CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Channa
Hearing dates:	14 – 18 December 2020 Lismore Local Court
Date of findings:	7 May 2021
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death following mental health treatment discharge; whether intention existed to end life; "malingering"; homelessness as a stressor in mental health; communication when transitioning care; "complex case"; drug and alcohol counselling
File Number:	2017/168064

Representation:	**Advocate Assisting**: Ms Tina Xanthos (Sergeant) **Channa's Family**: Ms Helen Cooper, solicitor Legal Aid Commission of NSW **Northern NSW Local Health District**: Ms R Mathur of counsel instructed by Ms J Hackett of Hicksons Solicitors **Dr Kerr:** Mr G Gregg of counsel instructed by Mr C Gates of Meridian Lawyers **Dr Perera, Dr Bhuyan, Dr Faingold and Dr Ahmed:** Mr Hewson of counsel instructed by Mr J Kamaras of Avant Law **Dr Wims:** Ms T Berberian of counsel instructed by Ms C Darouch of Meridian Lawyers **RN Burgess and RN Parker:** Ms K Doust, solicitor of the NSW Nurses and Midwives Association
Findings:	The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are: ***Identity*** The person who died was Channa. ***Date of death*** Channa died on 2 June 2017 ***Place of death*** Channa died at Minyon Falls, Northern NSW. ***Cause of death*** Channa died as a result of multiple injuries ***Manner of death*** Channa fell from great height. His fall was unwitnessed and occurred in the context of recent expressions of suicidal thought, homelessness and discharge from mental health care.
Non-publication Orders	1. Pursuant to section 74 I make the following order. The deceased is to be referred to as "Channa". There is to be no publication of the names (or other identifying information) of his parents, sibling, children or the mothers of his children.

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Introduction

1. This inquest concerns the tragic death of a young man, Channa. Channa died at Minyon Falls in northern NSW on 2 June 2017. Minyon Falls is a beautiful plunge waterfall on Repentance Creek in the Northern Rivers region of NSW. The drop is around 100 metres.

2. Channa was discovered by two tourists who were making a trek in the area. He had taken a taxi to the Falls, after having left Lismore Hospital that morning. He was homeless and had recently been discharged from mental health care. He is unlikely to have had much sleep in the preceding couple of days.

3. Channa is survived by his parents, brother, three children, loving friend R and by many in the community whose path he crossed.

4. Channa is missed by all those who loved and cared for him. The court heard a powerful and extremely moving family statement which described Channa's strengths and struggles. His mother told this court that he was born in the year of the horse and that he loved to run free. He was exuberant, gregarious, attractive and creative. He loved sport and music. He was at home on a sports field and sang from the heart. He had close ties to local Aboriginal communities and cherished the Northern Rivers environment where he had grown up[1]. He had a zest for life and brought great joy to many. It is clear that he will always be remembered and missed.

5. Beyond the circumstances of this individual tragedy, the investigation into Channa's death raised broader questions about the way we care for those in our community with mental illness, particularly when their symptoms are complex and ongoing. I acknowledge at the outset that Channa's symptoms made his treatment challenging for those involved in his care. Nevertheless I am convinced he deserved better and that we as a community can do better.

6. Channa's family approached these proceedings with enormous grace and a commitment to share their experience in the hope that positive change might follow. I thank them for their courage and determination in the face of such heartbreak. It was clear to me that Channa's family loved him greatly and that they were committed to helping him. I understand that the family's participation in this inquest came with enormous pain as they re-lived confusing times when they were unsure of how they could best help Channa. I acknowledge their

[1] Family statement 18/12/20 page 2 onwards

dignity, strength and generosity in participating in these proceedings. An inquest can only achieve a limited amount and I am aware that some of the changes to the system Channa's family may wish for are beyond the scope of the evidence we heard. Nevertheless in my view this inquest created a positive space for Channa's family and NNSWLHD to come together and reflect deeply on all that occurred.

7. In my view one of the great tragedies of this inquest is that Channa's death happened at a time when, with the correct support, he may have started on a journey towards greater stability and healing. After years of *ad hoc* and reactive treatment where he had been frequently been identified as a "malingerer", Channa had recently been diagnosed with a schizophrenic illness, commenced on depot medication and been given the structure of a community treatment order. It could have been the beginning of a positive trajectory. Unfortunately, he was released without accommodation, without drug and alcohol intervention, and without having met his community case worker. While his father is named on the Community Treatment Order, he had not been contacted or advised.

8. I was somewhat heartened by the daily attendance at these proceedings by Deidre Robinson, Director Mental Health and Alcohol and other Drugs, Northern NSW Local Health District (NNSWLHD) and Dr Alon Faingold, Acting Director of Richmond Clarence Mental Health Service. In my view it demonstrated leadership and a willingness to reflect, listen and learn. I acknowledge at the outset that the NNSWLHD recognised that the delivery of care to Channa was imperfect and that mistakes were made.[2] It was an appropriate concession. In my view it demonstrated a genuine commitment to learn from past errors by implementing better policies to reduce the risk of harm to vulnerable patients like Channa. I accept that NNSWLHD had already commenced important internal changes prior to the commencement of these proceedings. This has, to some extent reduced the need for recommendations.

The role of the coroner and the scope of the inquest

9. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[3] A coroner may also make recommendations, arising directly from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[4]

[2] Exhibit 3 [43]
[3] Section 81 *Coroners Act* 2009 (NSW).
[4] Section 82 *Coroners Act* 2009 (NSW).

10. In this case there was no dispute in relation to the identity of the deceased or to the date or place of death. However, the manner and circumstances of Channa's death required significant investigation. The court examined his recent health care and assessed the level of support that he had been provided. Given the circumstances of Channa's death it was also necessary to examine whether his death could properly be described as intentionally self-inflicted.

The evidence

11. The court took evidence over five hearing days. The court also received extensive documentary material, comprising two volumes. This material included witness statements, medical and legal records, policy documents, and photographs. The court heard oral evidence from members of Channa's treating team and from a police officer who had been involved in taking him to hospital on a number of occasions. The court was also assisted by a number of independent experts who reviewed the medical care Channa received in the period prior to his death.

12. While I cannot refer specifically to all the available material in detail in these short reasons, it has been comprehensively reviewed and assessed.

13. A list of issues was prepared before the proceedings commenced. These questions directed the focus of the evidence presented in court. However, as is often the case, a hearing tends to crystallise the issues which are really at stake. For this reason, after dealing with the chronological facts, I intend to distil my reasons under a small number of broad headings.

Brief Chronology

Personal Background

14. Channa was born on 11 September 1990. He was the first and much loved child of the family. He had a younger brother with whom he was close. Channa grew up in the Northern Rivers area of NSW, attending a local public school, before entering Richmond River High School at Lismore. He was creative and well-liked. After school he worked in a variety of jobs including as a cook, barista and in the building industry. He had periods of unemployment and at times worked at the Nimbin Permaculture garden.

15. In his final years of school he formed a relationship with a girl, who was later diagnosed with lymphoma. He was supportive but found the experience difficult. The relationship did not last

and it is thought that it was around this time that Channa began to experiment with drugs and then to rely on cannabis and other substances.

16. In 2010 Channa formed a relationship with another young woman, T. Before long she became pregnant and they moved in together. They had two children.

17. T gave evidence at the inquest, describing the difficulties in their relationship. It is clear she felt unsupported and as Channa's mental health became progressively worse she felt alone and that "no one believed her."[5] She described Channa's mental health deteriorating slowly and his use of illicit drugs increasing. She told the court "He was always prone to a bit of anxiety and always had more fear than I felt was reasonable but as time went on it became delusional. He didn't want to eat from the supermarket because they were poisoning us. He didn't trust the bank because he thought they were going to blow up our house and it was just an ongoing situation."[6] With hindsight she could see that it started earlier than she had realised at the time. She described herself as "in survival mode" with two young children.

18. Around June 2014, Channa's relationship with T had ended and Channa moved back with his parents. His family did all they could to facilitate his ongoing contact with his children.

19. Channa's parents suspected that he was continuing to use drugs and they were increasingly concerned about his mental state. They sought help, but the situation was often confusing and painful. Channa's father told the court how much he and his wife loved their son, and how they believed their beautiful, strong and intelligent man could learn to manage his issues. However, eventually they became so concerned for their own welfare they were forced to seek an AVO restricting contact. They had been advised that Channa needed to "hit rock bottom"[7] and that they needed to "draw a line in the sand." Channa's father explained they felt they were following the best professional advice.

