CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of RA
Hearing dates:	11-14 December 2023 Lismore Local Court
Date of findings:	6 March 2024
Place of findings:	NSW Coroners Court Lidcombe NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Self-inflicted death; death in involuntary mental health care; psychiatric care; consideration of mental health care, and treatment provided by Hospital; search policy in inpatient mental health care; frequency of observation care level
File Number:	2020/205630
Representation:	Ms Laura Thomas, Counsel Assisting, instructed by Ms Rebecca Campbell (Crown Solicitor's Office). Mr Jake Harris, instructed by McCabes for Northern New South Wales Local Health District.

Non publication orders:	Non-publication orders made on 10 July 2023 prohibit the publication of any information that identifies RA or any of her relatives. A further order made on 11 December 2023 prohibits the publication of particular evidence in the brief of evidence. A copy of the orders can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was RA. **Date of death** RA died on 11 July 2020. **Place of death** RA died at Tweed Hospital, Tweed Heads NSW. **Cause of death** RA's cause of death was hypoxic ischemic encephalopathy caused by neck compression and hanging. **Manner of death** RA's death was intentionally self-inflicted and occurred during a period of involuntary care at Tweed Hospital. Her death occurred in the context of inadequate processes in relation to inpatient searches.

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Introduction

1. This inquest concerns the death of RA. RA died during a period of involuntary mental health care at the Kurrajong Unit at Tweed Hospital in Northern NSW on 11 July 2020.

2. RA was 64 years of age at the time of her death. She was highly educated and had been awarded several degrees and academic prizes. She had worked for many years as a teacher and was loved and well respected in her profession. RA was also extremely creative and was a talented poet. RA's husband read some of her work to this Court at the conclusion of the proceedings and we were able to enjoy the power and extraordinary vision created by her words.

3. RA had been married to JB since 2006. JB spoke about how his years with RA were the happiest years of his life. He described her as his best friend and the love of his life. JB says that RA was regarded by both her colleagues and students as an excellent educator and helpful teacher. JB told the Court how RA loved dogs and he spoke of the many cherished memories he has of going on long walks with RA and their dog, holding hands and sharing the details of their day with one another. He described RA as an independent, vibrant, energetic and artistic person who adored her two sons and her grandson.

4. RA had two adult sons from a previous marriage. One of her sons spoke on behalf of him and his brother at the conclusion of proceedings and described his mother as his best friend and advisor. He described the tragedy of his mother not being able to meet all of her grandchildren nor being able to watch them grow up. He described missing their daily phone calls where he used to bounce ideas off her. He said that he and his brother will always cherish the values their mother instilled in them. His profound sorrow was palpable to everyone in the courtroom.

5. RA's family have been devastated by her death and I acknowledge their grief and their courage in participating in these difficult proceedings. It was clear RA is remembered with great love.

6. RA had a history of childhood trauma. The effect of childhood trauma must never be under-estimated. As an adult RA had battled with anxiety and depression, which was often, but not always well controlled. She had been hospitalised in 2005 and 2011, but had continued to work and when well, enjoyed a happy and productive life. Following a decline in her mental health around late 2019, RA had several

hospital admissions and two suicide attempts. Following the second attempt on 3 July 2020, she was admitted to the Kurrajong Unit at Tweed Hospital on 4 July 2020.

7. The following morning, on 5 July 2020 RA was found by a nurse standing on a toilet seat and holding a cord or lace, apparently looking for a ligature point. In a separate incident later that day, RA hanged herself from the door of a different bathroom, using a different cord. She was resuscitated but never regained consciousness. RA died on 11 July 2020.

8. The circumstances of her death left her family baffled and angry as they tried to understand how RA's death could have occurred within 24 hours of arriving at a place tasked to keep her safe.

The role of the coroner and the scope of the inquest

9. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

10. There was no dispute about RA's identity nor in relation to the place, date or medical cause of her death. For this reason the Court focused on the manner or circumstances of RA's death in an attempt to understand exactly how it happened and in an attempt to make sure that more robust systems are in place to protect patients like RA in the future.

11. It should be stated from the outset that the Northern New South Wales Health District (**NNSWLHD**) participated in this inquest having already made significant changes to its systems as a result of RA's death. NNSWLHD demonstrated a willingness to reflect openly on what had occurred. The organisation acknowledged the failure to keep RA safe, in particular the inconsistency in search procedures between units which existed at the time.[3] The organisation's cooperative approach to these inquest proceedings was commendable.

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).
[3] Submissions of NNSWLHD at T 14/12/23 18.35

The evidence

12. The Court took evidence over four hearing days. The Court also received extensive documentary material in five volumes. This material included witness statements, medical records, health policies and procedures, photographs and video footage. The Court heard from a number of medical and nursing witnesses directly involved in RA's care. I acknowledge their pain at reliving the events of July 2020. Dr Vitko (a Psychiatry Registrar at the Tweed Hospital who reviewed RA prior to her death) appeared particularly distressed. I thank him for his thoughtful and courageous participation in these difficult proceedings. I have no doubt he has reflected deeply on these events and that the care he continues to provide will always be informed by his involvement in this matter.

