CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Camilla Margolis
Hearing dates:	9 to 12 August 2021; 5 November 2021
Date of findings:	1 February 2022
Place of findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – care and treatment, Blue Mountains District ANZAC Memorial Hospital, discharge planning from mental health inpatient unit, care coordination, transfer of care, handover to community mental health team, logistics and transport upon discharge, communication with consultants and management decisions outside of rostered hours, fragmentation of electronic patient records, continuity and safety of patient care
File number:	2018/00148087
Representation:	Dr P Dwyer, Counsel Assisting, instructed by Ms S McKinnon & Ms A Smith (Department of Communities and Justice, Legal) Ms H Boyd, instructed by Crown Solicitor's Office (NSW), for Nepean Blue Mountains Local Health District Ms M Gerace for Ms M Margolis Mr J Longworth, instructed by Avant Mutual, for Dr S Stanek
Findings:	Camilla Margolis died on 10 May 2018 at Katoomba NSW 2780. The cause of Camilla's death was multiple blunt force injuries. Camilla died as a result of actions taken by her, in jumping from a cliff at the Echo Point Lookout, with the intention of ending her life. Camilla's death was therefore intentionally self-inflicted.

Non-publication order: Pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW), there is to be no publication of evidence given in these proceedings or contained in the brief of evidence, relating to the names or personal identifying information of the following persons:

(a) DB;
(b) MT;
(c) SB; and
(d) RM.

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1. Introduction

1.1 On 4 May 2018 Camilla Margolis was discharged from a hospital in Sydney after presenting in crisis two days earlier. During the course of Camilla's admission she was diagnosed as being at acute risk of suicide, and she voiced an intention to travel to the Blue Mountains region in order to jump from a specific spot.

1.2 Following her discharge, Camilla did indeed travel to the Blue Mountains region where concerns were raised for her welfare and police were notified. This eventually resulted in two presentations to the same hospital in the Blue Mountains. After being discharged on 5 May 2018, Camilla travelled to a lookout area at Echo Point where she expressed an intention to self-harm. Following the attendance of police, Camilla was returned to hospital and admitted, remaining there over the following days.

1.3 On the morning of 10 May 2018, Camilla was again discharged from hospital with a plan formulated for her to return to Sydney and engage with community mental health services there. Instead, during the afternoon, Camilla made her way again to Echo Point where she jumped from a lookout area and sustained fatal injuries. At the time of her tragic death, Camilla was 34 years old.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 Certain deaths are reportable to a Coroner. Some examples of reportable deaths are where the cause of a person's death is not due to natural causes, or where the cause or manner of person's death may not immediately be known. In Camilla's case, the coronial investigation focused on certain aspects of the manner of Camilla's death, given the close proximity in time between when she was last discharged from hospital and when her death occurred. In addition, the coronial investigation also sought to gain a better understanding of the care and treatment provided to Camilla during her last hospital admission, given her lengthy previous mental health history and the number of previous hospital admissions. For all of these reasons, an inquest was required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a

death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified during a coronial investigation, and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

3. Recognition of Camilla's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Camilla's life in a brief, but hopefully meaningful, way.

3.3 Camilla was born at the Women's Hospital in Paddington on 27 September 1983 to her parents, Michele and Jim. Camilla was named after one of Michele's university friends, and her mother describes her as perfect, and being overwhelmed with love and amazement at Camilla's birth.

3.4 As a young child, Camilla was very independent, confident, bright and active. Michele fondly recalls that Camilla could not wait to attend childcare, and had no separation anxiety at all on her first day there.

3.5 At school, Camilla made plenty of friends and often accompanied Michele, who was a teacher, on excursions and attended events with her. Camilla was a gifted student, and was chosen to enter a selective academic stream in both primary and high school. Camilla did well at school, played the flute in the school band, and attended drama classes at the Independent Theatre. By this time, Camilla had a sister, Natasha, and a brother, Darcy, both of whom she adored. Michele has many treasured memories of weekends and holidays spent with all of her children, and their friends, enjoying many parties and picnics together.

3.6 After finishing high school, Camilla completed a course at Sydney University in documentary making. She was the youngest student in the course and made an award-winning film which was screened at a cinema in Paddington. Camilla later went to study journalism at the University of Technology, Sydney where she again excelled academically. Michele describes Camilla as being a talented and creative force.

3.7 These brief words can in no way adequately capture who Camilla was as a person, emphasise the importance of her life, or describe what her loss means to her family and loved ones.

4. Camilla's medical history[1]

4.1 In order to understand the events of May 2018 in proper context, it is useful to briefly set out some relevant aspects of Camilla's medical history.

4.2 On 3 April 2009, Camilla contacted Lifeline and expressed a desire to self-harm. The police were notified and later attended Camilla's address in Five Dock where they spoke with Camilla and her housemate. Camilla told the police that she suffered from depression and was taking medication. Camila was subsequently involuntarily detained under the provisions of the *Mental Health Act 2007* (**MH Act**) and taken to Concord Mental Health Unit for assessment and treatment.

4.3 Between 2012 and 2015, there were a number of further interactions between Camilla and the police, similar to the incident described above, which involved expressions by Camilla of a desire to self-harm.

Engagement with Lower North Shore Community Mental Health Team

4.4 By January 2017 Camilla was engaged with the Lower North Shore Community Mental Health Team (**the North Shore CMH Team**). Her case manager was Myrelle Makhoul, who Camilla appeared to like and trust. At the time, Camilla was prescribed olanzapine and aripiprazole (antipsychotic medication used to treat schizophrenia and bipolar disorder), as well as venlafaxine (an antidepressant). Camilla reported to Ms Makhoul that she had daily suicidal thoughts with worsening paranoia, but that she was unlikely to act on her suicidal thoughts.

4.5 On 14 February 2017, Camilla reported to Ms Makhoul that she had increasing anxiety and suicidal thoughts "*all the time*". Ms Makhoul urged Camilla to contact a crisis team, an ambulance a hospital emergency department or an ambulance if she felt that she might act on her thoughts. Camilla indicated that she had begun contacting Lifeline when distressed (which helped to suppress her suicidal thoughts), and that she had stopped taking aripiprazole (because she believed that it made her "*cognitively slow*") but continued to take venlafaxine.

Admission to Royal North Shore Hospital in March 2017

4.6 On 3 March 2017, Camilla was admitted to Royal North Shore Hospital (**RNSH**) following an intentional overdose of benzodiazepine-class medication. This incident occurred in the context of

[1] This factual background has been drawn from the helpful opening submissions of Counsel Assisting.

Camilla expressing some concern that her brother had been recently diagnosed with depression and was having suicidal thoughts. Camilla was admitted overnight but discharged the following day.

4.7 On 8 March 2017, Camilla attended a review with Ms Makhoul. According to notes taken from this review, Camilla reported plans to kill herself before her birthday if her situation did not improve. At this review, the possibility of Dialectical Behavioural Therapy (**DBT**) was raised as potentially having some therapeutic benefit for Camilla moving forward. However, no further steps were taken to investigate this further as Camilla indicated that she wanted to learn more about the therapy.

4.8 DBT is a cognitive behavioural treatment developed which emphasises individual psychotherapy and group skills training classes to help people learn and use new skills and strategies to develop a life that they experience as worth living. DBT was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder DBT skills include mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness.

4.9 On 16 March 2017, Ms Makhoul exchanged some text messages with Camilla in order to check in with her. Camilla reported that she had attempted self-harm by using prescription pain relief medication after seeing her ex-partner on the ferry. Camilla told Ms Makhoul that was staying with a friend and assured that she would attend hospital if she needed to. Ms Makhoul encouraged Camilla to also contact the North Shore CMH Team if she needed help.

4.10 On 23 March 2017, Camilla attended a review with Ms Makhoul. Camilla reported that she had stopped taking venlafaxine and diazepam (Valium).

Admission to Gosford Hospital

4.11 On 1 April 2017, Camilla called Ms Makhoul and reported that she had consumed an excessive amount of diazepam tablets and that she wanted to "*find a bridge to jump off*", or run in front of a car on the road. Ms Makhoul stayed on the phone with Camilla whilst a psychologist collected Camilla from her home to take her to the RNSH Emergency Department.

4.12 On 2 April 2017, Camilla was transferred as an involuntary patient from RNSH to the mental health inpatient unit at Gosford Hospital. The following day, Camilla was assessed by the treating team who determined that her admission was causing Camilla unnecessary stress. It was determined that Camilla did not meet the criteria to be detained pursuant to the MH Act, and she was subsequently discharged. It was noted that Camilla was seeing a psychiatrist (Dr David Bell) from the North Shore CMH Team fortnightly (and was known to the crisis team), and that Camilla was engaged with Ms Makhoul.

4.13 On 7 April 2017, Camilla was seen by Dr Bell and Ms Makhoul. Camilla indicated that she found the recent admission to the emergency department to be traumatic. Dr Bell offered a direct admission to the Psychiatric Emergency Care Centre (**PECC**) at RNSH should the need arise again in the future, but Camilla declined this offer. During the review, Camilla also made reference to a number of different methods of self-harm, including jumping off a balcony. A plan was formulated for Ms Makhoul to continue to review Camilla in person, with support provided by the North Shore CMH

Team (even though Camilla was living out of area). It was also noted that an application for a Disability Support Pension (DSP) would be initiated on behalf of Camilla.

4.14 On 15 April 2017, Registered Nurse (**RN**) Caitlin Starkey from the Lower North Shore Acute Mental Health Team (**North Shore AMH Team**) contacted Camilla to check on her welfare. Camilla was very distressed, and reported feeling terrible following a relationship break up, and that she had been starving herself. Camilla indicated that she did not want to be admitted to hospital, but said that she was happy to receive calls until Ms Makhoul (who was away) returned to the office.