Mental Health history

20. The inquest had access to Channa's extensive medical and police records which were also carefully reviewed and examined by the experts. What follows is only a brief summary of some of the important material. It is reproduced to give a brief overview of Channa's ongoing contact with the local health system, rather than to record everything that happened. The records show a pattern of numerous unplanned hospital presentations. Channa expressed suicidal thoughts on numerous occasions and was at times psychotic. It is immediately apparent that his treatment lacked planning and that a strong therapeutic relationship was

[5] Transcript 14/12/20 Page 30, line 30
[6] Transcript 14/12/20 Page 30, line 20 onwards
[7] See discussion of this issue at Transcript 14/12/20, page 46 onwards

never formed between Channa and the various medical staff who were entrusted with his care. Channa's social issues, including unstable accommodation and troubled family relationships are constant themes.

21. Channa's first mental health admission in 2015 appears to have arisen from ongoing family concern. On 5 July 2015 the mental health line received a call from Channa's mother stating that Channa, then aged 24, had a history of a drug induced psychosis and was not eating, drinking, or caring for himself. It was reported that Channa was rejecting professional help and did not consider himself mentally ill. The family were concerned that he had burnt books and clothing. It was reported Channa had a history of drug use including cannabis, acid and mushrooms. It was reported that he had called his ex-partner threatening suicide at various times in the previous 12 months. On the same day the mental health line also received a call from Channa's ex-partner who had concerns about his behaviour. She reported that Channa had become "spiritual" and was walking in the bush in order to become an aboriginal elder. He had apparently told her that he would go and die if he was not allowed to live with her and the children. The mental health line called the Community Mental Health team and a decision was made to contact Channa's father and advise him to arrange taking Channa to the Emergency Department.

22. On 6 July 2015 a mental health assessment was conducted at Channa's brother's home. Channa was assessed to have a possible psychotic illness and he was taken to the Lismore Adult Mental Health Unit (LAMHU).

23. On 6 July 2015 Channa was scheduled. It is reported that he had threatened suicide and had burnt his belongings. He remained at the LAMHU until the 14 July 2015. The discharge summary notes that Channa was initially assessed as delusional. He was later not found to be clearly suffering from psychosis. He was not commenced on antipsychotic medication. He had refused drug and alcohol follow-up and was referred to the Acute Care Service (ACS). With hindsight this presentation is likely to have been his first experience of psychosis whilst in mental health care.

24. On 22 October 2015 Channa was brought to hospital on a section 22 after his father had called 000. Channa had cut his wrists and his father and a neighbour had restrained him. Police described him as agitated and irrational. Channa was assessed in the Emergency Department. The notes indicate that Channa had called his ex-partner while drinking. He had become upset during the call and had accidentally injured himself while stabbing a chair. Channa was determined not to be mentally ill or mentally disordered according to the *Mental Health Act* and he was discharged.

25. On 30 October 2015 Channa was brought to the Emergency Department on a schedule after he had made threats of suicide. Channa was not considered to be mentally ill according to the *Mental Health Act*. He was referred for an outpatient psychiatric assessment on 5 November 2015. He did not follow up this appointment.

26. On 11 November 2015 the mental health line called ACS and advised them that Channa had recently been in the Emergency Department on several occasions including with threats of self harm. Channa was contacted but denied thoughts of self-harm and refused further follow-up. The records note there was a pending family court matter and that he had broken into his ex-partner's home. The records state that Channa had "narcissistic personality traits".

27. On 14 November 2015 Channa was brought to the Emergency Department by ambulance after he was found to be pacing and agitated in a public place, stating that he could not live without his children. The report notes that he was considered to be "narcissistic" in his behaviour but that he denied suicidal plans. The report notes that he had recently threatened to take an overdose and that he had no reason to live if he could not see his children.

28. On 16 November 2015 the mental health line received a call from Channa's brother. He was concerned after Channa had made suicide threats to him over the phone. The mental health line contacted Channa who reassured them about his safety and declined further assistance.

29. On 18 November 2015 Channa presented to the community mental health service seeking medication to make him feel better and a certificate to excuse him from his work for the dole obligations. He was assessed as "not being psychotic". The record notes his social isolation, polysubstance use and other social problems. He was not suicidal. He was found to be quite uncooperative.

30. Throughout 2016 there were a number of further contacts with local mental health services. The contact was sporadic and it is not apparent that Channa established a strong therapeutic relationship with any practitioner he saw.

31. On 13 February 2016 Channa was brought to hospital by ambulance having taken an overdose of paracetamol and ibuprofen. The record notes that his rights to see his children had been withdrawn and that this weighed very heavily upon him. Channa was detained as a mentally disordered person under the *Mental Health Act.*

32. On 14 February 2016 Channa indicated that he was keen to be discharged from hospital and he was assessed as being “not suicidal”. He was considered to have some elevation of his affect that was out of context with his presentation. His thought content was described as “using references to physics and astrophysics” but he was not thought disordered and he was not considered to be hallucinating. His main stress was recorded as being his lack of access to his children.

33. On 9 March 2016 the mental health line received a call from Channa’s father saying that Channa was having anger issues and had paranoid ideas, including that his computer had been hacked and that his mother’s mobile was recording him.

34. On 1 July 2016 Channa was admitted to the Lismore Adult Mental Health Unit. Documents record that Channa’s parents had been concerned that he had been screaming and yelling to himself and had increasing outbursts of rage and recent self cutting. It was recorded that Channa had expressed some beliefs that people and the government were out to get him. There were reports of threats of self-harm and delusional thoughts. He was considered to be mentally ill according to the *Mental Health Act*.

35. The discharge summary of 18 July 2016 indicated that Channa had class A and B personality vulnerabilities. He was described as having a great interest in technology that bordered on paranoia and delusional thinking. Channa was started on the antipsychotic olanzapine at a dose of 10 mg a day during this admission. He was discharged on olanzapine 5 mg a day with the recommendation that he take this for at least 3 to 6 months. Following Channa’s discharge the community mental health team made attempts to contact him on a number of occasions.

36. This admission had been Channa’s first long admission. Unfortunately it does not appear that a strong therapeutic relationship with any particular doctor or nurse was established.

37. On 5 August 2016 Channa self presented to the Lismore Adult Mental Health Unit seeking admission. He was described as “quite destitute and miserable” and as “making vague suicide threats that stopped when he was told that they were no Lismore Adult Mental Health Unit beds”. He was directed towards various community supports. On 6 August 2016 Channa denied suicidal ideas during telephone follow-up.

38. On 8 August 2016 Channa presented to the Emergency Department by ambulance after taking an overdose of olanzapine tablets at the family home. He reported that he was living in a shared house, searching for a job and that he had been smoking cannabis. After

assessment it was decided that he was not suffering from psychosis and did not appear to be suicidal. He was discharged with a plan for follow-up. During later follow-up in August Channa indicated that he did not want further assistance at that time.

39. Contact with Mental Health Services continued in 2017.

40. On 27 January 2017 Channa's father presented to the community mental health team seeking advice about how to help Channa. It was reported that Channa had forced his way back into the family home and there had been ongoing threats and intimidation. It was reported that the police were involved and that an Apprehended Violence Order was being considered.

41. On 13 February 2017 police took Channa to Lismore Hospital under section 20 of the *Mental Health Act* after he had threatened to kill himself and had slammed a knife on the chopping board in front of his frightened parents. Police formed a view that he was delusional and recorded that he had been talking about satellites and other strange thoughts. The record indicated that Channa had a history of self harming behaviour including a history of an overdose of olanzapine in 2016. The primary diagnosis was considered to be drug induced psychosis and the secondary diagnoses were emotional dysregulation and borderline personality traits. He was recommenced on olanzapine.

42. At the time Channa reported that he had recently used MDMA and cannabis. He said that he had recently been at Minyon Falls and had stood at the edge of the falls contemplating his life. Channa was found to be grossly thought disordered. He had quite "cosmic ideas" involving telepathy and was quoted as talking about "preconceived notions of reality", "resonance crossover", "cross transmission synchronicity" and "telepathy in space". He was considered to be illogical and unrealistic.

43. On 15 February 2017 Channa was assessed and it was concluded that he had "Schizotypal characteristics" with a likely period of drug-induced psychosis. Olanzapine was ceased and paliperidone 3 mg a day was commenced. Channa was recorded to have risks of aggression, self-harm, homelessness, substance abuse and physical and mental deterioration.

