on overnight leave.

48. Dr San Pedro stated that during the review she confirmed with the deceased what the purpose of the review was, ie. to determine whether she should be permitted to go on overnight leave. Dr San Pedro stated that she recalled asking the deceased how she felt and "she was telling me look, 'To tell you the truth I don't have any ideas of ending my life now, but it's always there'". Dr San Pedro stated that when they discussed leave for the weekend, the deceased stated words to the effect of "I should go, but I don't know if I should". Dr San Pedro stated in her evidence that the deceased "appeared ambivalent" about going on leave and as a result of her previous history of suicidal thoughts she began to ask the deceased what she would do if those thoughts returned when she was on leave from the ward. Dr San Pedro stated that she did this to see if the deceased could "put a safety plan

in place". Dr San Pedro gave evidence that the deceased was unable to put together a plan and she asked the deceased whether she could trust herself to call for help if she needed it and the deceased said she could not.

49. In her statement to the police Dr San Pedro recalled that the deceased indicated to her that she did not believe that she could ask her mum to bring her back to Cowdy if things changed because on that particular day the deceased was aware that her mother would be drinking. At this point in time Dr San Pedro stated that if this occurred then Cowdy could arrange to send a taxi to collect her. Dr San Pedro recalled that the deceased seemed somewhat surprised about this offer as her mother's residence was in Virginia; however Dr San Pedro reassured the deceased that if transport was required then they would make arrangements for a taxi to come and get her.

50. Dr San Pedro gave evidence that because the deceased could not give her a "safety plan", she told the deceased that she thought it better that the deceased not have overnight leave. Dr San Pedro stated as follows:

> "I guess we made a decision together so she was happy about the – the decision. I don't know if you can say happy when you're in hospital, but content about the decision. She preferred it herself to be in the hospital."

Because of this, and because of the deceased's apparent insight into what was happening, Dr San Pedro gave evidence that she did not consider it necessary to "section", or change the deceased's status to involuntary because the deceased was cooperating with the treatment and confirming that she was to stay.

51. Dr San Pedro recorded her review with the deceased in the Cowdy Ward records as follows:

> "Emma seen re ONL. She does not feel safe to go home today. She says she wants to live life but she wants to end it (sic) because she feels like she is living life as a dead person. Plan – no overnight leave tonight"

I pause to note here that there is no reference to any other type of leave, only overnight leave (ie "ONL"). Dr San Pedro stated that her decision related only to overnight leave for the evening of 26 September 2009 and that she explained this to the deceased. Dr San Pedro stated that at no time did the deceased indicate a desire to leave the ward for a shorter period, or simply on a day basis, and that different considerations would have applied if the deceased had told her she wished to leave for a shorter period of time.

52. The review did not take place until sometime between 1 and 1.30pm. Mrs Claridge gave evidence that at about 1.30pm she spoke with the Cowdy staff and her memory was that she was told that the deceased was not permitted to leave the hospital, "Not at all this weekend". Mrs Claridge spoke with the deceased on the phone at about 2pm and the deceased told her that she planned to watch a DVD that day on the ward and she would call later that night.

53. Mrs Claridge was clear in her evidence that it was her understanding from the discussion with Cowdy staff that the deceased was not permitted to leave the hospital that weekend and had she been aware that the deceased may have been permitted to have daytime leave then she would have made alternative arrangements so the deceased could spend that time with her. It was clear from her evidence that Mrs Claridge remains very upset that this possibility was not made clear to her at the relevant time, particularly given the events that subsequently occurred.

54. Significantly, Mrs Claridge stated as follows in her evidence:

> "I was told that I couldn't watch her 24/7. So I don't understand why she was allowed out. I just – to this – until now I do not understand why she could be considered, you know, at risk and then be allowed to be let out. I think that it was appalling what had happened, you know, that – if the night before they say to you, 'You cannot watch her 24/7', you know, and then the following day they basically, 'You can't – you know, we still think that she's – she will be home', then why let her out? It's just the – it's the one thing I can't fathom at all.

> I thought she was safe. I actually relaxed a bit thinking, 'Well she's there, it's okay, they'll look after her', you know, and just to, you know – you know, yeah, they just – I can't fathom that that she was never allowed – that she wasn't allowed to come home with me, you know, where she was bloody safer as far as I'm concerned. She was safer with me at home with me, you know. To – to say that she's, you know, 'We'll call the police if, you know, she leaves' or, you know, 'She can't be watched – I can't watch her' and then, 'Hey, it's okay, just go shopping', you know. Knowing that she had no credit on her phone or couldn't get through on her phone, her phone actually wasn't working, so, you know, that just – something should have changed then. I just can't believe it".

It was clear to me that this aspect has caused Mrs Claridge a great deal of distress since her daughter's passing.

