STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	**Inquest into the death of XY**
Hearing dates:	5, 6, 7 and 19 November 2014 and 4 December 2014
Date of findings:	23 January 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
File numbers:	2012/392095
Findings:	I find that XY died on 18 December 2012 on the upline track of the Mount Colah train track near stanchion N37+082 as a result of multiple blunt force injuries after being hit by a train after taking steps to end her own life.
Recommendations:	To the Chief Executive of the Northern Sydney Local Health District: that consideration be given to clarifying the term of "adolescent" in the Brolga Unit Referral Package to reflect the existing discretion to admit patients at or under the age of 18 years who otherwise meet the admission criteria to that Unit.
Order:	Pursuant to s. 75(2)(b) of the *Coroners Act 2009* I order that there be no publication of any information that identifies: a. XY as being a person whose death may have been self-inflicted; or b. Any person as being a relative of XY.

Catchwords:	CORONIAL LAW – suicide – adolescent mental health CORONIAL LAW – expert evidence CORONIAL LAW – application of section 20R of the *Health Administration Act 1982* – meaning of "proceedings"
Representation:	Dr P Dwyer instructed by Ms L Turner (Crown Solicitor's Office) as Counsel Assisting the Coroner; Mr J Gracie with Ms T Moisidis instructed by Mr S Hall-Johnson (Beilby Poulden Costello) for the family of Ms Y; Ms L Cook (Clayton Utz) instructed by Mr R Turnbull (Clayton Utz) for Lifeline Australia and Lifeline Harbour to Hawkesbury; Ms J Sandford instructed by Mr B Wilford (Henry Davis York) for North Sydney Local Area Health District; Mr R Hood instructed by Mr N Regener (Makinson D'Apice) for the Commissioner of Police of the NSW Police Force.

Contents

FINDINGS

Introduction

XY was just 17 years old when she tragically took her own life on 18 December 2012. She leaves behind a devoted and loving family including her mother, WW, her father, ZZ and her younger siblings, A and B. The family had moved from New Zealand when X was seven or eight years old and lived in Sydney's upper north shore.

WW (who I will refer to as "Ms W") bravely and eloquently spoke of her daughter's attributes during the inquest, giving me insight into the girl who inexplicably took her own life when she clearly had so much to offer and live for. Amongst other things, Ms W spoke of X being in the enviable position of having difficulty choosing between a number of pursuits because she was equally talented and interested in them. On all accounts, X was an extraordinarily intelligent and gifted young person. She had topped her grade in year 11 and year 12 at Ku-ring-gai Creative Arts High School, having transferred there from a selective school. Despite changing schools, X made friends quickly and was active and very sociable.

In 2012, X was in her final year of secondary school and studying for the HSC. That time would, ordinarily, be a challenging one for any adolescent but for X there were a number of additional personal events which impacted upon her. Between January and April 2012, X experienced two stressors which were later identified by Child and Adolescent Mental Health Service Consultant Psychiatrist, Dr Alexander Lim, as the elements which *"unmasked and maintained her cognitive ruminations that life was no longer worth living"*. The first event was the breakdown of her relationship with a fellow student and his subsequent suicide attempt precipitated by that breakdown. The second event was an episode of familial disharmony. While it is unfortunate that such a personal issue is raised in these findings, regrettably, it is necessary to do so at least briefly in order to address oral submissions made by Mr Gracie of Counsel for Ms W and Mr Z. I will address those submissions further at a later point in these findings.

These two events occurred against a background of X's low level experimentation with alcohol and recreational drugs; her feelings of exclusion early in 2012 after two close friends commenced a romantic relationship; and her continuing difficulties sleeping. In relation to the latter she underwent a tonsillectomy in the hope that it would help her to sleep. It reportedly did not.

Following her tonsillectomy, Ms W noticed that X's mood changed and this event, it seems, marked the beginning of the downward spiral that X and her loved ones found themselves in the ensuing months until her death.

Prior to this time, there was no indication that X suffered from any serious medical condition.[1] In contrast, in 2012 she sought fairly regular and at times intensive care and treatment for mental health issues. X saw a school counsellor in February 2012 and made sporadic contact with Lifeline. The overwhelming majority of her therapeutic mental health care was provided by Hornsby Ku-ring-gai Hospital ("**Hornsby Hospital**") and Hornsby Ku-ring-gai Child and Adolescent Mental Health Service ("**CAMHS**"). Both are facilities and services administered by the NSW Health public health system and specifically, the Northern Sydney Local Health District ("**NSLHD**").

On 31 July 2012, X made the first known attempt on her life by taking an overdose of 16 paracetamol tablets. She was found by her father who took her to Hornsby Hospital. X was admitted to its Emergency Department and reviewed by Dr Terence Yang, who diagnosed her with paracetamol poisoning and suicidal thoughts and subsequently issued a Schedule 1 certificate pursuant to s. 19 of the *Mental Health Act 2007*. A mental health assessment was conducted by a CAMHS team consisting of psychiatric registrar Dr Rose Damaio and social worker Thomas ("Tom") Campbell ("**Mr Campbell**"). Mr Campbell took a detailed history and noted some of the stressors for X at the time. That was the beginning of a clinical and therapeutic relationship between Mr Campbell and X that continued until her death.

Thereafter, X found herself back at Hornsby Hospital on 8 October 2012 and 16 December 2012 following reported overdoses. It was during the 8 October 2012 admission that X was first seen by CAMHS psychiatrist, Dr Alexander Lim ("**Dr Lim**"). In anticipation of X's discharge, Mr Campbell and Dr Lim took steps to apply for a Community Treatment Order to be made pursuant to s. 51(1) of the *Mental Health Act 2007* authorising the compulsory treatment in the community of X. An order was made by the Mental Health Review Tribunal on 5 November 2012 which required X to attend on Mr Campbell or a delegate, attend on Dr Lim or a delegate, accept the treatment or medication as prescribed by Dr Lim or a delegate, and comply with any medical examination as requested by the treating psychiatrist or delegate. X remained the subject of that order at the time of the reported overdose on 16 December 2012 and at the time of her death.

[1] There are notes in the medical records exhibited before me (Exhibit 1) that suggest X, as described by psychiatric expert Dr Matthew Large, "*experienced a degree of unhappiness and possibly intermittent suicide ideas for some years prior to 2012*". However, there is no evidence that X disclosed these feelings to her parents or that she sought mental health treatment prior to 2012.

The final overdose occurred just 48 hours before her death. On this occasion, X was found by her parents who took her to Hornsby Hospital where she was admitted at 1.23am on 16 December 2012. In contrast to the previous overdoses, on this occasion X denied ingesting the substances with the intent to end her own life. X was discharged at about 1.30pm on 17 December 2012 once again into her parents' care. Following her return home, Ms W contacted Hornsby Hospital regarding, at least, X's behavior (the precise contents of the communication are in dispute). Although Dr Lim and Mr Campbell had not seen X during her brief admission, they were made aware of it and decided that X would be safe in her parents' care until her appointment with them the following day at 2.00pm. Unfortunately, X thereafter took steps to evade her parents and end her life approximately 15 hours later, on 18 December 2012.

The function of the Coroner

The role of a Coroner as set out in s. 81 of the *Coroners Act 2009* is to make findings as to:

1. the identity of the deceased;
2. the date and place of a person's death;
3. the physical or medical cause of death; and
4. the manner of death; in other words, the circumstances surrounding the death.

A Coroner, pursuant to s. 82 of the *Coroners Act 2009*, also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

It is convenient to note at this juncture the comments of the then State Coroner, Derek Hand, in the *Inquest into the Thredbo Landslide* at p.10[2]:

> *"The inquest plays an important function as a fact finding exercise, essential to investigate and answer the relatives' and public's need to know the cause of death free from the constraints of inter partes litigation. It does not apportion guilt. Although not expressly prohibited by the Act, it is not the function of the inquest to determine any question of civil, let alone, criminal liability."*

Similar observations were made by his Honour Justice Hedigan in *Chief Commissioner of Police v Hallenstein*[3] at [15].

[2] 19 June 2000, unreported

[3] [1996] 2 VR 1

Issues

As indicated by Counsel Assisting at the outset of this inquest, there is no controversy in relation to X′s identity, the date and place of her death or the medical cause of her death. The focus of this inquest was in relation to the manner and/or circumstances of X′s death and what possibly can be learned from this tragedy in order to prevent future deaths and the pain and suffering endured by X′s family and friends. The Issues List circulated to the interested parties identified the following issues:

1. Was XY appropriately cared for and treated during her inpatient admission to Hornsby Ku-ring-gai Hospital on 31 July 2012, 8 October 2012 and 16 December 2012?
2. Was XY appropriately cared for and treated as an outpatient of the Hornsby Ku-ring-gai Child and Adolescent Mental Health Service in 2012?
3. In relation to the care and treatment of XY generally in 2012:
    a. Should X have been discharged from Hornsby Ku-ring-gai Hospital on 17 December 2012?
    b. Were the risks accompanying discharge from Hornsby Ku-ring-gai Hospital on 17 December 2012 appropriately managed?
    c. Should X have been readmitted to Hornsby Ku-ring-gai Hospital at any time following her discharge on 17 December 2012?
    d. Was X′s difficulty sleeping appropriately investigated and managed?
    e. Should X have been medicated prior to 8 October 2012?
    f. Should any further steps have been taken with respect to XY under the *Mental Health Act 2007*?
4. Did the NSW Police Force appropriately respond to the report of a concern for XY′s welfare on 18 December 2012?
5. Were policies and procedures concerning the communication of information between Lifeline and the NSW Police Force appropriate and were they appropriately applied?
6. Are there recommendations which ought to be made which would reduce the likelihood of similar deaths occurring or otherwise contribute to an improvement in public health and safety?

The initial Issues List as disseminated to all parties of sufficient interest to this inquest attempted to break down various stages of X′s care and treatment. After reviewing all the evidence, written and oral, it seems artificial to break down her care and treatment as an inpatient and outpatient of Hornsby Hospital and CAMHS, respectively. It seems to me that the medical care and treatment issues may conveniently be dealt with together. I acknowledge, in doing so, that different NSW Health policies and guidelines would apply depending on the place and/or capacity in which X was

treated. Nevertheless, for convenience, I will address the matters identified in the Issues List under the following truncated headings:

1. Did X receive appropriate care and treatment from Hornsby Hospital and CAMHS during her various admissions and during her outpatient treatment?
2. Did the NSW Police Force appropriately respond to the report of concern for X's welfare on 18 December 2012?
3. Were policies and procedures concerning the communication of information between Lifeline and the NSW Police Force appropriate and were they appropriately applied?
4. Are there recommendations which ought to be made which would reduce the likelihood of similar deaths occurring or otherwise contribute to an improvement in public health and safety?

Conduct of the inquest

Before addressing those issues, it is necessary to outline some matters relating to the conduct of this inquest generally.

This inquest was listed before me over three days commencing on 5 November 2014. The dates and duration of the hearing had been known to the interested parties since January 2014.

In September 2014, the solicitor for Ms W and Mr Z provided a proposed amended Issues List. The amended document comprised four pages of 19 issues (when there had previously been one page of six issues), of which one (issue 7) included sub-issues (a) to (y) (where previously it had listed sub-issues (a) to (f)).

On 7 October 2014, I held a directions hearing at which I addressed the issue of the proposed amended Issues List. Ms W and Mr Z were represented by a solicitor. After hearing submissions regarding the proposed amendments, I explained that almost all of the matters were captured by the issues already identified by me and, for the most part, for that reason I did not propose to amend the Issues List.

The legal representatives for Ms W and Mr Z had also expressed their view that the inquest should be listed for five days instead of three days. My view at the time (and it remains my view) was that this inquest should be completed within three days.

Unfortunately, we did not finish all of the evidence until late on the final day of the inquest. As a result the matter was re-listed before me on 19 November 2014 for the purpose of short oral submissions only. Practitioners were advised that they would be limited to 20 minutes for their respective submissions. There was no objection to that course, particularly as I had indicated my intention that I wished to be in a position to hand down these findings prior to Christmas for the sake of the family who had suffered too much and deserved, in my view, to start the New Year with hopefully some, if not all, of the issues that this inquest seeks to resolve, answered.

On 19 November 2014, all parties complied with the stopwatch submission guidelines as previously set by me; however, Mr Gracie handed up a small folder which consisted of 34 pages of written submissions and 30 pages of chronology. The former had not previously been provided to Counsel Assisting in order that she be in a position to respond orally thereto and I had, during the inquest, declined to accept Counsel for the family's offer that the latter be provided to me (whether by way of tender by Counsel Assisting or otherwise). Counsel Assisting noted that she and Counsel for the NSLHD had the benefit of chronologies prepared by them or their instructing solicitor. As a result leave had to be given to both Ms Sandford and Dr Dwyer to provide a reply in writing. I directed that the NSLHD provide an outline of submissions by 27 November 2014 and that the matter be listed for findings on 5 December 2014. Due to an oversight, no direction was made for Counsel Assisting to serve an outline of submissions in reply.

Prior to Ms Sandford providing supplementary submissions, the solicitors for the NSLHD provided to the solicitor assisting a letter dated 28 November 2014 addressing Mr Gracie's submissions in relation to the currency and application as at 16 December 2012 of the NSW Health Policy Directive entitled 'Transfer of Care from Mental Health Inpatient Services' (PD2012_060) and the reference to the admission of patients "*Aged 12 and no older than 17 years of age*" in the 'Referral Package' of the Brolga Child and Adolescent Inpatient Unit.

Counsel for the NSLHD provided supplementary submissions in writing on the evening of 1 December 2014. I had previously provided an extension for those submissions until 28 November 2014, then again on 30 November 2014. Due to the delay, it was impossible for Counsel Assisting to provide her outline of submissions in reply by 1 December 2014, as was foreshadowed to the interested parties. The interested parties were notified of Counsel Assisting's intention to serve a written reply on 3 December 2014.

However, in the late afternoon of 2 December 2014 the legal representatives for the family provided, separately, to each of the interested parties and the solicitor assisting, further written submissions by Counsel. Amongst other things, in those supplementary submissions the family

sought leave to tender the Root Cause Analysis report ("**RCA report**") prepared for NSW Health and the NSLHD in respect to X's death. The submissions annexed a copy of the RCA report. No application to this effect was raised with Counsel Assisting during the coronial investigation or made when this inquest was heard before me on 5 to 7 November 2014. Mr Gracie later advised me that this was because the family were unaware as to whether I, or those assisting me, had obtained a copy of the report.

On the afternoon of 3 December 2014, the legal representatives for the NSLHD provided to the solicitor assisting further written submissions in reply to those submissions provided by Counsel for Ms W and Mr Z.

The solicitor assisting provided a copy of the NSLHD's further written submissions to the solicitor for the family and requested that he obtain instructions as to whether his clients wished to withdraw their application for leave to have the RCA report form part of the evidence. I was advised that the family pressed the application and that Counsel was preparing additional written submissions.

Given the provision of the 28 November 2014 letter from the solicitors for the NSLHD, the family's application for the RCA report to be tendered, the provision of supplementary submissions for Ms W and Mr Z on 2 December 2014 and further submissions for the NSLHD on 3 December 2014 and there having been no direction for Counsel Assisting to file submissions in reply, I re-listed this matter before me at 2.00pm on 4 December 2014 to address those matters.

At 12.39pm on 4 December 2014, Counsel for the family's further submissions addressing the admissibility of the RCA report was provided to the solicitor assisting. At 12.40pm, the solicitor assisting was provided with a letter from the solicitors for the NSLHD in which a further submission was made in reply to the submissions made on behalf of the family on 2 December 2014, and leave was sought to have those submissions read.

The matter came before me at 2.00pm on 4 December 2014. On that occasion, Ms Emma Sullivan of the Crown Solicitor's Office appeared as Counsel Assisting, Mr Gracie of Counsel appeared for Ms W and Mr Z and Ms Sandford of Counsel appeared for the NSLHD. The other interested parties were excused. The letters from Henry Davis York to the Crown Solicitor dated 28 November 2014 and 4 December 2014 were tendered and marked as Exhibits 13 and 14 respectively. I granted leave to Ms W and Mr Z to file supplementary submissions dated 4 December 2014 (which mirrored the 2 December 2014 supplementary submissions save for the omission of any reference to the RCA report); the further supplementary submissions for the NSLHD dated 3 December 2014 and the further supplementary submissions for the family dated 4

December 2014 (which addressed the admissibility of the RCA report). I directed that the NSLHD provide further supplementary submissions addressing the admissibility of the RCA report by 10 December 2014; that Counsel Assisting provide any submissions in reply (addressing the admissibility of the RCA report and the substance of the inquest) by 8 January 2014; and that the listing for findings be vacated and re-listed on 23 January 2015.

In summary, in addition to the exhibits and the oral evidence, in preparing these findings I have had regard to:

1. The oral submissions made on 19 November 2014;
2. The written submissions for the family dated 19 November 2014 ("**the first written submissions for the family**") and the chronology referred to therein;
3. The written submissions for the NSLHD dated 1 December 2014 ("**the first written submissions for the NSLHD**");
4. The supplementary written submissions for the family dated 4 December 2014 (which addresses the matters referred to in the letter from Henry Davis York to the Crown Solicitor dated 28 November 2014 (Exhibit 13)) ("**the second written submissions for the family**");
5. The written submissions for the family dated 4 December 2014 (which addresses the admissibility of the RCA report in relation to X's death) ("**the RCA report submissions for the family**");
6. The written submissions for the NSLHD dated 11 December 2014 (which responds to the RCA report submissions for the family) ("**the RCA report submissions for the NSLHD**");
7. The written submissions of Counsel Assisting dated 8 January 2015 (which addresses the admissibility of the RCA report in relation to X's death) ("**the RCA report submissions of Counsel Assisting**"); and
8. The written submissions in reply by Counsel Assisting dated 9 January 2015 ("**Counsel Assisting's submissions in reply**").