44. Channa had various periods of leave and was finally discharged on the 23 February 2017 on his own request. It is reported that he had found temporary accommodation. A discharge summary completed on 28 February 2017 indicates that the diagnosis was likely drug-

induced psychosis, on a background of prodromal Schizophreniform illness and borderline personality disorder.

45. There were numerous presentations in March 2017. On 2 March 2017 Channa presented at the Emergency Department seeking medication and feeling unwell and depressed. After psychiatric review Channa was assessed to be "simulating delusional ideas." He was noted to be noncompliant with medication and using cannabis. Channa was not considered suicidal. The recorded impression was antisocial behaviour with malingering. He was discharged from the Emergency Department and it was suggested that he continue his paliperidone medication.

46. On 5 March 2017 Channa re-presented to the Emergency Department seeking a mental health review. At triage he said "the system was letting him down". Channa described himself as homeless and "semi-psychotic". He was described as agitated and rambling. When he was told there was no bed for him in the Emergency Department it is recorded that he threatened to go and jump off a bridge. Channa was asked to wait in the waiting room for a psychiatric review because he was demanding and disturbing other patients. The plan was for mental health review, but is not apparent that this occurred. This presentation was described in the notes as history of "antisocial malingering."

47. On 7 March 2017 ambulance and police brought Channa to the Emergency Department pursuant to section 22, in a suicidal state. He was considered to be delusional, talking about satellites and again considering jumping from Minyon Falls. It was further documented that the police had been called to the Southern Cross University where he had been behaving oddly and expressed suicidal ideas. On arrival he spoke about his separation from his ex-partner and children. Later, during the evening he again stated that he would jump off Minyon Falls if he could not see his children.

48. On 8 March 2017 the mental health line received a call informing them that Channa had been at the local library and had closed his Facebook and email accounts and said that he was going to Minyon Falls. Later the same day Channa was assessed in the Emergency Department after his arrest for a breach of the AVO in place in relation to his former partner. Again he was described as "manipulative".

49. On 9 March 2017 Channa was assessed by the Justice Health Court Liaison Service and observed to be acutely psychotic, untreated and recently engaged in deliberate self-harm.

50. On 10 March 2017, Channa was transported to Lismore Base Hospital under section 22. The schedule notes “POI found at top of Minyon Falls after being released by Lismore adult mental health! POI threatening to jump off cliffs at the cliff edge for 3 hours negotiations with police. VERY SUICIDAL. POI has been scheduled by police the past 2 days and let out. POI delusion talking about satellites and powers. POI wanting to kill himself because he can’t see his children. POI VERY SUICIDAL AT TOP OF CLIFF THREATENING TO JUMP.”.

51. Channa was assessed on 11 March 2017 by Dr Haque who noted “he is known to me from ED presentation on 8 March 2017. He has been reviewed by at least five psychiatry registrars and a psychiatrist over the last few weeks. He is well known to MH for malingering, manipulating and taking advantage of the service, also benzodiazepine seeking.” He was noted to have self presented to the Emergency Department earlier in the day on 10 March 2017 requesting paliperidone and went to Minyon Falls which resulted in police contact. He was noted “not for MH act” and discharged in the morning with ACS follow-up. Dr Henderson reviewed Channa in the morning and noted a number of stressors. He noted Channa had reported his paliperidone had run out. The doctor noted that Channa “wanted to die the evening due to the stress of not seeing his children”. He was not felt to exhibit signs of psychosis or major mood disturbance and was discharged into his own care with a recommendation he self present to community mental health services. He was not suitable for ACS follow-up because “he had no phone”.

52. On 14 March 2017 Channa was noted to self-present to the Emergency Department expressing suicidal thoughts. He was discharged on the basis that he should present himself to the community mental health service.

53. On 17 March 2017 Channa self presented to the Emergency Department. The triage nurse noted that he “has seriously contemplated suicide over the past two weeks. No regular meds. Describes being stuck in middle of war with between grey nomads and casino. Describes psychological poisoning. Compliant, cooperative. Was involved in CSG protests”. Dr Fraser noted “reports wanted to jump off Minyon Falls to realign his magnetic energy and transform into something else.” He was noted to have “delusional thought processes with risk of misadventure and harm to self in setting of relationship breakdown AVO and not able to access his children complicated by homelessness - very convincing if malingering”. He was noted to be homeless, without money. Again he was noted to have said that he wanted to die and he made references to jumping from Minyon Falls. He was discharged the following morning to a friend’s place.

54. On 19 March 2017 Channa self presented to the Emergency Department "seeking admission to LAMHU to get his life on track". He was discharged on the basis of no identified symptoms of major mental illness and it was noted that he was "aware of how to access services if risk escalates."

55. On 20 March 2017 Channa self presented to the community mental health service. He was noted to be "experiencing some vague suicidal ideation and would like to discuss with the doctor some medication to help sedate him through these thoughts". It was recorded that he had ongoing problems with accommodation. An appointment was made for him at the Community mental health service on 24 March 2017.

56. On 24 March 2017 Channa presented to the Emergency Department. He was described as having "ongoing suicidal ideation". He had "rambling speech", "flight of ideas", "difficulty focusing". He stated that "he attempted jumping off the waterfall last night". He was escorted to his scheduled appointment at the community mental health service by security.

57. On 1 May 2017 Channa was brought to the hospital pursuant to section 33 (1) of the *Mental Health (Forensic Provisions) Act.* He was noted to have made reference to living on "a land belonging to an aboriginal people" "repeating the same old delusions …being abused by the intelligence" and it was noted on mental state examination that he was "uncooperative and evasive during the interview, trying to convince me that he has delusions". There was "no current evidence of delusions apart from the old grandiose delusions." He was discharged back to the care of the police as he was considered "not mentally ill or mentally disordered". It was recorded that "hospital admission won't help him with his current situation".

58. On 4 May 2017 Channa was noted to have self presented to the Emergency Department and reported having visions and seeing white lights. He was assessed by a doctor and noted "not to be mentally ill".

59. On 7 May 2017 Channa presented to the Emergency Department stating that he had nowhere to reside. He was noted to be "known to mimic a psychotic illness." He was discharged for follow-up with ACS.

60. On 9 May 2017 Channa presented to the Emergency Department and was assessed by Dr. Delaney. He reported auditory hallucinations and expressed a fear of people poisoning his food, among other concerns. "Malingering" was queried again. The doctor noted "I did not find evidence of a major mood or psychotic disorder requiring inpatient treatment. [Channa]

is a man who knows how to manipulate the hospital system to get his needs met. Admission would have no therapeutic benefit."

61. On 12 May 2017 Channa was transported to Lismore Base Hospital under a section 22 schedule that noted he was "highly delusional talking about satellites GPS tracking. POI threatening to take place gun and shoot himself in the head. POI stated that he wished to jump off Minyon Falls. POI previously found at Minyon Falls. Three hours of negotiation to prevent him from jumping. POI serious suicide risk".

62. Channa was then admitted involuntarily under mental health legislation to a high dependency unit for treatment of acute psychosis. This appeared to be largely due to the intervention of Dr. Freeman, consultant psychiatrist on call, who felt there may have been a family member with schizophrenia. On 13 May 2017 Channa was assessed as "acutely psychotic with high risk of violence to others" by Dr Wims and given Acuphase, haloperidol and Lorazepam. The form one completed by Dr Perera noted a diagnosis of schizoaffective disorder with a differential diagnosis of delusional disorder. Channa appears to have been treated with olanzapine and then required oral haloperidol three times daily from 17 May 2017. He was also given Accuphase and Lorazepam. At this point there seems to have been more of a consensus amongst psychiatry clinicians that Channa was indeed psychotic and that he required high doses of antipsychotic medication to stabilize his mental health.

63. Channa was observed to improve in his mental state and behavior following treatment with antipsychotic medication on the ward, but his progress was patchy. He deteriorated in his behavior on 23 May 2017 which continued until 24 May 2017. This may have been in the context of having to receive his depot paliperidone loading dose. As his medication continued he appeared to be somewhat more settled in his behavior.

64. Records show that Channa did not receive any drug and alcohol intervention while an inpatient. Nor did he meet the care coordinator to whom he would be assigned in the community.

65. It appears a decision was made on 29 May 2017 that Channa would be discharged from Hospital and referred to CMH for the allocation of a case manager. The following day, at the CMH Team allocation Meeting RN Burgess was allocated as his case manager. She told the court that she was not present at the meeting. That day RN Burgess completed the Treatment Plan documentation in preparation for the Tribunal hearing. She also requested a script and medication chart for Channa's depot injection.

66. The Treatment plan is a pro forma document which RN Burgess added information to. She told the court that it was quite common for a case manager to be allocated very close to a Tribunal hearing.