55. Shortly after the review with Dr San Pedro, the deceased approached Nurse Kullack and requested leave to go to Casuarina to recharge her mobile telephone account. Nurse Kullack stated that this occurred "probably around about 20 minutes" after the review. Nurse Kullack stated that the deceased still appeared to be "quite happy, quite pleasant in her … manner". Nurse Kullack recalled the deceased as being "positive, engaging and … she had good eye contact at the time". Nurse Kullack asked the deceased how she was feeling and whether she had any thoughts of self harm. The deceased told her she "was fine" and that she had no thoughts of self harm. The deceased stated that she would be going to Casuarina with patient Z. Nurse Kullack told the deceased that she would need to check with the nurse in charge, and as a result she went and spoke with Nurse Noto.

56. Nurse Noto gave evidence and provided a statement to police. She recalled Nurse Kullack approaching her and advising her that the deceased wished to go to Casuarina to recharge her mobile phone account with patient Z. Nurse Noto stated that this conversation occurred less than half an hour after the deceased had been reviewed by Dr San Pedro and refused overnight leave. Nurse Noto asked Nurse Kullack whether the deceased was okay and Nurse Kullack advised that she had asked questions of the deceased about thoughts

of self harm and this had been denied by the deceased. Nurse Kullack gave evidence that she told Nurse Noto that she thought it was okay for the deceased to go.

57. In terms of her decision making process in determining whether day leave could occur, Nurse Noto stated she considered the following factors

a. the deceased had gone for a walk around the hospital earlier that morning as part of "ground leave" with patient Z and that had occurred "without a problem";

b. the deceased wished to go out again with patient Z;

c. the deceased was a voluntary patient;

d. there was nothing to indicate an "acute risk" of suicide, simply the same risk that had existed throughout;

e. the deceased had provided a "specific and reasonable reason why she wanted to go out and where she wanted to go";

f. There was no report of any suicidal thought.

58. As a result the deceased was permitted day leave and left with patient Z sometime after 2pm. At about 2.24pm the deceased and patient Z caught a bus from RDH to the Casuarina bus depot. Upon arrival at the depot however the deceased and patient Z parted company. The deceased continued to the Casuarina Shopping Centre, whilst patient Z went to her home. Police investigations reveal that the deceased attended at Casuarina and scheduled an appointment for a haircut at 3.30pm. She then went to the bookstore and purchased 3 books. She returned for her hair appointment, and this finished just after 5pm. She then left the centre and took a bus back to her residence at 9 Griffe Street, Nakara arriving sometime between 5.30 and 5.45pm.

59. As at the date of her death the deceased occupied her residence with a flat mate, namely Mr Rodd O'Malley. Mr O'Malley provided a statutory declaration to the police detailing his recollection of the deceased returning home some time after the grand final had finished. He stated the deceased told him that she had been to Casuarina. He recalled the deceased appeared to be suffering some side effects and he asked what drugs she was on and she told him that she felt the best she had in days. At that stage he asked the deceased why she was permitted to leave Cowdy when she appeared to be having difficulties in walking and the deceased said to him words to the effect of "I get 2 hours". Mr O'Malley then commented that because it was almost 6pm it must be time for her to go back. At this point in time the deceased said words to the effect of "Oh yeah, yeah, as long as I'm back by 8pm".

60. Mr O'Malley described the deceased as appearing happy and smiling and that they "had a bit of a yarn and a bit of a laugh". Mr O'Malley recalled that at around 7.20pm the deceased stated that she was going to walk to the phone box to contact Cowdy to see if they could come and collect her. I received evidence that there was a phone box at the intersection of Ellengowan Road and Brinkin Terrace, however it appears that on this day the public phone was not working and the deceased was unable to make her call. Mr O'Malley told police that the deceased returned about 5 to 10 minutes later and stated that she was going to stay the night and would return to Cowdy the next morning. Mr O'Malley stated that he offered money to the deceased so that she could get a cab, but she refused and the two of them sat down and watched some television for a short time.

61. Sometime between 8 and 8.30pm the deceased told Mr O'Malley that she was going to bed to read a book. Mr O'Malley described the deceased as still appearing happy and there had been no changes in her mood during the time that she was at the home. Mr O'Malley stated that there was no discussion in relation to suicide or anything similar and it is clear from his

statement to the police that even with his prior knowledge of the deceased's mental health and circumstances, he had no concerns for the deceased's welfare at all during the time of his interaction with her on that day. This was the last time that Mr O'Malley saw the deceased alive and he then went to bed himself at approximately 8.45pm.

62. RN Tatjana Butler was the nurse the deceased had been allocated to for that shift. She stated that she had not had any dealings with the deceased during that day but was aware when she commenced her shift that the deceased had gone on day leave to Casuarina. Nurse Butler stated that she was not aware of the deceased being given any time to return from her leave and "as far as I knew she was a voluntary patient and that she would be back before tea time or medication time". I was told that tea time was between 5 and 6pm and medication was between 7.30 and 8.00pm. Nurse Butler stated that although the deceased had not returned by tea time, she was not alarmed at that stage as "the shops were still open, she could have had tea out. … And it was still light outside too".