4.15 On 16 April 2017, RN Starkey called Camilla again to follow up. Camilla reported having a very bad day, and that she had consumed half a bottle of vodka and then gone for a run to try and lose weight. RN Starkey (who was a DBT therapist) raised the possibility of DBT and short-term admission to the PECC. However, Camilla indicated that she could not afford the therapy, that she would soon be moving to a friend's place, and she hoped she would have "*the guts*" to jump from the balcony.

4.16 On 17 April 2017, Ms Makhoul called Camilla, who reported low mood and suicidal intent. Ms Makhoul also suggested using DBT distress tolerance strategies, along with mindfulness and relaxation. Camilla indicated that she would try implementing such strategies but said that she thought nothing would help. Ms Makhoul and Camilla discussed short term admission to the PECC (at Dr Bell's recommendation), but Camilla asserted that she was treated poorly by nursing staff on a previous occasion and would not return.

4.17 On 20 April 2017, Camilla called Lifeline expressing suicidal ideation and an intention to jump from The Gap. Police were notified and later conveyed Camilla to RNSH where she was admitted as a voluntary patient. Camilla was later transferred to the PECC on the same day for assessment by the medical team. The next day, Camilla was reviewed by a consultant psychiatrist and asked to return to her previous medication regime. Camilla agreed to try both venlafaxine and aripiprazole again. On 24 April 2017, Camilla was discharged following review by the psychiatric team. It was noted that Camilla was a long-term suicide risk, but that there was no suggestion of acute risk at the time of discharge. The discharge plan involved Camilla continuing with her prescribed medication and for follow up by the North Shore CMH Team.

4.18 On 29 April 2017, Camilla presented to the RNSH Emergency Department after having ingested an excessive amount of olanzapine tablets in an apparent self-harm attempt. Following review, Camilla was found to be increasingly anxious and agitated. Following discussions between nursing staff and Dr Bell attempts were made to formulate a plan to keep Camilla engaged with the North Shore CMH Team. Camilla was later discharged, at her request, and arrangements were made for daily follow-up by the North Shore CMH Team.

4.19 Ms Makhoul contacted Camilla a number of occasions between 1 and 26 May 2017. During this period, Camilla indicated that she had again ceased taking venlafaxine, and reported feeling depressed and isolated, and not sleeping properly. Camilla also indicated that her suicidal ideation was "*still there*" but had not worsened.

Admission to Royal North Shore Hospital in May 2017

4.20 On 29 May 2017, Ms Makhoul received a crisis call from Camilla who reported that she had intense thoughts of cutting her wrists whilst in the bathtub. Following discussion between Ms Makhoul and Dr Bell, Camilla was admitted to RNSH where she was found to have a chronically elevated baseline risk of suicide in the context of personality and situational factors. It was also noted that this risk was unlikely to be modified by further inpatient treatment. On 30 May 2017 Camilla was transferred to the PECC and reviewed the following day. She was noted to have a depressed and despairing mood, but no overt mania or psychosis. A plan was formulated for Camilla to remain in the PECC as a voluntary patient with no leave, and a referral was made to the Mental Health Inpatient Unit.

4.21 Camilla was reviewed again on 2 June 2017 and it was noted that she was at a very high risk of suicide in the medium term. Camilla presented with no formal thought disorder or psychotic symptoms, and attributed her inability to take part in CBT due to a lack of time and finances.

4.22 On 5 June 2017, Camilla was review for a final time prior to discharge. Camilla indicated that she could always return to RNSH if she was "*about to jump off a building or something*". The use of DBT skills were discussed with Camilla as a strategy for dealing with painful emotions, but Camilla indicated that she did not have the time to utilise DBT; rather, Camilla indicated that she needed to be earning money. Camilla also declined social work assistance to find alternative accommodation. A plan was formulated for community mental health follow-up in the area where Camilla would eventually move to, including further social work assistance.

4.23 Following her discharge, Camilla became engaged with the St George Community Mental Health Team (St George CMH Team). Records reveal follow-up communication between the North Shore and St George CMH Teams regarding Camilla's collateral medical history, and the availability of suitable interventions.

4.24 However, on 20 June 2017 Camilla was discharged from the St George CMH Team's service after advising that she had moved from the Monterey area and was staying with a friend in Cammeray. On 23 June 2017, Camilla called Ms Makhoul, requesting to reengage with her and Dr Bell. Camilla also indicated that she had allegedly been physically and sexually assaulted by a male person, but declined to report the matter to police due to a previous incident where she felt the police had ignored her.

4.25 On 28 June 2017, Camilla was reviewed by Ms Makhoul and reported being at The Gap the previous night and contemplating self-harm. Camilla was subsequently reviewed by Dr Bell, who noted multiple categories of maladaptive personality traits and underlying delusional disorder, and determined that an admission of more than 3 or 4 days was required.

4.26 On 3 July 2017, Dr Bell reviewed Camilla, who reported an improvement in her mood. Discussions were had regarding a change in medication from venlafaxine to fluoxetine, as well as a discharge plan and housing options for Camilla. Camilla was later transferred to the PECC. On 5 July 2017, Camilla was discharged with a plan for review in the community the following week.

4.27 Between 11 and 21 July 2017, Camilla was reviewed a number of times by Ms Makhoul. On occasion, Camilla was noted to be "flat and restrictive". It was also noted that Camilla had made a request for temazepam (a benzodiazepine that can be subject to abuse), raising concerns that Camilla may be drug seeking. A decision was made to not prescribe temazepam, prompting some anger from Camilla towards Dr Bell, and paranoia that he did not like her. During this period, Camilla sent Ms Makhoul a number of text messages in which she expressed her anger at the medical system. Available records indicate each of these communications was diligently followed up by Ms Makhoul.

4.28 On 7 August 2017, Camilla reported to Ms Makhoul that she had taken a Valium overdose because she was a "sex slave" and not in a safe or good place. Camilla denied suicidal ideation and declined to seek assistance from women's homelessness services. Camilla was subsequently brought into Royal Prince Alfred Hospital (**RPAH**) Emergency Department by police after Michele contacted the Mental Health Access Line and Redfern Police Station, indicating that Camilla was mentally unwell.

4.29 Camilla was later reviewed by a psychiatrist and assessed as having acute suicidal ideation on the background of recent sexual trauma and perceived abandonment from her mother and the RNSH Acute Care Services team. With Camilla's consent, a plan was made to admit her as a mentally disordered patient, preferably to the Professor Marie Bashir Centre (**PMBC**), and to consider a referral to DBT in the community. A plan was also made for Camilla to be followed up at the RPAH Sexual Health Clinic or with a general practitioner (**GP**).

Admission to the Professor Marie Bashir Centre

4.30 On 9 August 2017, Camilla was admitted to the PMBC. She was noted to have chronic thoughts of suicide but no concrete plans at that time. Camilla disclosed several previous overdoses in the context of domestic violence and relationship breakdowns, and express suicidal intent if she was forced to return to the man that she had previously been living with. A decision was made to admit Camilla to the High Dependency Unit (**HDU**). Although initially admitted as a voluntary patient, Camilla's admission later became involuntary following a deterioration in her condition.

4.31 During the course of her admission, Camilla was noted to be irritable and hostile for certain periods. Clinical notes record times when Camila was verbally abusive, and was sexually suggestive and aggressive towards male staff members. On one occasion, Camilla had to be restrained and placed in seclusion after throwing a chair at the nursing station window, and being hostile and abusive towards staff and other patients.

4.32 On 15 August 2017, was reviewed by the psychiatric team. It was agreed that a prolonged admission would not be of assistance, and that Camilla needed to engage with trauma informed psychological therapy or DBT as an outpatient. It was further noted that commencing therapies whilst Camilla was an inpatient was unlikely to be of much benefit and may in fact cause further damage.

4.33 On 18 August 2017, Camilla and Michele attended a family meeting with the treating team. It was discussed that Camilla was a chronic risk of self-harm and suicide due to her borderline personality disorder, and that the risks of remaining an inpatient outweighed the risk of discharge. The

treating team advised Michele of their intention to refer Camilla to an outpatient DBT. Upon discharge, Camilla declined accommodation provided in a hotel, and instead was discharged into the care of an ex-partner. A plan was made for ongoing social work input regarding DBT and CBT.

Admission to Cumberland Hospital Acute Patient Unit

4.34 However, later in the evening on 18 August 2017, Camilla presented to Parramatta police station threatening suicide due to being homeless, indicating that her only option was to live with her abusive ex-partner. Camilla was subsequently taken to Westmead Hospital and reviewed by the psychiatric registrar on duty. A plan was made to admit Camilla to Cumberland Hospital Acute Patient Unit for a short admission. Michele later contacted the Unit to advise of Camilla's high risk of suicide and background, indicating that she was willing to be involved in Camilla's recovery. These matters were later discussed with Camilla who instructed staff that they were not to discuss her treatment with Michele.

4.35 On 21 August 2017 Camilla was reviewed by the psychiatry team and alleged that she had been assaulted by a co-patient, and that three men had threatened to kill her during her admission. Camilla was transferred to the Hainsworth Unit, an acute adult inpatient unit, as a voluntary patient. Camilla was reviewed by the treating team again the following day. She indicated that she intended to return to live with her ex-partner, that she was agreeable to follow up by Parramatta Community Mental Health and confirmed that she was not at risk of harm. That afternoon, Camilla was discharged, with a plan made for follow up by Parramatta Community Mental Health due to her expressed suicidality.

4.36 Later on the same day, Camilla was re-admitted to Westmead Hospital as a voluntary patient after police attended her apartment following an altercation involving her ex-partner, with Camilla attempting to jump off the balcony. Camilla was subsequently transferred to Cumberland Hospital as a mentally disordered patient.

4.37 On 23 August 2017, Camilla was reviewed by the psychiatry team and refused to give permission to staff to contact Michele for background information. During the course of her admission, Camilla was noted to express hopelessness, indicating that she would not be alive in a months' time. At times, it was noted that Camilla was disruptive and agitated in the unit, and that her charted medication had limited effect.