67. On 31 May 2017 a Community Treatment Order (CTO) was made by the Mental Health Review Tribunal. The treatment plan noted that Channa was prescribed paliperidone by injection and allocated a care coordinator with the community mental health team. He was discharged about 10.15 am. He had not met his case manager.

68. Channa's progress in hospital was not noted on the discharge summary. There are troubling discrepancies about who he was to reside within the community with his CTO plan indicating it would be at [a specified street address] in Lismore and the hospital discharge summary nominating the Winsome Hotel, Lismore. His discharge plan stated "discharged under a six month CTO"" and "CM aware – Anne B". This appears to have been a reference to RN Burgess. It is now clear that neither address was confirmed.

69. RN Burgess, who was a case manager, working out of the Community Mental Health Unit at the time of Channa's discharge gave oral evidence. She confirmed that she completed the Community Treatment Order Treatment Plan[8]. She stated that she would have recorded Channa's father and [a specified street address] in Lismore from information provided by the inpatient team. She stated that she would have "had no reason to question it."[9] She stated that she did not receive any message to meet with Channa prior to his release.[10]

70. On 1 June 2017 Channa re-presented to the Emergency Department. At 7am the triage nurse notes "discharged from LAHMU and hasn't been able to find anywhere to live". Channa is recorded to have said "it is hard to find a reason to live when you have nowhere to live". RN Free was the triage nurse on duty that morning. After speaking with Channa she ordered a social worker consultation on the NPROD system. She told the court that given there was no social worker attached to the ED, there was no guarantee about how long that would take. In the meantime she saw and approached the mental health clinical nurse, Kathleen Waters who apparently told her to send Channa to see his caseworker at Community Mental Health[11].

71. Channa appears to have walked unescorted the 150-200 metres to the CMH. RN Burgess saw him in an interview room. She states that accommodation was the first thing Channa

[8] Tab 28
[9] Transcript 17/12/20 Page 174, line 24
[10] Transcript 17/12/20 Page 174, line 44 onwards
[11] Transcript 17/12/20 Page 209, line 1 onwards

raised when he spoke to her.[12] She recorded in her notes that Channa said "I want to die". When questioned about that statement in oral evidence, she stated "Yes he did say those things, that's why, you know, they- I put them there, but I didn't get a sense that he was – that he was actually suicidal at that time. He didn't present as depressed or – he was anxious and – but he wasn't distressed, he wasn't – he was dressed in brand new clothing, he'd obviously been shopping the day before and bought himself all new clothes and a new backpack, so – and he'd come to me and as I said, he didn't – he was more concerned about accommodation, not about harming himself."[13]

72. RN Burgess said she called Link2home, a referral point for housing and passed the telephone over. She tried to "build up rapport" and told him some information about what case management involved.

73. RN Burgess did not complete a formal mental state review and had "no concerns at all" that he was mentally unwell on the day. She did not have a chance to read his past medical records. She explained that she did not have time as Channa had attended in unusual circumstances and without an appointment[14]. She explained that she felt he seemed positive when they parted.

74. In my view RN Burgess showed little insight into the missed opportunities involved in her interaction with Channa. Her almost total lack of curiosity about a patient re-presenting so soon after discharge was in my view alarming. Her reliance on a hasty impression to assess his mental state is concerning.

75. Channa re-presented to the ED, later on 1 June 2017 around 2 PM. RN Free was on duty. He complained of chest and back pain. For this reason she did not use precious time to talk about what had happened in earlier presentations. Chest pain indicated that he should be seen by a doctor within 10 minutes. Channa was assessed and treated by Dr. Kerr. Dr Kerr outlined to the court the various physical tests she undertook. She reported that Channa did not at any stage tell her he was suicidal. If he had, she said that she would have been obliged to schedule him.

76. While Dr Kerr did not have detailed knowledge of Channa's mental health history, she was aware that he had recently been discharged from LAMHU the day before. She told the court that "the fact that he'd been discharged made me feel that the psychiatrists had been happy with his mental health and that they didn't think he was suicidal."[15] She also spoke with a

[12] Transcript 17/12/20 Page 176, line 44 onwards
[13] Transcript 17/12/20 Page 177, 24 onwards
[14] Transcript 17/12/20, Page 180
[15] Transcript 17/12/20, Page 202

charge nurse, whom she respected who told her that she knew Channa well and that "he's always saying he's suicidal."[16]

77. She was also aware that Channa had already presented earlier that day, but was unaware that he had only just met his case manager. She described Channa as a calm and pleasant young man and she was not concerned about his mental health. It was noted that he had nowhere to live and had been referred to link2home but that no accommodation was available. It was recorded that he could sleep in the emergency department overnight.

78. Dr Kerr gave evidence that she examined him and took the usual observations such as respiratory rate, oxygen saturations. She listened to his heart, took blood tests and did an ECG and chest x-ray. There were no abnormal findings. She told the court that he did not at any time mention to her that he was feeling suicidal and I accept that she would have recorded it if he had. Unfortunately his recent discharge gave her confidence in his mental state rather than triggering concern. It was another missed opportunity.

79. On the morning of 2 June 2017 RN Merric Parker was the triage nurse. She became aware that Channa had been granted permission to sleep in the Emergency Department. RN Parker approached Channa to offer him some breakfast and find out what his plan was for the day. The triage note documented "feeling suicidal due to homelessness and social issues, recent depot, good communication." On 2 June 2017, a note by RN Parker stated "pt for further assessment at community mh as per Cath." There is no dispute that Channa was not accompanied to the CMH or that on this occasion he never arrived. I accept RN Parker's evidence that she took the advice of the mental health clinical nurse in referring Channa to see his case manager.[17]

Channa's final journey to Minyon Falls

80. On 2 June 2017 Channa left the Emergency Department but did not attend the community mental health centre. He took a taxi at about 9:27 AM to Minyon Falls. The driver Mr Vanleuven stated that Channa told him that he had $400 cash on him. He observed Channa to be in a calm and quiet mood.

81. There are no eye witness accounts of how Channa fell from great height.

82. Channa's body was found later that day by tourists who had trekked to the bottom of the falls.

[16] Transcript 17/12/20, Page 201, line 21 onwards
[17] Unfortunately that nurse is now deceased and her evidence was unavailable to the inquest

83. A limited postmortem examination was conducted on 8 June 2017. Channa was found to have multiple injuries to the head, chest and limbs which were consistent with a fall from height. Toxicological testing showed therapeutic levels of paracetamol and an anti-psychotic medication.

Was Channa's death "intentionally self-inflicted death"

84. A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be extremely clear and cogent in relation to intention.[18]

85. Records indicate that Channa had prior serious self harm attempts for which he had been treated in Hospital.

86. There is also ample evidence that Channa had expressed suicidal thoughts on numerous occasions. The medical records note many occasions where he stated he would kill himself by jumping from Minyon Falls. Senior Constable Hayes also gave evidence of a lengthy negotiation he had been involved in with Channa at Minyon Falls where Channa expressed the wish to jump.

87. There are also references in the notes to Minyon Falls when Channa may have been psychotic and where his attraction to the place appears to be incorporated into his delusion. On 17 March 2017, for example it is recorded that Channa stated that he wanted to "jump off Minyon Falls to realign his magnetic energy and transform into something else." The statement raises the possibility that Channa may have later attended the Falls in a state where he was not properly able to form a rational intention, but may nevertheless have placed himself at great risk of misadventure or death.

88. Some self-inflicted deaths are the clear result of a logical decision to end life. Others occur at a time where it is not possible to confirm intention, particularly against a background of thought disorder and delusion. Channa had been discharged from mental health care on 31 May 2017, but his mental state had not been re-assessed on either 1 June 2017 or 2 June 2017 when he re-attended Hospital. By that time he had been homeless and it is likely that he had little or disrupted sleep.

[18] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard (*Briginshaw* v *Briginshaw* 60 CLR 336).

89. At the conclusion of the evidence I had been minded to record Channa's death as suicide or as "intentionally self-inflicted". His family have asked me to reconsider. It was submitted that "it is impossible to know with any certainty what state of mind [Channa] was in, or whether his stressors had precipitated any relapse" given that no mental state examination had taken place following discharge.