63. According to the evidence before me it was at approximately 6pm that patient Z returned to the ward. RN Melody Charles was the supervising nurse for the "PM" shift and gave evidence that when patient Z returned she asked her where the deceased was and was advised that the last place patient Z had seen the deceased was at the bus depot. RN Charles gave evidence that she spoke with RN Butler and arranged for RN Butler to attempt to make contact with the deceased on her mobile phone. It did not work. Attempts were made on the home phone number for the deceased but this also did not work. Mr O'Malley set out in his statement that the home phone was in the name of the deceased and this had been disconnected for some time as a result of the deceased not paying the bill.

64. RN Butler set out in her statement that as a result of being unable to contact the deceased she attempted to telephone Melissa Claridge at approximately

7.30pm, but there was no answer. She left a message and Mrs Claridge returned the call. It is clear on the evidence that the call from Nurse Butler to Mrs Claridge asking if the deceased was with her, was very upsetting, particularly given that Mrs Claridge was clearly of the understanding that the deceased was not permitted to leave Cowdy that day. Mrs Claridge told Cowdy staff that she believed the deceased would be at her residence at Griffe Street and requested that attempts be made to locate her there. In addition Mrs Claridge herself attempted to make contact with Mr O'Malley, but unbeknownst to her Mr O'Malley had changed his mobile telephone number and therefore the number she was ringing was incorrect.

65. Both RN Charles and RN Butler gave evidence before me that at around 8pm contact was made by Nurse Charles with Dr San Pedro advising of their concerns in relation to the deceased and querying whether contact should be made with the police. I heard evidence that Dr San Pedro agreed with this course of action. Nurse Charles gave evidence that this was in accordance with the procedure for when a patient went AWOL, ie absent without leave. I note that a copy of that policy was tendered in evidence before me as part of exhibit 1 (at folio 82). Nurse Charles stated that she did not contact the on call team as she was aware that at that time there was only one nurse on duty and that nurse would not go to the address of the deceased with the police, and was also "tied up" with a patient in the ED.

Police Involvement

66. As a result, at around 8.26pm RN Charles contacted police communications ("COMMS"). RN Charles told police in her statement that she advised the COMMS officer that the deceased was a voluntary patient and had not returned to the ward since leaving at approximately 2pm. She advised the COMMS officer that the deceased had ongoing "thoughts" of self harm and that doctors intended to "section her" when she returned to the ward. In evidence before me Nurse Charles stated that she told the police that she

was concerned for the deceased "because it was possible the patient could be at risk of self harm". I heard evidence that COMMS requested that if the deceased was to be sectioned, then Cowdy staff were required to fax through the appropriate paperwork. RN Charles stated that she advised police that the doctor was not on the ward at that time to sign the paperwork, but she would send it through as soon as possible.

67. According to the evidence, a job was entered into the Integrated Computer Assisted Dispatch ("ICAD") records at 8.26pm, and a PROMIS job was then created recording the job as a "priority 3". I received evidence that police have a "Graded Response Policy" which provides guidance to members for determining the appropriate level of response to a request for police assistance. A copy of this policy was tendered in evidence (exhibit 3). The policy is to ensure that police resources are applied efficiently and effectively to calls for assistance received from the public and outlines how supervisors and managers can exercise judgment in a manner which ensures that the right amount of police resources are applied at the right time.

68. It is clear that from that policy there are 5 levels of response, namely:

i. Grade 1 – Immediate

ii. Grade 2 – Prompt

iii. Grade 3 – Routine

iv. Grade 4 – No attendance/referral

v. Grade 5 – No action

69. The policy itself sets out examples of the types of jobs that would fall within each level. In this regard I pause to note that during the course of her evidence, Dr San Pedro referred to the deceased as being a "missing person" when she had not returned to the ward. I note that at page 4 of the policy, "missing persons – not high risk" are recorded in the list as a grade 3. Also

attached to the policy are a number of annexures, in particular annexure B, which sets out a more extensive list of those types of jobs that fall within the grade 3 level. Again this includes "missing person", but also "mentally ill person" and "absconder hospital". Based on the evidence before me I consider the categorisation by police of the initial call from Cowdy ward in relation to the deceased was appropriate.

70. As a result of the placement of the job onto the system, I received evidence that the COMMS supervisor for the evening, namely Senior Constable Josette Rourke, reviewed the job and held discussions with Watch Commander, Senior Sergeant Gary Smith. Senior Sergeant Smith gave evidence before me as to his recollections of this "job" and of the information police had been provided. A copy of the job as it appeared on the COMMS screen that evening was attached to Senior Sergeant Smith's statement (see folio 64 of exhibit 1).