4.38 On 25 August 2017, Camilla was reviewed by the treating team and found to be non-compliant, and engaging in derogatory conversations. Camilla's legal status was changed from involuntary to voluntary, however she was to be monitored closely to avoid any allegations of staff misconduct. Later that day it was noted that Camilla's behavioural issues were driven by her borderline personality disorder and she was making no specific threats of self-harm.

4.39 On 27 August 2017, Camilla was rescheduled as a mentally disordered person under the MH Act, after she became aggressive and started throwing furniture and other objects around the ward. Camilla was reviewed the following day by the treating team who had made enquiries with Camilla's family and friends in an effort to find suitable discharge accommodation. Camilla remained ambivalent and refused the assistance of support services, and advised that she did not

want Michele or community mental health teams made aware of her discharge. Progress notes indicate that it was considered that Camilla would not benefit from a prolonged hospital admission. She was returned to being a voluntary patient and later discharged from Cumberland Hospital.

4.40 On 13 September 2017, Camilla presented to St George Hospital Emergency Department on a background of a situational crisis. Camilla was later medically cleared for discharged on the same day, with a plan for follow up in the community.

4.41 On 16 September 2017, Camilla presented to St George Hospital Emergency Department again with suicidal ideation on a background of a situational crisis following the breakdown of her relationship. She was admitted, and later discharged on 20 September with a plan for community follow up.

Admission to Prince of Wales Hospital

4.42 On 21 October 2017, Camilla was taken by ambulance to Prince of Wales Hospital (**POWH**) following an attempt to medication overdose. On review it was noted that Camilla would benefit from psychotherapeutic support with DBT or another modality. Camilla was subsequently admitted to St George PECC as a voluntary patient. The following day, Camilla was transferred to Sutherland Hospital Emergency. On 24 October 2017, Camilla was assessed by the psychiatric team and noted to be suffering from chronic suicidal ideation. Again, DBT was recommended and explained to Camilla.

4.43 During the course of her admission, Camilla was reviewed by a consultant psychiatrist and psychologist. Camilla agreed to future planning in relation to long term goals of alternative accommodation and support networks. On 27 October 2017 Camilla was discharged for follow up with a community team, but later refused to engage.

4.44 On 16 December 2017, Camilla presented to the POWH Emergency Department and indicated that she was planning to jump from a height and attempting to obtain medication in order to overdose. Camilla was subsequently admitted and reviewed by Dr Mathew Large, consultant psychiatrist, on 18 December 2017.

4.45 During the course of Camilla's admission, Michele contacted POWH on a number of occasions, understandably seeking information regarding Camilla's treatment. However, similar to a number of Camilla's previous admissions to hospital, Camilla did not provide her consent for such information to be disclosed to Michele.

4.46 On 19 December 2017, following social work review, it was noted that Camilla's immediate stressors were joblessness, finances and accommodation. On 25 December 2017, Camilla left the ward at around 10:00am to attend a Christmas Day celebration. She returned in the afternoon, notably distressed, and stated that she contemplated jumping off the cliffs at Bronte. The following day, Camilla reported ongoing suicidally and that the events of Christmas Day brought back memories of trauma with her family. That evening, Camilla presented to the nursing station

ruminating on her life and stating that she was constantly thinking about suicide. She said that she wanted to jump off a cliff and continued to request discharge.

4.47 On 27 December 2017, Camilla was reviewed by Dr Large and again requested discharge, whilst also admitting that she would walk past the cliffs every day to contemplate suicide. On 28 December 2017, Camilla was discharged from the PECC, with the discharge summary noting that Camilla was cooperative during her admission and had no current suicide plans. Dr Large did not consider that the provisions of the MH Act ought to be engaged to prolong Camilla's admission as she was able to understand and weigh up the benefits of her admission, and to communicate with staff upon discharge. A plan was made for follow up by an acute care team, whilst noting that Camilla would likely benefit from DBT if she was willing to engage.

4.48 On 30 December 2018, Camilla was re-admitted to the PECC at POWH as a voluntary patient after expressing plans to jump from the cliffs at Coogee. Again, Camilla did not consent for information about her treatment to be provided to Michele but consented to the treating team listening to her concerns.

4.49 During the course of her admission, Camilla was again reviewed by Dr Large and a plan was formulated to change Camilla's medication regime prior to discharge. In addition, the possibility of longer term interventions and the importance of DBT were discussed with Camilla. However, Camilla indicated her unwillingness to engage with DBT (despite repeated previous referrals) as she did not agree with a diagnosis of borderline personality disorder. Camilla was assessed as being at a chronic risk of self-harm, suicide and misadventure due to her personality disorder, and that this risk was not able to be predicted nor mitigated by inpatient care. Camilla was subsequently discharged and follow-up was conducted by the POWH Acute Care Team (**ACT**) between 10 and 19 January 2018.

4.50 On 22 January 2018, Camilla self presented to POWH again with fear of imminent death, but denied any suicidal ideation. She reported that she had run out of citalopram and quetiapine. Clinical notes indicate that Camilla reported attempting to strangle herself with a jumper one week prior and also accidentally swallowing glass. Dr Large spoke with Camilla and advised that she could not be admitted to the PECC due to capacity issues, but offered a voluntary admission to the Kiloh Centre (the acute mental health inpatient unit at POWH), but this was declined by Camilla.

4.51 On 24 January 2018, Camilla attended an appointment with Dr Large and was offered a voluntary admission to the PECC over the weekend due to a breakdown regarding her current accommodation. Camilla agreed and was admitted the following day. On review, Camilla denied any active suicidal ideation and continued to express the view that hospital admission provided minimal therapeutic benefit, and that DBT would not be of assistance to her. Notwithstanding, on 29 January 2018, Camilla received a DBT consult and was asked to consider being referred to the program.

4.52 On 1 February 2018, Camilla was reviewed by Dr Large, and also saw a psychotherapist prior to discharge. Efforts were made to provide Camilla with psychotherapy in the community, and or follow up by the Marrickville CMH Team.

4.53 On 15 February 2018, Camilla disclosed that she had suicidal ideation and expressed an intention to visit a friend who owned a firearm, which she intended to use to self-harm. Emergency services attended a location in Marrickville where Camilla was residing, and she disclosed that she was non-compliant with her medication and suicidal. Camilla was subsequently conveyed voluntarily to RPAH.

4.54 On 16 February 2018, Camilla was assessed by a consultant psychiatrist and presented with a sense of hopelessness and rejecting her diagnosis. Camilla stated that she attempted suicide by strangulation three weeks ago, and that she was living with a friend, Monica Clavijo, in Marrickville. Camilla's collateral medical history was reviewed, and the treating team agreed that this history highlighted that prolonged admissions were not of therapeutic benefit to Camilla. She was subsequently discharged that afternoon, for follow-up within the community and, preferably, with a female psychologist.

Engagement with Marrickville Community Mental Health Team

4.55 Between 17 February 2018 and 14 April 2018, Camilla was managed in the community while she stayed at the home of her friend, Ms Clavijo, in Marrickville. During this period, Camilla received support from the Marrickville CMH Team during times of distress and suicidality. One such occasion arose when Camilla attended court on 21 February 2018 in relation to criminal proceedings involving her ex-partner.

4.56 On 3 April 2018, following a Marrickville CMH Team meeting, it was noted that Camilla was at high risk of self-harm, with this risk being unpredictable. Arrangements were made for Camilla's caseworker, Melissa Tweedie, to follow up with Camilla regarding engagement with DBT programs. The following day, Ms Tweedie contacted Camilla, who reported attempting self-harm over the previous weekend and her belief that she would "*end up killing herself*" within the next two weeks. Camilla declined any assistance from Ms Tweedie, as well as any additional mental health support or the possibility of a hospital admission.

Admission to Royal Prince Alfred Hospital in April 2018

4.57 On 14 April 2018, Camilla was taken by ambulance to RPAH Emergency Department after collapsing at a train station due to anxiety. Camilla reported experiencing abdominal pain and feeling suicidal. On assessment it was noted that Camilla had attempted self-harm on two occasions over the previous 14 days. Camilla was admitted voluntarily and, over the following four days, she was seen by the psychiatric care and social work teams.

4.58 On 19 April 2018, Camilla requested to be discharged the follow day. She was assessed as being at a risk of suicide and ongoing self-neglect. Although it was acknowledged that Camilla's risk of self harm would remain high given her personality structure, it was noted that it was unclear whether this risk would be modifiable with a prolonged hospital admission. Accordingly, a plan was made for Camilla to be discharged the following day, after it was identified that there was no acute risk of self-harm, with follow up from the Marrickville CMH Team.

Admission to Concord Repatriation General Hospital

4.59 On 2 May 2018 Camilla presented to RPAH after being dropped off at a police station by Ms Tweedie. On review on 3 May 2018, Camilla presented as in crisis with borderline personality disorder and poor ability to cope with distress. A plan was made to admit Camilla as a voluntary patient to Concord Repatriation General Hospital (**CRGH**), however Camilla refused to leave RPAH expressing a view that she had been treated unfairly at CRGH during a previous admission. Clinical notes indicate that Camilla voiced a plan to leave the RPAH and travel to the Blue Mountains in order to jump from a specific spot, although she later denied making this comment.

4.60 Camilla was diagnosed with an acute risk of suicide that was above a chronically elevated baseline. Camilla was subsequently scheduled under the provisions of the MH Act as a mentally disordered patient and admitted to CRGH. The following day, on 4 May 2018, Camilla was discharged at her request, once her acute risk phase was deemed to have passed.

5. Events in the Blue Mountains

Saturday, 4 May 2018

5.1 After being discharged from CRGH Camilla travelled to the Blue Mountains region on the same day. At around 8:00pm, Camilla arrived at the Hotel Gearin in Katoomba, seeking overnight accommodation. Camilla was informed that there were no vacancies and when asked by a staff member if she was okay, responded, "*Not really*". Camilla made some additional enquiries regarding how to travel to the Three Sisters lookout area at Echo Point.