I note that in addition to the above documents, I have also had regard to *X v Deputy State Coroner for New South Wales*[4] and *Decker v State Coroner of NSW and Anor*[5]. Those cases were referred to me by Counsel for the family on 4 December 2014, following the conclusion of the hearing that day, by letter from the solicitor for the family to the solicitor assisting. That letter stated that those authorities *"are directly relevant to the stated question"* in relation to the admissibility of the RCA

[4] [2001] NSWSC 46 at [2] and [13]; (2001) 51 NSWLR 312
[5] [1999] NSWSC 369; (1999) 46 NSWLR 415

report. It was requested that those citations be conveyed to me *"consistent with his* [Mr Gracie's] *professional duty to the Court".*

For the sake of completeness, it is necessary to firstly address the family's application for the RCA report to be tendered prior to dealing with the matters outlined in s. 81 of the *Coroners Act 2009.*

Admissibility of the Root Cause Analysis report

In the submissions for the family in relation to the RCA report, the following question is posed:

> *"Does section 20R of the Health Administration Act 1982 prevent the admission into evidence in coronial proceedings of a Root Cause Analysis published pursuant to Part 2 Division 6C of the Health Administration Act 1982?"*

It is submitted for the family that s. 20R of the *Health Administration Act 1982* does not prevent the admission of a RCA report into evidence in coronial proceedings.

Part 2, Division 6C of the Health Administration Act 1982

Part 2, Division 6C of the *Health Administration Act 1982* governs root cause analysis in the NSW public health system. Section 20M(1) requires that when a "*reportable incident*" involving a relevant health services organisation is reported to the chief executive officer of the organisation, the organisation is to appoint a root cause analysis team in relation to that incident. A "*reportable incident*" is defined as an incident of the type set out in Appendix D of the Ministry of Health Policy Directive PD2014_004 'Incident Management Policy' (s. 20L of the *Health Administration Act 1982* and cl. 13 of the *Health Administration Regulation 2010*). Relevantly to this inquest, a reportable incident includes a suspected suicide of a person (including an inpatient or community patient) who has received care or treatment for a mental illness from the relevant health services organisation where the death occurs within seven days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation, and the probability of recurrence is considered to be "frequent" (defined as an expectation that the incident will recur immediately or within weeks or months), "likely", "possible" or "unlikely" (defined as the possibility that an incident may recur at some time in two to five years). The relevant health services organisation is to appoint members of an RCA team in accordance with the regulations (s. 20M(2)).

The RCA team does not have authority to conduct an investigation relating to the competence of an individual in providing services (s. 20N(1)). The RCA team has specified responsibilities (s. 20O) including, relevantly, the responsibility of preparing a written report on completion of its consideration of an incident (s. 20O(3)). That report is to contain:

a) a description of the incident,
b) a causation statement, being a statement that indicates the reasons why the RCA team considers the incident concerned occurred, and
c) if the RCA team has any recommendations as to the need for changes or improvements in relation to a procedure or practice arising out of the incident – those recommendations.

The report furnished or information made available by the RCA team must not disclose the name or address of an individual who is a provider or recipient of services unless the individual has consented in writing to that disclosure or, as far as is practicable, any other material that identifies, or may lead to the identification of, such an individual (s. 20N). An RCA report was prepared in relation to X's death.

Section 20O(3A) provides that subject to s. 20R, the contents of an RCA report may be disclosed to any person and used for any purpose. Section 20R of the *Health Administration Act 1982* provides:

> ***20R Notifications and reports not to be admitted in evidence***
>
> *(1) Evidence as to the contents of a notification or report of a RCA team under section 20O cannot be adduced or admitted in any proceedings.*
>
> *(2) Subsection (1) does not apply to proceedings in respect of any act or omission by a RCA team or by a member of a RCA team as a member.*

Meaning of "proceedings" at s. 20R(1) of the Health Administration Act 1982

Counsel for the family (correctly) notes that the *Health Administration Act 1982* does not define the term "*proceedings*", nor is "*inquest*" or "*coronial proceedings*" defined in the Act so as to either incorporate that exercise of jurisdiction into s. 20R(1), or excise it from that section. Moreover they go on to submit that:

1. had the legislature intended s. 20R(1) to apply to coronial proceedings, it would have used the words "coronial proceedings", which is defined at s. 46 of the *Coroners Act 2009*, as opposed to the word "proceedings"; and
2. in construing the meaning of the term "proceedings" at s. 20R(1) of the *Health Administration Act 1982,* regard should be had to the definition of "civil proceedings" at s. 3 of the *Civil Procedure Act 2005*, which was extant at the time of the *Health Legislation Amendment Act 2010.* It is submitted that the work of s. 20R is in the adjudication of civil proceedings within the meaning of s. 3 *Civil Procedure Act 2005* and to which the *Evidence Act 1995* applies.

Accordingly, the critical question is whether "*proceedings*" at s. 20R(1) has a meaning that includes "*coronial proceedings*".

In *Project Blue Sky Inc v Australian Broadcasting Authority*[6], the High Court stated that *"The primary object of statutory construction is to construe the relevant provision so that it is consistent with the language and the purpose of all the provisions of the statute."*

This approach is complemented by s. 33 of the *Interpretation Act 1987*, which states that *"a construction that would promote the purpose or object underlying the Act… (whether or not that purpose or object is expressly stated in the Act…) shall be preferred to a construction that would not promote that purpose or object."*

It is well-established that the starting point in construing a statute is the text itself. It was stated by the majority of the High Court in *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue*[7]

> *"This court has stated on many occasions that the task of statutory construction must begin with a consideration of the text itself. Historical considerations and extrinsic materials cannot be relied on to displace the clear meaning of the text. The language which has actually been employed in the text of legislation is the surest guide to legislative intention. The meaning of the text may require consideration of the context, which includes the general purpose and policy of a provision, in particular the mischief it is seeking to remedy."*

In *The Owners Strata Plan 62930 v Kell & Rigby Holdings Pty Ltd*[8], Justice Ward summarised the various meaning of "*proceedings*" in law. It is sufficient in this case to set out her Honour's statements at [388] to [390]:

> *Cases considering the meaning of "proceedings" in other legislative contexts indicate that rather than there being one uniformly accepted definition of the term, courts have adopted varying definitions of "proceedings" according to overriding purpose and operation of the particular legislation in question.*
>
> *In* Blake v Norris *(1990) 20 NSWLR 300, Smart J stated (at 306–307):*
>
> *The defendant pointed out that the word "proceeding" was used throughout the Act (except in headings which are ignored for the purpose of statutory construction of the* Interpretation Act 1987*, s 32(2) rather than the term "proceedings". The defendant submitted that the Act contemplated that out of the whole of the proceedings in the Supreme Court there may be transfer of part only.*
>
> *The defendant relied on the definition of "proceeding" in the* Shorter Oxford English Dictionary On Historical Principles*, 3rd ed (1933) at 1677. He referred to part of that definition and relied on part of the second meaning given: "A particular action or course of action; a piece of conduct or behaviour; a transaction. Usu in pl" and part of the third meaning given. I set out in full the third meaning:*

---

[6] [1998] HCA 28; (1998) 194 CLR 355; 72 ALJR 841; 153 ALR 490 at [69]

[7] [2009] HCA 41 at [47]; (2009) 239 CLR 27; (2009) 260 ALR 1; (2009) 83 ALJR 1152; (2009) 73 ATR 256

[8] [2010] NSWSC 612 at [388] to [401]

> *3. spec. The instituting or carrying on of an action at law; a legal action or process; any act done by authority of a court of law; any step taken in a cause by either party.*
>
> *Reference was also made to the definition in the* Macquarie Dictionary*. It is apparent from the meaning given in the* Oxford Dictionary *that "proceedings" can mean either the action itself or a step taken in such action.*
>
> *In* Stroud's Judicial Dictionary*, 5th ed, vol 4 at 2029–2035, some fifty-five instances are given of the use of the words "proceeding" or "proceedings" in legislation, rules of court or documents having legal significance. The meaning depends on the context in which the word is used.* In some cases it is equivalent to "an action" whereas in others it may mean a step in an action. Sometimes it may include a counter claim. *The Oxford Companion To Law* (1980) by Professor Walker states (at 1002–1003) that "proceedings" is sometimes used as including, or meanings, an action or prosecution, and sometimes as meaning a step in an action. The word "proceeding" is capable of such a variety of meaning that dictionary definitions as to its ordinary or natural meaning are not of much use. They tend to highlight the number of meanings which the word can bear. *(my emphasis)*
>
> *Any assistance as to its meaning has to be derived from the statutory context and the objects of the legislation in question.*
>
> *In* Oates v Consolidated Capital Services Ltd *(2009) 257 ALR 558; (2009) 233 FLR 283; (2009) 72 ACSR 506; [2009] NSWCA 183, the meaning of "proceedings" was considered to similar effect in the Court of Appeal, at [116]:*
>
> *Third, there is no definition of "proceedings" in the legislation. The word "proceedings" is capable of covering the whole variety of forensic exercises which may occur in a court:* Proust v Blake *(1989) 17 NSWLR 267 at 270 per Samuels JA (with whom Mathews J agreed);* Re Doran Constructions Pty Ltd (in liq) *(2002) 194 ALR 101; 168 FLR 116; 20 ACLC 909; [2002] NSWSC 215 at [100]–[102] and cases there cited. There is nothing about the word "proceedings" in itself that could make it inapplicable to an application for leave to be given to Mr Oates to bring proceedings asserting CCL Australia's right to bring a derivative action that enforces the rights of CCL UK. The question though, is whether a meaning of "proceedings" that extends so far is the intended one in the context of s 236.*

It is apparent that the word "*proceedings*" is capable of significant breadth. It is also apparent that the best aid in interpretation, consistent with the statement of principle by the High Court in *Alcan*[9]*,* is to construe the word with reference to its context and purpose.

The High Court in *CIC Insurance Ltd v Bankstown Football Club Ltd*[10] stated that "context" should be understood "in its widest sense to include such things as the existing state of the law and the mischief which, by legitimate means such as [reference to reports of law reform bodies], one may discern the statute was intended to remedy". It includes explanatory memoranda (*Newcastle City*

[9] Supra note 6 at [47];

[10] [1997] HCA 2; (1997) 187 CLR 384; 71 ALJR 312; 141 ALR 618

Council v GIO General Ltd[11]) and second reading speeches (*Gerah Imports Pty Ltd v Duke Group Pty Ltd (in liq)*[12]).

Section 34(1) of the *Interpretation Act 1987* similarly provides that in the interpretation of a provision of any Act, if any material not forming part of the Act is capable of assisting in the ascertainment of the meaning of the provision, consideration may be given to that material to confirm the meaning of the provision is the ordinary meaning conveyed by the text of the provision (taking into account its context in the Act and the purpose or object underlying the Act) or to determine the meaning of the provision if the provision is ambiguous or obscure, or if the ordinary meaning conveyed by the text of the provision (taking into account its context in the Act and purpose or object underlying the Act) leads to a result that is manifestly absurd or unreasonable. The extrinsic material which may be considered includes any relevant report of any relevant report of a committee of inquiry or other similar body that was laid before either House of Parliament before the provision was enacted or made (s. 34(2)(b)), any explanatory note or memorandum relating to the Bill for the Act (s. 34(2)(e)) and the speech made to a House of Parliament by a Minister or other member of Parliament on the occasion of the moving by that Minister or member of a motion that the Bill for the Act be read a second time in that House (s. 34(2)(f)).

The rule of *noscitur a sociis* ("a word is known by the company it keeps") is the rule that the meaning of a word may be ascertained by the context in which it appears. It was described as follows by his Honour Spigelman CJ in *Deputy Commissioner of Taxation v Dick*[13] at [13]:

> *This general principle of the law of interpretation that the meaning of a word can be gathered from its associated words* – noscitur a sociis – *has a number of specific sub-principles with respect to the immediate textual context. The most frequently cited such sub-principle is the* ejusdem generis *rule. The relevant sub-principle for the present case is the maxim propounded by Lord Bacon:* copulation verborum indicat acceptationem in eodem sensu – *the linking of words indicates that they should be understood in the same sense. As Lord Kenyon CJ once put it, where a word 'stands with' other words 'it must mean something analogous to them'. (*Evans v Stevens *(1791) 4 TR 224; 100 ER 986 at 987.)*

Accordingly, in interpreting the meaning of "*proceedings*" at s. 20R it is necessary to have regard to the conjoining word "*any*". The Macquarie Dictionary defines "*any*" to include, relevantly, "… *(with plural noun) some, whatever or whichever it may be*"; "*in whatever quantity or number, great or small*" and "*every*". The words "*any proceedings*", as used in s. 20R(1), suggests that the type of

---

[11] [1997] HCA 53; (1997) 191 CLR 85; 72 ALJR 97; 149 ALR 623

[12] [2004] SASC 178; (2004) 88 SASR; 183 FLR 57; 49 ACSR 660; [2004] ALMD 5103

[13] [2007] NSWCA 190; (2007) 226 FLR 388; 242 ALR 152

proceedings to which s. 20R(1) applies should be interpreted inclusively; that is, with a meaning akin to "every proceedings". The only limitation is at s. 20R(2), which expressly provides that s. 20R(1) does not apply to proceedings in respect of any act or omission by a RCA team or by a member of a RCA team as a member. There is otherwise nothing in the context (of the provision, the Part or the Act as a whole) to indicate that "*any proceedings*" should have a limited or extraordinary meaning. Accordingly, "*any proceedings*" includes "coronial proceedings".

While it is my view that, having regard to the text, "*any proceedings*" at s. 20R(1) of the *Health Administration Act 1982* includes "coronial proceedings", for completeness it is necessary to have regard to extrinsic materials to determine the existing state of the law and the mischief which that provision was intended to remedy.

Turning first to the legislative history, the root cause analysis of certain incidents in NSW public hospitals was implemented in 2005 following recommendations of the Special Commission of Inquiry into Camden and Campbelltown Hospitals. A useful summary of the object and operation of the *Health Administration Act 1982* in force prior to the *Health Legislation Amendment Bill 2010*, as it applied to root cause analysis, is contained in the following passages of the Second Reading Speech to that Bill:

> *"The root cause analysis [RCA] provisions:*
>
> *required RCA teams to be appointed by health service organisations in respect of the most serious category of clinical incident – so-called Severity Assessment Code 1 [SAC 1] incidents;*
>
> *required RCA teams to investigate incidents and to provide a report setting out the underlying causes of the incident and any recommendations to avoid such incidents in the future;*
>
> *gave statutory protections to the members of RCA teams, including a statutory privilege against the disclosure of information acquired or documents produced for the purpose of root cause analysis; and*
>
> *made it an offence for RCA team members to disclose information acquired in the course of root cause analysis, except in accordance with the Act.*
>
> *An important characteristic of root cause analysis is that RCA teams are prohibited from investigating the competence of individuals or making findings that identify individual patients or clinicians. For this reason root cause analysis has been described as an investigation into the "systemic" causes of incidents.*
>
> *If during the course of an investigation an RCA team considers there are concerns about the performance, conduct or impairment of any individual, the RCA team must notify the chief executive of the health services organisation of the concern, but dealing with such concerns is not the function of the RCA team.*
>
> *It is the responsibility of the chief executive to ensure the concerns raised by the RCA team are fully investigated and, if appropriate, referred to the relevant regulatory bodies, such as the health professional registration body or the Health Care Complaints Commissioner."*

Prior to the enactment of the *Health Legislation Amendment Act 2010,* s. 20O omitted sub-section 3A, which currently provides:

> *(3A) Subject to section 20R, the contents of a report of a RCA team under subsection (3) may be disclosed to any person and used for any purpose.*

Also, prior to the enactment of the *Health Legislation Amendment Act 2010,* s. 20R provided as follows:

> ***20R Findings of RCA team not evidence of certain matters***
>
> *A notification or report of a RCA team under section 20O is not admissible as evidence in any proceedings that a procedure or practice is or was careless or inadequate.*

The effect of the precursor s. 20R, as it applied to coronial proceedings, was that RCA reports could be admitted as evidence of, for example, the measures which the relevant health organisation had taken to remedy any shortcomings identified by the RCA team. It could not be admitted into evidence in coronial proceedings to prove, for example, that the care provided by a clinician to the deceased was careless or inadequate. The precursor provision reflected the prohibition against the RCA teams investigating the competence of individuals. It was also consistent with the accepted principle that an inquest is not concerned with apportioning guilt or determining any question of civil or criminal liability.[14]

Section 20R was reviewed in accordance with s. 20U of the *Health Administration Act 1982* in force at the time. A NSW Department of Health Report entitled 'Review of Statutory Privilege in Relation to Root Cause Analysis and Quality Assurance Committees Under the *Health Administration Act 1982*' ("**the NSW Health Report**") was prepared. At pages 38 and 39 of the NSW Health Report it was stated, with respect to the now superseded s. 20R:

> *A more significant issue relates to section 20R's focus on the use of RCA reports in litigation where there is a claim that a health service or clinician was negligent. It. does not necessarily protect against the use of RCA reports in other contexts for which they were not intended, such as coronial inquests, criminal or disciplinary matters.*
>
> *The Department's view, which is discussed further in section 7 below, is that generally there should be no legal restriction on the persons to whom an RCA report may be disclosed. An important public policy justification for the privileging of RCA processes is that the report and recommendations should be generally available for the purpose of improving the health system. Having said that, it is reasonable that there should be limits on the use to which RCA reports can be put in the context of litigation and other proceedings. The current section 20R of the Act recognises that an RCA report cannot be relied upon as evidence of negligence in civil litigation. Whilst the restrictions in the Act on RCA team processes and reports make it*

[14] *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 at 15 per Hedigan J.

inherently unlikely that an RCA report may be used in criminal or disciplinary matters, the Department is aware that RCA reports have been referred to in a number of coronial inquests. The Department's approach to coronial inquests is that it makes available any relevant RCA report (or alternatively the recommendations of the report) to assist the coroner, as well as interested parties to the inquest, in understanding the system issues that have been identified by the RCA team, the recommendations that have been made to address those issues, and any steps that have been taken to implement the recommendations by the AHS. The Department is aware that in this way findings and recommendations by RCA teams have been of considerable assistance in a number of coronial inquests.