71. At approximately 8.35pm a Form 52, pursuant to s166A of the MHRS Act was faxed by RN Charles to the police. RN Charles gave evidence that it was her understanding that this was the only form applicable given that the deceased was a voluntary patient who had not returned from leave. At the time of the initial faxing, the Form 52 had only been signed by RN Charles. I pause to note that s166A(2) requires that before police can apprehend a person and return them to the facility they must be authorised by "an authorised psychiatric practitioner" to do so. RN Charles is not an authorised psychiatric practitioner pursuant to the definition contained under s4 and 22 of the MHRS Act, and although RN Charles had placed Dr San Pedro's name in the form, it had not yet been signed by the doctor. As a result when Senior Constable Rourke received the Form 52 she telephoned Cowdy ward and advised that the paperwork was incorrect and needed to be signed by a doctor.

72. At or about 9.28pm a further Form 52 was sent by Cowdy ward to the police. Included with that form was a Form 10, pursuant to s39 of the MHRS Act. Both of these forms had been signed by Dr San Pedro. At or about 9.45pm the Form 10 and Form 52 were delivered to Senior Constable Rourke. Although it appears that on this night there was some discussion between police and Cowdy staff about the forms, I received evidence from Senior Sergeant Smith that the police response to this job was not dependent upon paperwork. Senior Sergeant Smith stated that the issue for him was resources to be able to respond to the request for assistance given all the other jobs that police were receiving that evening. Senior Sergeant Smith made clear that it was not the case that police were "sitting around waiting for paperwork" before taking action in relation to the deceased. I heard and received evidence that Saturday 26 September 2009 was a particularly busy evening. It does not surprise me that this is the case, particularly given that it was the evening of the AFL grand final. In addition I heard evidence that police had received an urgent job with a report that a taxi driver was seen being driven around with a knife to his throat. As a result police had a number of extremely urgent jobs to which they had assigned significant resources as well as dealing with the many other jobs that had been received that evening.

73. Also tendered in evidence before me (exhibit 7) was a statement from Police Auxiliary, Andrea Parkanyi, who is employed within the Joint Emergency Services Communications Centre (JESCC). This statement helpfully details (inter alia) the number and nature of the jobs police were dealing with on this particular evening. It shows just how busy police were attending to various call outs from the public and for a number of matters classified as significantly more serious than that related to the call from Cowdy concerning the deceased.

74. Senior Sergeant Smith made clear that the information that he had received from Cowdy was that the job related to a patient who was voluntary, had

been outstanding from the Ward for six hours before contact was made to the police, had only been having what was described to be as "thoughts" of suicide and "could be" suicidal. Senior Sergeant Smith stated that as a result of that information he made a "judgment call" that there were other jobs that took priority. Senior Sergeant Smith stated that had he been given other information to suggest that there was a significant risk related to the deceased, then he would have given the job higher priority and done all he could to get a vehicle to the job, including even attending himself.

75. Senior Sergeant Smith stated that when the new shift commenced at 10.00pm he had the "luxury" of some additional members and he immediately tasked them to attend at 9 Griffe Street, Nakara. At about 10.36pm, unit 409 from the Casuarina Police Station containing Constables Damon Innes and Matthew Lindsay was dispatched. I find that it is clear on the evidence that as soon as the resources were available to police they attended to this job as quickly as they possibly could.

76. Both Constables Lindsay and Innes provided statements in relation to their recollection of events that evening. It is clear that at or about 10.47pm the officers arrived at the residence to conduct a welfare check. Police made numerous attempts to raise a response from inside the house but to no avail. Constable Lindsay noticed a light on, on the right hand side of the residence and squatted down to look through the window. There, he observed what appeared to be a person. Initially he thought they were positioned in such a way that they were attempting to hide next to an air conditioner unit.

77. Constable Lindsay jumped the side fence and proceeded around the back of the residence. There he found an unlocked sliding glass door. Constable Lindsay yelled out that he was the police, but again there was no response. Both he and Constable Innes remained outside waiting for permission from COMMS to enter the house. When permission came approximately 3 or 4

minutes later, both he and Constable Innes entered the residence and proceeded through the house calling out that they were police.

78. Shortly after entering, the officers entered into a bedroom and announced that they were police. The room was occupied by Mr O'Malley who got out of bed and said words to the effect of "I was expecting you to come. Are you looking for Emma?". Mr O'Malley then took the police to the bedroom of the deceased. When police entered the room, they noticed a female in the corner, on her knees, slumped over with her head resting on the wall just next to the air conditioner. Constable Lindsay noticed that she was not moving and her hair was down over her face. The opening of the bedroom door had not roused her.

79. Mr O'Malley walked over to the deceased, gave her a slight shake on the shoulders and told her to "wake up". Mr O'Malley stated to the police that the deceased was on medication and that "she sometimes does this". Constable Lindsay told Mr O'Malley to move out of the way so that he could assess the deceased. He lifted the deceased's head and noticed purple blotches on her face. Thereafter he saw a piece of fabric wrapped around her neck very tightly. Constable Lindsay told Constable Innes to get a knife at which point Mr O'Malley ran from the room. Constable Lindsay then told Constable Innes to go to the vehicle and grab the resuscitation gear.