13. The Court also heard from two independent experts about the care RA received. Associate Professor Danny Sullivan, a well-respected forensic psychiatrist reviewed RA's medical records and gave evidence about the psychiatric care RA received and Ms Claire Swanton, a nursing expert gave evidence in relation to the nursing care provided.

14. While I am unable to refer specifically to all of the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

15. A list of issues was prepared before the proceedings commenced.[4] However, an inquest can tend to crystallise the areas of real importance and I intend to deal briefly with the issues under several broad headings after setting out the chronological facts.

Background and brief chronology

16. JB's statement records that RA's early childhood was marked by emotional neglect. She was sent to boarding school at the age of seven or eight, where she suffered physical abuse and other cruel and humiliating treatment.

17. In oral evidence JB explained that RA always felt she had been unwanted and unsupported as a child. She had a difficult relationship with her mother and her experiences at boarding school left her with a continuing fear of institutions. JB said:

[4] Issues list dated 2 June 2023.

> …So the St Hilda's School experience really I think…certainly contributed to her fear of hospitals and institutions and her belief that no one cared for her, so no hospital was going to care for her, no doctor was going to care for her, and I think that was – became a real issue for her because she would not listen to the doctors. She wouldn't take their advice. And I mean I'm not saying they're right all the time either. I get that, you know, they can be wrong but she never trusted anyone to help her.

18. JB also spoke of RA's distrust of prescription medicine. She was always reluctant to stay on large doses of medication. JB says that RA was initially prescribed the antidepressant mirtazapine during her hospitalisation at St John of God at Burwood in 2011. She gradually reduced her dose from 30mg to 7mg in the following years, remaining on a dose of 7mg until around December 2018.[5]

19. JB recalls that in about December 2018, RA decided that she wanted to cease mirtazapine and gradually reduced her dose further, so that she was taking 3 mg by February 2020. In retrospect, JB considers that this change in her medication, together with anxiety precipitated by hospitalisation for a lung infection in late 2019, may have caused her worsening mental health in the period leading up to her suicide attempts and death.[6]

31 January 2020 to 16 June 2020

20. Between 31 January 2020 and 15 June 2020, RA had numerous appointments with general practitioners, two admissions to the Currumbin Clinic (lasting eight and ten days, respectively) and two shorter hospital admissions, as follows:

- On 31 January 2020 and 22 February 2020, RA had appointments with general practitioners, Michaela Rickcord and Neil Hannah at the Bay Medical Centre.[7]
- On the evening of 2 March 2020, RA presented to Ballina District Hospital complaining that she had not been able to sleep for the last three days. She was admitted and given a diagnosis of panic disorder. She was given olanzapine and discharged in the early morning of 3 March 2020 with a prescription for zopiclone.[8]

[5] Exhibit 1, Volume 1 Tab 23, Statement of JB at [8].
[6] Exhibit 1, Volume 1 Tab 23, Statement of JB at [30].
[7] Exhibit 1, Volume 4, Tab 63, Bay Centre Medical Clinic Patient Health Summary, pp. 4-5.
[8] Exhibit 1, Volume 1, Tab 26A, Ballina District Hospital Discharge Summary, p. 148.

- RA had further appointments with Dr Rickcord on 3 March 2020, 1 April 2020 and 3 April 2020.[9]
- On 3 April 2020, RA was admitted to Currumbin Clinic, where she was given a diagnosis of generalised anxiety disorder with an additional diagnosis of major depressive disorder. Her mirtazapine dose was increased to 15mg and she was also prescribed propranolol and zopiclone. She discharged herself on 11 April 2020.[10]
- Between 11 April 2020 and 29 May 2020, RA had a further six appointments with Dr Rickcord and one with Dr Hannah.[11] On 1 May 2020 she had an appointment with Dr Jamie Rickford, who prescribed cannabis oil.[12]
- On 1 June 2020, RA had a brief admission to Byron Central Hospital for abdominal pain.[13]
- On 2 June 2020, RA was again admitted to the Currumbin Clinic. On this admission she was given a diagnosis of generalised anxiety disorder and major depressive disorder, with an additional diagnosis of benzodiazepine and codeine dependency. Her discharge summary notes intermittent suicidal thoughts during her admission and that she chose to discharge herself earlier than expected, on 12 June 2020.[14] This appears to be the first record of suicidal thoughts in her medical records.
- On 15 June 2020, RA had an appointment with general practitioner Gregory Gover, also of the Bay Medical Centre.[15]

21. It is apparent throughout this period, that RA's medical practitioners struggled to find a medication regime that was effective and that she would adhere to. She was treated with various combinations of mirtazapine, diazepam, olanzapine, propranolol, zopiclone and periciazine. At times, she was also taking codeine and cannabis oil. RA complained of various unpleasant side effects from her medications and her preoccupation with these side effects contributed to her ongoing anxiety.