However, the Department would be opposed to the tendering of RCA reports, or their use in cross-examination of witnesses, including for example clinicians involved in an incident, in coronial inquests or in any other proceedings such as criminal or disciplinary matters. From discussions with stakeholders, the Department is aware that there is ongoing clinician concern as to the risk of RCA reports being use[d] in this manner, particularly in coronial inquests. The Department's view is that use of RCA reports in this way is not consistent with the purpose for which RCA reports are prepared, and that the Act should be amended to clarify this. The Department does however emphasise that the practice of making RCA reports and recommendations available for the purposes of assisting coronial processes will continue as described above. Similarly, RCA reports would also continue to be available to the HCCC where relevant, particularly in respect of an investigation into an AHS.

Recommendation 6.5 of the NSW Health Report was as follows:

> *6.5 Amend section 20R of the [Health Administration] Act to provide that a notification or RCA report:*
>
> *(a) is not admissible as evidence in any proceedings,*
>
> *(b) cannot be tendered in any proceedings and*
>
> *(c) cannot be used to cross-examine any witness in any proceedings,*
>
> *Except in proceedings in respect of any act or omission by a RCA team or by a member of a RCA team as a member.*

The NSW Health Report is referred to in the Second Reading Speech, which relevantly stated that *"The bill before the House contains all of the amendments proposed by the review".* Counsel for the NSLHD also refers to parts of the Second Reading Speech. It is instructive to set out certain passages referred to in full:

> *"The statutory review was provided with evidence of instances where non-RCA team members have been cross-examined in court proceedings in relation to what was said during a root cause analysis. This is clearly contrary to the intention of the statutory protections and is a loophole which has the potential to undermine the confidence of those assisting RCA teams that any information they provide will be used only for the purpose of the root cause analysis.*
>
> *…*
>
> *The bill also proposes clarifying that the final report of an RCA team may be provided to any person, including patients, but that such reports cannot be adduced or admitted in evidence in any proceedings.*

> *Whilst the current legislation is silent on the issue of disclosure of RCA reports the Government's view is that the availability of RCA reports is part of the "quid pro quo" for the protections given to RCA proceedings and team members. This proposed amendment will clarify the availability of RCA reports whilst at the same time broadening the restrictions on the use of such reports in court or other proceedings."*

The Explanatory Note to the *Health Legislation Amendment Bill 2010* provides:

> ***Schedule 2.1 [12]*** *provides that evidence as to the contents of a notification or report of a root cause analysis team cannot be adduced or admitted in any proceedings. Currently, any such notification or report is not admissible as evidence in any proceedings that a procedure or practice is or was careless or inadequate.*

Mr Gracie and Ms Moisidis refer to the Second Reading Speech and Explanatory Note and submit that neither *"recite the intended application"* of s. 20R of the *Health Administration Act 1982* to this jurisdiction.

While it is correct to saying that neither of those materials expressly refer to coronial proceedings, it is nevertheless possible to discern the purpose for which that provision was enacted and, by inference, its intended application to these proceedings.

In my view, the extrinsic materials (which I have set out in detail in the proceeding paragraphs) support the inference that the current s. 20R was enacted to remedy the lack of clarity attending to the precursor provision. The mischief was remedied by broadening the evidentiary limitation to prohibit the use of RCA reports in any proceedings, save for those described at s. 20R(2). Further, the Second Reading Speech makes plain that one of the reasons for broadening the restrictions on the use of RCA reports was to avoid undermining the confidence of those participating in the RCA process. As a matter of commonsense, it could be expected that persons called upon to provide information to the RCA team may be reluctant to provide full and frank information should there be a real possibility that the RCA report may be admitted into evidence in any proceedings, and particularly those proceedings from which adverse consequences may flow to an individual. While Coroners are specifically enjoined from making findings as to issues of criminal conduct (s. 81(3) of the *Coroners Act 2009*)), we are empowered to recommend that a matter be investigated or reviewed by a specified person or body (s. 81(2)(b) of the *Coroners Act 2009*). Given the Coroners' power to make such a recommendation, it would be contrary to the legislature's intention if s. 20R(1) of the *Health Administration Act 1982* were <u>not</u> to apply to coronial proceedings.

I turn now to address Counsel for the family's submission that in construing the meaning of "*proceedings*" at s. 20R(1) of the *Health Administration Act 1982*, regard should be had to the following definition of "*civil proceedings*" at s. 3 of the *Civil Procedure Act 2005:*

3 Definitions

(1) In this Act:

***civil proceedings** means any proceedings other than criminal proceedings.*

Counsel for the family submitted that Parliament will be accepted to have enacted the *Health Legislation Amendment Act 2010* in the context of s. 3 of the *Civil Procedure Act 2005*, which was extant at the time of the passage of the Bill. In support of that submission, Counsel referred me to DC Pearce, *Statutory Interpretation in Australia,* 1974 (1st ed.) at pages 25 – 26 [34] where the author provides commentary of the principle of statutory interpretation that words in the same legislation (as opposed to different legislation) are assumed to be used consistently. As noted by Counsel for the NSLHD, the current (8th) edition of the same text emphasises that distinction in the following passage:

> *"To the extent that the rule carries any weight… it is applicable only in respect of words appearing in a single piece of legislation. It is not applicable where the same word is used in different Acts:* Totalizer Agency Board v Federal Commissioner of Taxation *(1996) 69 FCR 311 at 320…"*[15]

Counsel for the NSLHD further notes the comments of Beech J in *The State of Western Australia v G (A Child)*[16] per Beech J:

> *"In some cases, where a word or phrase is defined in one Act, and the same word or phrase is used but not defined in another Act, and the Acts deal with similar subject matters, it may be permissible to have regard to the definition in the other Act. See Pearce DC & Geddes RS, Statutory Interpretation In Australia (6th ed, 2006) [3.38]. However, with the exception of a generally applicable statute such as the Interpretation Act, a court should not use a definition of a word or phrase in one Act to qualify or extend the meaning of the statutory definition of the same word or phrase in another Act: Yager v R [1977] HCA 10; (1977) 139 CLR 28, 43. That is all the more so where, as here, the phrases are not identical."*

"*Proceedings*" or "*any proceedings*" is not defined in the *Civil Procedure Act 1995*. That Act and the *Health Administration Act 1982* do not deal with similar subject matters. Accordingly, I am not assisted in this task of statutory construction by referring to the definition of "*civil proceedings*" at s. 3 of the *Civil Procedure Act 1995.*

Finally, for completeness, it is necessary to address Counsel for the family's submission that the intended work of s. 20R of the *Health Administration Act 1982* is limited to the adjudication of civil proceedings in NSW (within the meaning of s. 3 of the *Civil Procedure Act* 2005) to which the *Evidence Act 1995* applies. Except insofar as it is submitted that "*proceedings*" at s. 20R(1) of the *Health Administration Act 1982*:

---

[15] DC Pearce & RS Geddes, *Statutory Interpretation in Australia,* 2014 (8th ed.) at p. 152 [4.6]

[16] [2009] WASC 234 at [53]; (2009) 201 A Crim R 1; [2011] ALMD 2277

1. should be construed with regard to the definition of "*civil proceedings*" at s. 3 of the *Civil Procedure Act 1995*, and
2. section 20R(1) is a limitation on the admissibility of "*evidence*" (and the *Evidence Act 1995* "*comprises a code with existing common law governing, amongst other things, laws and rules concerning the admissibility of evidence"*),

it is unclear on what basis it is submitted that s. 20R(1) has no work to do in any other type of proceeding (for example, proceedings before a Tribunal or criminal court). In any event, in light of my conclusion that "*proceedings*" at s. 20R(1) of the *Health Administration Act 1982* includes "coronial proceedings" it follows that I do not accept this submission.

Are Coroners bound by s. 20R of the Health Administration Act 1982?

Further, or in the alternative, Counsel for the family submit:

> *"Equally, section 20R 1982 [Health Administration Act 1982] utilises the same word as used by the legislature in the EA 1995 [the Evidence Act 1995] and in the CA 2009 [the Coroners Act 2009], i.e. "evidence". It is a section directed to evidentiary law and rules. The Coroner in the exercise of jurisdiction is not bound by procedural or evidentiary stipulations governing other Courts."*

It is submitted that a Coroner *"exercises a unique jurisdiction untrammeled by the rules of evidence and procedure"* and is not bound to observe the prohibition against the admission of a RCA report into evidence at s. 20R of the *Health Administration Act 1982*.

Section 58 of the *Coroners Act 2009* states:

> ***58 Rules of procedure and evidence***
>
> *(1) A coroner in coronial proceedings is not bound to observe the rules of procedure and evidence that are applicable to proceedings before a court of law.*
>
> *(2) Except as otherwise provided by this Act, a witness in coronial proceedings who is a natural person cannot be compelled to answer any question or produce any document that might tend:*
>
> *(a) to incriminate the witness for an offence against or arising under an Australian law or a law of a foreign country, or*
>
> *(b) to make the witness liable to a civil penalty.*

The rationale for s. 33 of the *Coroners Act 1980* (being the precursor provision to s. 58 of the *Coroners Act 2009*) was explained by his Honour Justice Hunt in *Mirror Newspapers Ltd v Waller*[17]

> *"The other section of the Coroners Act to which I referred in this context was s 33, which provides that the coroner is not bound to observe the rules of procedure and evidence applicable to proceedings before a court of law. The need for such a departure from the rules of procedure is obvious, because an inquest or an inquiry*

[17] (1985) 1 NSWLR 1 at 16

does not have parties, and there are no pleadings, charges or indictments which define the issue to be tried.

Although usually there are legal representatives for the interested parties, the coroner must consider the interests not only of those parties but also of other persons as well. It is often left to the coroner himself to maintain a vigilant eye upon the relevance of evidence, and objections to the evidence are not always readily apparent. The absence of defined issues is of paramount importance in relation to this question. Their absence necessarily requires the adoption of different procedures to those applicable to proceedings before the ordinary courts of law.

At least one of the coroner's functions, in particular, would make an observance of the usual rules of procedure and evidence an impossibility. I refer to the coroner's residual investigatory function. Historically, the coroner investigated all cases of sudden death. He did so because his duties originally were fiscal in nature, and the unnatural death of a citizen could produce revenue to the Crown. According to the Statute De Officio Coronatoris of 1276, the coroner was obliged to determine where such a person was slain, who was present and who was guilty. Since the establishment of a regular police force, this investigatory function of the coroner has been largely, but not entirely, superseded. According to a report of the Chief Justice's Law Reform Committee, submitted in 1964 (and published as Appendix B to the Report of the Law Reform Commission on the Coroners Act 1960 (LRC 22 1975)) a coroner's inquest is still used as an aid to the police, in order to afford to them an opportunity of furthering their investigations by the examination and perhaps cross-examination of witnesses under oath (par 3 at 88). That was the nature of the inquiry which the coroner was conducting in the present case in the 'preliminary part' of the inquest into the death of Mrs Watson, and which was the subject of the prohibition order pursuant to s 44(1) …."

Contrary to the submissions of Counsel for the family, s. 58(1) does not *"oust"* rules of evidence and procedure. Section 58(1) provides only that a coroner in coronial proceedings *"is not bound"* by those rules; that is, that rules of evidence and procedure do not necessarily, but may, apply to the holding of an inquest. Those rules may, in any event, be a useful guide in determining questions of procedural fairness and natural justice.

In my opinion, it is necessary to have regard to the clear and unambiguous terms in which the evidentiary limitation is expressed at s. 20R of the *Health Administration Act 1982.* The language of the provision and the relevant Part, supported by the extrinsic materials, suggest that the legislature intended s. 20R to operate in this jurisdiction (and others) in order to safeguard against the prospect of an RCA report, which is primarily prepared as a tool for the health organisation to independently and critically analyse incidents and respond to any identified systemic issues, being used in proceedings in which an involved individual may suffer adverse consequences. As stated above, were it not the case then those individuals may be reluctant to openly engage with the RCA process, thereby frustrating the purpose of the RCA.

It is also necessary to address Mr Gracie and Ms Moisidis's submission that a wide reading of s. 20R of the *Health Administration Act 1982* inhibits the exercise of a Coroner's jurisdiction.

In my opinion, my preferred construction of s. 20R does not. In *Nicholas v R*[18] Brennan CJ said:

> *"[21]…A law that purports to direct the manner in which judicial power should be exercised is constitutionally invalid. However, a law which merely prescribes a court's practice or procedure does not direct the exercise of the judicial power in finding facts, applying law or exercising an available discretion. For the purposes of the accused's first submission, the function of a court to which s 15X relates is the finding of facts on which the adjudication and punishment of criminal guilt depend.*
>
> *…*
>
> *[23] The judicial power of a court is defined by the matters in which jurisdiction has been conferred upon it. The conferral of jurisdiction prima facie carries the power to do whatever is necessary or convenient to effect its exercise. The practice and procedure of a court may be prescribed by the court in exercise of its implied power to do what is necessary for the exercise of its jurisdiction but subject to overriding legislative provision governing that practice or procedure. The rules of evidence have traditionally been recognised as being an appropriate subject of statutory prescription. A law prescribing a rule of evidence does not impair the curial function of finding facts, applying the law or exercising any available discretion in making the judgment or order which is the end and purpose of the exercise of judicial power….*
>
> *[24] In Commonwealth v Melbourne Harbour Trust Commissioners, Knox CJ, Gavan Duffy and Starke JJ said:*
>
> > *A law does not usurp judicial power because it regulates the method or burden of proving facts.*
>
> *And in Williamson v Ah On, Higgins J said that "the evidence by which an offence may be proved is a matter of mere procedure". He added:*
>
> > *The argument that it is a usurpation of the judicial power of the Commonwealth if parliament prescribe what evidence may or may not be used in legal proceedings as to offences created or provisions made by parliament under its legitimate powers is, to my mind, destitute of foundation.*
>
> *However, Isaacs J pointed out a difference between a rule of evidence and a provision which, though in the form of a rule of evidence, is in truth an impairment of the curial function of finding the facts and hence an usurpation of judicial power. He said:*
>
> > *It is one thing to say, for instance, in an Act of Parliament, that a man found in possession of stolen goods shall be conclusively deemed to have stolen them, and quite another to say that he shall be deemed to have stolen them unless he personally proves that he got them honestly.*

Section 20R of the *Health Administration Act 1982* prescribes against the use of an RCA report in "*any proceedings*" except those proceedings described at s. 20R(2). That it is an evidentiary limitation of the use of an RCA report in coronial proceedings does not inhibit a Coroner's function of directing coronial investigations, finding facts, applying the law or exercising any available discretion.

---

[18] (1998) 193 CLR 173 at 188-189 [20], [23] and [24].

I appreciate the family's desire for all available information to be put before me. However, I am bound to apply the law. In the hope that this provides Ms W and Mr Z with some measure of comfort, I note that notwithstanding that the RCA report cannot be admitted in coronial proceedings, a Coroner remains empowered to obtain documents and things for the purposes of coronial investigation (s. 53 of the *Coroners Act 2009*) and to require witnesses to give evidence on oath or affirmation (s. 59 of the *Coroners Act 2009*). A Coroner has at his or her disposal adequate powers to undertake a coronial investigation. In this inquest, amongst other things, X's Hornsby Hospital and CAMHS medical records were obtained as were statements and evidence from all relevant clinicians and staff involved in X's care and treatment in 2012. I also had the benefit of all relevant NSW Health policies and information from the NSLHD regarding measures taken since X's death. I am satisfied that a comprehensive coronial investigation was undertaken sufficient for me to determine the matters required by s. 81 of the *Coroners Act 2009* and to determine whether any recommendations ought to be made.

Does section 20R of the Health Administration Act 1982 prevent the admission into evidence in coronial proceedings of a Root Cause Analysis published pursuant to Part 2 Division 6C of the Health Administration Act 1982?

Yes.

For the foregoing reasons, I consider that "*proceedings*" at s. 20R(1) of the *Health Administration Act 1982* includes "coronial proceedings". I also consider that I am bound by s. 20R of the *Health Administration Act 1982* and accordingly, the RCA report in relation to X cannot be admitted into evidence in this inquest.

Did X receive appropriate care and treatment from Hornsby Hospital and CAMHS during her various admissions and during her outpatient treatment?

X was admitted to Hornsby Hospital three times prior to her death. She was a CAMHS client from the first admission.

<u>The admission to Hornsby Hospital on 31 July 2012 ("**the first admission**")</u>

In the late evening of 30 July 2012 or the early morning of 31 July 2012, X wrote a suicide note and overdosed on 16 paracetamol tablets. She was found by her father at approximately 8.00am on 31 July 2012.