5.2 Camilla's conversation was overheard by Ashleigh Telford, who was working at the hotel that night. Ms Telford formed the view that Camilla was in a distressed state and not dressed warmly enough for the weather conditions in the Blue Mountains region at the time. Ms Telford engaged Camilla in conversation, telling her that she would be unable to see the Three Sisters at night time, and offered Camilla the spare bed in her twin room upstairs. Ms Telford obtained a flannelette shirt and some socks for Camilla and ordered a pizza for them to share for dinner, hoping to persuade Camilla not to leave the hotel. Camilla agreed to stay on the condition that Ms Telford was to take her to Echo Point during the day.

5.3 Ms Telford continued with attempts to engage Camilla that night but found that the conversation was "stunted", with Camilla seeming to be "not really present". At some point the conversation began to decline and Camilla appeared depressed, asking Ms Telford if she could give her some phone numbers (with one of the numbers being for Michele) in case anything happened to her over the next few days. Camilla also asked a number of questions, including the height of the Three Sisters and whether she would die if she slept outside overnight, which raised concerns by Ms Telford for Camilla's mental welfare.

5.4 Using the number given to her by Camilla, Ms Telford made an excuse to go to the bathroom and called Michele to explain the situation. Michele informed Ms Telford that Camilla had serious mental health issues and that Ms Telford should call the police if she became concerned for Camilla. Ms Telford subsequently gave her phone to Camilla to allow her to speak with Michele.

After eating the pizza, Camilla went to bed. After speaking with another staff member, Ms Telford decided to call the police to ask for their assistance.

5.5 Sergeant Brett Mills arrived at the hotel at approximately 10:00pm and spoke with Ms Telford. Sergeant Mills then went to see Camilla in the upstairs room and spoke with her, noting that she appeared to have a depressed mood and was constantly putting herself down. Sergeant Mills enquired as to the purpose of Camilla's trip to Katoomba, and she reported that she wanted to clear her head and see the Three Sisters. Whilst admitting to previous self-harm attempts, Camilla denied wanting to hurt herself. Camilla also made repeated references to a storage unit (which contained photos and her university degree) that she had told Michele about in the event that something happened to her. As a result of the conversation, Sergeant Mills became concerned for Camilla's welfare and formed the view that she had travelled to Katoomba with the intention of harming herself. Sergeant Mills suggested to Camilla that she accompanied him to hospital in order to speak to a mental health staff member. Whilst initially reluctant, Camilla eventually agreed, with the assistance of Ms Telford, to accompany Sergeant Mills voluntarily. As there was no ambulance available, Sergeant Mills drove Camilla to Blue Mountains District ANZAC Memorial Hospital (**Blue Mountains Hospital**), with Ms Telford accompanying them. Blue Mountains Hospital is located within the Nepean Blue Mountains Local Health District (**NBMLHD**).

5.6 On arrival, Camilla was reviewed by a medical officer in the Emergency Department and referred for a telepsych assessment through the triage and assessment Centre. This is a mental health patient review service operating from Nepean Hospital, with the telepsych assessment conducted via audio-visual link after hours, when no psychiatric registrar is available on site at Blue Mountains Hospital.

5.7 The telepsych assessment was conducted between around 2:00am and 3:00am on 5 May 2018 by Dr Nicholas Stubbs, the on-call psychiatry registrar. At the time of assessment, Dr Stubbs had access to electronic medical records which disclosed that Camilla had an established diagnosis of borderline personality disorder, and that she had previously attempted self-harm, including by medication overdose. Dr Stubbs was also aware of Camilla's recent admissions to RPAH and CRGH, although he did not have access to any of the progress notes that had been taken at CRGH. Relevantly, Dr Stubbs was unaware that Camilla had conveyed a planned to travel to the Blue Mountains region in order to jump from a specific spot.

5.8 On assessment, Camilla denied any suicidality and told Dr Stubbs that she had come to the Blue Mountains "for some fresh air". Camilla informed Dr Stubbs that she did not want to be admitted to hospital, and expressed the belief that she had decision-making capacity. She also specifically denied having any plan to take her own life. Following consultation with the on call consultant psychiatrist, Dr Sean Stanek, a decision was made to discharge Camilla later that morning, with follow-up to be conducted by the local acute mental health team.

5.9 Following the assessment, Camilla remained in the emergency department and was discharged later that morning.

Saturday, 5 May 2018

5.10 Ms Telford attended Blue Mountains Hospital at around 9:00am on 5 May 2018 with the intention of visiting Camilla. However, on arrival, Ms Telford found (to her surprise) that Camilla was in the process of being discharged, and Camilla was later discharged into the care of Ms Telford. Upon discharge, Camilla insisted that Ms Telford keep to her promise made the previous evening to take her to Echo Point. Whilst understandably concerned for Camilla's welfare, but unsure of what else to do, Ms Telford suggested that they walk to the lookout area, rather than catch the bus, in order to give herself more time to assess the situation. Whilst walking, Camilla repeatedly asked Ms Telford whether Michele had called the police (with Ms Telford repeating that she had in fact done that), and indicated that she wanted to provide Ms Telford with the phone number for her storage unit. Ms Telford formed the view that although she remained concerned for Camilla's welfare, Camilla did not appear to be as incoherent or erratic as the previous evening, and appeared to be relatively calm.

5.11 Upon arrival at Echo Point, Camilla ran to the safety fence at the lookout and then ran to the lower level, appearing to have no interest in the scenery. Concerned that Camilla was going to jump from a cliff area, Ms Telford followed Camilla as closely as possible, holding her arm and attempting to guide her away from the lower platform viewing areas. Ms Telford also attempted to lead Camilla away from Echo Point and back into Katoomba but Camilla maintained that she wanted to be left on her own and attempted to persuade Ms Telford to leave her. Still concerned, Ms Telford sought the assistance of a bystander who ran to the Echo Point Visitor Centre, where a staff member contacted police.

5.12 During this time, Ms Telford engaged Camilla in conversation, confronting Camilla about the need to return to hospital, telling her that suicide was not a solution to her problems, that she would not let Camilla harm herself, and that other people would miss her. In response, Camilla vacillated between saying that she would not do anything when Ms Telford was around, whilst at the same time commenting that suicide was the only solution for her.

5.13 At around 11:30am, Senior Constable Robert Porley attended Echo point and found Camilla and Ms Telford. Camilla, who was crying while she spoke, indicated that she was unable to cope with life and wanted to end it by jumping off the cliff. In contrast to what she had told Sergeant Mills the previous evening, Camilla indicated that she had travelled to Katoomba with the specific intention of ending her life.

5.14 Senior Constable Porley spoke with Camilla for some time and made arrangements for her to be conveyed to Blue Mountains Hospital by ambulance for a mental health assessment. Camilla remained insistent on staying at Echo point in order to kill herself, requiring her to be physically restrained, but eventually was persuaded to be taken by ambulance to hospital. Upon her departure, Ms Telford asked Camilla to call her when she got better. Ms Telford later sent Camilla the following text message: "*I'm sorry you are going through what you are going through. Please call me if you need anything. I'd like for us to be friends. Hang on. I care for you and want you to get to the other side*".

5.15 Upon arrival at Blue Mountains Hospital, Senior Constable Porley remained with Camilla, while she waited to be triaged and assess. Senior Constable Porley noted that Camilla appeared agitated and nervous, and she repeatedly told him that she wanted to end her life. Camilla asked Senior Constable Porley what was the best way to accomplish this, and Senior Constable Porley told Camilla that her life was important and our actions would affect her mother and other family members. At one point, Camilla pleaded with Senior Constable Porley to kill her and asked him what she needed to do in order for a police officer to kill her. Senior Constable Porley emphasised that there was no way that this would occur, and told Camilla that he was there to assist her to seek help.

5.16 Following triage, Camilla was admitted to the mental health ward pursuant to the provisions of the MH Act.

Sunday , 6 May 2018

5.17 On 6 May 2018, Camilla was reviewed by Dr Asvini Nagarah, psychiatry registrar. Camilla reported that she had nothing to live for an hospital was only prolonging her life. A plan was formulated to continue Camilla's admission and to obtain collateral records from CRGH. Upon nursing review later that evening, Camilla presented as having low mood and making constant references to ideas of self-harm. During the course of the evening, Michele contacted hospital staff, concerned for Camilla's safety, and requesting that she be referred for DBT.

Monday, 7 May 2018

5.18 On 7 May 2018, Camilla was reviewed by Dr Stanek and Dr James Lawler, psychiatry registrar. Camilla was noted to be distressed, ambivalent and described suicidal ideas. She refused to provide consent for any contact to be made with any family members, including Michele. Concerns were raised regarding the fixated nature of Camilla's plan to harm herself, and she was formally detained further as a mentally disordered patient, with attempts made to obtain further information from previous training services such as CRGH.

5.19 During the afternoon, Dr Lawler received a triage note from Camilla's previous admission to CRGH. He noted that Camilla had a plan to travel to the Blue Mountains and jump off one of the lookouts, and that "*her plan for suicide appears to be quite fixed and played out in the days after discharge*".

Tuesday, 8 May 2018

5.20 Upon review by Dr Stanek and Dr Lawler on 8 May 2018, Camilla was noted to be more argumentative, and unwilling to discuss any plans, either positive or negative. Later in the morning, Camilla was reviewed by a social worker and indicated that she wanted her status changed to a voluntary patient so that she could be discharged. At around lunchtime, nursing staff reported to Dr Lawler that Camilla had expressed a desire to leave the ward and jump from the Echo point Lookout. Both Dr Stanek and Dr Lawler informed Camilla that her plan was not rational and that she would not be discharged. During the course of the day, Michele spoke with the nursing staff, requesting information regarding when Camilla would be discharged. Michele was advised that Camilla had not provided consent for information regarding her treatment to be shared.

5.21 Nursing entries for 8 May 2018 disclose that Camilla was anxious, agitated, and to be low in mood. It was also noted that Camilla displayed "*possible persecutory thinking*" together with paranoia, with themes of hopelessness and worthlessness being features of her presentation.