90. I have given the matter considerable thought and reviewed the evidence many times. On reflection there are a number of possibilities including suicide and accident. There is also the possibility that Channa's actions were based in disordered thinking that precluded him from properly understanding the finality of his decision. There had been numerous past episodes of delusional thinking and auditory hallucination. It is possible that his decision making on 2 June 2017 occurred in a grey area of confused thinking where it is not possible to find rational intention. If for example Channa jumped "to realign his energy", I would not be persuaded that it would be correct to record his death as suicide, which in my view carries with it the notion of rational intention and a proper understanding of the consequences which follow.

91. Channa's fall was unwitnessed and undoubtedly occurred in the context of recent talk of suicide, homelessness and discharge from mental health care. I do not know if he had relapsed into psychotic thinking. I accept his family's submission that to class his death as simply "suicide" is to miss the complexity of the tragedy.

Psychiatric and Emergency review after death

92. The court was greatly assisted by a number of experts. Three psychiatrists, Professor Large[19], Dr Eagle[20] and Dr Bertucen[21] reviewed the material. Professor Large and Dr Eagle were called to give evidence. An experienced Emergency physician and intensivist, Dr Greenberg[22] was also called.

93. The experts reviewed records of Channa's care since his first contact with mental health services and also looked specifically at the adequacy of the care and treatment during the final admission between 12 May and 31 May 2017, including his discharge and re-presentations in the following days. There were significant agreements in their opinions, particularly in relation to correctness of Dr Perera's diagnosis of schizophrenia during the 12 May -31 May 2017 admission and Channa's need for depot anti-psychotic medication.

[19] Report of Professor Large, Exhibit 1, Tab 8
[20] Report of Dr Eagle, Exhibit 1, Tab 6
[21] Report of Dr Bertucen, Exhibit 1, Tab 5. Dr Bertucen was not called to give evidence. His report has been considered but his views were untested in cross examination.
[22] Report of Dr Greenberg, Exhibit 1, Tab 7

94. Dr Eagle stated that at the time of his death Channa had a diagnosis of schizophrenia which appeared well established on the available information. She noted that past episodes of psychosis had been exacerbated by his use of illicit substances and by a range of social stressors such as losing access to his children, homelessness and social isolation. She noted that he had a substance use disorder, particularly focussed on the use of cannabis which would have exacerbated his psychotic illness. It was not apparent to her, on the records, that he suffered from a personality disorder or that he showed any signs of malingering.

95. Professor Large agreed that it was more likely than not that Channa suffered from a schizophrenic illness. He stated that there was evidence that he had thought disorder and delusions associated with some decline in his psychosocial functioning over a period of some years. He agreed that drug induced psychosis may have been a factor at times and felt that Channa's substance use disorder is likely to have exacerbated his symptoms. He took a different view to Dr Eagle in relation to the likelihood of Channa suffering a personality disorder.

96. I accept Professor Large's expert opinion that Channa was always a high risk patient. "He was a high risk patient on the first day he was seen by the service and was a high risk patient on the last day he was seen. There was never a day when his risk was actually lower and this whole idea that you can like, detect a person's risk and then like flick them into a place of safety on the basis of their suicidal ideation, there's very little evidence for that." It is clear that Channa had long term mental health challenges, including long term suicidal ideation. He was a complex patient, at risk of suicide.

97. Professor Large, Dr Eagle and Dr Greenberg were asked to comment on the quality of care provided to Channa. Professor Large expressed the view that the care given to Channa during his involuntary admission in May 2017, including the decision to discharge him on a Community Treatment Order was adequate. He also told the court that the care delivered to Channa on 1-2 June 2017 when he re-presented to the Emergency Department was "not of an unacceptable standard". He acknowledged that the period after discharge is a time of increased suicide risk, however he was of the view that this risk is not reduced by longer stays in hospital. In essence his expert opinion was that Channa's care was, by that time, best facilitated away from the hospital setting and in the community.

98. While expressing the view that the overall care delivered to Channa was within acceptable standards, Professor Large accepted that his care could have been improved by facilitating a referral for a specialist drug and alcohol counselling intervention and by psychological input whilst he was an impatient during May 2017. An earlier referral to his community case

manager to facilitate rapport and engagement upon discharge would also have been preferable. In oral evidence he agreed that fostering better communication and connection with the community health service would have improved the care given to Channa. This would have included a more timely referral to the case manager and more continuity in his overall care.

99. Dr Eagle was more critical of the care given. Channa clearly had a complex mental illness with a number of psychosocial stressors. In her view he needed "assertive mental health treatment" and support following his discharge in May 2017. His psychosocial stressors were impacting on his level of function and needed attention. I accept her view.

100. She was also critical of the discharge process. In her view it should have been patently clear that his discharge plan did not work when he re-presented three times immediately after discharge. In her opinion a review of his discharge plan was called for and should have been initiated. She noted that he had been discharged without appropriate accommodation and without adequate consideration of his substances issues.

101. Dr Eagle told the court that on 1 and 2 June 2017 Channa should have received a comprehensive psychiatric assessment. He would also have benefitted from a social worker assessment. The seriousness of his diagnosis and his potential for deterioration in the absence of accommodation and support needed to be recognised.

102. Dr Greenberg was critical of individuals involved in the care offered to Channa over the years. Perhaps most significantly he also identified that a local culture may have developed whereby it was agreed that Channa was "manipulating the system" and ultimately this may have adversely affected the care he was offered.

Failures in communication between practitioners and services

103. I accept the family submission that at the heart of many of the failings in Channa's care was poor communication – communication with the family, between clinicians and with the Mental Health Tribunal.

104. In examining the care given to Channa since his first contact with mental health services, one is struck firstly by the lack of continuity of care. As Professor Large points out there were a number of locums and apparent staff changes. There is no evidence in the voluminous notes that any particular practitioner established a strong rapport or took a leading role in caring for Channa, despite his many presentations and admissions. There is a sense that his care was disjointed and proceeded in an *ad hoc* manner. There was little recognition at the beginning of his contact with the service that early psychosis intervention strategies may be called for or planned. Later, there was little explicit recognition of his complex needs or clear

identification of the fact that his care needed to be reviewed as a complex case. His care was for the most part fragmented and disjointed. His many ED presentations were not identified as raising a red flag. Curiosity was not a driver in his management or treatment.

105. In my view it is fair to characterise his care as largely reactive. Staff dealt with him when he turned up or was brought in, often it seems by sending him away again. I think it likely this process was dispiriting and harmful. There is evidence that Channa had little confidence that the health system would assist him.

106. Failures in communication were certainly evident in the final discharge process. I was surprised Professor Large characterised what occurred as adequate and of a "reasonable standard". On this I do not accept his opinion.

107. In my view Dr Eagle in correct in describing Channa's final discharge as poorly managed. In my view his discharge was doomed to fail. There had been no proper assessment of his accommodation needs, he had not met his case manager, there was no plan in relation to drug and alcohol intervention or identification of adequate community support. When his discharge plan failed, as it almost immediately did, there was no recognition of this failure or attempt to reassess his needs.

108. I was particularly troubled by the discharge without even meeting the case manager. Dr Faingold agreed that this would be "best practice" but was unable to say why it had not occurred in this instance.[23]

109. It appeared to me that Dr Faingold understood the nature of some of these failings. He is now Acting Director of Richmond Clarence Mental Health Service and has the capacity to drive change. He gave evidence that a number of improvements have already been introduced at Lismore Base Hospital. These included weekly multidisciplinary team meetings; weekly community intake referral meetings; earlier allocation of community case managers on discharge; complex care reviews of all patients presenting on multiple occasions at the Emergency Department; more training generally and specifically more relating to suicide prevention; improved consultation with Alcohol and other Drug services.

110. Dr Faingold recognized the potential dangers involved in the manner in which Channa was sent from the Emergency Department to the Community Mental Health Service.[24] In oral evidence he made it clear that patients who are to be seen by a Community Mental Health clinician are now escorted from the Emergency Department. Further he produced a memo from the Northern New South Wales Local Health District which describes the current

[23] Transcript 15/12/20, Page 85, line 45 onwards
[24] Transcript 15/12/20, Page 93, line 4 onwards

process that is now required for the transfer of patients who present to the Emergency Department and require transfer to the Community Mental Health building for mental health assessment. There is now a clear requirement that they must now be escorted.[25] The court was also informed that mental health services have enhanced their mental health emergency care services in the ED and hospital setting by expanding the service to encompass 24 hour, seven day a week care. This model of care has already been developed and implemented.

111. Ms. Robinson in her statement of 16 December 2020[26] also speaks directly to many of the improvements which the Local Health District has implemented since Channa's death.

112. Significantly since March 2019 a Complex Case Review – Mental Health Services Procedure (NNSW – L HD – PRO – 0572 – 19) was developed and endorsed by the Mental Health Clinical and Corporate Governance Committee for complex presentations.