X was admitted to Hornsby Hospital Emergency Department at about 8.22am. This was her first admission to that hospital. Soon after triage, she was seen by Dr Terence Yang who took a

detailed history and conducted physical observations. Dr Yang diagnosed X with paracetamol poisoning and suicidal thoughts. He issued a Schedule 1 certificate pursuant to s. 19 of the *Mental Health Act 2009* (certifying that X was a mentally disordered person who required scheduling to protect herself from serious physical harm). This allowed X to be detained in the Emergency Department while blood testing and a mental health review could be undertaken.

It was CAMHS social worker, Mr Campbell, who conducted X's mental health assessment. As part of that assessment, Mr Campbell took a detailed history and conducted a mental state examination. He formed the overall clinical impression that X suffered from mild or moderate depression and suicidal ideation against a background of some recent stressors. Mr Campbell devised and discussed a management plan in consultation with both psychologist Lydia Senediak and psychiatric registrar Dr Rose Damaio. That management plan included further consultation with CAMHS.

That same day, X was discharged into the care of her family with a safety plan.

The evidence was that the safety plan was formulated by Mr Campbell and agreed to by X. It noted that she agreed to contact her mother, KIDS Helpline (on 1800 55 1800), a named mentor/teacher at school, or Lifeline (the number was not provided) if her mood was 1 on a scale of 1 to 10, with 1 being the most distressed.

Ms W was also provided with a card. It is likely that card was a copy of the 'Stay Safe Card' exhibited before me which lists, on one side, 'Survival Strategies' and on the other, a list of resources. That list includes the operating hours and telephone numbers for the Child Adolescent Family Team ("CAFT") and the Acute Care Team. It also notes that the Emergency Department of the nearest hospital can be attended and names Hornsby Hospital and its address. It lists the websites for Beyond Blue, Headspace, Reach Out and the NSW Health drugs webpage dedicated to youth. The telephone numbers for the Kids Helpline, Lifeline and Mental Health Helpline are also listed.

<u>CAMHS treatment following discharge</u>

On 1 August 2012, the day following her discharge from Hornsby Hospital, Mr Campbell called X to check on her welfare and to confirm that she had an appointment at CAMHS the following day. X attended that appointment, as arranged, with her mother.

The records from CAMHS indicate that X attended appointments with Mr Campbell weekly between 2 August 2012 and 24 August 2012. There were four sessions during that period.

Mr Campbell recorded that on 7 August 2012 they discussed, amongst other things, "*X's poor sleep pattern.*" He noted that X did not usually get to sleep until 1:00am. Mr Campbell also recorded that by 15 August 2012, X's sleep had improved with Valerian tablets. He also noted that they discussed treatments for depression, including cognitive behavioural therapy and medications. He noted: *"X not convinced she is depressed, however displaying a lot of interest in what I have to say. Agreed to stick to safety plan as discussed previously & to consider treatment.*" He also noted that Ms W was curious about treatments.

On 11 September 2012, Mr Campbell was on leave and so he arranged for X to see Ms Senediak (a psychologist) instead.

It was the evidence of Ms Senediak that she initially saw X and her mother together and then X on her own at the appointment. Her notes of that session recording the following (with my interpretation of shorthand in [brackets]):

> *"X + mo[ther] seen together initially – X pleased with results of recent HSC Trials – feels she is on track for desired HSC outcomes & entry to Unv [University?]. Has two plans for study (?UNSW; ?triple major) Hopes to enter training with ASIS (Aust. Security/Intelligence) after Unv [University]. Notes she still feels v. low + disconnected fr[om] peer group. Mo[ther] raised [as?] of concerns [sic] re: observing XY to be 'flat'/withdrawn low. – X _ mo[ther] appear able to communicate re: these concerns adequately.*
>
> **X seen alone. Continued –ve [negative] ruminating thoughts re: hopelessness/social isolation, etc. No DSH [deliberate self harm]. Underlying SI [suicidal ideation] but low intent & no clear plan. Finds being alone calming. Raised concerns re: failure of natural/herbal treatments ("they're not working["]). Somewhat reluctant to consider antidepressants. Able to acknowledge clear reason for living (relationship [with] family, schoolies, Graduation, Formal [Nov 17th]. Agreed plan for safety currently → [?] [with] Tom Campbell next week → Agreed ph/c [with] Mo[ther] + L[ydia] S[enediak] this week –*
>
> *Lydia Senediak (Sen[ior] Cl[inical] Psych[ologist])"*

In contrast was the evidence of Ms W who was adamant that she did not attend the session between X and Ms Senediak. Ms W gave evidence that the appointment was scheduled at 4.00pm on a day that she was required to pick up her younger child and accordingly, as she could not attend the appointment, X had taken the bus after school and attended the appointment by herself. It was the evidence of Ms W that after X saw Ms Senediak, X told her that she wanted to try anti-depressant medication. It was also Ms W's evidence that she later found out that X had told Ms Senediak that she had been obsessively researching suicide methods on the internet and that this was never reported by Ms Senediak or Mr Campbell. She believed that had she and Mr Z known this, they would have taken action to prevent X's subsequent overdose. In his cross-examination of Ms Senediak, Mr Gracie appeared to query the reliability of Ms Senediak's record.

Ms Senediak (as she indicated in her notes), did follow up with Ms W by phone on 13 September 2012. In this conversation Ms W requested a consultation with a psychiatrist to discuss the issue of medication. Ms Senediak agreed that this course of action was appropriate. The evidence indicates that she made a note that the plan was for Mr Campbell to follow up the next week.

X's next appointment with Mr Campbell was on 18 September 2012, after he returned from leave. From the notes of this consultation it seems that X was less engaged and was disinclined to continue with further therapy and counselling. However she reluctantly agreed to a further appointment in two weeks' time, namely on 2 October 2012.

It seems that on 28 September 2012, Ms W received a call from CAMHS notifying her that an appointment with a psychiatrist was cancelled. She was never made aware of the appointment. I am told that there are no records of such an appointment in X's medical files.

X cancelled her scheduled appointments with Mr Campbell on both 2 and 5 October 2012.

The admission to Hornsby Hospital on 8 October 2012 ("**the second admission**")

X's second admission to Hornsby Hospital was on the morning of 8 October 2012, after X again attempted suicide by overdosing on 44 paracetamol, 25 Valium[19] and 2 Travel Calm tablets. It seems clear that this was a serious suicide attempt by X, with Mr Campbell's notes recording: "*that she planned this overdose over a number of weeks, had arranged a picnic with friends as a way to say goodbye, and researched methods extensively on the internet*"[20]

Following this attempt on her life, X was again scheduled pursuant to s. 19 of the *Mental Health Act (NSW) 2007*. X was admitted to the Emergency Department where she was triaged and a mental health assessment was completed. While it was noted that X was considered for admission in a paediatric ward, X was instead transferred to a medical ward and, on 9 October 2012, she was transferred to the Psychiatric Emergency Care Centre ("PECC") which is contained within Hornsby Hospital. On 10 October 2012, she transferred to the Lindsay Madew Unit ("LMU"), an acute adult psychiatric ward. None of the wards were designated paediatric wards. From

[19] There is evidence before me that X obtained the Valium illicitly on this occasion
[20] Exhibit 1, Volume 2, Tab2, page 8

11 October 2012 X was a voluntary patient. She spent a total of 16 days admitted to Hornsby Hospital and was discharged on 24 October 2012.

Whilst detained within the LMU the records indicate that X was treated by a multi-disciplinary team. It was during this admission that she was seen for the first time by CAMHS Clinical Nurse Consultant Andrea Simpson ("**CNC Simpson**") (on 11 October 2012) and CAMHS psychiatrist, Dr Lim (on 12 October 2012). Both would be involved in X's care after this admission.

X was also seen by Mr Campbell during this admission. This followed a phone call with X's parents on 15 October 2012. Mr Campbell's note of that conversation is as follows:

> *"P.C. from Y [sic], wishing to discuss X's treatment post discharge from LMU. Y wondering what service would be appropriate – discussed private options she had researched (Hills Centre), advantages/disadvantages of private services. Also discussed was post disch[arge] planning, whether a private admission would be appropriate post LMU (although X would have to have less suicidal ideation). Also discussed was a request to see the file, Y concerned about decisions made prior to her suicide attempt. I advised her of this process & the need to have X's permission. I then spoke to Z, and again discussed public/private options. Y asked me to see X this week, which has been her request. Also I arranged to see both parents this Friday.*
>
> *Plan – see X at LMU*
>
> - *session with parents"*

It was alleged by Ms W that whilst X was an inpatient at the LMU *"nothing happened"* and *"there was no form of mental therapy"*[21]. The medical records from this period indicate that this was not the case. In summary:

- X was seen by Dr Lim on six separate occasions during the period of her admission[22];
- X was seen by Mr Campbell twice[23];
- Ms W and Mr Z had an appointment with Mr Campbell on 19 October 2012, which they did not attend;
- X was seen by Dr Orosco, CAMHS psychiatric registrar, on two occasions[24];
- X was seen by CNC Simpson, on three occasions[25]; and

[21] Exhibit 1, Volume 1, Tab 6, paragraph 36
[22] On 12/10/12, 17/10/12, 18/10/12, 19/10/12, 22/10/12 and 24/10/12
[23] On 17/10/12 and 23/10/12
[24] On 15/10/12 and 23/10/12
[25] On 11/10/12, 12/10/12 and 16/10/12

- X was commenced on fluoxetine (an anti-depressant also known as Prozac) for the first time on 11 October 2012, in addition to being prescribed quetiapine and temazapam.

The evidence as a whole indicates that although X was subject to variable mood throughout her admission to the LMU, she steadily began to improve. The evidence of her parents concurred with this.

It was during this admission that Dr Lim prescribed X fluoxetine. Her initial dosage was 10mg per day which was increased to 20mg per day after 5 days. X continued to take the fluoxetine after her discharge from Hornsby Hospital on 24 October 2012. She had an appointment with Mr Campbell and attended that appointment the following day.

Community Treatment Order and continuing treatment from CAMHS

The seriousness of the suicide attempt made by X on or about 8 October 2012 was recognised by staff at Hornsby Hospital and CAMHS. There are multiple medical notes of the extraordinary planning that X undertook to ensure success and her initial anger when she realised that she had failed. X's attitude at her appointment with Mr Campbell on 18 September 2012 and her cancellation of the two subsequent appointments took on a different complexion in light of the ensuing events. These matters informed Dr Lim's and Mr Campbell's decision to apply for a Community Treatment Order ("**CTO**") with respect to X to reinforce the importance of her attending CAMHS appointments.

On 5 November 2012 Mental Health Review Tribunal made a CTO with respect to X. The orders obtained were, inter alia, that:

- X in the company of at least one of her parents, to meet with Mr Campbell or a delegate on a weekly then at least a fortnightly basis;
- X to meet with Dr Lim as required by him; and
- To accept treatment and medication as required by Dr Lim.

It is apparently unusual, at least in Dr Lim's experience, to have a patient as young as X be the subject of a CTO. He gave evidence that she was probably the only patient of his on a CTO at the time.

In accordance with the CTO, X met with Mr Campbell weekly during the month of November.
On Friday 16 November 2012, X and Ms W met with Dr Lim. It was the evidence of Ms W, inter alia, that:

- She asked for X's medication (namely, the Prozac) to be increased to assist X's mood but Dr Lim wanted to give the dosage she was on longer to work;
- She was advised at this appointment that the Prozac could take up to six months to take effect;
- She asked for him to prescribe some sleeping pills to assist X however he refused as they are addictive even though she indicated that she would supervise them and ensure X did not take them every night;

Dr Lim's treatment notes state:

> *"X presented with her mother today.*
>
> *Engaged well. Ongoing therapeutic rapport intact.*
>
> *Reports sleep is her main struggle, with going to bed at 11pm and not falling asleep for another two hours. Reporetd [sic] ruminations of purpose of life, low level suicide ideation, and activities of the next day.*
>
> *Appetite, energy and motivation all intact. No DV, or early morning wakening.*
>
> *No problems with large crowds; no obsessions or compulsions of note. Ruminations at night noted.*
>
> *No psychotic symptoms. No manic symptoms.*
>
> *Been attending school and looking forward to schoolies.*
>
> *Enjoying activities with friends.*
>
> *Mother and daughter reported compliance with medication.*
>
> *Mother in charge of meds.*
>
> *MSE*
>
> *Engaged well in interview with and without mother.*
>
> *Full range of affect, appropriate throughout.*
>
> *Mood was described as "okay" "sometimes low"*
>
> *Normal speech.*
>
> *No formal thought disorder.*
>
> *Thought content revealed themes of future oriented ideas, and wanting to derive benefit from thereapy [sic].*
>
> *No perceptual disturbance*
>
> *Reasonably [sic] insight and judgment.*
>
> *Risk: denied suicidal ideation. Low level (abseline) [sic] suicidal ideation. No psychosocial stressors. Denied homocidality (laughed at this). Denied drugs, reported intermitted [sic] use of alcohol (accepts this is a depressant. Future oriented ideas – wants to be a public servant after university.*

Impression

Stable in mental state.

No evidence of major depression.

Suicidality at baseline.

Seeing [T]om Campbell – case manager.

Plan

Continue with [T]om Campbell

No change to meds (fluoxetine 20mg mane)

Review in approx. 1 month."

Despite understandable hesitation by her parents, X attended Schoolies Week on the Gold Coast with her friends in late November 2012. The evidence indicates that she returned home in good spirits. She reported that she had a good time with her friends. However, X's telephone records (subsequently obtained for the purposes of this inquest) show that she attempted to call Lifeline once during the trip.

Although X did have an appointment with Mr Campbell on 6 December 2012 (after her return from Schoolies Week) she cancelled that, citing her work commitments. The appointment was rescheduled for 11 December 2012 (one week later). It was at this appointment that Ms W expressed concern to Mr Campbell regarding X's sleep, suicidality and "post schoolies low". Mr Campbell noted that X was dissatisfied with Cognitive Behavior Therapy and that they were discussing alternatives. Mr Campbell had suggested trying a form of Interpersonal Therapy.

Following that appointment on 12 December 2012, Mr Campbell sent an email to Dr Lim stating:

"*Hi,*

X's file is at Hornsby so I haven't had the chance to put a file note in about my last contact with her so i thought I would email you about the latest session I had with her which occurred yesterday.

Mother is still very, very concerned and wants X to be referred to a sleep specialist, and be put on more medication.."…something HAS to be done". So that is why she has booked a time for X to see you about increasing the medication.

She appears quite drained and depressed herself (probably more than X) and doesn't seem to have much faith in what we are doing. She is constantly on the watch for X to kill herself. I asked if there was anyone else that could help her out (she said no), and have her the speech about looking after herself.

I spoke to X who had a good "schoolies" week. She said her mood is much the same (i.e. 2 to 3 out of ten), however there are some objective signs I think that she is improving. She seems to be making some positive and realistic plans for the future –

eg getting another job (moving on from KFC), holidays over Xmas, thinking about life at Uni etc She told me she has decided not to kill herself because her mother would be too upset, altho she may change her mind, she said. She doesn't seem to be spending much (if any) time thinking about suicide, let alone planning it.

One difficulty is that while I have been telling X she has depression she says you told her she has generalised anxiety disorder.

Perhaps we could say she has both to save the confusion/splitting ??

Getting to sleep is a problem, she goes to bed at 10.30 pm but does not get to sleep till 2 am..she spends her time reading and trying to relax,……but she seems to sleep at least 8 hours, as she doesn't get up till 10 am (which she doesn't want to change). I have been talking to her about relaxation and calming techniques, which she is practicing, without them having much affect as yet. I am also attempting some IPT-A with her, which she seems engaged with, altho it is a slow process (13 sessions) and it has been interrupted on numerous occasions. We started with some CBT but she seems disinterested in it.

I will be seeing X next week then not again till after 7th Jan.

Good luck

regards Tom"

Dr Lim responded that same day stating:

"*Thanks Tom,*

i'm happy with calling it mixed anxiety and depression.

I had a phone call to make an appointment to review her meds -- I've offered a brief one on Friday.

Cheers,

Alex"

Administration of diazepam (Valium)

It was the evidence of Ms W that sleep was a huge issue for X and she was desperate to assist her in that regard. To that end, on a couple of nights prior to 15 December 2012 she provided X with one tablet of 5mg of diazepam (otherwise known as Valium) for which she personally had a prescription, despite X having no such prescription in order to aid X's sleep. The Valium was kept by Ms W at the back of the kitchen cupboard. Unfortunately, from what unfolded, X was able to locate them.

The admission to Hornsby Hospital on 16 December 2012 ("**the third admission**")

X's third and final admission to Hornsby Hospital was in the early hours of the morning of 16 December 2012. X had been left the evening before to babysit her younger siblings. Sometime after 6:20pm, X drank at least several glasses of wine and took a quantity of Codral and 5mg Valium tablets (which had been prescribed to her mother).

Whilst babysitting X texted a number of her friends including a friend named Max. Relevantly, at 11.14 and 11.15pm the following texts were exchanged:

Max to X (at 11.14pm):	Haha,it's good I've had a six pack of beer. Just chilling
X to Max (at 11.15pm):	Ahh jealous…I've just been stealing my rents shiraz while they're out haha. Classy to the max!