80. Mr O'Malley returned to the room and gave a knife to Constable Lindsay. Constable Lindsay removed the fabric from the deceased's neck and resuscitation was commenced immediately, however it was quickly established that the deceased had passed away, and their attempts at resuscitation ceased. At 11.03pm St John Ambulance Officers, namely David Beck and James Leigh, arrived and noted that the deceased's extremities were cold to touch, her skin was mottled, her face and hands cyanosed (ie. blue) and her pupils were fixed and dilated. Cardiac monitor pads were placed upon the deceased but no rhythm was found. At about

12.57am forensic pathologist Dr Terrence Sinton attended the scene and estimated the time of death to be between 9 and 10pm, but closer to 10pm.

81. I received evidence that a subsequent interrogation of the IPod phone belonging to the deceased revealed a number of images had been downloaded onto the phone showing how to tie a rope into a noose like fashion. There was also a note found from the deceased on her computer desk outlining her desire to end her life.

Issues raised for consideration at this inquest

82. At the commencement of this inquest, Counsel assisting outlined a number of issues that she suggested perhaps required my consideration as to whether I should make comment upon pursuant to my powers under s34(2) of the Act. Those issues can be summarised as follows:

1. The appropriateness of the decision making by Cowdy staff when dealing with the deceased on Friday 25 and Saturday 26 September 2009, particularly in terms of her status as a patient and also her entitlement to ward leave.

2. The sufficiency of the handover by Cowdy staff of information and any changes in risk assessment or critical incidents concerning the deceased.

3. The delay between Cowdy staff permitting the deceased to go on daytime leave (ie. at approximately 2.24pm when she leaves the ward) and when concerns begin to be raised in relation to her failure to return (ie. at about 7.30pm when Casuarina shopping centre has well and truly been closed for a number of hours) and attempts made to locate her.

4. The adequacy of understanding by police and Cowdy staff as to the provisions of the MHRS Act relating to what action can be taken and

the powers that are available to police when a patient is absent from the Cowdy ward.

5. Whether the role to be undertaken by police in relation to the *Protocol for Cooperative Arrangements in Mental Health Matters* (an agreement between the Commissioner of the Police and the Department of Health and Families) requires greater clarification.

6. What role, if any, should be undertaken by the mental health on call team when patients, either voluntary or involuntary, are absent without leave from the Cowdy ward.

83. I will now deal with each of the above matters in turn in light of the evidence I have received during the course of this inquest.

The appropriateness of the decision making by Cowdy staff when dealing with the deceased on Friday 25 and Saturday 26 September 2009, particularly in terms of her status as a patient and also her entitlement to ward leave

84. In order to properly analyse and consider the decisions made on 25 and 26 September 2009 concerning the deceased's status and her entitlement to leave, I consider it appropriate to consider her history of admissions to the Cowdy ward. It is clear on the evidence before me that the deceased was a very complex patient and was described as a "diagnostic dilemma". This was in spite the fact that, somewhat unusually (given what I have seen in numerous inquests is often a high turnover of staff in the mental health arena) the deceased had been able to have the assistance of a single treating psychiatric consultant throughout all of her admissions to Cowdy ward, namely Dr Sharon Crabbe. Dr Crabbe stated in evidence that although the deceased's case was complex, she considered that upon her fourth (and what was her final) admission, the deceased's symptoms were becoming more psychotic in nature thus leading to the considered diagnosis of hebephrenic schizophrenia. Dr Crabbe gave evidence that one of the difficulties in

diagnosing schizophrenia is that it can often take approximately 6 months to confirm such a diagnosis.

85. Dr Crabbe gave evidence that given her extensive knowledge and familiarity of the deceased, in terms of her symptoms, her compliance and her behaviour, she found the deceased to usually be manageable on a voluntary basis for the majority of her time at the ward and complied fully with her treatment during the course of such admissions. As a result and particularly given that the deceased had volunteered herself upon her final admission seeking assistance, and was no longer expressing suicidal ideation, Dr Crabbe made a decision to change her status to voluntary on 15 September 2009.

86. Dr Crabbe gave evidence that assessing the deceased as voluntary was also in accordance with the ideal which underpins the MHRS Act of promoting the least restrictive therapeutic environment while preventing patients from committing self harm. Dr Crabbe stated that in general terms there were 4 criteria to be considered as to whether a patient should be made involuntary:

a. Whether the person was suffering a mental illness;

b. Whether they required treatment at an approved facility;

c. Whether they were a risk of harm to self or others; and

d. Whether they were incapable of consenting to such treatment or were unreasonably refusing such treatment.

87. Dr Crabbe stated that given the deceased was consenting to treatment and was a chronic, rather than acute, risk of self harm, she considered it appropriate to keep the deceased as a voluntary patient. Dr Crabbe stated that a further aspect was that because the deceased was presenting with symptoms more suggestive of an on-going psychiatric disorder (ie schizophrenia), which would likely require long term management with

mental health services, she was attempting to engage the deceased in treatment but also allow her some degree of autonomy in her management so that she could engage more effectively in the long term with the system. Dr Crabbe stated this was particularly important when dealing with a young person such as the deceased.