113. An orientation booklet for Psychiatry Registrars had a significant update in February 2020 which outlines the expectations for their involvement in mental health care planning and standards for eMR documentation.

114. The NNSWLHD has implemented the clinical procedure entitled "Early Psychosis clinical procedures" (NNSW – LHD – PRO – 0519 – 19) was published on 29 May 2019. This procedure provides clear direction and guidance for mental health services staff regarding appropriate service response to people presenting with first episodes psychosis and their family and/or carers.

115. In early 2017 a new policy in relation to discharge planning and transfer of care for consumers of New South Wales health mental health services commenced. Of particular relevance is that the new policy makes it clear that patients are not to be discharged without issues of homelessness being addressed.

116. An e-referral system between the emergency department and the MHEC has been introduced replacing the prior paper-based process.

117. A number of other services are being implemented in 2021 as part of the Toward Zero Suicides initiatives across the NNSWLHD mental health service. Other suicide prevention initiatives are in the pipeline and were outlined in evidence.[27]

[25] Exhibit 4
[26] Exhibit 3
[27] Statement of Ms Robinson, Exhibit 3

118. A number of other relevant changes were set out in NNLHD submissions. Of particular relevance was the establishment of a governance committee between Mental Health Services and Community Managed Organisations to review procedures and pathways.[28]

119. I accept that these policies represent significant improvements and if they are correctly implemented will provide increased safety for patients such as Channa.

120. In my view, after carefully reviewing the outlined improvements, the need for some of the recommendations which had been proposed at the conclusion of evidence was diminished

The use of the term malingering as a clinical barrier

121. The court closely examined the use of the term "malingering" as it appeared in Channa's medical records and tried to assess whether the concept became a clinical barrier to proper assessment or treatment.

122. There were numerous references to malingering or suspicion of faking symptoms for secondary gain. I do not intend to refer to each example. They were often recorded in summary form, apparently without formal assessments having been completed. The term was used by a variety of doctors, both junior and senior over a long period. Submissions from Channa's family referred to eleven specific examples recorded in notes from March 2017. There are others.

123. On 11 March 2017 Dr Haque recorded that Channa "has been reviewed by at least 5 psychiatry registrars and a psychiatrist over last few weeks. He is well known to MH for malingering, manipulating and taking advantage of this service, also benzodiazepine seeking." Later in May 2017 he was described as "trying to convince [clinicians] that he has delusions". These kinds of notations are not aberrant or isolated in the records.

124. It is important to stress that some of these opinions were discussed with and endorsed by relevant senior clinicians on call. Use of the term was made in both emergency and mental health departments by both nursing and clinical medical staff. It appears to me that by early 2017 at least, Channa had a reputation as a malingerer. I find it hard to accept it did not affect the care he was given.

125. When asked, Dr Wims, the former Clinical Director for Mental Health at Lismore Base Hospital, was not concerned about the use of the term. He denied that there was a "culture" operating at Lismore Base Hospital which acted as an obstacle to independent assessment

[28] Submission of NNSWLHD

of Channa.[29] He told the court that there were times when Channa was malingering. In his view malingering was a legitimate description. [30]

126. Dr Faingold was acting in that position at the time of the inquest and had been an unaccredited trainee in psychiatry when he personally reviewed Channa. He was questioned on his note from 3 March 2017. It recorded a "malingering attempt" and noted that Channa had "tried to simulate delusional ideas". Dr Faingold told the court that Channa's presentation left a "malingering impression" because there were no clear symptoms of delusional thought. He noted that malingering and schizophrenia are not mutually exclusive.[31] He stated that he came to his opinion independently but that it was discussed by the team. When pressed about whether he may have been influenced by opinions that had already been formed in the unit, he could not say "it's completely contamination free", but believed it to be based on his independent assessment.

127. Dr Faingold appeared to have reflected deeply on the use of the term malingering. While he confirmed it was a well-established term in psychiatry and he felt he used it in accordance with the relevant NSW Health guideline, he appeared to no longer endorse its use in the way that had frequently occurred during Channa's contact with the service. He told the court ""I acknowledge that this word is stigmatising and I'm sure I will never use again and not because of [Channa]…it's because as a human being and as a professional we're growing and as a community we can grow…"[32]

128. Dr Eagle was troubled by the records. She stated "[Channa] presented repeatedly to the Emergency Department in the months preceding his May 2017 admission and was assumed or assessed as "simulating delusional ideas", "malingering" and "seeking benefits and a place to live". Although I have not personally assessed [Channa] I am of the view that these assumptions were not in my view made on reasonable clinical grounds. They were made without the benefit of collateral information and in the absence of any acceptable structured assessment or psychometric process."[33] In her view the assumption that Channa was malingering or manipulating became a barrier to accessing care and would have possibly contributed to his suicidal behaviours prior to the admission by preventing access to appropriate care and treatment at an earlier time. She also expresses the view that it is likely this process eroded Channa's confidence in the mental health system which may also have indirectly contributed to a sense of hopelessness on 2 June 2017.

[29] Statement of Dr Wims, Exhibit 2
[30] Transcript 16/12/20, Page 162, line 15
[31] See discussion of these issues at Transcript 15/12/2020, page 66, line 30 onwards
[32] Transcript 15/12/20 Page 74, line 15 onwards
[33] Report of Dr Eagle, page 20

129. She expressed the firm view, having reviewed all the available information, that Channa did show any signs of malingering. She stated "Malingering is not a medical or clinical diagnosis….It is inherently difficult to reliably identify and if suspected the use of a structured tool is recommended to support any assessment of malingering. In my view, it should not be routinely used as a barrier to assessment with the provision of appropriate clinical care or treatment."[34] In oral evidence she stressed that it is a term that needs to be used carefully and with a clear basis such as psychometric assessment and/or collateral information and longitudinal assessment. She explained that use of the term without care can "create a barrier to accessing proper assessment and treatment."[35]

130. Professor Greenberg was also highly critical of the use of the term. He told the court "that coming from an emergency physician's point of view, if someone, one of my doctors used that language in the notes I would have severe words with them and absolutely told them to stop". Professor Greenberg said "I just think there should have been someone senior saying please don't use that language." Professor Greenberg stated "There appears to have been a culture that developed whereby everyone agreed that this man had no mental illness and was "manipulating the system." I accept his view that there was a lack of oversight, given Channa's multiple presentations.

131. Professor Large had a different view. Given his undoubted eminence in the field I have considered his opinions very carefully. He stated that "he found little evidence that Channa was treated in a confrontational, disrespectful, or perfunctory way as a result of speculation about the presence of simulated symptoms".[36] In oral evidence he stated "Look, "malingering" is a "perfectly sound medical word, with a long history." While admitting it "does have some slightly pejorative aspects to it", it was nevertheless a "perfectly established medical term". While suggesting malingering was "a perfectly sound medical word", I found it particularly noteworthy that Professor Large agreed that he wouldn't use the term "a malingerer" himself. In that context I found his insistence that the many references to malingering were no cause for concern somewhat troubling. I do not accept his opinion on this issue. I do not reject his opinion lightly but in my view he appears to have given insufficient weight to the number of references contained in the notes and the possibility that this characterisation of Channa may have affected both the treatment he was offered and his confidence in seeking help.

[34] Report of Dr Eagle, page 14
[35] Transcript 17.12.20 page 222, line 15 onwards
[36] Report of Professor Large, page 47

132. NNSWLHD provided the court with the relevant NSW Health guideline "NSW Health Psychiatric Malingering – Detection and Management guideline GL2009_016.[37] While it was in place at the time of Channa's care, there is no evidence that practitioners were aware of it or that they considered it in their clinical practice. Dr Wims advised the court that he did not believe the guideline formed part of the relevant local policy at the time of Channa's treatment. [38]

133. The guideline states that "malingering is a rare and extremely difficult diagnosis to accurately detect" and that apparent malingering of psychiatric symptoms is almost invariably associated with the presence of another concurrent psychiatric diagnosis. Decisions about the diagnosis and management of psychiatric malingering must be made in consultation with the senior mental health colleague." The guideline also outlines "recommended standards" or mechanisms which should apply to decisions about a diagnosis of malingering "because clinicians are unlikely to be able to successfully identify a psychiatric malingering in all but extraordinary circumstances."[39]

134. I have carefully considered the use of the term malingering in the context of Channa's care. I note that the NNSWLHD submitted that there was insufficient evidence to support a finding of fact that use of the term operated as a barrier to care. It was submitted that the evidence reveals Channa was prescribed anti-psychotics and admitted when necessary.