At about 11:50pm on 15 December 2012, X sent a text to her parents asking how "it" (presumably, the Christmas party they were attending) was going. Her mother replied that they were on their way back and would return in about 30 minutes. X responded: *"Just falling asleep haha, cya in ze morning xx"*

At about midnight X texted Max again. The following texts were exchanged:

X to Max (at 11.59pm):	Hey! who spent the night chasing around a hyperactive toddler ay
Max to X (at 12.00am on 16 December 2012):	Hah, loving those siblings?
X to Max (at 12.01am):	Oh yeah lovin' the toilet training! Haha
Max to X (12.02am):	"Haha, fun Times. In really intoxicated"
X to Max (at 12.03am):	Ssaaammmeee + pills so feeling rather good
Max to X (at 12.04am):	Haha, where was my invite? What pills?
X to Max (at 12.05am):	Yeah invite to my one woman party haha ;) just valium, so feeling chilled
Max to X (at 12.06am):	Haha, sounds chilled. And a party with a beautiful woman is the best kind of party :-)
X to Max (at 12.07am):	Aww max i actually wish you were here right now
Max to X (at 12.08am):	Haha, it probably would be the best idea. I might romance you too much
X to Max (at 12.10am):	Pft no such thing as too much! …except heroin. Cause any at all is too much haha
Max to X (at 12.11am):	I agree. So why the valium?

X to Max (at 12.12am):	Mnmn dulls life
Max to X (at 12.13am):	Whats so bad about life?
X to Max (at 12.13am):	Hahahaha
X to Max (at 12.14am):	Dw, i provavalh shouldnt be dragging you into my shit anyways
Max to X (at 12.15am):	No, I wanna know
Max to X (at 12.23am):	:-)
Max to X (at 12.23am):	I have shit too, and I'm the worlds best listener

There was no further text from X to Max.

At about 12:30am on 16 December 2012, X's parents returned home to discover an open bottle of wine and an empty bottle of Valium which, according to Ms W, had 48 tablets missing. X was in bed with her "*eyes rolling back into her head and she couldn't speak*"[26]. An ambulance was called and X was taken to Hornsby Hospital.

This was X's third admission to Hornsby Hospital. The records indicate that X was initially treated in the Emergency Department and then transferred to the PECC unit for further management. The PECC unit, as indicated above, is a mental health inpatient unit.

It was during this admission that X was attended to by both CNC Simpson (who had seen X during her 8 October 2012 admission) and Dr Connie Kaufman, psychiatric registrar.

Dr Kaufman gave oral evidence on the second day of the inquest. Her evidence[27] can be summarised as follows:

- She assessed X after she had been medically cleared and transferred to the PECC for monitoring;
- Her routine was to review the notes made in relation to a patient's presentation prior to seeing the patients and she has no reason to believe that she did not do this before she saw X on 17 December 2012 in the PECC;
- She recalls reviewing the notes from the Emergency Department and noting that X's blood alcohol level was low and her paracetamol level was in keeping with therapeutic use and therefore consistent with the history that X had provided of taking 1 or 2 Codral tablets[28];

[26] Exhibit 1, Volume 1, Tab 6, Paragraph 58
[27] Exhibit 1, Volume 1, Tab 39

- That she saw X in her room alone and that she did not see or speak to her parents that day nor was she asked to[29];
- That she spoke with X for approximately 45 minutes. X was not initially happy to engage and was irritable and reluctant to "*speak at first*", however did so as the interview progressed;
- X presented as logical and coherent throughout the interview despite being a little groggy. This presentation did not accord with an overdose of 48 5mg Valium tablets. If X had consumed that quantity, Dr Kaufman would expect her not to be lucid and unable to communicate; moreover she would likely be in intensive care with respiratory depression;
- The story X told was consistent to what was in the notes as has been told to CNC Simpson and Dr Goripati to the effect that she denied it was a suicide attempt and that "*she always feels suicidal*";
- X stated she had no memory of taking a larger quantity of Valium and said "*I knew my parents were coming home, why would I do this?*" though she did say "*maybe subconsciously I wanted to die?*";
- After she spoke with X, she telephoned Dr Lim, but was unable to speak with him so she began to write up her notes of her consultation;
- Whilst writing her notes she had a telephone conversation with Dr Lim regarding X's presentation. CNC Simpson was present during this conversation and also spoke with Dr Lim on the telephone regarding X;
- Dr Lim requested that an ECG be performed. He indicated that a safety plan could be put in place with X's parents prior to her discharge;
- Dr Kaufman ordered the ECG. She later reviewed the ECG, which was normal;
- She had been advised by CNC Simpson that a safety plan had been put in place with X and her parents and that X had been discharged after further discussion with Dr Lim;
- She did not have time on 17 December 2012 to prepare X's discharge summary prior to her discharge or before the completion of her shift. She had planned to complete it the next day however, she was advised on her return to Hornsby Hospital of X's death. As a result she was unable to access X's notes and unable to complete her discharge summary. She therefore did not complete the draft discharge summary until sometime before 14 January 2013. She did <u>not</u> sign the electronic version on 16 January 2013 (that is on X's medical file) and therefore cannot account for a number of statements in that documents including:
    - Under the heading "*Current risks/safety issues*" marking "*Suicidal intent*" as "Low";

---

[28] Ibid at paragraph 13

[29] Ibid at paragraph 14

- "*Mother affirmed that X taking the diazepam was to help with sleep that evening, and did not believe it was a suicidal attempt*"; and
- "*Mother agreed to and was happy with this discharge plan*".

The evidence of CNC Andrea Simpson was, inter alia, that:

- She first saw X as an inpatient at the LMU during the second admission. During that period she saw X's mood improve and risk decrease every day;
- Her next interaction with X was when she had been admitted to PECC over 16 to 17 December 2012 with a suspected overdose;
- She initially interviewed X by herself where X told her that she had taken 1 to 2 Valium;
- She then interviewed X's mother, who said:
  - that around 40 tablets of valium were missing from the bottle found at home; and
  - *"and around 40 tablets of valium were mi*[30]
- After she spoke with Ms W, CNC Simpson had a further conversation with X and challenged her about the missing tablets. X responded "*that she may have been drowsy and taken more but she didn't think so*"[31];
- As there was no CAMHS registrar on the roster that day, CNC Simpson spoke to Dr Kaufman about her impressions of X's presentation;
- Thereafter she spoke with Dr Lim and conveyed that X had stated that the incident was not a suicide attempt and her mother was of a similar belief;
- After speaking with Dr Lim, she then returned and spoke with X and her mother regarding safety planning and discharge and confirmed with Ms W that she did not believe this to be a serious suicide attempt;
- That if Ms W had expressed differently namely, that she thought that the overdose was a serious suicide attempt she would have documented those concerns;
- In relation to the discussions with X and her mother regarding safety planning she:
  - asked X what she would do if she felt unsafe and X agreed that she would tell her mother;
  - spoke with Ms W separately about what the family could do to keep X safe which would have included providing her with relevant contact numbers and advising her to re-present to the hospital if she felt that there was an increase in the level of the risk; and

[30] Exhibit 1, Tab 37, Paragraph 11
[31] Exhibit 1, Tab 37, Paragraph 12

- She specifically recalls advising Ms W that if she had concerns about X overnight that she should call the Acute Care Team.

It was the evidence of Dr Lim, inter alia, that firstly, he did not attend on X in either the Emergency Department or the PECC unit during the third admission – he was in his office on hospital grounds at the time; and secondly, he gave the approval for her discharge based on his discussions about her presentation with both CNC Simpson and Dr Kaufman and with confirmation that Ms W was confident that it was not a suicide attempt, that Ms W agreed with the plan, (which included an appointment for X to see him the following day).

Dr Large provided expert evidence to the Court in relation the care and treatment X received. His evidence about the admission and subsequent discharge on 16 to 17 December 2012 is as follows:

> *"although in retrospect, it would have been preferable for Ms* [X] *Y to have remained in hospital longer than she did, I am not critical of the decision that was made to discharge Ms Y shortly after the presentation on 16 December 2012. Ms Y gave consistent history that she had taken the overdose without suicidal intent and the subsequent course was more suggestive of her having taken a smaller rather than larger dose of diazepam. She admitted ongoing suicide ideas that were know nabout previously and she denied suicide intent or plans. Ms Y expressed future orientated plans and wishes. Most importantly Ms Y was discharged into the care of the family who were aware of her difficulties and she had appropriate follow-up planned for the following day…."*[32]

Events following discharge from Hornsby Hospital on 17 December 2012

X went home with her parents following her discharge from Hornsby Hospital. However, it was their evidence that when they arrived home the following occurred:

- She refused to stay downstairs with her family as was agreed upon in the safety planning at the hospital;
- They became aware that she had begun self-harming or cutting herself and Mr Z discovered some knives in X's drawers next to her bed; and
- She admitted to Ms W that she had intentionally overdosed and taken the full bottle of Valium[33].

It is uncontroversial that Ms W was understandably concerned and called the hospital and spoke to CNC Simpson. It was the evidence of Ms W that:

[32] Exhibit 1, Volume 3, Tab 2, page 12

[33] Exhibit 1, Tab 6 at Paragraph 69

"Andrea's response was that it was probably not a good idea to bring her back because she had already been discharged and there would be [a] lengthy wait in emergency. …

Shortly after this Tom [Campbell] *called (after Andrea had spoken to him). I told him that we were desperate and I wanted to bring her back to hospital. I told him that we were on zero out of ten, meaning that this was an extreme crisis…I told him about the knives in her room and the cutting. Tom told me that he would speak to Dr Lim about it but probably best not to come back to hospital. During this time Z was upstairs watching X. Because of her serious condition we didn't want to leave her alone.*

Tom called back just before 5pm to say that he had spoken to Dr Lim, and he repeated not to come back to hospital. He would call the next morning to arrange a time to come and see CAMHS the next day…."[34]

CNC Simpson sent an e-mail to Mr Campbell at about 2:35 PM, after having spoken to Ms W, which states:

"hi

We discharged X about an hour ago.

Both her and mom gave their accounts of what happened and was saying the Saturday night episode was not suicide. While she was definitely tired, she was still lucid, and able to respond to questions.

She was quite ambivalent about life, her dad, the schoolies trip etc and Connie felt she was very sarcastic.

I just had mom on the phone wanting to bring her back in, as she is refusing to co-operate with their boundaries- she have to sit down stairs with everyone. She also told them she would run away.

Mum now feeling there is more to Saturday night and she first thought.

I spoke about the level of risk and that refusing to accept limits is not a criteria for admission. She agreed to a 24 hour watching period and to discuss further with you tomorrow…"[35]

Mr Campbell responded to CNC Simpson at 2:48 PM by e-mail:

"thanks Andrea. I'm not sure what is going on but a break down in relationship between mum and X is not good- also just prior to the massive OD back (I think) in June X was very sarcastic so maybe pressing a few buttons for mother…

If you don't mind I will give W call and try to work out what is going on"[36]

It's clear that Mr Campbell did that.

His notes of that conversation are recorded as follows:

---

[34] Ibid paragraphs 70-73

[35] Exhibit 1, Volume 1,Tab 38 Annexure "A"

[36] Ibid

> *"PC to W(M). She's advised that she was concerned about X - in had refused to "stay downstairs" as was agreed at hospital. She was now on the bed? Asleep/ resting. X had advise mother of some superficial self harm and I found 2 knives in her room. X had also said she had thought of throwing herself in front of the train last week on the way home from work. I advise I will contact Dr Lim re this issue"*[37]

Moreover it was the evidence of Mr Campbell inter alia that:

- Ms W was friendly and very open during the discussion but was expressing her concern and confusion about what was happening with X[38];
- He concedes that his recollection of this conversation with Ms W is imperfect however it is "not at all" his recollection that the situation was being described by Ms W "*as one of desperation and/or of extreme crisis or that X was 'zero out of ten'. Nor … that Ms W expressed an urgent desire to bring X back to the Hospital*".[39]

Mr Campbell then spoke to Dr Lim. His file note of that conversation records as follows: "*P/C to Dr Lim - above discussed and it was thought best that X be seen at Hornsby tomorrow by him and me jointly*".[40]

It was Mr Campbell's evidence that thereafter, he spoke to Ms W. He told her that he had spoken to Dr Lim and they thought it was best for X to see both of them the next morning. Ms W was agreeable to this and said she would watch over X. Mr Campbell's file note of that conversation states:

> *"PC to W - I advised her of plan to see X Dr Lim and me tomorrow - Time to be advised. X still in bed she said that they will watch her till tomorrow.*
>
> *Plan- see Dr Lim at CAMHS Hornsby tomorrow"*[41]

That night, despite X's parents attempts to keep her safe and X's mother sleeping on the floor of her room, X managed to sneak out of the house and take the steps that ultimately ended her life.

Expert evidence of Dr Matthew Large

Psychiatrist, Dr Matthew Large, was appointed to assist Court and provide expert evidence as to the care and treatment received by X.

Relevantly, the following documents form part of Volume 3 of the Brief of Evidence:

1. Letter of instruction to Dr Large dated 1 September 2014

---

[37] Exhibit 1, Volume 1, Tab 32 paragraph 60

[38] Exhibit 1, Volume 1, Tab 32 paragraph 61

[39] Exhibit 1, Volume 1, Tab 32 Paragraph 77

[40] Exhibit 1, Volume 1, Tab 32 paragraph 62

[41] Ibid paragraph 63

2. Expert report of Dr Large and appended chronology dated 20 September 2014
3. Curriculum vitae of Dr Large
4. Second letter of instruction to Dr Large dated 26 October 2014 (in which he was, relevantly, instructed with the various NSW Health policies and guidelines which also form part of the Brief)
5. Third letter of instruction to Dr Large dated 27 October 2014
6. Second expert report of Dr Large dated 28 October 2014.

That material was served on the interested parties prior to the inquest. It was tendered, unchallenged, and forms part of Exhibit 1.

Dr Large was instructed to provide expert opinion on a number of questions relating to the care and treatment of X by Hornsby Hospital and CAMHS. While I will consider his expert opinion in greater detail further on in these findings, it suffices to note, at this stage, that Dr Large was not critical of any of the care afforded to X.

In oral submissions, Mr Gracie submitted (on behalf of Ms W and Mr Z) that the expert opinion of Dr Large should not be accepted. While the written submissions of Mr Gracie and Ms Moisidis tangentially appear to query the basis upon which Dr Large forms some of his opinions, it appears to me that the acceptability of or weight to be placed upon Dr Large's report is an issue raised for the first time in oral submissions.

Mr Gracie cited the decisions of *Ahmedi v Ahmedi*[42] in support of the proposition that the tribunal of fact would not unequivocally accept the evidence of an expert if it was not founded in reason or logic. Mr Gracie also referred to the oft-cited decision of Heydon JA (as he then was) in *Makita v Sprowles* in support of the proposition that "*one must be wary of the expert who comes to Court and makes oracular pronouncements*". Mr Gracie referred to this part of Dr Large's expert report in particular:

> *"4. The appropriateness of the care and treatment received by X while an inpatient at Hornsby Ku-ring-gai Hospital during the 8 October 2012 admission.*
>
> *Within the limits of a general psychiatric ward I am not critical of the care received by Ms Y after her overdose of 8 October 2012. Appropriately qualified staff saw her regularly and I think that the medication she was treated with was appropriate."*

Mr Gracie submitted that was "*an oracular statement by any measure*".

[42] (1991) NSWLR 288

The common law principles as enunciated by Heydon JA in *Makita v Sprowles* in relation to expert evidence are:

- The opinion has to be on an area that the Court accepts is an area of specialised knowledge;
- The witness must demonstrate that by reason of specified training, study or experience they are an expert in that area;
- The opinion must be on matters within that area of expertise;
- The expert must state, and the party calling the expert must prove, the facts upon which the expert opinion is based;
- If any facts relevant to the opinion are assumed they must be identified and proved in some other way; and
- The expert must explain how the opinion expressed was reached.

Interestingly, Mr Gracie did not refer me to the more recent High Court decision of *Dasreef v Hawchar*[43] where the majority said that s. 79(1) of the *Evidence Act 1995* must be understood in its statutory context as an exception to the general prohibition of opinion evidence pursuant to s. 76 of the *Evidence Act 1995*. Accordingly, the first issue to determine when addressing the admissibility of expert evidence is its relevance to the proceedings. The majority then went on to refer to two criteria that must be satisfied for expert evidence to be admissible:

> *"To be admissible under s79(1) the evidence that is tendered must satisfy two criteria. The first is that the witness who gives the evidence 'has specialised knowledge based on the person's training, study or experience"; the second is that the opinion expressed in evidence by the witness "is wholly or substantially based on that knowledge".*[44]

With respect, I am not sure how the principles enunciated in both cases cited by Mr Gracie assist him in his submission that the evidence of Dr Large should not be relied upon.

Dr Large was appointed to assist the Court and provide expert evidence as to the care and treatment received by X. He is the senior clinical psychiatrist working fulltime at the Prince of Wales Hospital, dividing his time between the Emergency Department and Inpatient Units. Moreover, he is a member of the RANZCP committee tasked with writing the clinical practice guidelines for the management of self-harm and he is a committee member of Suicide Prevention Australia's Suicide Prevention Research Steering Committee. In fact, when Counsel Assisting commenced her examination by asking Dr Large about his qualifications, Mr Gracie rose to his feet and said that there was no need to do so, because they were not challenged.

---

[43] (2011) 277ALR 611; 85 ALJR 705;

[44] Ibid at [34];

Dr Large was fully briefed with all the medical records pertaining to X prior to her death and the subsequent statements obtained for the purposes of this inquest. He also took the time to listen to the oral evidence of all X's treating practitioners who gave evidence over 6 and 7 November 2014 prior to giving his own oral evidence. His views did not change. Mr Gracie alleged that the evidence of Dr Large had an "*oracular*" quality. An "oracular" response is defined as one that is enigmatic or cryptic, confusing or obscure. There was nothing in the evidence of Dr Large that could be regarded as having an "oracular" quality to it. On the contrary, in my view it was clear and concise.