88. I also received evidence in relation to the issue of the deceased's status as a voluntary patient from Nurse Press. Nurse Press stated that she was also a qualified designated mental health practitioner and as a result was qualified to change a patient's status from voluntary to involuntary pursuant to the MHRS Act. Nurse Press gave evidence that she had carefully reflected on the issue of the maintenance of the deceased as a voluntary patient despite her chronic suicidal ideation. Nurse Press stated that she considered that because the deceased, although unhappy, had complied with the decision to cancel overnight leave and was in agreeance to continue with treatment, she did not consider it appropriate to change her status. Nurse Press stated that she considered it important to attempt to maintain the deceased's status as a voluntary patient as it "ties in with National Mental Health Strategy" of "least restrictive care" that "underpins our practice". Nurse Press stated that she considered providing a patient like the deceased with "autonomy was important" as it gave the patient "control over treatment" which in turn "helps with compliance and recovery". It is also clear from the statement of Nurse Press that she considered this particularly important with a young patient like the deceased.

89. Likewise Dr Khalid gave evidence that had the deceased indicated that she would not comply with treatment or the decision made regarding her leave, then he would have considered changing her status to involuntary, but that "whilst she was irritable" about the decision that was made, Dr Khalid stated that "it wasn't the case that she stated that she would not comply".

90. In terms of the decision to grant day time leave to the deceased after Dr San Pedro's review on 26 September 2009, as previously noted Dr San Pedro stated that had the deceased asked her for day time leave after the refusal for overnight leave she would nevertheless have considered permitting such leave. Dr San Pedro stated that her concerns related more to a "long period" of leave, rather than to day time leave because of the deceased's inability to provide a safety plan and that she more than likely would have granted day leave, even though she considered overnight leave was not appropriate.

91. It is clear therefore that there was a tension between the provision of "least restrictive care" and the containment of risk when treatment plans were being prepared, particularly given the significant fluctuations in the deceased's mental state that appear on her medical records to have occurred from time to time. However overall it appears that the deceased was generally accepting of treatment and managed previous periods of leave successfully and regularly, both in terms of day and overnight leave.

92. Whilst institutions, including mental health institutions, are properly the subject of rigorous scrutiny in the course of the coronial process, in doing so it is always necessary to make allowance for the fact that the coronial process is conducted with the benefit of hindsight. It is not appropriate to judge those individuals whose actions are the subject of scrutiny during the course of that process in accordance with the counsel of perfection. That, of course, does not detract from the requirement that the coronial process identify any institutional deficiencies with a view to making recommendations directed to the prevention of future deaths. I, as Coroner, am required in these circumstances to find any relevant circumstances concerning the death, and to make relevant recommendations, if any, with respect to the prevention of future deaths in similar circumstances.

93. These duties reflect the fact that one of the primary purposes of the coronial jurisdiction is "to seek out and record as many of the facts surrounding the

death as public interest requires": see *R v South London Coroner; Ex parte Thompson* (1982) 126 Sol J 625 at 628. This function finds voice in ss.26 and 34(1)(a)(v) of the Act. It falls therefore to me as the Coroner to, inter alia, draw together the investigation materials to see what can be learned and understood, and what may be done to avoid repetition of adverse events.

94. In this regard I note that during the course of this inquest I received a copy of the "Critical Incident Review" conducted at the request of the Director of Mental Health, Department of Health and Families, namely Bronwyn Hendry (exhibit 15). I also received evidence from Ms Hendry. I note that the review was undertaken with the intention of critically examining all the processes relevant to the care of the deceased and to identify any potential areas for service improvement. I pause to note that I consider it important that such reviews are undertaken (particularly when deaths like this occur) independently of the coronial inquest process as it enables the various Departments to quickly identify failures in systems and to address them proactively for the better provision of services, rather than simply wait for recommendations by me which may flow from the findings of an inquest.

95. Included within that review is a report from Professor Christopher Tennant, a consultant psychiatrist of the University of Sydney and therefore external to the Department and to Cowdy ward itself. Within his report Professor Tennant expresses the opinion that "many clinicians would have preferred to maintain this patient under the mental health act until at least the nihilistic delusions and suicidality had clearly settled, and indeed fully documented". Dr Crabbe provided an additional statement to me as part of her evidence which addressed this issue (see exhibit 12). Dr Crabbe set out in her statement that she did not agree with such an opinion and noted that if this were the case, and such an approach had been adopted by her during the course of her treatment of the deceased, then this would have meant that the deceased would have been required to remain as an involuntary admission from her initial presentation in March 2009 until her death, ie some six

months later. Dr Crabbe stated that she did not consider this would be an appropriate outcome and I accept her evidence in this regard.