135. In my view characterisation of Chana as a malingerer is likely to have acted as a barrier to treatment on a number occasions during the years leading up to Channa's death. It seems most likely that his reputation coloured the way he was at times received, especially when one examines the number of occasions when he appears to have been summarily dismissed. There is also strong evidence that Channa's trust in the medical system was affected. Senior Constable Hayes described a conversation he had with Channa after the lengthy negotiation with Channa at Minyon Falls on 10 March 2017. He stated "I went with [Channa] in the ambulance, that was part of the negotiation to get him back on the falls, that I would go with him to hospital. He goes that – he said, ""I've been to the hospital, they won't help me," and I said "I will come to the hospital and I'll make sure that they'll help you."[40] This occurred three days after police had taken Channa to the ED, where "malingering" had been noted.

[37] Tab 32
[38] See Transcript 16/12/20 Page 159 at line 29 and in his statement
[39] Tab 32
[40] Transcript 16.12.2020 page 24 at line 40

136. It is noteworthy that the officer had no doubt that Channa was unwell. Senior Constable Hayes had completed mental health training as a police officer and had been in the Police Force 14 years. He told the court that he had contact with Channa on four occasions (13 February 2017, 7 March 2017, 10 March 2017 and 12 May 2017). While not a psychiatrist, on each occasion he had no doubt that Channa was genuinely delusional. He recounted some of the conversations which included references to the CIA and satellite tracking. His contact was not brief or superficial. On 10 March 2017 he spoke with Channa on a rocky ledge at Minyon Falls for around three hours while waiting for police negotiators. He took Channa to Hospital, but the following day it was recorded that Channa was "well known for malingering."

137. NNSWLHD did not support a recommendation in relation to malingering for a number of reasons. It was submitted that the current guideline already provides an adequate safeguard against the misuse of the term "malingering" by requiring specialist level input prior to diagnosis. Further, it was submitted that education on malingering has already been incorporated into the junior medical officer orientation at NNSWLHD.

138. An audit for the use of the term malingering was apparently completed in December 2020 and will be continued as an annual audit in the NSWLHD's audit calendar. Dr Faingold stated "we did a review of five patients that had multiple presentations to ED in the past six months to see if the word "malingering" would appear and no patients had that word in the document, five patients that had multiple presentations that could end up on those blacklist if they existed so I would say I'm more than happy to further provide education." [41]

139. The NNSWLHD also informed the court that the New South Wales health guideline on malingering which was created in 2009 is currently under review. It stated that it intended to provide consultation and input as a result of the learnings from this coronial inquest. The LHD informed the court that it has already conveyed an intention to provide feedback and advice to the New South Wales Health chief psychiatrist after this coronial inquest.

140. In my view the guideline needs update and review. There appeared to be consensus from the experts in relation to this issue, with even Professor Large agreeing the guideline was old and could benefit from review. In my view the term presents potential risk for the treatment of persons with mental health issues. In Channa's case it appears to have been one of the barriers to prompt and well-planned treatment. While the Ministry of Health was not represented at this inquest, it is likely an issue that requires consideration in other Local Health Districts too. I intend to make a recommendation aimed at driving change in this area.

41

The effect of Channa's homelessness on his mental health

141. In my view Channa's homelessness was a significant factor in his stress and despair after discharge. Channa had been homeless for many months and this was well documented by hospital staff. On many occasions he expressed the difficulty of having no place to live. Despite this being a recurrent issue and a trigger for some of Channa's presentations at the ED, there appears to have been little coordinated assistance to deal with this issue. Channa had been referred to link2home, but supported accommodation or other options do not appear to have been fully addressed by any social worker in a comprehensive manner.

142. The problem was still evident when the time came for an address that could be used for discharge. Two different addresses were nominated for him on his CTO and his hospital discharge summary. Referrals were recorded for the social worker to assist him with finding housing, but the responsibility appears to have nevertheless fallen to Channa himself.

143. Dr Faingold suggested that patients may get a sense of empowerment by finding the right accommodation. He explained that this "doesn't mean that we shouldn't do other things on the side like the social worker or the welfare worker helping him in the process but I think he should be the one leading the process."[42] Dr Faingold thought Channa had accommodation at the time he was discharged, but nobody seems to have had sufficient curiosity about the issue.

144. In my view the accommodation problem appears to have been under-estimated. Even without the deficits, disorganisation and overall impairments that can be associated with schizophrenia, Channa was hampered by the fact that there is limited inexpensive accommodation available. He had clearly tried to the best of his ability. The message he sent his brother makes it clear that he had tried every option he knew of. He wrote that he had "even tried the Winsome and they do not have a place for me, at the moment it is looking like I will have to sleep either at the emergency department of Lismore base or on the street in my swag which is going to be freezing"[43] He explained that he had slept on the concrete slab under R's home and that he was stiff and aching because of it.

145. It was Dr Faingold's evidence that Tallowwood has increased its treating team so that there are now two social workers who might be able to assist in these kinds of situations, but I think the problem is greater than that and one that Government need to take greater responsibility for. Discharging a man like Channa on a CTO when he is essentially homeless risks a failed discharge.

[42] Transcript 15/12/20 Page 83, line 40 onwards
[43] Annexure to Tab 9A

146. Professor Large appeared pessimistic about what can be done in this area. He told the court "Look, homelessness is obviously an important part of psychiatric care. There's a strong association between homelessness and mental disorders. I guess the problem is, you know, we're not …the Department – it's the Department of Health, not the Deaprtment of Housing and there's an expectation that we can do a lot more with respect to housing than we actually can do."[44]

147. I cannot accept that this is an adequate end to the matter. The Northern Rivers area has a significant homelessness and home affordability issue. The effect of this on people such as Channa who have particular vulnerabilities is severe. I was heartened to hear from Dr Faingold that policies in relation to homelessness are being worked on.[45] In my view this needs to be taken up at the highest level.

Managing patients with complex needs

148. It is perfectly clear that Channa was a patient with complex needs. After Channa's ten day admission to the LAMU in February 2017, there were 14 further presentations to the ED. Channa was not admitted and follow up was sporadic at best. It is shocking that this pattern did not trigger some kind of complex case review.

149. Counsel assisting suggested a recommendation aimed at this deficiency. It was not supported by NNSWLHD. While there was some recognition that this was a deficiency in Channa's care, NNSWLHD submitted that the issue had been adequately reviewed and dealt with since Channa's death.

150. According to submissions provided by NNSWLHD the mental health service has now reviewed and made changes to the way complex care of patients is identified and managed. Structures are now in place where information is shared for the purposes of complex care planning and establishing a memorandum of understanding between health, ambulance and police.[46]

151. Dr Faingold also gave evidence in relation to this issue. He stated "patients nowadays that present to ED multiple times we've been working towards having complex case reviews, that's a procedure that I think it's from 2019, which also includes patients that could not – could be from ED not patients that were in the inpatient unit or community mental health, so we can assess and bring the team to think what's wrong."[47] Later he confirmed that the

[44] Transcript 17/12/20 Page 223, Line 39 onwards
[45] Transcript 15/12/20 Page 94, Line 10 onwards
[46] Exhibit 3, The statement of Ms Robinson [16] and [42]
[47] Transcript 15/12/20 Page 106, line 29 onwards CHECK

process had previously been quite *ad hoc*, but he was now confident that multiple presentations would trigger a complex case review.

152. The NNSWLHD informed the court that the MHS complex case review procedure is currently under review and in the consultation phase. The court was supplied with the Complex Case Review draft audit tool" which is apparently being developed into an electronic audit tool.

153. The NNSWLHD informed the court that Complex Case Review is scheduled as part of the annual education program for mental health clinicians and will include annual education on the procedure, audit results and proposed actions for improvement.

154. I was confident that Dr Faingold understood that cultural change is required. Patients cannot attend the ED time after time without proper analysis of what is going wrong or how care can be improved.

Failures to provide options for Drug and Alcohol treatment

155. It is clear that Channa's mental health issues were exacerbated and at times triggered by his substance use. All the experts recognised his diagnosis of substance use disorder. It is thus difficult to understand why he was not seen by a Drug and Alcohol worker, especially during his final admission. When questioned, Dr Faingold agreed it was a missed opportunity.[48] He stated that if a patient is not ready to engage then an assessment will be fruitless, but assessment should be offered and there was no evidence to suggest Channa was offered this opportunity during his final admission.[49]

156. I note that counsel for NNSWLHD opposed making a recommendation in relation to drug and alcohol intervention, stating that appropriate pathways already exist. It was submitted that the structured screening process in place contains an option for staff to complete substance use assessments. It was further submitted that referrals can already be made to AOD specialists during business hours and that consideration is being given to providing further skills to Mental Health staff so that they may provide brief interventions with acute inpatients in conjunction with formal referral to the AOD service. These initiatives are to be applauded.