The evidence of Dr Large is clearly relevant and based upon his specialised training, study and experience. I am also satisfied that the opinion he expressed in both his written report and his oral evidence was substantially based on that knowledge and accordingly, his evidence is admissible.

Dr Large's initial report dated 20 September 2014, was served on persons of sufficient interest, including the family, on 22 September 2014. Ample opportunity was afforded the family (and other parties of sufficient interest) to provide their own expert yet they did not. Indeed, at a directions hearing on 7 October 2014 the solicitor who appeared for the family indicated that the family would brief an expert but on 31 October 2014 those assisting me were advised that the family had been unable to retain an expert and would not be relying upon one.

What is "appropriate care and treatment"?

It was submitted for the family that *"This Coroner's Inquest is about whether or not XY was afforded timely and high quality care and treatment in accordance with professionally accepted standards, as expected by the community, over six months and whether that treatment should have included acquiescence or promotion* [in a number of listed modalities]". Similarly, it was submitted that in determining this question I should have regard to what is thought to be reasonable from a properly qualified practicing psychiatrist whether public or private. It was submitted that I should have regard to:

1. Dictionary definitions as understood by the general community;
2. The pre-2002 common law position (that is; as opposed to reference to the *Civil Liability Act 2002*); and
3. The *Mental Health Act 2007*

Elsewhere in the written submissions for Ms W and Mr Z it is said that *"It has never been Australian law before 2002 that professional persons in any discipline are assessed according to the opinion of their professional colleagues. This was an English position. It has been steadfastly resisted in Australia."*

While I reiterate the point made by then State Coroner Hand (cited earlier in these findings) to the effect that an inquest is not concerned with determining issues of civil liability, it is nonetheless necessary to engage with the common law position as asserted by the family, insofar as those submissions are made in support of the proposition that I should place little or no weight upon the expert opinion of Dr Large.

The position at common law as to the relevance of professional opinion in determining negligence was cogently outlined by Ms Sandford for the NSLHD in supplementary submissions as follows:

> *57. A succinct statement of the common law of Australia is to be found in the joint judgment in Rogers v Whitaker (1992) 175 CLR 479 at 489. The principal issue in Rogers was whether a patient who underwent elective ophthalmic surgery should have been warned of the remote risk that surgery to one eye may affect vision in the other eye. In contrasting what their Honours (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) described as the "fundamental difference" between the field of non-disclosure of risks, and the provision of diagnosis and treatment, their Honours said:*
>
> > *"Whether a medical practitioner carries out a particular form of treatment in accordance* ***with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play;*** *whether the patient has been given all the relevant information to choose between undergoing or not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practice". (writer's emphasis added)*
>
> *58. In her Honour's separate judgment in Rogers, Gaudron J said (at 493):*
>
> > *"…the evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis and treatment. However, even in cases of that kind, the nature of the particular risks and their foreseeability are not matters exclusively within the province of medical knowledge or expertise…they are often matters of simple commonsense".*
>
> *59. The Court of Appeal in New South Wales had occasion to revisit the separate remarks of Gaudron J in Rogers at 493 , in Ambulance Service of NSW v Worley [2006] NSWCA 102, a case which did not concern the application of the Civil Liability Act, 2002 (NSW). Basten JA (Tobias and McColl JJA agreeing) said (at [36]):*
>
> > *"…The role for "simple common sense", to which her Honour referred at p 493, may be different in relation to questions of causation from its role in relation to the duty of care. Common sense may be coloured by specialist knowledge and experience.* ***It is necessary for a person without medical training to guard against an opinionated judgment which flies in the face of expert opinion****, even where the expert is unable to articulate with precision the basis for his or her conclusions.*

For the reasons set out above, I do <u>not</u> accept that Dr Large has simply made pronouncements as submitted by Mr Gracie and Ms Mosaidis on behalf of the family. Dr Large provided evidence to

this Court which was considered, clear and concise. He was and is more than appropriately qualified to provide the expert evidence which he was retained to provide. There was no other expert evidence put before me which countered his view. Accordingly I will rely on his expertise in relation to this matter.

Did X receive appropriate care and treatment from Hornsby Hospital and CAMHS during her various admissions and during her outpatient treatment?

It was submitted generally by Counsel for the family that X was *"not appropriately cared for and treated by the relevant publicly employed non medical and medical practitioners"* and he supports this generalised submission on the basis that there were *"twenty incontestable facts and circumstances"*. Counsel set these out in paragraphs 37.1 to 37.18 of the written submissions, which can be summarised as follows:

- That on 43 occasions the medical records, record X's planning and/or thoughts of suicide;
- That on 13 occasions medical records make reference to X's ongoing difficulty in *"securing a decent night's sleep"*;
- That on 16 November 2012 Mr Campbell was told by X that the side effects of not sleeping was that she wished to kill herself;
- On two occasions Ms W made a request to see X's file;
- On one occasion the option of private health care was discussed with X's parents;
- There was a lack of monitoring or increase in the medication levels;
- There was no prescription of medication to assist in sleeping;
- That Dr Lim despite being at the hospital on 16 December 2012 did not meet with X on 16 December 2012;
- That X should not have been discharged despite having a history of suicidality;
- That X should have been readmitted to Hornsby hospital with the parents advise their concerns after discharge.

There are a number of flaws with the submissions proffered by Mr Gracie and Ms Moisidis.

Firstly, the care and treatment provided by Hornsby Hospital and CAMHS was reviewed by Dr Large, senior psychiatrist at Prince of Wales Hospital who, I accept, is one of the top experts in New South Wales on risk assessment for suicidality and self-harm. His expert opinion was that in the circumstances of this case, the actions of the staff who cared for X, including doctors, nurses, psychologists and social workers, were reasonable and appropriate. Significantly, Dr Large sat through the oral evidence of the professional witnesses the actions of whom he was asked to review, so he had the opportunity to assess their oral evidence, as well as having read their statements and clinical notes. His expert opinion was that they presented as caring, skilful people,

who acted reasonably in their assessments, decision-making and care. He did not alter his opinion when he gave his or evidence on the final day of the inquest, or during the course of cross-examination.

Secondly, no alternate expert opinion was provided to challenge Dr Large's expert opinion.

Thirdly, I was offered no evidence (expert or otherwise) in support of the nexus between Counsel for the family's submissions and X's tragic decision to end her life on 18 December 2012.

Having regard to the NSW Health policies and guidelines, which I accept may inform my decision as to whether the care and treatment afforded to X was appropriate, I find that staff at Hornsby Hospital did comply with NSW Health Policy Directive PD2005_121 *Suicidal Behaviour – Management of Patients with Possible Suicidal Behaviour* which applied with respect to the management of X during her 31 July 2012 admission. X was triaged, medically assessed by Dr Yang and physical investigations were performed (such as the taking of blood samples, urine analysis, an ECG and physical observations). Importantly, X was seen promptly and thoroughly by appropriately qualified mental health practitioners, including Mr Campbell, who performed a mental health assessment and a risk assessment. A psychiatric registrar, in consultation with Mr Campbell, formulated a management plan which was agreed to by X and which provided for ongoing consultation with Mr Campbell as part of the CAMHS service. CAMHS then appropriately followed up with X the next day.

Equally, I find, having regard to all of the evidence before me, that staff at Hornsby Hospital complied with that policy during X's second and third admissions. During both admissions, X was promptly medically assessed and a comprehensive mental health assessment was made. During her second admission, the seriousness of her medical condition was acknowledge and she was "specialled" (provided with one on one nursing) during the initial stages of her admission. Risk assessments were undertaken and reviewed. She was seen promptly and regularly by medical and specialist mental health staff and she was provided with information (at least during the second admission) regarding the *Mental Health Act 1990.* On both occasions she was discharged with a plan which was conveyed to her parents.

Accordingly, I am satisfied that X did receive appropriate care and treatment from Hornsby Hospital and CAMHS during her various admissions and during her outpatient treatment.

I will now deal with the specific concerns regarding care and treatment raised by counsel for the family in support of their general submission that X was not appropriately care for and treated..

Specific issues regarding the care and treatment of X

Should X have been medicated prior to 8 October 2012?

Dr Lim first prescribed fluoxetine (otherwise known as Prozac), to X upon her second admission to Hornsby Hospital on 8 October 2012.

The medical records and evidence indicate that prior to this date that the issue of anti-depressant medication was raised with X and that she was resistant to it, in particular:

- on 15 August 2012, in her session with Mr Campbell. It was the evidence of Mr Campbell that he *"discussed the pros and cons of treatment with anti-depressant medication"* and that X expressed *"great reluctance to taking anti-depressant medication"*, and
- on 11 September 2012 in her session with Ms Senediak - the notes of Ms Senediak of this session record *"somewhat reluctant to consider antidepressants"*;
- the evidence of Mr Campbell who recalls that in her appointment of 18 September 2012, that X *"flatly refused to accept my suggestion, which I recall having made at this meeting (as per follow-up plan documented by Lydia in my absence on leave) that she consider seeing a psychiatrist and having medication"*[45]

Moreover, this accords with the evidence of Ms W that in about September 2012, X came to her and said *"Mum I think I should go on anti depressants"*. This was during the period when Mr Campbell was on leave and X had seen Ms Senediak. It is clear that Ms W did speak to Ms Senediak the next day about making a psychiatrist appointment; however, it seems that for whatever reason Ms W was only advised of the cancellation of that appointment (she was never told of the actual appointment) on 28 September 2012.

It was the evidence of Dr Large that:

> *"I do not necessarily believe that the prescription of medication prior to 8 October 2012 would have made very much difference. Anti-depressant medications are of limited value in mood disorders in this period of life and have well recognised problems. It would be very unusual, and almost certainly counter-productive, to have compelled Ms W to take medication at this time."*[46]

The evidence clearly, in my view, indicates that X was resistant to taking anti-depressant medication up until about 12 September 2012. However, there is no evidence before me to even

[45] Exhibit 1, Volume 1, Tab 32, paragraph 29

[46] Exhibit 1, Volume 3, Tab 2, page 13

suggest that the commencement of anti-depressant medication from this date (being the earliest date on the records that X seems open to the idea of taking anti-depressant medication) may have assisted her mood or prevented her from attempting to take her own life on either 8 October 2012 or 18 December 2012.

Should X's dosage of fluoxetine been increased from 20mg to a higher dosage?

On 10 October 2012, X was first prescribed fluoxetine 10mg. The dose was titrated to 20mg on 15 October 2012.

The medical records indicate that she remained on a dosage of 20mg per day of fluoxetine and that it was not increased. The Post Mortem toxicology reveals fluoxetine in X's blood, which suggests that X was medication compliant up until her death.

It was submitted by Mr Gracie and Ms Moisidis that "o*ver the period of nine weeks, between 10 October 2012 and 18 December 2012, there was no testing of higher dose of medication notwithstanding the multiple mentions of sleeping problems and the recurring suicidal teens including diagnosis of depression*..."[47]

It is true that X was not prescribed a dose of fluoxetine that was higher than 20mg per day. However, at no time was it put by Mr Gracie to Dr Lim that he should have increased the dosage and what the effects of such an increase would be. Furthermore, this issue was also never put to the expert, Dr Large.

I do note generally however, that the medical records and evidence indicate that X's mood was relatively stable after she was discharged from the LMU (and whilst she was being prescribed the 20mg of fluoxetine per day). She had attended school without incident and while she had cancelled her appointments with Mr Campbell prior to the incident of 16 December 2012, there was nothing on the face of her presentation over this period to suggest the worsening of her mood. If so, I suggest her parents would never have left her babysitting her siblings on 16 December 2012.

Accordingly, there is no evidence before me that an increase in the dosage of fluoxetine would have assisted X or may have prevented her from taking that fateful decision on 18 December 2012 to end her life.

[47] Paragraph 37.8 of written submissions dated 19 November 2014

Was X's difficulty sleeping appropriately investigated and managed?

It was submitted by Mr Gracie and Ms Moisidis that *"On 13 occasions in the clinical notes within the same records the ongoing difficulties in securing a decent night's sleep and the equivocal effect of remedies and medication dealing with that problem were identified"*[48] and she should have been afforded treatment by a sleep specialist[49].

Counsel goes further later in their submissions where they state:

> *"likewise the questions of medication for sleep or referral to sleep specialist there is nothing logical at all about any involved person failing to refer an adolescent who suffers from gross sleep deprivation to a specialist in order to seek to alleviate that underlying cause which the patient herself has identified as a major factor in her suicidality. There is no answer to this on the material presented to the coroner on this point. The public system was so hopeless that the consultant psychiatrist was forced to avail himself of some peripheral contact in a New South Wales country town in order to address, in a city of 5.5 million people, the question of adolescent suffering from sleep difficulties. On any view, this is a ridiculous system, at least, so far as the particular case of XY is concerned."*[50]

This latter submission is, in my view, flawed for a number of reasons, not least of which is the emotion it seeks to evoke and hyperbole it uses. Firstly, there is no evidence before me that X suffered from "gross sleep deprivation". The medical records indicate she was having difficulty falling to sleep at night (sometimes being in bed for two hours being falling asleep), however, she reported that she was getting up at about 10.00am and did not want to change that, so she appeared to be getting about eight hours of sleep a night. Secondly, Ms W only sought a referral to a sleep specialist from Dr Lim in the week prior to X's death.

It is uncontroversial that sleep was a reported issue for X. It was a topic for discussion at most if not all her sessions with Mr Campbell. It clearly and understandably was a major cause of concern for her mother.

It was the evidence of Dr Lim that his options for treating X's problem of sleeplessness post discharge from the LMU included:

> *"prescription of:*
>
> *(a) benzodiazepines (for example temazepam);*
>
> *(b) low doses of antipsychotic medications, (for example Seroquel).*

[48] Paragraph 37.2 of written submissions dated 19 November 2014

[49] Paragraph 51.3 of written submissions dated 19 November 2014

[50] Paragraph 56 of written submission dated 19 November 2014

(c) Melatonin, which is used in disorders of sleep-wake cycle. Its pharmacological effect assists the resetting of the brain into a usual day/night routine.

In my practice, I strongly discourage the use of antipsychotics for night sedation, even at low doses. It is an "off label" usage of this medication and best used only under hospital-based clinical supervision. In addition the medium term and long term side effects of ongoing exposure to antipsychotics to the developing brain, is unclear; the risk of weight gain, diabetes, tremor, and sedation are present at any stage in its use. By reason of this, I wanted to cease X on Seroquel as soon as clinically appropriate.

It is also my initial practice to be judicious about the use of benzodiazepines, and limit its use to hospital based treatment. The risk of physiological dependence and overdose when it is not supervised is ever present, any age group, including disorganised young people.

At the time of prescribing, my preference for X was to trial the use of Melatonin. The medication has a better tolerance and effectiveness profile for treatment of sleep onset difficulties; although its effectiveness is could time if the cause of sleep onset difficulties are anxiety or mood based"[51]

From about mid November 2012 the medical records record the following about X and her issues with regard to sleep.

On 16 November 2012, Mr Campbell recorded that X reported that "*sleep is erratic however is getting 8 or 9 hrs/day"....."we discussed sleep issues and went through relaxation and claiming strategies again"*[52]. From X's appointment with Dr Lim that same day, he also records "reports sleep is her main struggle, with going to bed at 11pm and not falling asleep for another two hours."[53]

On 11 December 2012[54], Mr Campbell notes:

"…Y expressed concerns re X's sleep, suicidality and 'post schoolies low'…X said/indicated…Sleep remains a problem- does not get to sleep till 2AM, but gets 8hrs as sleeps till 10AM. We discussed relaxation calming strategies again….PLAN- arrange for session with Dr Lim ASAP (W to do so) see again next week"[55]

The day following this appointment[56] Mr Campbell sent an email to Dr Lim where he stated:

"Mother is still very, very concerned and wants X to be referred to a sleep specialist, and be put on more medication.." …something HAS to be done". So that is why she has booked a time for X to see you about increasing the medication…"[57]

---

[51] Exhibit 1, Volume 1, Tab 36 at paragraphs 36-39

[52] Exhibit 1, Volume2, pages 104-106

[53] Exhibit 1, Volume 2, pages 102-103

[54] X did have a further appointment with Mr Campbell on 22 November 2012 however the notes made by Mr Campbell make no reference to sleep issues

[55] Exhibit 1, Volume 2, page 112

[56] 12 December 2012

[57] Exhibit 1, Volume 2, page70

The records indicate an appointment is made with Dr Lim on Friday 14 December 2012 but it was cancelled.

Mr Campbell was clearly concerned about X's reported sleep issues, and Ms W's heightened anxiety in relation to it, and had appropriately referred those concerns to Dr Lim in his email of 12 November 2012. Dr Lim, in my view appropriately, provided X (and her mother) with an urgent appointment in three days' time, namely on Friday 14 December 2014. However, that appointment was cancelled.

Moreover it is clear from the records that prior to this, Mr Campbell had explored alternatives with X including relaxation techniques and herbal remedies such as valarium and then melatonin which were reported initially to have some effect.

Finally it was the expert evidence of Dr Large that

> *"Insomnia is a very common symptom in the community and particularly among people who have mood and similar disorders. Further investigation (for example by a sleep study) is usually of little value. I am not critical of the non-prescription of sleeping tablets to Ms Y [X]. In my view sleeping tablets have no real role in the management of insomnia. I note that Ms* [X] *Y was prescribed Melatonin for insomnia."*[58]

Accordingly, I am satisfied that X's treating practitioners were aware and appropriately concerned and were taking appropriate measures to treat and assess her sleeping difficulties.

Should WW have been provided with a copy of X's treatment notes with Mr Campbell?