96. I note that Professor Tennant makes further comment within his report about the appropriateness of the deceased's status and also whether Cowdy ward should remain an open ward, unlike most psychiatric wards in this country. After having read and considered the Critical Incident Review, and also the statements and evidence of Fran Pagdin and Bronwyn Hendry given during the course of this inquest, I have determined that there is no need to make recommendations in relation to the issue of the appropriateness of the decisions made concerning the deceased's status as a patient and her entitlement to leave. This is particularly so in light of the adoption, and acting upon, of the findings made during the course of the review by the Department. Were this not the case, then perhaps my decision in this regard may have been different, however I accept that the Department is acting proactively.

97. I accept that on this occasion the Cowdy staff involved in the care of the deceased were attempting at all times to provide an appropriate level of care to the deceased for her protection and safety, but also to allow her some level of autonomy so she could learn her own safety skills in order to lead a life outside in the community. Whilst, with the benefit of hindsight some staff may now make a different decision, I do not consider that means the decisions that were made at the relevant time were necessarily wrong, or were contributory to the ultimate passing of the deceased. I accept each individual careful considered the options before making the relevant decisions concerning leave and patient status.

98. One of the matters that became clear to me as a result of the evidence is that one of the difficulties facing staff was that the deceased's mental state would fluctuate regularly and significantly. However, it also appears on the evidence that at no time on 26 September 2009 did the deceased express

suicidal ideation; she was simply unable to provide a safety plan to Dr San Pedro, hence the reason for the refusal for overnight leave. The deceased was then permitted day leave on the basis that she stated that she had no intention of hurting herself. She was then seen by her flatmate, Mr O'Malley, for several hours and was described by him as happy and caused him no concern as to her mental state. Despite all of that, the deceased then went to her bedroom and spent time researching how to make a noose and writing a note setting out her reasons for wishing to die and apologising. It is clear that the deceased had therefore become resolute and determined to take her own life. It is pure speculation as to when she arrived at this decision.

99. I also note that there has been a complete overhaul at the Cowdy ward in terms of assessing a patient's entitlement to leave and a closure of the ward itself. The overhaul of leave appears to be a positive change and I make no further comment in relation to this issue. In terms of the closure of the ward, this appears to be subject to further review by the Department, however given that I consider the death of the deceased was not in any way contributed to by the fact that the ward was open at the time I do not consider it necessary to make any further comment other than to encourage the Department in its endeavours to continue to improve safety and services at the ward.

The sufficiency of the handover by Cowdy staff of information and any changes in risk assessment or critical incidents concerning the deceased

100. I have already noted that during the course of her evidence, Nurse Kullack stated that she did not consider the notes related to the deceased when she commenced her shift on 26 September 2009. This was in spite of the fact that the deceased was assigned to Nurse Kullack as her patient that day. I also note that it appears that no one either noticed or considered the notation made by Dr Crabbe on 24 September 2009 that leave should only take place with the deceased's mother, although I accept the evidence of Dr Khalid and

San Pedro that they did in fact read the notes prior to their reviews of the deceased.

101. I do not consider that the failure by Nurse Kullack to read the notes contributed to the death of the deceased, particularly given that it is clear that Dr San Pedro herself read the notes, and given that Nurse Kullack sat in on the interview with the deceased and was aware of the refusal of the overnight leave. I find therefore that it appears that the failure to read the notes would have made no difference to the subsequent decision to grant day leave.

102. However, as I have said many times in many previous inquests, it is extremely important that better note taking and more formal handovers of a patients care be carried out. When this occurs it more often than not means that the decisions made and the reasons why, can be examined by the next person who takes over the care and/or treatment of a patient. That next practitioner is then able to become better involved and quickly assess the circumstances of the patient and assure themselves that those things that should have been considered in relation to the patient, have in fact been considered. The next practitioner is then able to have those notes of the prior decisions made to compare against their own examinations and/or assessment of the patient. I therefore encourage the Department to carry out the recommendations noted within Ms Hendry's statement concerning communication.

The delay between Cowdy staff permitting daytime leave at approximately 2.24pm and when concerns begin to be raised in relation to her failure to return at about 7.30pm and the subsequent attempts made to locate the deceased

103. It is clear from the evidence that there was a certain amount of delay before any action was taken by Cowdy staff in terms of attempting to locate the whereabouts of the deceased. As noted earlier in these findings the deceased left the ward with patient Z who returned to the ward at

approximately 6pm and advised staff that she had not seen the deceased since they separated at the bus depot not long after departing the ward at 2.24pm. Despite this, no action was taken to locate the deceased at that time. It appears from the evidence that the reasoning for this is that staff simply expected the deceased to eventually return.

104. By 7.30pm the deceased had still not returned. By now it had been 5 hours since the deceased had been at the ward. Tendered in evidence before me as part of exhibit 1 was the Guidelines in place at the time for Mental Health Unit staff where a client leaves without notice (AWOL) (see folio 82). The guideline details the procedure to be undertaken when a patient leaves the ward. In accordance with that policy, the deceased's mother and police were contacted however it appears that the On Call Team (OCT) were not contacted. I heard evidence that this was because they were "busy", however I consider that at least an attempt should have been made at that time. It also appears that the urgency of the situation was not adequately communicated to the police by the Cowdy staff involved. I consider this was because the Cowdy staff were not significantly alarmed themselves given their level of familiarity with the deceased.