Wednesday, 9 May 2018

5.22 On 9 May 2018, Dr Lawler spoke with Ms Tweedie and obtained information regarding Camilla's previous history of borderline personality disorder, with multiple admissions to various hospitals in Sydney, exhibiting suicidality. Ms Tweedie reported that Camilla had been difficult to engage during the months that she had known her, and felt that limited therapeutic gains had been made with Camilla. Ms Tweedie also noted that there were both public and private DBT services available for Camilla to engage with, but that she was generally reluctant to do so.

5.23 During the course of the day, Dr Lawler telephoned Ms Clavijo (with Camilla's consent) in order to follow up on a call made by Ms Clavijo to Blue Mountains Hospital on 7 May 2018. Whilst there are some factual differences between Dr Lawler and Ms Clavijo regarding the content of their conversation, Ms Clavijo expressed difficulty in having Camilla stay with her due to Camilla's reluctance to engage in psychotherapy, and recurrent themes in Camilla's behaviour involving paranoia and false accusations of sexual harassment. Notwithstanding, Ms Clavijo indicated that she was content for Camilla to be discharged to stay with her, but requested some guidance regarding her management. In response, Dr Lawler suggested that some boundary setting would be appropriate.

5.24 Dr Stanek and Dr Lawler reviewed Camilla again in the afternoon. It was noted that Camilla expressed suicidal ideas but that she was "*quite vague*" about her plans. Further, Dr Lawler noted:

> We could argue whether we should keep Camilla as an involuntary patient for a further time due to the risk of harm to herself, rational behaviour. However, there seems to be absolutely no benefit she would receive from this as this is her chronic state. We have encouraged her to go home tomorrow and engage with the community mental health team the further management.

5.25 Later that evening, Dr Stanek recorded a retrospective progress note entry, indicating that the most marked feature of Camilla's admission was ambivalence regarding treatment and her future plans. Dr Stanek concluded that Camilla's involuntary admission would not be continued pursuant to the MH Act (noting that, to date, she had been admitted for three days as a mentally disordered patient), having regard to her history and the likelihood that Camilla would become frustrated and dysphoric. In addition, Dr Stanek noted that he did not consider Camilla would benefit from a prolonged admission. In coming to the decision to discharge Camilla, Dr Stanek consulted with Dr Kathryn Drew, the Medical Director of the NBMLHD, who expressed her support for the plan to discharge Camilla upon the expiration of her three days of involuntary admission.

Thursday, 10 May 2018

5.26 At around 8:00am on 10 May 2018, Camilla was reviewed for the final time by Dr Stanek, and it was noted that she appeared to have maintained a future focus, agreeing to return back to Marrickville.

Further, Camilla appeared concerned about the possibility of missing a previously arranged appointment in Burwood on that day, and accepted a social work intervention for this appointment to be rescheduled. Upon discharge, it was noted that follow-up for Camilla was to be organised through the Marrickville CMH Team.

5.27 Ms Clavijo called Blue Mountains Hospital at around 11:00am and spoke with RN Jennie McHalick, who informed her that Camilla would be discharged at around lunchtime. Ms Clavijo expressed concern that Camilla intended self-harm, and indicated that Camilla had previously said that she would not be coming back. On this basis, Ms Clavijo queried the decision to discharge Camilla.

5.28 As Dr Stanek was no longer at the hospital at this time (having left to attend to patients in his private practice) RN McHalick spoke with Dr Pauline Byrne, a consultant psychiatrist who was on site. Although Dr Byrne had not reviewed Camilla personally at any time during her admission, she was aware of Camilla from her attendance at the multidisciplinary meeting on the morning of 10 May 2018 when Camilla's case had been discussed. Dr Byrne was aware that Camilla had a history of presentations to other mental health inpatient units, that she had a chronic high risk of suicidality, that she had previously been diagnosed with borderline personality disorder, and that she had been brought to Blue Mountains Hospital for a second time after travelling to Echo point with a specific suicide plan. Dr Byrne expressed the view that Camilla was suitable for discharge.

5.29 At around 11:00am, Camilla was discharged from the Blue Mountains Hospital mental health unit. According to receipts later found in Camilla's handbag, it appears that she took a taxi from the hospital to Katoomba CBD where she purchased a beanie from a retail store at 1:54pm. Camilla subsequently took another taxi to Echo point, arriving at around 3:33pm.

5.30 At around 3:35pm an employee of the National Parks and Wildlife Service observed Camilla to be falling from the lower observation platform of the Echo Point Lookout to the valley below, a distance of approximately 180 metres. Enquiries made with a witness in the area established that Camilla had been witnessed to jump from the platform moments earlier. Emergency services were contacted and, with the assistance of a police helicopter, Camilla was located in a section of the valley below the Lookout platform, with no signs of life and having sustained catastrophic injuries.

6. The postmortem examination

6.1 Camilla was later taken to the Department of Forensic Medicine in Sydney where a postmortem examination was performed by Dr Jennifer Pokorny, forensic pathologist, on 14 May 2018. A computed tomography scan identified multiple blunt force injuries including base of skull and facial fractures, multiple spinal fractures, multiple bilateral rib fractures with bilateral pneumothoraces, complex fractures of the pelvis and fractures of both lower limbs. Routine toxicological analysis detected a therapeutic concentration of mirtazapine, together with concentrations of diazepam, nordiazepam and paracetamol.

6.2 In the autopsy report dated 31 May 2018, Dr Pokorny opined that the cause of Camilla's death was multiple blunt force injuries.

7. What issues did the inquest examine?

7.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues:

(1) Whether Camilla was adequately assessed for her mental health condition, at Royal Prince Alfred Hospital, on 2 May 2018?

(2) Whether Camilla was adequately assessed and treated at Concord General Repatriation Hospital, on 3 May 2018 to 4 May 2018?

(3) Whether Camilla's discharge on 4 May 2018 from Concord General Repatriation Hospital was appropriate, and complied with the relevant policies and procedures?

(4) Whether Camilla received adequate care and treatment at Blue Mountains District ANZAC Memorial Hospital, from 4 May 2018 to 5 May 2018?

(5) Whether Camilla's discharge on 5 May 2018, from Blue Mountains District ANZAC Memorial Hospital was appropriate, and complied with relevant policies and procedures?

(6) Whether Camilla received adequate care and treatment at Blue Mountains District ANZAC Memorial Hospital, during her admission from 5 May 2018 to 10 May 2018?

(7) Whether Camilla's discharge on 10 May 2018, from Blue Mountains District ANZAC Memorial Hospital was appropriate, and complied with the relevant policies and procedures?

(8) Whether there are any recommendations that are necessary or desirable to make in relation to any matter connected with Camilla's death, for example, is there a need for specialist units which provide longer periods of inpatient care, for the evaluation and management of persons diagnosed with severe personality disorders?

7.2 Each of the above issues is discussed in detail below, and it will be convenient to consider some of the issues together. In order to assist with consideration of some of these issues, an opinion was sought from Dr Olav Nielssen, consultant forensic psychiatrist. Dr Nielssen provided a report which was included in the brief of evidence tendered at inquest, and also gave evidence during the hearing.

8. Was Camilla appropriately assessed at Royal Prince Alfred Hospital on 2 May 2018?

8.1 In his report dated 14 July 2020, Dr Nielssen notes that Camilla presented to RPAH on 2 May 2018 because of abdominal pain, and not because of depression or suicidal ideation. Despite this, it was identified that Camilla had a history of suicidal ideation and planning, and related psychiatric care. This resulted in Camilla being detained as a mentally disordered person pursuant to the provisions of the MH Act. Dr Nielssen notes that this was done "*on the assumption that [Camilla's] state of mind was a temporary response to a crisis and that she would not require a long admission. The decision was informed by the history of numerous previous brief emissions in similar circumstances*".

8.2 **Conclusion:** Given the nature of Camilla's presentation on 2 May 2018, and the subsequent identification of her relevant mental health history, it was appropriate for Camilla to be admitted on 2 May 2018. The available evidence indicates that Camilla was discharged two days later when it was deemed that any acute risk associated with her chronic suicidality had passed. Therefore, the assessment conducted at RPAH was appropriate.

9. Was Camilla appropriately assessed at Concord General Repatriation Hospital on 3 and 4 May 2018, and was her discharge on 4 May 2018 appropriate?

9.1 Dr Nielssen noted that the records of Camilla's admission to CRGH are less detailed than her other brief inpatient admissions, possibly suggesting that Camilla was not as thoroughly evaluated prior to discharge. However, Dr Nielssen also noted that Camilla was reviewed by a specialist psychiatrist before discharge and agreed with the formulated plan for follow-up and management by the Marrickville CMH Team.

9.2 Dr Nielssen also noted that it would have been preferable to detain Camilla at CRGH for a longer period of time and to have attempted to establish adequate treatment for severe mood disorder. Further, Dr Nielssen noted the following:

> However, it seems the assessing doctors were willing to take [Camilla] on her word that she did not plan to commit suicide, that she had a place to live and that she had an established relationship with her case manager, and to see her threat of suicide as a response to a crisis triggered by discussing distressing experiences with the police the previous day. It is difficult to say whether it was reasonable in the circumstances to take her on her word, as it would depend on her presentation that day. However, [Camilla] was familiar with the routine of admission and discharge from psychiatric hospitals, and one can assume that she wanted to be discharged and was able to convince the psychiatrist who assessed her that she did not need to be in hospital.
>
> It is also within an acceptable standard of care to accept a patient's assurance that they do not intend to commit suicide, unless there is information to the contrary, for example, in the circumstances of admission, preparations for suicide, the presence of very severe depression or active psychotic illness.

9.3 **Conclusion:** Given that the clinicians at CRGH were best placed to assess Camilla's presentation firsthand at the time of discharge, there is no evidence to suggest that this assessment was either unreasonable or inadequate. Further, noting the opinion expressed by Dr Nielssen, and in the absence of any evidence inconsistent with Camilla's reassurance that she had no active suicidal plans, it cannot be said that the decision to discharge Camilla was inappropriate.