It was argued by Mr Gracie and Ms Moisidis that:

> *"on 2 occasions, being 15 October 2012 and 19 October 2012, the primary carer, WW, raised with Mr Campbell a request to see the file. On 15 October 2012 WW is recorded by Mr Campbell to be "concerned about decisions made prior to suicide attempt". This matter was raised again in the phone call which occurred on 19 October 2012"*[59]*.*

It was suggested in the evidence of Ms W that the refusal of Mr Campbell to provide the file made them "*suspicious that he was protecting CAMHS at the expense of X's welfare and life."*[60]

X was 17 years old she was to turn 18 on 1 April 2013. Accordingly, she was still defined as a 'minor' pursuant to the *Minors (Property and Contracts Act) 1970 (NSW)* as she was under

---

[58] Exhibit 1, Volume 3, page 13

[59] Written submissions dated 19 November 2014 paragraph 37.4

[60] Exhibit 1, Volume 1, Tab 6, paragraph 33

18 years old when she was receiving treatment from CAMHS and Hornsby Hospital and the request to view her records were made by her parents.

However, that is not the end of the matter. The 1992 High Court in *Secretary of the Department of Health and Community Services v JWB and SMB*[61] (known as *"Marion's Case"*) endorsed the "mature minor principle" and recognised the rights of mature minors to make decisions about their medical treatment and to receive confidential health care.

I note the comments made by Dr Large during the course of his oral evidence on the final day of the inquest where he stated, inter alia, that to hand over X's treatment records without her consent would at her age risk damaging the therapeutic relationship. It was not a simple matter.

X was a bright, intelligent almost 18 year old. For her treating practitioners to simply hand over her medical records without her consent would have risked, in my view, damaging the ongoing therapeutic relationship and would on the balance of probabilities have been inappropriate in the circumstances.

Was Ms W dissuaded from seeing a Private Psychiatrist by either Dr Lim or Mr Campbell?

Mr Gracie in his written submissions under the heading, "Discouragement of Private Treatment Options" suggests that "on one occasion, individually with both parents, both WW and ZZ raised with Mr Campbell the possibility of private options".[62]

It was the evidence of Mr Campbell that during X's admission to the LMU he had a discussion with Ms W on 15 October 2012 his evidence regarding this conversation was:

> *"she [Ms W/ W] raised with me the possibility of engaging private clinicians at a private facility. I did not discourage X's family from seeking private assistance. So far as seeing a private clinician outside CAMHS, the policy is that it is much preferred that a patient choose whether they wish to be treated privately or publicly. One reason for this distinction is the potential for difficulty in resolving differences of opinion between public and private treating clinicians, which in turn impacts on continuity of care. This was a particular concern as we were then considering managing X in the community within the structure of the community treatment order (**CTO**). I spoke with W at some length about the advantages and disadvantages of private versus public mental health care…."*[63]

[61] (1992) 175 CLR 218

[62] Written submissions paragraph 37.5

[63] Exhibit 1, Tab 32, paragraph 38

There seems to be an undercurrent throughout Mr Gracie's written submissions that somehow private health care is to be preferred, better or somehow a superior option to that of public health care. There is no evidence before me to that effect.

The evidence at its highest was that Ms W:

1. raised the issue of a referral to a private psychiatrist and Mr Campbell discussed this option with her; and
2. also discussed the option of X seeing private treatment (psychologist and Psychiatrist) with Dr Lim who also discouraged her from that course.

There is no evidence from Dr Lim in relation to that alleged conversation and it was never put to Dr Lim that he discouraged Ms W from seeking a private psychologist or psychiatrist.

Accordingly, I am satisfied on balance that Ms W did make inquiries about private health care for X and those options were discussed. However, I am not satisfied that Ms W actively sought a referral to a private psychiatrist or that even if she did so, taking such a step would have prevented this terrible tragedy from occurring.

Should X have been discharged from Hornsby and Ku-ring-gai Hospital on 17 December 2012?

Mr Gracie submitted that X should not have been discharged from Hornsby Hospital on 17 December 2012. He argued (from what I have managed to extrapolate from the lengthy submissions) inter alia that:

- her treating psychiatrist, Dr Lim didn't attend her personally to authorise her discharge;
- she was highly suicidal at the time and expressed thoughts of a violent self inflicted death in recent times; and
- there was no contact between Dr Lim and and Ms W as primary carer and therefore she was "*left in the dark with the tools to manage*" her daughter upon discharge.

I have considered in detail the facts leading up to the decision to discharge.

It was the evidence of Dr Lim, who gave evidence on the final day of the inquest, inter alia that, firstly, he did not attend X in either the emergency department or the PECC unit during the third admission, and secondly, he gave the approval for her discharge based on his discussions about her presentation with both CNC Simpson and Dr Kaufman and with confirmation that Ms W was confident that it was not a suicide attempt and that X had an appointment to see him the following day.

Dr Large provided expert evidence to the Court in relation the care and treatment X received. His evidence in relation to the admission and subsequent discharge on 17 December 2012 are as follows:

> *"although in retrospect, it would have been preferable for Ms Y to have remained in hospital longer than she did, I am not critical of the decision that was made to discharge Ms Y shortly after the presentation on 16 December 2012. Ms Y gave consistent history that she had taken the overdose without suicidal intent and the subsequent course was more suggestive of having taken a smaller rather than larger dose of diazepam. Significant ongoing suicide ideas that would know about previously and she denied suicide intent or plans. Ms Y expressed future orientated plans and wishes. Most importantly Ms Y was discharged into the care of the family were aware of the difficulties and she had appropriate follow-up planned for the following day…."*[64]

Accordingly, I am satisfied on the balance of probabilities that the discharge of X on 17 December 2012 from Hornsby Hospital was appropriate in the circumstances.

Were the risks accompanying discharge from Hornsby Ku-ring-gai Hospital on 17 December 2012 appropriately managed?

The written submissions of the family contend that the risks accompanying discharge from Hornsby Hospital were not appropriately managed for the following reasons:

- That Hornsby Hospital did not comply with the requirements of:
    - The NSW Health Policy Directive entitled "Suicidal Behaviour - management of patients with possible Suicidal Behaviour"[65];
    - The NSW Health Policy Directive entitled "Transfer of Care from Mental Health Inpatient Services 14 November 2012[66] ("**Transfer of Care Directive**")
- The treating team, namely CNC Simpson, Dr Kaufman and Dr Lim were confused and inconsistent in their evidence in relation to the availability of the Acute Care Team (whom the submissions refer to as the suicide response team) and its operation hours;
- That Ms W, the primary carer, was not provided with the details of the Acute Care Team;

The evidence before me indicates that the NSW Health Policy Directive PD2011_015 *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* applied to X's discharge on 17 December 2012 but was not complied with. That Policy Directive requires staff to use a "Transfer of Care Checklist" when a patient is to be transferred home "to meet the needs of

[64] Exhibit 1, Volume 3, Tab 2, page 12
[65] Exhibit 1, Volume 2, Tab 4
[66] Exhibit 1, Volume 2, Tab 8

patients before leaving the hospital". The Transfer of Care Checklist is required to cover the following information:

- Estimated Date of Transfer
- Destination of Transfer
- Notification/Transport Booked
- Personal items Returned
- Referral Services Booked
- Care Plan
- Transfer of Care Summary provided to patient that includes medication information, communication and GP referrral information and follow up appointments. This is to be provided in plain language and explained to the patient.

The documents of possible import in X's case were the Care Plan (which, presumably, would have set out the planned management of X) and the Transfer of Care Summary. I agree that it appears that neither of these documents were provided to X.

I also agree that there was confusion on the part of the team who were involved in X's care on 16 and 17 December 2012, namely CNC Simpson, Dr Lim and Dr Kaufman, as to hours of operation of the Acute Care Team.

However, the evidence clearly indicates that Ms W could access assistance in the event she became concerned about X and her behaviour, and she did access such assistance on the afternoon of 17 December 2012 by her phone call to CNC Simpson. That phone call resulted in her being called by Mr Campbell and Mr Campbell liaising with Dr Lim and then speaking again to Mr Campbell about what their thoughts were about future planning. They decided that it was appropriate for X to remain in her family's care until her appointment with them the following day at 2.00pm.

Nobody could have predicted what would have occurred on the morning of 18 January 2012.

<u>Should X have been readmitted to Hornsby Ku-ring-gai Hospital at any time following her discharge on 17 December 2012?</u>

Mr Gracie submits that X should have been readmitted to Hornsby Hospital, following her discharge on 17 December 2012. He states in essence, that the treating team prevaricated and

ignored Ms W's plea *"for intervention within one hour of discharge"*[67] and the treating team (according to his view of the evidence) placed the burden on Ms W on making the decision as to whether or not to bring X back to hospital and it was the family who ultimately made the wrong decision. He also argues that the treating team, namely CNC Simpson, Mr Campbell and Dr Lim should have erred on the side of caution and advised Ms W to bring her back to hospital when she expressed her concerns regarding her behaviours by phone on the afternoon of 17 December 2012.

The evidence of Ms W regarding her conversations with CNC Simpson and Mr Campbell was inter alia that she was pushing for readmission[68] and that X was "0 out of ten"[69] meaning that she was in extreme crisis[70].

However, it was the evidence of Mr Campbell however Ms W was:

- "friendly and very open in her discussion, but expressing concern and confusion"[71] regarding X's behaviour;
- the tone of the discussion was one of co-operation[72];
- that he has no recollection of Ms W describing the situation as being one of desperation and/or extreme crisis or that X was "zero out of ten"[73];
- That if Ms W had said that X was "zero out of ten" or the situation was "desperate" he would have advised her to bring her back to hospital or call the police.

In addition, Mr Campbell gave evidence that one piece of new information that had been communicated by Ms W to CNC Simpson, and passed on to him, was that X was expressing a desire to run away. When he spoke to Ms W, he was told that X was lying in bed so he felt that it was no longer an issue and the situation had calmed down somewhat. He considered that to create a further escalation, by recommending that X attend hospital, was itself a risk.

Mr Campbell gave evidence on the final day of the inquest. He gave evidence in an open and forthright manner and was clearly affected by X's death. I found him a witness of truth.

---

[67] Written submissions dated 19 November 2014 at paragraph 46
[68] Exhibit 1, Volume 1, Tab 6, paragraph 70
[69] Exhibit 1, Volume 1, Tab 6, paragraph 72
[70] Ibid
[71] Exhibit 1, Volume 1, Tab 32, paragraph 61
[72] Ibid
[73] Ibid at paragraph 77

Ms W provided her statement to police on 21 December 2012, only 3 days after her daughter's death. At the time of giving this statement she, understandably, was and clearly still is (and always will be) grieving the loss of her first born child and wondering what more she could have done to prevent her from taking her own life on 18 December 2012. Her evidence in my view is tainted by this emotion. Moreover, the evidence of Mr Campbell is also somewhat corroborated by the file notes he took at the time and the emails between himself and CNC Simpson. Accordingly, I prefer the evidence of Mr Campbell over Ms W. Furthermore, the evidence does not in my view indicate that the final decision as to whether or not X was to be readmitted rested with Ms W, it is clear this option was discussed by Mr Campbell and Dr Lim and they were of the view that she should remain at home and come in the following day for reassessment.

Dr Large opined in his report dated 20 September 2014:

> *"I am also not critical of the hospital not immediately encouraging readmission when more information came to light on her return home. Again the treating team would have been aware that the only reason for readmitting Ms Y would be for her protection and I believe that they would have been reasonably assured of the safety of Ms Y with knowledge of the family's concerns. While it is true that the new information might be considered to have been evidence of an elevated level of suicide risk at that time, even patients who can be considered to be at the highest risk of suicide have a very low risk of suicide on any given day. The decision to defer a further assessment until the following day as reasonable and consistent with good medical care"*[74]

Accordingly, I am satisfied on the balance of probabilities that on the information the treating team had available to it on the afternoon of 17 December 2012 it did not err by advising Ms W to maintain the status quo and defer further assessment until the following day and keep X at home.

Should any further steps have been taken with respect X under the *Mental Health Act 2007*?

At the time of her death X was under a Community Treatment Order pursuant of s. 51 of the *Mental Health Act 2007* for a period of 6 months[75]. The Community Treatment Order was made in respect of X in accordance with an attached Community Treatment Plan, which relevantly provided:

> *"Goals of Treatment:*
>
> - *Compliance with Medication and Counselling*
> - *Attendance at Appointments for Psychotherapy, review of medication and mental state*

[74] Exhibit 1, Volume 3, Tab2, page 12-13

[75] Exhibit 1, Volume 2, Tab 2, page 15

- *Maintaining a stable mental State thus preventing acts of major self harm and suicide*
- *Taking responsibility for taking medication and attending appointments with a view to discharge from CTO.*

…

Obligations:

1. Obligations on the client to make contact with the treating team.

1.1. Appointments with Case Manager (primary treating clinician)

XY must attend and meet with Tom Campbell or delegate at the places specified as negotiated being weekly at first then at least fortnightly and with at least one [parent present. Attendance will be between the hours of 9 am to 4 pm, Monday to Friday.

The frequency and timing of the appointments may be varied as required by the case manager or delegate.

XY must attend and meet with Tom Campbell or delegate at Hornsby CAMHS or Hillview Community Health Centre.

1.2

Appointments with Treating Doctor

XY must attend with the treating Doctor for the purpose of implementing the implementing the community treatment order, including prescribing or administering prescribed medication and to review mental state.

Frequency and Timing of Appointments

XY must attend and meet with Dr Alex Lim or delegate at the places indicated and between the hours of 9 am and 4 pm Monday to Friday.

The frequency and timing of appointments will be varied as requested by the treating Doctor or delegate.

Where Appointments with Treating Doctor will be Held

XY must attend and meet with Doctor Alex Lim or delegate at Hornsby CAMHS, Derby road Hornsby.

2. Obligations on the client to accept or comply with medication and Treatment

XY is required to accept the treatment and/or medication prescribed and/or varied by Dr Alex Lim or delegate.

Current Medication:

Fluoxetine 20 mg

3. Any other duties or obligations of the Affected person

XY is required to comply with any medical examination as requested by the treating Psychiatrist or delegate.

4. Obligations of the Community Health Facility

Hornsby CAMHS will continue to provide support, therapy, monitoring and education to XY and her parents about her mental illness by providing family sessions as required.

Hornsby CAMHS will ensure that XY is aware of her rights of appeal and rights in relation to seeking revocation or variation of the Community Treatment Order.

Hornsby CAMHS will facilitate the effective implementation of the Community Treatment Order by arranging and supporting effective communication between XY, Tom Campbell and Dr Alex Lim or the Director of Hornsby CAMHS."

It was submitted by Mr Gracie and Ms Moisidis, inter alia, that further steps should have been taken with respect to X under the *Mental Health Act 2007*. I assume that Counsel grounds that submission on the basis that the CTO powers could have been exercised and they were not, that is an ambulance or the police could have been called and X forceably returned to the hospital.

The difficulty with this submission is that X's treating team (namely Mr Campbell and Dr Lim) were of the view that she did not need to be returned to hospital. Mr Gracie's submissions may have been skewed by the prism of hindsight. I have set out the evidence in relation to the decisions made by the treating team in the preceding section of these findings and have found them to be appropriate in the circumstances.

Submissions of Mr Gracie in relation to Dr Lim

Before proceeding to deal with the issues concerning the response to X's report that she was intending to grievously harm herself, it is necessary to comment on one further aspect of Mr Gracie's oral submissions.

Mr Gracie directed me to a number of text message records between X and each of her parents on 22 September 2012. Those text messages are exhibited before me electronically as part of the Brief of Evidence. It suffices to note that X and her father exchanged text messages in the late

afternoon and Mr Z was en route home from Woy Woy. The text messages indicate that the two had a warm and comfortable relationship at the time.

Counsel then proceeded to make submissions as to the import of those text messages. Morevover, Mr Gracie relied upon those text messages to make submissions with respect to the evidence of Dr Lim. It is appropriate to set out the relevant oral submissions in full:

> *"The second matter that I'd like to point out - and I remind all the parties that I am using the Queen's English - was the chilling autism in which Dr Lim couldn't help but blame Mr Z's extramarital affair as a contributing cause to her depression. The Court was chilled when it heard that. And when we read these text messages we realised just how wrong Dr Lim was, first of all to say that and secondly, how wrong he was in point of fact. That should never have been raised. It wasn't raised by Counsel Assisting, Ms Sandford professionally stayed completely away from it but in a cold manner that doctor defending his own decisions thought he should throw that into the mix. And on behalf of the parents I vehemently criticise him for that."*

Counsel's strong criticism of Dr Lim and the manner in which that criticism was expressed require some consideration. That it is required to form part of the public record is particularly regrettable given, as noted by Mr Gracie, neither Counsel Assisting nor Ms Sandford raised it during the inquest, presumably out of respect for the family given the likely sensitivity of the issue and having made a forensic decision that examination on that issue would not assist me.

Dr Lim appropriately referred to the extra-marital affair in the context of his oral evidence. He referred to it briefly as one matter which he was aware of which impacted upon X. While I understand the family's discomfort and possibly anger at hearing the evidence, Dr Lim should not be criticised for answering fully and frankly. Much less should it be imputed, as Counsel may have been inviting me to do, that Dr Lim did so with the intent to defend his actions.

That the extra-marital affair occurred and that it was deeply felt by X are both matters of fact. Indeed, Ms W states that is the case. Ms W's evidence was that X was initially angry at her father but that the relationship between them had *"returned to a normal father daughter relationship in June 2012."* The text messages referred to between them simply confirm that is the case. It is clear that X spoke to many of those treating her about the episode and its affect upon her and it was rightly recorded and noted by them. It was open to Dr Lim, as X's treating psychiatrist, to consider the episode as possibly relevant to X's presentation.