157. I remain concerned. It was perfectly clear to all staff that Channa had long term substance use issues and it remains a mystery why no intervention – brief or otherwise was made.

[48] Transcript 15/12/20, page 77
[49] Transcript 15/12/20, Page 77, line 30 onwards

Failures to supply correct information to the Mental Health Review Tribunal or contact the family

158. In my view the provision of important information such as the address and nominated carer to the Mental Health Review Tribunal was undertaken in a careless and unprofessional manner. While I accept that pro forma forms will be used, there appears to have been minimal or no checking of information and no attempt to obtain collateral information.

159. Dr Faingold explained that sometimes in these situations there is considerable time pressure because the Tribunal is ready to sit and the patient is no longer detainable under the *Mental Health Act.* I accept time pressure may exist, but it offers no excuse for failing to make appropriate inquiries. In Channa's case the nominated carer, Channa's father was not in the country and had not been contacted. The occupier of the residence nominated had also not been contacted by the treating team.

160. I accept Dr Eagle's opinion that it was important, if not essential, for collateral information to be obtained at a number of times during Channa's treatment.

I

161. It became clear during the hearing that there was considerable confusion among the treating team and even the family about what legal restrictions were in place preventing information flow between Channa's doctors and his parents. This is exactly the sort of issue which should have been clarified by a social worker or once release was an option by the community case worker. The court was taken to a note from February 2017 which indicated that Channa's father would like to be notified of Channa's discharge or if there was "fresh new unknown aspect with positive result".

162. Tragically the lack of communication meant that until after Channa had died, his parents had not been contacted by Channa's treating team or informed of his admission on 12 May 2017, his diagnosis of schizophrenia or his discharge on a CTO.

Was the care provided by Northern NSW Local Health District (NNSWLHD) adequate?

163. Professor Large told the court that he was satisfied that the Lismore Adult Mental Health Unit provided adequate care and treatment during his admission between 12 May and 31 May 2017.[50] Nevertheless he agreed that a case manager should have been appointed earlier and ideally visited Channa on the ward prior to release.[51] He agreed that "it would have been

[50] Report of Professor Large, Tab 8 Page 50
[51] Report of Professor Large, Tab 8 Page 50

better" if Channa had "specialist drug and alcohol imput" during his admission.[52] Professor Large agreed that some psychiatrists may have detained Channa longer but stated he did not think this was necessarily called for. The discharge and on a CTO with a case manager was appropriate in his view. He was not particularly concerned about the way Channa was sent from ED unaccompanied to the CMH.

164. Dr Eagle identified significant failings in the care offered to Channa, many of which I have already referred to. While she did not necessarily consider that discharge was inappropriate, the manner in which it occurred was flawed. I accept her view that it should have been immediately apparent that the discharge had failed and steps should have been taken to properly re-assess Channa's mental health state when he returned so quickly to the ED after release. I note that some of the concerns she raised were accepted by the NNSWLHD and have been acted upon.

Outstanding concerns and the need for recommendations

165. Section 82 of the *Coroners Act* 2009 confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

166. A number of recommendations were put forward by the Coronial Advocate assisting the court and by the family's representative. While I do not refer specifically to each, all have been carefully considered and weighed against the evidence before me. It is noted that the LHD did not support many of the recommendations, submitting that while some raised pertinent issues they had already been addressed by changes already made. In some cases I have accepted this view.

167. Having considered all the evidence before me I am satisfied that local procedures have been introduced which improve the pathways between the Emergency Department and the community mental health services. I am also satisfied that there are now appropriate processes in place in relation to complex case reviews and for identifying complex patients. I accept for example that there is now a policy in place which should trigger a complex case review for a patient such as Channa. I accept Dr Faingold understands the importance of this change. I have been told that there are audit mechanisms in place to ensure multiple attendances at ED would trigger consideration of these policies.

[52] Report of Professor Large, Tab 8 Page 51

168. There remain areas which in my view need a further response.

169. I remain concerned that use of the term malingering was a clinical barrier in this case. I have read the current guideline and am confident it needs review. While the Ministry of Health was not represented at these proceedings I think it appropriate that the statewide policy should be reviewed and I was informed that this is occurring. I note that the NNSWLHD submissions state it has already been in contact with the chief psychiatrist in relation to this issue. I intend to make a recommendation which requests NNSWLHD's further assistance in driving change in this policy area.

170. As I have stated, I am of the view that homelessness was a critical stressor that exacerbated Channa's illness at a critical time. I remain concerned that the NNSWLHD needs further support to assist its clients in relation to accommodation. It is clear that there were social workers at the Hospital and that Channa was referred to link2home. The referral was inadequate in the circumstances and in my view always likely to fail. NNSWLHD need to have access to appropriate supported social housing for their community mental health patients.

171. I remain concerned that alcohol and other drug issues were largely ignored during Channa's mental health admissions. I have not been persuaded that this issue has been adequately addressed.

172. One final matter which arose during the evidence, but was not explored to any great degree was the possibility of safety improvements for those experiencing distress at Minyon Falls. The court was told that there have been a number of suicides in the area over the years. Senior Constable Ruebner, the officer in charge of the investigation gave evidence that while there is now a LifeLine sign in the area, he did not think it was there at the time of Channa's death.[53] He also explained that mobile reception was very poor in the area. The Commissioner or Local Council were not represented at the inquest and I do not make a formal recommendation, however I intend to write to the Local Area Command and ask them to consider contacting the Local Council to discuss safety options such as a landline phone which connects automatically to a service such as LifeLine. These kinds of initiatives have been supported by NSW Police in other areas.

Findings

173. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

[53] Transcript 14/12/20 Page 15, line 16

Identity

The person who died was Channa

Date of death

Channa died on 2 June 2017

Place of death

Channa died at Minyon Falls, Northern NSW.

Cause of death

Channa died as a result of multiple injuries

Manner of death

Channa fell from great height. His fall was unwitnessed and occurred in the context of recent expressions of suicidal thought, homelessness and discharge from mental health care.

Recommendations pursuant to section 82 *Coroners Act 2009*

174. For the reasons stated above, I make the following recommendations:

To the Northern NSW Local Health District

That NNSWLHD develop local guidelines and training regarding the use of the term "malingering". Policy should specify the need for the use of recognised assessment tools. Training should make it clear that use of the term can be a barrier to treatment. After new guidelines have been introduced and training has occurred, ongoing audits should be conducted to guard against use of the term creating a barrier to treatment.

That NNSWLHD make representations to the Ministry of Health (or relevant body) in relation to the need for a review and update of a statewide policy on malingering, which should be conducted after wide ranging consultation with appropriate experts.

That NNSWLHD engage in advocating for dedicated housing in the local area for their mental health patients as a matter of some urgency.

That NNSWLHD create policy to ensure that all Mental Health inpatients, diagnosed with substance use disorder, have access to drug and alcohol counselling during and after release.

That NNSWLHD establish adequate quality control mechanisms to check the information provided to the Mental Health Review Tribunal for the purpose of making of appropriate Community

Treatment Orders. This includes processes for checking carer and address information, as well as checking that contact has been made between the Community Mental Health case manager and the patient prior to discharge.

That NNSWLHD continue regular audits to ensure that patients with multiple presentations at ED for mental health issues are appropriately managed in compliance with complex case policies and procedures.

Conclusion

175. Finally, I offer my sincere thanks to advocate assisting Ms Tina Xanthos for her hard work and enormous commitment in the preparation and conduct of this inquest. I acknowledge Senior Constable Hayes for his genuine and compassionate attempts to get help for Channa and I thank him for his service in this regard.

176. Once again, I offer my sincere condolences to Channa's friends and family. I acknowledge that the pain of losing a loved one in these circumstances is profound and that their grief is ongoing. I have found that the care offered to Channa fell below an acceptable standard. Channa was not offered the support he needed.

177. I greatly respect Channa's family's decision to participate in these difficult proceedings to achieve change and I thank them again for their courage and grace in such circumstances. Their participation protects the integrity of the proceedings and honours the life of the young man they love so deeply.

178. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
7 May 2021
NSW State Coroner's Court, Lidcombe