10. Did Camilla receive adequate care and treatment at Blue Mountains District ANZAC Memorial Hospital, from 4 May 2018 to 5 May 2018, and was her discharge on 5 May 2018 appropriate?

10.1 As noted above, Dr Stubbs did not have access to the records from Camilla's admission to CRGH in which she disclosed a plan to travel to the Blue Mountains to jump from a specific spot, and Camilla did not make reference to this during the telepsych assessment. Dr Stubbs gave evidence that had he known that Camilla had a longer-standing premediated plan, then it "*would have made some difference*" in his assessment of her. Dr Stubbs acknowledged that this was "*an important piece of information and one that [he] would like to have discussed more at length with Camilla*".

10.2 Dr Stubbs also indicated that awareness of such a plan was one factor (taken in consideration with other factors, such as Camilla's capacity to make reasonable and rational decisions, and whether she had a major treatable mental illness that could benefit from inpatient management) that might have persuaded him that Camilla should be involuntarily detained pursuant to the MH Act. Notwithstanding, Dr Stubbs was unable to be definitive as to whether awareness of this plan would have resulted in Camilla's involuntary admission. Dr Stubbs summarised the issue in this way:

> With the, I suppose with the benefit of retrospect, I certainly would have behaved differently towards Camilla and the question of whether I would have detained her on that particular night and whether I would have had the legal right to detain her on that night is a difficult question.

10.3 Dr Nielssen noted that the assessment interview conducted by Dr Stubbs elicited the main aspects of Camilla's history, and that she was subsequently admitted to the ward for observation. However, Dr Nielssen expressed the following view:

> […] [Camilla] was allowed to take her discharge before an adequate review of her longitudinal history and without an adequate plan for the longer term care, and hence she could not be said to have been adequately assessed or treated on that occasion.

10.4 In evidence, Dr Stubbs acknowledged that as part of his assessment of Camilla, he did not speak to Ms Telford or to any members of Camilla's family, noting that it was around 3:00am at the time. However, Dr Stubbs described that it was "*probably a weakness in [his] discharge plan*" for no attempt to be made by him, or any other staff member, to speak with Camilla's family or friends prior to her discharge. Dr Stubbs indicated that it was his "*hope*" that this would be pursued by a community mental health team upon discharge, but also accepted that at least contacting Ms Telford prior to Camilla's discharge was "*perhaps something that could have been done*". Further, Dr Stubbs did not make any recommendation for Camilla to be assessed by a member of the psychiatry staff prior to discharge. When asked whether he would take such a step now, Dr Stubbs indicated:

> Knowing what I know now about Camilla, I certainly would. Would I do it for every other patient in her situation, no, I couldn't answer to that. It's a very complicated question.

10.5 In order to investigate the issue relevant to Camilla's case regarding the accessing and sharing of information regarding mental health patient presentations across different Local Health Districts, an enquiry was directed to NSW Health. In response, NSW Health advised of a number of developments to address this issue :

(a) the HealtheNet Clinical Portal, which "*enables summary patient information to be shared across Local Health Districts*";

(b) discharge summaries from inpatient and community mental health services able to be sent from the NSW Health Electronic Medical Record (**eMR**) to the HealtheNet, with implementation of such functionality being planned for NBMLHD;

(c) in mid-2020, NBMLHD became a user of the Clinical Health Information Exchange, which "*is a clinical repository that provides clinicians with access to more detailed clinical information contributed by multiple eMR systems in a single unified view*"; and

(d) funding received by NSW Health to support the initial phase of the Single Digital Patient Record program, which seeks to consolidate existing eMR and Patient Administration Systems, and "*ensure that all patient records [including records related to mental health services] can be accessed in any public health facility around the state in near real-time*", with the procurement phase scheduled to be completed in the first quarter of 2022.

10.6 **Conclusion:** The available evidence establishes that on 5 May 2018 there was a missed opportunity to obtain and review a longitudinal history for Camilla prior to her discharge. This omission was acknowledged by Dr Stubbs who gave evidence that further steps could have been taken to perform this review. The result is that Camilla was not adequately assessed prior to being discharged.

10.7 It is clear that Dr Stubbs did not have available to him an important piece of information that Camilla had disclosed only several days earlier, regarding a premeditated planned to travel to the Blue Mountains in order to self-harm. Clearly, had this information been available, it would have factored into Dr Stubbs' reasoning process as to whether or not Camilla ought to have been involuntarily detained. However, it is not possible now, to reach any conclusion as to whether this information would have resulted in an involuntary admission for Camilla.

10.8 As submitted by counsel for Michele, it is less than ideal that clinicians at times must "*scramble and search to piece together a patient's history*", when that patient has a number of presentations across different mental health inpatient units. Since May 2018, NSW Health has implemented, and is in the process of implementing, a number of developments which seeks to address the fundamental challenge of fragmented electronic patient records across New South Wales, in order to improve the continuity and safety of patient care. Having regard to these welcome developments, it is neither necessary nor desirable for any recommendation pursuant to section 82 of the Act to be made.

11. Did Camilla receive adequate care and treatment at Blue Mountains District ANZAC Memorial Hospital, during her admission from 5 May 2018 to 10 May 2018?

11.1 Dr Nielssen noted that upon Camilla's second presentation to Blue Mountains Hospital on 5 May 2018, she was appropriately detained as a mentally disordered patient, consistent with her presumed diagnosis and the available information as to the need for temporary protection from harm to herself. Dr Nielssen also considered that an appropriate assessment was conducted, a reasonably complete history was taken, and that an appropriate level of observation was ordered for Camilla.

11.2 Overall, Dr Nelson opined that Camilla appeared to receive an appropriate level of medical review during the course of her admission, whilst noting two apparent shortcomings in his report regarding Camilla's treatment:

(a) First, a possible reliance on sedating medication, rather than resuming treatment with antidepressant medication, given Camilla's degree of dysphoria and her history of past treatment with that class of medication; and

(b) Second, possibly not giving adequate weight to nursing entries in the progress notes on 9 May 2018, which suggested that Camilla remained very distressed and preoccupied with ideas of ending her life.

11.3 As to the first matter, Dr Stanek gave evidence that he did not consider antidepressant medication to be a "treatment of choice" for Camilla, and expressed the view that such medication would not have made "much difference" for Camilla. Dr Stanek disagreed with the assumption that antidepressant medication would treat Camilla's dysphoria, describing it as "a complex amalgam of other psychosocial difficulties which she was struggling to come to grips with".

11.4 As to the second matter, Dr Stanek gave evidence that he reviewed Camilla on two occasions on 9 May 2018, and took into account a variety of factors including observations by nursing staff, his own observations, and discussions within a multidisciplinary team context. Ultimately, Dr Stanek indicated the following:

> […] I understand the nursing staff have very close contact with patients and I did try to take that into account at that particular time.

11.5 In evidence, Dr Nielssen acknowledged that the question of treatment options for a particular patient is open to genuine debate amongst clinicians and that reasonable minds may differ regarding available options as to medication. Dr Nelson explained:

> Yeah, I think that's a very reasonable comment actually and neither argument is on very strong scientific ground, so there's no definitive right or wrong answer and I always tend to defer to people who have actually got to know and assess people face to face. They've got a better idea perhaps of what is needed. The emerging research is interesting in the sense that the neurological pathways of effect of antidepressant medication seem to be quite different to those of psychotherapy and our research from our online treatment service which has very good results, is that people who have been on antidepressant medication who are still depressed and haven't responded, respond equally well to evidence based psychological treatment. So yeah, both kinds of treatment do have a good effect [...]

11.6 As to the issue regarding the weight to be given to the nursing progress note entries from 9 May 2018, Dr Nielssen again deferred to the observation of Dr Stanek "*on the ground*". Dr Nielssen explained:

> [Dr Stanek has] obviously been very diligent in seeing Ms Margolis and he has to make a judgment and we cannot predict what people are going to do quite often and I would defer to him in his decision.

11.7 One final matter considered by Dr Nielssen was whether Camilla's history of multiple hospital admissions raises the need for a specialist unit, or units, that are able to provide longer periods of inpatient care for the evaluation and management of people diagnosed with severe personality disorder. Dr Nelson opined:

> [Camilla's] history of as many as twenty admissions to at least nine different psychiatric hospitals over a period of several years suggests that [Camilla] placed a significant burden on the health system without ever receiving consistent care or having her particular needs met. Presenting to hospitals outside the area in which a person normally resides carries the risk of being assessed by clinicians who are unfamiliar with the person's condition or do not have access to all of the information needed to make a complete assessment, and reduces the likelihood of receiving appropriate post discharge care.

11.8 However, Dr Nelson noted that the only unit in New South Wales that has been able to provide longer term inpatient care for people with severe personality disorder has been a complex trauma service offered at Westmead Hospital, which only accommodates involuntary patients with leave provisions. Dr Nielssen gave evidence that in "*all other services there's just immense pressure to discharge people*", with the mean duration of admission being about nine days. Further, Dr Nielssen noted that whilst attempts have been made in the United Kingdom to create wards for people with severe personality disorder (with a forensic focus), these attempts have been abandoned after being found to be unhelpful and costly.

11.9 It is evident that the issues surrounding the availability treating arrangements involving specialist units that provide longer period of inpatient care, and their utility, are complex. Although such issues have been considered abroad, with apparent limited success, Dr Nielssen gave evidence that

nothing similar has been considered within New South Wales. Given these limitations, and the fact that NSW Health was not a sufficiently interested party at the inquest, further consideration of these issues is beyond the scope of the inquest.