105. I note that counsel for the Department has requested that I refer to this period as a "lack of clarity of the terms of the leave", rather than the delay, however I do consider it was a delay that occurred and that such delay was brought about by a lack of clarity of the terms of the leave that could have been addressed at the time that leave was granted to the deceased. I do note however that these issues have also been considered extensively in the Critical Incident Review undertaken by the Department and recommendations made in relation to ongoing education of staff as to correct procedures and policies and also, and importantly, the use of mental health services where possible in the first instance. I also note that there has been a review of the policies and procedures and that part of the *Protocol for Cooperative Arrangements in Mental Health Matters* is anticipated to

address this issue. It is in these circumstances that I do not consider it necessary to make any further comment or recommendations regarding this issue as I consider that the Department is adequately addressing the matter.

The adequacy of understanding by police and Cowdy staff as to the provisions of the MHRS Act relating to what action can be taken and the powers that are available to police when a patient is absent from the Cowdy ward.

106. I note my comments made above in relation to the issue of further education of Cowdy staff concerning the protocols and procedures and do not intend to repeat those comments here. I note that some criticism was raised in the material tendered before me in relation to the action of police in waiting on further documentation and forms before attending at the address nominated as the deceased's residence. I do not consider that such criticisms can be upheld and given the evidence of Senior Sergeant Smith I do not accept that police were waiting for the relevant forms.

107. I also do not consider that the action taken by police could have been taken any earlier given the information they had received about the nature of the concerns of Cowdy staff and therefore the prioritisation of the "job", particularly in light of the other work that police had to attend to and undertaken on that evening. I also anticipate that once the *Protocol for Cooperative Arrangements in Mental Health Matters* has been finalised by both the Commissioner of Police and the Department of Health and Families that there will be further education of police members and that this will serve to ensure a greater understanding of police powers and obligations when dealing with the mentally ill.

Whether the role to be undertaken by police in relation to the *Protocol for Cooperative Arrangements in Mental Health Matters* requires greater clarification

108. I note that work upon the finalising of this Protocol is nearing completion and it is intended that this protocol will replace the current *Police and*

Mental Health Services Memorandum of Understanding. I encourage both the Department and the Commissioner of Police to continue their work in this regard and to attempt to finalise the protocol as soon as possible in the hope that this provides greater clarification of the roles of all parties when dealing with persons suffering from a mental illness. Given that this work is almost completed however, and given that it will address the roles to be undertaken by all parties, I do not consider it necessary to make comment or recommendation in this regard.

What role, if any, should be undertaken by the Mental Health On Call Team when patients, either voluntary or involuntary, are absent without leave from the Cowdy ward

109. I consider this to be an important feature that has been raised during the course of this inquest. I note that it appears from the evidence that despite the existence of the Mental Health On Call Team ("OCT") no member of Cowdy staff communicated with the OCT in relation to the absence of the deceased. Instead communication was made with police.

110. In this regard I note that Fran Pagdin provided significant and important evidence related to the OCT and in particular its staffing and resources both pre and post this death. It is clear that during the relevant period when the OCT may have been contacted by Cowdy staff (ie from 6pm until 8.30pm); there was only one staff member on duty at the OCT at the time. It is also clear that the relevant staff member was busy undertaking other duties which may have made it impossible for that staff member to have been able to have done anything to assist in attempting to locate the deceased. That however is not to the point as obviously no attempt at all was made to communicate with the OCT and indeed it appears from the statements of Nurse Charles and Senior Constable Josette Rourke that it was the practice of Cowdy staff not to contact the OCT but instead to contact police.

111. It appears however from the evidence of Ms Pagdin and Ms Hendry that it is intended that this practice change and that further funding has been allocated to improve services. I further note that Ms Pagdin has referred to the restructure of the OCT into a Critical Assessment Team ("CAT") which will function over 24 hours and enable a better level of response.

Conclusion

112. Given these significant changes I do not consider it necessary to say anything further other than to RECOMMEND that what is set out in the materials included in the statements of Ms Pagdin and Ms Hendry at exhibits 14 and 15 as being promised to occur, actually occur. This is an important service and it is not the first time that I have had cause to consider during the course of an inquest that additional funding should be provided to the On Call Team. As I stated during the course of proceedings, Government must be accountable for properly funding and resourcing these teams so that they can properly undertake their duties and responsibilities in taking care of the mentally ill.

113. The death of this young woman is a tragic reminder of the significant needs of the mentally ill in our community and the continued responsibility of Government and the wider community to maintain efforts to improve services in the hope that this kind of death can be avoided in the future.

Mr Greg Cavanagh :

Dated this 4th day of February 2011

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GREG CAVANAGH
TERRITORY CORONER