Bearing in mind Mr Gracie's exhortation to Counsel at the outset of his oral submissions to refrain from taking an emotional response to the written submissions for the family and to understand that they are written in *"Shakespeare's English"* and should be replied to in plain and sober fashion, and his specific reminder that he is using the *"Queen's English"*, I note that the Oxford Dictionary defines 'autism' as:

"A mental condition, present from early childhood, characterized by great difficulty in communicating and forming relationships with other people and in using language and abstract concepts.

Origin

early 20th century (originally with reference to a condition in which fantasy dominates over reality, regarded as a symptom of schizophrenia and other disorders): from Greek autos 'self' + -ism."

If Mr Gracie described Dr Lim's evidence as being given with "chilling autism" within the original meaning of "autism", I do not accept this submission for the reasons set out above; that is, it is a matter of fact that the event occurred and that it impacted upon X. If Mr Gracie intended to refer to the medical meaning of "autism", it was inappropriate and insensitive to those who may be diagnosed with autism spectrum disorder.

Did the NSW Police Force appropriately respond to the report of concern for X's welfare on 18 December 2012?

In the early hours of 18 December 2012, X left her home at Hornsby without her parents' knowledge. She travelled to an overpass between Mt Colah and Asquith stations. She was still wearing her pyjamas but she had taken her Samsung mobile telephone with her.

At 3.22am, X wrote the following memorandum on her mobile telephone:

"Suicide:

to mum, dad, A.and.B

, love you all with all my

heart.

To.my friends, thank you for

always being there for me,

love you all.

To peter, you've been the

best friend anyone.could

hope you, love you.

To everyone else in my life,

im so sorry it had to end this

way. L.ife just doesn't suit.

Thank you to tom and the

camhs team for trying to
save.me.

Infinite loves, kisses and
apologies. Xx"

According to Lifeline Australia's records, at 3.57am X called the service from her mobile telephone for the third and final time. It was answered by Lifeline Harbour to Hawkesbury Telephone Crisis Supporter Fernanda Mascarenhas at 4.03am. Ms Mascarenhas recalls that X said that she was tired and there was no point living and that she said she was sitting on a train track waiting for a train.

The *Lifeline Crisis Support Police Intervention Protocols "Version 2 (March 2012)" and "Version 3 (March 2012)"* were both annexed to statements exhibited in this inquest. The deponents to those statements are of the belief that the respective version is that which was current at 18 December 2012. As they appear identical in all material respects I will refer to both documents as the "*Lifeline Crisis Support Police Intervention Protocols (March 2012)*".

The *Lifeline Crisis Support Police Intervention Protocols (March 2012)* is a document which is self-described as providing *"Intervention Protocols for Lifeline and the Police Communications Centres when it is identified that there is* "a serious and imminent threat to the life or health of a person" *(as detailed in Section 287 of the Telecommunications Act 1997) who is contacting Lifeline through either its telephone or online crisis support service"*. Relevantly, at [4] it outlines the "Intervention Procedures" for telephone contact (which is reflected in a flow chart at [4.1.1]. There is no issue as to whether Lifeline Harbour to Hawkesbury appropriately responded to X's call and it is clear that its internal protocol was followed.

In accordance with that protocol, at some point during that call, Ms Mascarenhas informed her supervisor, Ms Caroline McGrory, that there was a serious and imminent threat to the life and safety of the caller by making eye contact with Ms McGrory and communicated that the call involved "train tracks". Ms McGrory says that she stood beside Ms Mascarenhas and ensured that the Malicious Call Identification button was pressed in case the call needed to be traced. Ms McGrory states that she directed to Ms Mascarenhas to encourage X to get off the train tracks and to ascertain X's location.

While Ms Mascarenhas provided a statement on 30 October 2014 recalling that X refused to tell her which station she was at, the Lifeline Contact Sheet record for that call notes: *"Caller stated that she was sitting on the track at a station between Asquith and Waitara and was waiting for the 4:24am train".* This is supported by Ms McGrory's evidence and also conveyed by her to police later that morning.

Both of them heard the sound of a train nearby, confirming that X was indeed if not on a train track then at least near one. Ms Mascarenhas encouraged X to get off the tracks. The call was suddenly terminated at 4.08am after X said that she was going to get off the train track.

Again in accordance with the *Lifeline Crisis Support Police Intervention Protocols Version 3 (March 2012)*, at 4.13am Ms McGrory notified police. This was done by calling the Duty Operations Inspector at the Sydney Radio Operations Centre on a direct line which is made available to Lifeline and other crisis support services. Inspector Darren Gregor of the NSW Police Force was rostered there as the Duty Operations Inspector at the time.

The audio recording of the call shows that Ms McGrory advised Inspector Gregor of the NSW Police Force that, inter alia:

> *"…we've just had a very alarming call from a young girl who's sitting on a train track … we heard the train go past … she's 17 years old called X and she said she was on a train track … between Waitara and Asquith … and that she was waiting for the 4.24 train…"*

Ms McGrory provided X's telephone number. The call concluded at 4.15am.

The NSW Police Force policy at the time with respect to responding to concern for welfare calls from Lifeline or any other mental health crisis service required the Duty Operations Inspector to, relevantly:

1. Make manual checks to see which telecommunications carrier held the telephone number;
2. If the telephone number was a landline, send a subscriber request to Telstra and those details provided to operational police to respond;
3. If the telephone number was a mobile handset, police at the Sydney Radio Operations Centre would check the prefix to identify the telecommunications carrier (an online system of making these checks was not available in December 2012);
4. A request form would be sent to the identified telecommunications carrier for the subscriber details;
5. Once the address associated with the telephone number has been provided by the telecommunications carrier, police officers "in the field" would be advised via police radio of

the incident. Those police officers would conduct initial investigations which involved attending the subscriber's address to see whether the person at risk was at that location;

6. If the police officers were unable to find the person at the subscriber's address, they would contact the Sydney Radio Operations Centre and, if telephone number was mobile, request triangulation.

In accordance with the NSWPF policy, at the conclusion of the call, Inspector Gregor completed a request form for customer details for the mobile telephone number provided and faxed it to Vodafone. He also completed a request form to conduct a call trace on the Lifeline telephone number and faxed it to AAPT. These actions were in accordance with NSWPF procedures.

Inspector Gregor received responses between 4.21am and about 4.28am or 4.29am. At about 4.26am, Inspector Gregor received a facsimile from AAPT indicating that the call trace had identified the mobile telephone number. At about 4.21am, he had received a telephone call from Vodafone advising that the mobile telephone number was disconnected; he recalls that this information was revised at 4.29am when Vodafone called Inspector Gregor again to advise that the mobile telephone number was registered with wholesaler Crazy Johns. Vodafone faxed the subscriber details. Those details indicated that the phone was registered to Ms W. It included her home address, date of birth and home telephone number.

Inspector Gregor states that he then caused a CAD job to be created requesting police to patrol between Waitara and Asquith railway stations. The CAD log shows that an "all resources" broadcast was made at 4.28am. This suggests that Vodafone called him for the second time by 4.28am and not at 4.29am as recollected by Inspector Gregor.

Senior Constable Callan Parsons responded in police vehicle KU14 almost immediately at 4.28am. He proceeded to Hornsby station before following the railway corridor northbound towards Asquith.

The CAD log shows that at almost 4.30am, police vehicle KU18 (containing Probationary Constable Brodie Mulry and Constable Chad Sessions) proceeded urgently to Waitara station. They both recall that they proceeded at about 4.25am; however, given the CAD log and the times provided by Inspector Gregor it is unlikely that was the case. Probationary Constable Mulry and Constable Sessions arrived at Waitara station at 4.32am and commenced searching the tracks.

However, by that time, X had already been struck by a train at 4.30am. This was reported to police and broadcast on CAD. Other police subsequently responded and commenced the investigation.

There is no issue as to the manner or efficiency of the police response once the incident was broadcast on CAD. There is a question that arises in relation to the decision of Inspector Gregor to request that checks be conducted on X's telephone number in circumstances where it was reported to him that she was between two train stations reasonably close together; that the fact that she was near trains was independently verified by the noise of the train passing heard by Ms McGrory and Ms Mascarenhas; and it was reported that she was waiting for a train that was to arrive imminently at 4.24am. The importance of the information obtained from the subscriber check in this case is also unclear given, once obtained, police did not proceed directly to the subscriber address (X's home) but, quite properly, proceeded to search between Hornsby and Waitara stations. However, the weight of the evidence clearly shows that Inspector Gregor followed NSW Police policy at the time. It also cannot be said that any different response could have prevented X from taking the course of action that she did, given she reported that she was between Asquith and Waitara stations when she was, by 4.30am, at a location slightly north between Asquith and Mt Colah stations.

Accordingly, I am satisfied that the police did respond appropriately in the circumstances as they complied with the policy at the time.

Were policies and procedures concerning the communication of information between Lifeline and the NSW Police Force appropriate and were they appropriately applied?

The policy concerning the communication of information between Lifeline and the NSW Police Force current at the time is the "*Lifeline Crisis Support Police Intervention Protocols (March 2012)*". The relevant aspects of that policy are outlined above and were in my view complied with.

I am satisfied that the "*Lifeline Crisis Support Police Intervention Protocols (March 2012)*" were and are appropriate.

Are there recommendations which ought to be made which would reduce the likelihood of similar deaths occurring or otherwise contribute to an improvement in public health and safety?

Dr Large was asked whether there are any recommendations that I could make to prevent deaths occurring in similar circumstances. Dr Large provided an instructive and cogent opinion on this question, which I set out in full:

"Australian Bureau of [S]tatistics figures for 2012 show that in NSW there were 27 deaths by suicide of women aged 15 to 24. The great majority of these would have been in the older part of this age group and it is likely that there were only a very small number of suicides by women of Ms [X] Y's age in 2012. As a result of the rarity of suicide among women of this age group, specific clinical measures aimed to prevent suicide are difficult to recommend because they would need to be acceptable to a very much large number of other young people with psychological and psychiatric problems very few of whom would actually suicide.

In general, the methods that have met with some success in reducing suicides in Australia have been those that have led to the reduction in availability of lethal suicide methods. It considered that methods of reducing access to railway property probably do prevent some suicides. However, I have insufficient information to make specific recommendations in relation to railways and the death of Ms Y.

While the suicide of young people is very rare – suicide attempts, particularly by young women are not rare. Almost 0.5% of the general population makes a suicide attempt in any given year and young women are the group who are most at risk of single and repeated suicide attempts. It makes sense to believe that any measure that could reduce suicide attempts might also prevent some suicides. Some evidence is emerging that some psychological therapies can reduce suicide attempts. However, specific psychological therapies, for troubled young people are best delivered in a sustainable way by specialized youth oriented teams. Such teams can accumulate more experience with this group of patients than adult teams and can commit to treating them for longer than child and family teams.

Over the years I have treated a small number of likable young patients with high intelligence, notable self-destructive tendencies, and who had strong perceptions that their life was unsatisfactory. While I would not want to overestimate any similarities between Ms Y and any other patient, patients with these characteristics, such as Ms Y, are very challenging. Severe or even critical episodes of self-harm seem to be inevitable. The place of hospitalization in the treatment of their condition is of limited value and can be both counter-productive and inevitable. In caring for such patients I place great value on the multidisciplinary team with a range of allied health skills and potential for a match between the patient and their primary therapist. In such cases the outcome is unpredictable but can be excellent."

During the inquest, X's parents, through their legal representatives, expressed their thanks to Mr Campbell for the care he provided to their daughter. That there was a good therapeutic relationship between X and Mr Campbell, her primary therapist, is perhaps evidenced by the X's final note in which, amongst her goodbyes to family and friends, she was at pains to express her thanks to him and the CAMHS team.

X was cared for by a CAMHS team which primarily consisted of a social worker, Mr Campbell, and a psychiatrist, Dr Lim. She saw a psychologist, Ms Senediak, on one occasion. During her inpatient admissions she was seen by a number of clinicians and health workers with a range of allied health skills; however, it is fair to say that it was Mr Campbell and then also Dr Lim who provided X with regular and sustained mental health care. X may have benefited from a multidisciplinary team with a range of allied health skills, as described by Dr Large. However, a key benefit of that team

would be their ability to commit to an adolescent patient's care for a longer period than child and family teams, while having the expertise and experience to care for a patient of that age. In X's case, she first came to the attention of mental health service providers on 31 July 2012 and she took her own life on 18 December 2012. Her treating team knew her for less than six months. In that period of time she made at least three serious, intentional attempts at her own life (one of which was, tragically, successful). I do not consider that any recommendations as to the consideration of a multidisciplinary team described by Dr Large should be made as a consequence of this inquest. Nor were any submissions made to that effect.

X during her lifetime and while she was in crisis never derived the benefit of the Brolga Unit, a specialized 12 bed adolescent mental health facility which was opened at Hornsby Hospital in 2013. That Unit undoubtedly will provide those adolescents like X that require specialised inpatient care (like she did during her October admission to the LMU) an alternative to admission to an adult facility.

While the establishment of such a facility is undoubtedly of benefit, the 'Brolga Unit Referral Package' which guides the use of that facility defines "adolescents" in the admission criteria as "no older than 17 years of age". That definition reflects that in NSW Health PD2011_016 'Children and Adolescents with Mental Health Problems Requiring Inpatient Care', which has statewide application. While I have received submissions and evidence to the effect that "*clinicians are able to exercise their clinical judgment to make a referral of an 18 year old patient who otherwise satisfies the admission criteria for the Brolga Unit*"[76] there is a potential for confusion. Counsel Assisting submits that in order to minimize any risk of confusion, I may consider a recommendation that the Brolga Unit Referral package specifically include a sentence after the definition of "adolescent" noting that clinicians may exercise their judgment and admit an 18 year old who satisfies the admission criteria to the Brolga Unit. However, Counsel Assisting also notes the importance of applying a consistent definition throughout NSW.

I have also considered whether any recommendations should flow from the involvement of the NSW Police Force, Lifeline Australia and Lifeline Harbour to Hawkesbury in this inquest. In a letter exhibited in this inquest, the solicitor for Lifeline Australia and Lifeline Harbour to Hawkesbury advised that the *Lifeline Crisis Support Police Intervention Protocols* had been relevantly updated in the following manner:

> *"The protocol (in force at the relevant time) required Lifeline Harbour to Hawkesbury to contact the relevant Police Communications Centre to initiate a police intervention regardless of whether the precise location of the caller to Lifeline was known or not.*

[76] Exhibit 13

The Protocol was changed in November 2013, in the form of version 4, such that, where Lifeline knew the exact location of a caller in New South Wales, Lifeline would contact Triple Zero, rather than the relevant Police Communication Centre. Where the caller's exact location was not known, Lifeline was to still contact the relevant Police Communication Centre."

Accordingly I do not propose to make any recommendation regarding the policies and protocols currently in place for the NSW Police Force and Lifeline Australia and Lifeline Harbour to Hawkesbury.

Conclusion

Much of these findings were taken up addressing the care and treatment X received while cared for by Hornsby Hospital and CAMHS.

How does one measure "high quality care", particularly in regard to a chronically medium to high risk suicidal individual, who ultimately ends up taking their own life? Does the eventual outcome mean that care was not of high quality or inadequate?

The question asked of our expert was whether or not the care X received was appropriate and he advised it was. X was, unfortunately, one of a very small number of young women who successfully take their own lives. The outcome was devastating, it could not have been predicted and it was nobody's fault.

X's parents loved her unconditionally and were desperate to save her – they could not. Of course they feel that the NSW public health system failed them. It is not a perfect system but the care and treatment X was afforded by Hornsby Hospital staff and CAMHS, including Mr Campbell, Dr Lim, CNC Simpson and Dr Kaufman, was caring and professional. In my view, they did their best with an adolescent who was clearly wrestling with many demons.

X for her own reasons decided to take her own life.

I hope she rests in peace and her parents derive some small measure of comfort that they did their best and they could do no more.

Accordingly, I now turn to the findings I am required to make pursuant to s. 81 of the *Coroners Act 2009*.

I find that XY died on 18 December 2012 on the upline track of the Mount Colah train track near stanchion N37+082 as a result of multiple blunt force injuries after being hit by a train after taking steps to end her own life.[77]

In making those findings I have had particular regard to the P79A Report of Death to the Coroner and the autopsy report.[78]

For the reasons set out in these findings I make the following recommendations pursuant to s. 82 of the *Coroners Act 2009*:

To the Chief Executive of the Northern Sydney Local Health District: that consideration be given to clarifying the term of "adolescent" in the Brolga Unit Referral Package to reflect the existing discretion to admit patients at or under the age of 18 years who otherwise meet the admission criteria to that Unit.

Magistrate Sharon Freund

Deputy State Coroner

23 January 2015

[77] Mr Gracie submitted that I would find that XY died as a result of internal injuries sustained when she "jumped" from an overpass onto the path of a train or "lay on the train tracks", not (as submitted by Counsel Assisting) when she "fell" from an overpass onto the path of a train, having decided to end her own life. Mr Gracie submitted that a finding that X "fell" suggests that the act may have been accidental. Mr Gracie did not appear to resile from his submissions. I do not think it is necessary to describe the manner of death with reference to the particular action which preceded the medical cause of death. However, for the avoidance of any doubt, I note that during Mr Gracie's oral submissions I commented that when read in context it is clear that the act of falling was intentional. I note now, also, that there is positive evidence that X fell or jumped, as opposed to suffering her injuries by laying on the train tracks.

[78] Exhibit 1, Tabs 1 and 4