11.10 **Conclusion:** The evidence establishes that the care and treatment provided to Camilla during her admission to Blue Mountains Hospital between 5 and 10 May 2018 was adequate and appropriate. Although a different approach may have been taken regarding the use of sedating or antidepressant medication for Camilla, it is acknowledged that reasonable, but differing, views may be held by clinicians, with those clinicians having the opportunity to assess a patient first-hand being typically best placed to make such treatment decisions. Further, there is no conclusive evidence that observations made by nursing staff on 9 May 2018 were not appropriately taken into account so as to result in any inadequacy regarding Camilla's course of treatment.

12. Was Camilla's discharge on 10 May 2018 from Blue Mountains District ANZAC Memorial Hospital appropriate, and did it comply with any relevant policies and procedures?

12.1 Evidence given during the course of the inquest focused on two particular aspects of Camilla's discharge from Blue Mountains Hospital:

(a) First, an issue arose regarding information provided by Ms Clavijo, and the response to this information.

(b) Second, an issue arose in relation to discharge planning for Camilla.

Information conveyed by Ms Clavijo on 10 May 2018

12.2 At around 11:00am on 10 May 2018, Ms Clavijo called Blue Mountains Hospital and spoke with Rn McHalick. In a progress note entry, recorded retrospectively, RN McHalick described the conversation in the following way:

> Phone call received from Monica at approximately 11, prior to Camilla leaving the ward. Monica reported that Camilla had called her and told her that she was to be discharged on that day. Monica was anxious because Camilla had told her that she wouldn't be coming back and could she say goodbye to someone for her. Monica believed Camilla's intention was to kill herself. She asked the writer her opinion about the decision to discharge Camilla. Dr Stanek was not available to refer the call to because he had left the ward, but Dr Byrne was in the office at the time so you put Monica on hold and spoke to Dr Byrne, requesting advice about what to say. Dr Byrne was not Camilla's treating psychiatrist, but was aware of her case and treatment decisions. Dr Byrne concurred with Dr Stanek's decision to discharge Camilla due to his assessment that further treatment in hospital would not be of benefit to Camilla.

12.3 At the time of Ms Clavijo's call, both RN McHalick and Dr Byrne were in the nurses' office on the ward. After placing Ms Clavijo on hold, RN McHalick and Dr Byrne had a discussion that, according to Dr Byrne, "*wouldn't have been more than a few minutes*". On the basis of what she was told, Dr Byrne did not consider there was any need to either review Camilla's progress notes, or to review Camilla herself. Ultimately, Dr Byrne indicated to RN McHalick that there was no need to depart

from the discharge plan that had been formulated for Camilla earlier that morning. When asked about the basis upon which she formed her opinion, Dr Byrne explained:

> Well, I guess I was basing my opinion on the discussions that had taken place in the multidisciplinary meetings and, as I say, my own, you know, habit of reviewing the clinician notes in the mornings before the handover meeting. So that I, you know, the discussion around the decision to discharge had been an ongoing discussion within the multidisciplinary meetings, so I felt like I had an overview sufficient to understand the complexities of the case and the difficulties around the decision making.

12.4 RN McHalick gave evidence that she did not think to call Dr Stanek to inform him of Ms Clavijo's call, and that she did not know whether Dr Stanek was, in fact, available by phone at the time. Dr Byrne gave evidence that if Dr Stanek had been available on the ward she would not have discussed Ms Clavijo's call at all and would have referred RN McHalick to Dr Stanek. However, Dr Byrne gave evidence that it was her understanding that on Thursdays Dr Stanek was not on the ward and not available to be contacted. Dr Byrne explained:

> I didn't even consider consulting Dr Stanek because it isn't my practice to do that on Thursdays. It's my understanding that he's not available. You know, that's my experience. So I was trying to do the best I could with the situation.

12.5 Dr Stanek gave evidence that he was available by phone after leaving Blue Mountains Hospital on the morning of 10 May 2018, and that his phone number was known to relevant hospital staff. Further, Dr Stanek described the information conveyed by Ms Clavijo as both "*new and significant*" and said that he had an expectation that he would be told about this information on 10 May 2018 or that, at least, some attempt would have been to convey the information to him. When asked about the importance of this, Dr Stanek explained:

> You can't meddle with my patient. You know, we often - there are two psychiatrists on our ward and we often certainly discuss patients but the primary responsibility for management of that patient remains with either myself or the other doctor. Initially if we can't be contacted - so the initial point of contact is either the registrar or, if that's not possible - primarily if that's not possible, certainly me and I would've expected there to be at least an attempt to do that. As far as I was aware, there was no attempt.

12.6 Further, when asked what he would have done if told about the "*new and significant information*" from Ms Clavijo, Dr Stanek gave evidence that "*it would probably have changed [his] view] on discharging [Camilla]*", and explained:

> It was new information for me. I would've expected to be contacted or at least an attempt to be contacted about that and, secondly, it is highly likely that I would've asked for [Camilla] to be detained so I could review her the next day.

12.7 Dr Kristof Mikes-Liu, the Medical Director, Mental Health at Blue Mountains Hospital gave evidence that he expected Dr Byrne would sufficiently familiarise herself with Camilla's circumstances to allow her to reach a conclusion as to whether any departure from the discharge plan for Camilla

was required, based on the information conveyed by Ms Clavijo. As to Dr Byrne's assessment, Dr Mikes-Liu explained:

> […] I think at that time unless there was a way that Dr Stanek could be contacted, [Dr Byrne] would have made a decision based on the information available to her and her best understanding of Camilla's case, situation.

12.8 As to the question of contact, Dr Mikes-Liu gave evidence that, as a general matter, consultants may either be asked to be informed or updated about their patients when absent from the ward, or may defer to consultants on the ward at the relevant time. Ultimately, Dr Mikes-Liu considered that this issue ultimately rests with an individual consultant, "*informed by the thinking formulation management plan as communicated in the written form or verbally or by other means of the treating team*". When asked if some formal guidance is required to ensure that the expectations of individual consultants regarding the question of contact when absent from the ward is properly understood, Dr Mikes-Liu indicated the following:

> I'm happy to follow that up. I think I've also - because the weekends is another issue where I've asked treating consultants to make sure that their thinking and their formulation and proposed treating plans are well documented to assist after hours staff in making decisions in their absence. Yes, I think all of those issues need to be maybe better articulated.

12.9 Following the conclusion of the evidence given during the inquest the NBMLHD issued a procedure titled *Mental Health: Communication and care arrangements by admitting inpatient consultants for management decisions outside of rostered hours* (**the Communication Procedure**) to clinical and administrative staff working on mental health inpatient units. The Communication Procedure provides for Senior Medical Officers (consultant psychiatrists) (**SMO**) to identify and document their preference in terms of contact when not rostered on. For example, a SMO may request not to be contacted when not rostered on, or may agree to be contacted where significant decisions need to be made or where there is a change to a patient's circumstances that warrant further discussion that cannot be deferred. Once the preference of a SMO has been documented it is to be summarised and circulated to the Duty Operations Manager, Nursing Unit Managers and inpatient SMOs, with copies stored electronically and also distributed in hard copy form to Junior Medical Officers at the beginning of each rotation.

12.10 **Conclusion:** Whilst Dr Stanek had a clear expectation that he would be told about the information conveyed by Ms Clavijo to RN McHalick on 10 May 2018, despite being absent from the ward at the time, it is evident that this expectation was either not communicated to staff on the ward, or not well understood by them. It is likely that, if told about this information, Dr Stanek would have taken a different approach to that of Dr Byrne regarding the timing of Camilla's discharge, with the possibility that her discharge would be deferred at least until the following day when Dr Stanek could review her.

12.11 Notwithstanding, it is not possible now to reach a conclusion as to whether such a deferral would, or should, have occurred. Equally, whilst Dr Stanek may have taken a different approach, there is no evidence to suggest that Dr Byrne's assessment of the information conveyed by Ms Clavijo, relevant to the issue of Camilla's discharge, was inadequate. As noted by Dr Mikes-Liu, Dr Byrne was required to sufficiently inform herself of Camilla's circumstances. Having attended the multidisciplinary meeting on the morning of 10 May 2018 when Dr Stanek was present and Camilla's discharge plan was discussed, and being of the view that Dr Stanek was unavailable following the meeting, Dr Byrne reached the conclusion on the information that was available to her at the time.

12.12 The lack of clarity regarding Dr Stanek's expectation as at May 2018 appears to be largely due to the absence of any guidance provided to clinicians regarding the need to convey such individual expectations, and methods of ensuring that such expectations are understood by other clinicians. The introduction of the Communication Procedure (which is noted to have commenced from 9 December 2021) adequately and appropriately addresses this previous deficiency. Accordingly, it is neither necessary nor desirable for any recommendation pursuant to section 82 of the Act to be made.

Discharge planning

12.13 The NSW Health Policy Directive, *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* (PD2011_015) (**the Care Coordination Policy Directive**), provides that referrals and liaison for patient transfer of care is one of the stages of care coordination. Further, as part of this stage, the Care Coordination Policy Directive provides

> […] it is important to identify what services the patient will require during the acute episode of care. Each facility is required to develop referral structures to enable staff to easily contact the relevant service providers
> […] if a need for services has been identified, a referral to the appropriate community service provider or general practitioner should be made. Follow-up by the organisation with the patient will then take place on their return to the community.

12.14 The Care Coordination Policy Directive also notes that a transfer of care checklist must be used to meet the needs of patients before leaving the hospital, and that this checklist must cover certain information including the destination of transfer and notification/transport booked. Relevantly, the policy directive notes that "*patient transport needs are to be considered in the transfer of care planning processes*".

12.15 The NSW Health Policy Directive, *Discharge Planning and Transfer of Care for consumers of NSW Health Mental Services* (PD2019_045) (**the Discharge Planning Policy Directive**) provides that one of the key principles in effective discharge planning and transfer of care is that there is continuity of care following transfer. The Discharge Planning Policy Directive notes that:

> […] effective coordination and continuity of care following transfer of care relies on clear and timely verbal communication and documentation between the treating team, the consumer, their family/carer and the receiving service.

12.16 Further, the Discharge Planning Policy Directive provides that mental health services must engage the receiving service (for example a community mental health team) in discharge planning, and provides that mental health services "*must establish a standard procedure for transferring a consumer's care that includes both verbal and written handover*". The Discharge Planning Policy Directive also notes that:

(a) mental health services must establish mechanisms to enhance the transition experience and reduce the risk of the consumer being lost to care, by facilitating the consumer's engagement with the receiving community mental health team; and

(b) transfer of care discussions should include the consumer's goals and practical considerations, including transportation needs.

12.17 Evidence given during the inquest established that at the time of her discharge on 10 May 2018 Camilla was provided with a taxi voucher. Despite Camilla's stated intention regarding the purpose of her travelling to the Blue Mountains region on 4 May 2018, and her being physically discharged to the same area, no other action was taken by Blue Mountains Hospital staff to facilitate Camilla's travel away from the area and back to Sydney. In addition, although part of Camilla's discharge plan involved her reconnecting with the CMH Team at Marrickville, no verbal handover was provided to the CMH Team at the time of discharge.

12.18 In his report, Dr Nielssen noted:

> With regards the adequacy of her transfer of care, clearly the decision to discharge [Camilla] to make her own way back to live with Ms Clavijo and to make contact with her case manager at Marrickville CHC was more in hope than with any confidence that [Camilla] would remain stable or continue psychological or other treatment. Like a great many hospital discharges (including the numerous discharges to homelessness I encounter at the Matthew Talbot Hostel clinic), [Camilla's] discharge plan and transfer of care did not fully comply with the [Care Coordination Policy Directive].

12.19 Dr Stanek gave evidence that, as at May 2018, he was aware that consideration of transport options for a patient upon their discharge was an appropriate component of the discharge and transfer of care process, but could not recall whether this was particularly important for a patient from a metropolitan area who may be discharged in a regional setting. In this regard, Dr Stanek acknowledged that it may have been "*defective judgment*" in considering that, based on his assessments of Camilla, that she would simply return to Marrickville upon being discharged. In this regard, Dr Stanek gave the following evidence:

> Look, this is one of the - one of the changes I've made to my own practice and I must admit I haven't had anybody who have been largely [geographically] distanced. We - it's not uncommon, for example, for us to get patients or me to get a patient from Blacktown, Parramatta, so many - even the South West of Sydney find themselves somehow with us, and I have certainly made it my own rule now that the discharge transport needs to be very carefully thought about. Now, often what we do is in fact even give them a taxi voucher and pay, you know, for a taxi to take them down home. Sometimes that can be with a nurse, it may not be. It's a very individual thing, but

> certainly, my practice has changed over that time to use this more and more, just make sure the patient gets home.

12.20 During the hearing, Dr Nielssen was asked whether it was incumbent on Blue Mountains Hospital staff to facilitate Camilla's travel away from the Blue Mountains area upon her discharge, given her previously stated intentions. Dr Nielssen stated:

> In terms of [Camilla's] clear intent, it's very hard to say what her clear intent was the whole time. I mean, she as I understand it bought a beanie, from a shop, after leaving the hospital. Similarly was talking about her Centrelink appointment as I understand it or that was raised. It's very hard to say that you could definitively say prospectively that she had a clear plan to commit suicide by jumping. It's really only in retrospect, when you've been able to put all that information together and also the outcome that it seems like a very strong advice that she should have been taken to somewhere away from that place she was fixated on.

12.21 In addition, during his evidence, Dr Nielssen was asked about the appropriateness of simply providing Camilla, upon discharge, with a taxi voucher to go the train station so that she could return to Sydney. Dr Nielssen indicated the following:

> It's very hard to comment on those things without using the benefit of hindsight because we know what the outcome was. But it's almost certain that the previous 20 discharges were no more securely arranged than the one at Blue Mountains and again the notes I reviewed suggest that the care at the Blue Mountains was in many ways superior to the care, certainly medical care, in some of the other presentations.

12.22 In a response provided during the coronial investigation phase, Dr Mikes-Liu acknowledged that whilst Marrickville CMH Team had been contacted during Camilla's admission, and advised on 9 May 2018 of the possibility of her discharge the following day, no verbal handover was actually provided by Blue Mountains Hospital staff upon Camilla's discharge. Dr Mikes-Liu also acknowledged the importance of a discharge team ensuring the verbal acceptance of transfer of care upon discharge.

12.23 In response to the above, in September 2018 the NBMLHD introduced the *Mental Health: Transfer of Care Procedure* (**the Transfer of Care Procedure**) which provides that as part of planning for transfer of care to the community:

(a) it should be determined whether a patient is to reside outside the Local Government Areas of NBMLHD upon their discharge;

(b) prompt contact by phone is to be made with the relevant CMH Team to discuss the transfer of care plan for a patient; and

(c) a receiving CMH Team should be regularly updated of progress and plans throughout the inpatient stay.

12.24 Further, as part of confirming readiness for transfer of care, the Transfer of Care Procedure notes that at the point of transfer, a verbal handover is to be provided to the CMH Team using the ISBAR

tool (a mnemonic used to improve safety in the transfer of critical information). This requirement for a verbal handover is relevantly noted in the Transfer of Care checklist.

12.25 Dr Mikes-Liu indicated that in February 2020 a retrospective baseline audit of verbal handover at the point of discharge in accordance with the Transfer of Care Procedure was completed which indicated more than 80% compliance. Further, the Transfer of Care procedure forms part of a quarterly education module provided as part of mental health education, and is in the preparatory stage of being embedded into the beginner career pathway within the NBMLHD.

12.26 On 29 November 2021, Dr Mikes-Liu distributed a memorandum to all NBMLHD clinical staff regarding discharge planning from inpatient mental health facilities, and patient transport needs and logistics (**the November 2021 Memorandum**), which was prepared in response to a suggestion made to Dr Mikes-Liu in evidence that consideration be given to the development of a guideline that stresses the importance of considering transport needs in planning for safe handover of care. The November 2021 Memorandum notes:

> Inpatient mental health treating teams consider and balance a number of concerns and perspectives when planning for and facilitating the discharge of a consumer.
>
> The period following discharge is recognised to be a period of increased risk for some consumers. Treating teams should consider strategies for mitigating risk on a case by case basis. Such strategies should be considered alongside the consumer's preference and wishes, as well as that of the consumer's family, carers and/or social supports. Not all risks can necessarily be removed and acknowledging risk may also be part of a person's recovery.
>
> A key element of discharge planning involves consideration of a person's formal and informal supports.

12.27 Further, the November 2021 Memorandum invites treating teams to consider a number of questions regarding logistics to assist in the discharge planning process, including where a patient may be going and their transport options, noting the following:

> Confirm disposition address. Confirm any interim arrangements. The team may discuss with the consumer and their supports strategies for avoiding or contingency planning around certain triggers. Triggers include historic or current concerns about access to certain locations or means. Consideration should be given to transport options that may reduce risk.

12.28 In addition, a team member is to be nominated as being responsible for addressing disposition issues, and confirming transport and logistics. Finally, the November 2021 Memorandum is to be integrated into an updated Local Procedure (consistent with the Discharge Planning Policy Directive), currently under review.

12.29 **Conclusion:** The evidence established that Camilla's discharge on 10 May 2018 did not comply with the Care Coordination Policy Directive. No verbal handover was provided to Marrickville CMH Team and, as acknowledged by Dr Stanek, little consideration was given to transport issues relevant to Camilla's discharge despite her previously stated intentions, beyond providing her with a taxi voucher.

12.30 However, as acknowledged by Dr Nielssen, despite the above, the likelihood of Camilla acting on her previously stated intentions upon discharge is a matter that can only be determined in retrospect. Further, Dr Nielssen's evidence established that, due to a number of practical limitations, compliance with the Care Coordination Policy Directive is, regrettably, not always achievable, and that Camilla's discharge on 10 May 2018 was likely no different from her many previous discharges from inpatient units. This, of course, does not mean that the discharge on 10 May 2018 was therefore adequate and appropriate simply by virtue of consistency, as the deficiencies with it have already been described above. However, it is noted that Dr Nielssen opined that the overall quality of care provided to Camilla at Blue Mountains Hospital was likely superior to previous inpatient settings.

12.31 The introduction of the Transfer of Care and Procedure and the November 2021 Memorandum adequately and appropriately address a number of logistical issues relevant to discharge planning identified by the inquest. Accordingly, it is neither necessary nor desirable for any recommendation pursuant to section 82 of the Act to be made.

13. Findings pursuant to section 81 of the *Coroners Act 2009*

13.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Dr Peggy Dwyer, Counsel Assisting, and her instructing solicitors, Ms Skye McKinnon and Ms Abigail Smith, from the Department of Communities and Justice, Legal. The Assisting Team has provided outstanding assistance during the conduct of the coronial investigation and throughout the course of the inquest. I am also extremely grateful for the sensitivity and empathy that they have shown throughout the course of this distressing matter.

13.2 I also thank Senior Constable Christopher Jayne for conducting a comprehensive investigation and compiling the initial brief of evidence.

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

Identity

The person who died was Camilla Margolis.

Date of death

Camilla died on 10 May 2018.

Place of death

Camilla died at Katoomba NSW 2780.

Cause of death

The cause of Camilla's death was multiple blunt force injuries.

Manner of death

Camilla died as a result of actions taken by her, in jumping from a cliff at the Echo Point Lookout, with the intention of ending her life. Camilla's death was therefore intentionally self-inflicted.

14. Epilogue

14.1 On behalf of the Coroner's Court of New South Wales and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences to Michele and the other members of Camilla's family, as well as Camilla's friends and loved ones, for their most painful and devastating loss.

14.2 At the conclusion of the evidence in the inquest, Michele graciously shared some private and treasured memories of Camilla. Michele described Camilla as a beautiful, unique person, and not someone anyone who knew her can forget. There is no doubt that Camilla will not be forgotten and remains very much alive in the hearts of her mother, and those who feel the loss of Camilla most deeply.

14.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
1 February 2022
Coroner's Court of New South Wales