22. It appears that during this period, RA was also seeing a psychologist, Mee Hee Douglas. Ms Douglas provided a statement to the Court which outlined the sessions she undertook with RA. Between 25 November 2019 and 18 March 2020 she

[9] Exhibit 1, Volume 4, Tab 63, Bay Centre Medical Clinic Patient Health Summary, pp. 5-7.
[10] Exhibit 1, Volume 4, Tab 70, Currumbin Clinic Discharge Summary, pp. 81-84.
[11] Exhibit 1, Volume 4, Tab 63, Bay Centre Medical Clinic Patient Health Summary, pp. 7-10.
[12] Exhibit 1, Volume 1, Tab 26A, Referral letter dated 1 May 2020, pp. 135-136.
[13] Exhibit 1, Volume 1, Tab 26A, Byron Central Hospital Discharge Referral, p. 153.
[14] Exhibit 1, Volume 4, Tab 70, Currumbin Clinic Discharge Summary, pp. 3-5.
[15] Exhibit 1, Volume 4, Bay Centre Medical Clinic Patient Health Summary, pp. 7-10.

conducted 14 sessions with both RA and her husband JB present, and saw RA alone on only two occasions (15 and 24 June 2020). While RA had been referred to Ms Mee Hee by Dr Rickcord, it appears that much of the work the psychologist undertook with RA focussed on communication issues for the couple. I note that after the final joint session, JB indicated that he would like to continue sessions with Ms Mee Hee alone. I understand that this is what then occurred.

17 June 2020 to 2 July 2020 — first suicide attempt and Coffs Harbour Hospital

23. On 17 June 2020, RA attempted suicide by overdosing on diazepam and zopiclone (consumed with alcohol). JB became worried when he could not find RA. He called her repeatedly and eventually spoke to her over the phone. He then called police who were able to locate RA in her car.

24. RA was admitted to Coffs Harbour Hospital, where she remained until 23 June 2020. Her discharge summary notes a diagnosis of generalised anxiety disorder, intentional benzodiazepine overdose and suicidal deliberate poisoning. It also records no thoughts of self-harm and *"limited value in ongoing admission".* On discharge, RA's medications were mirtazapine, propranolol and quetiapine.[16]

25. It appears that RA saw her psychologist, Ms Douglas, on 24 June 2020.[17] She then saw Dr Rickcord on 25 June 2020 and a psychiatrist, Dr Roberto D'Angelo, on 26 June 2020 and 2 July 2020.[18] Dr D'Angelo's notes of 26 June 2020 are suggestive of ongoing suicidal ideation: *"Even last night I was still thinking about it. I do not want to die…"*. There is no suggestion of suicidal thoughts in Dr D'Angelo's notes from 2 July 2020. On 26 June 2020, his plan was for mirtazapine, quetiapine and lorazepam. On 2 July 2020 he recorded a plan to start on an SSRI (escitalopram) and limit lorazepam to 1mg daily.[19]

3 July 2020 to 4 July 2020 - second suicide attempt and Byron Central Hospital

[16] Exhibit 1, Volume 4, Tab 65B, Coffs Harbour Hospital, MH Community Discharge/Transfer pp. 1-5.
[17] Exhibit 1, Volume 4, Tab 63, Bay Centre Medical Clinic Patient Health Summary, p. 10.
[18] Exhibit 1, Volume 4, Tab 63, Bay Centre Medical Clinic Patient Health Summary, p. 10.; Exhibit 1, Volume 4, Tab 68, Dr D'Angelo's consultation notes.
[19] Exhibit 1, Volume 4, Tab 63, Bay Centre Medical Clinic Patient Health Summary, p. 10.; Exhibit 1, Volume 4, Tab 68, Dr D'Angelo's consultation notes.

26. On the evening of Friday 3 July 2020, JB found RA lying on the bathroom floor with a plastic bag over her head and a rubber band around her neck. Paramedics and police attended, and RA admitted taking lorazepam, zopiclone, temazepam and alcohol. She told paramedics that her intention was to kill herself.[20]

27. RA was admitted to Byron Central Hospital. JB told the Court that when he arrived at the hospital with her bag of clothes she was asleep. When she woke she said "*I just want to die."* He stated that she appeared terrified of *"being scheduled*". He said *"…she used to say to me, 'Don't you ever schedule me'," you know, and I think I said to her* "*Well, it's not my choice*."[21] JB also told the Court that that while RA had been anxious and depressed before, she was not someone who had regularly talked of ending her life before this period. [22]

28. On the morning of Saturday 4 July 2020 RA was reviewed by emergency department chief medical officer Sarah Tranter, who recorded that she continued to express suicidal thoughts and was "*high risk*". After consulting with JB and Dr D'Angelo, Dr Tranter scheduled RA under the *Mental Health Act 2007* and arranged for her transfer to the Tweed Hospital.[23]

29. In relation to her call with Dr D'Angelo (which appears to have occurred before 9.20am on that Saturday), Dr Tranter recorded: *"I have also discussed last night's events with her psychiatrist Dr Roberto D'Angelo who is happy to be contacted with regards to his input over the last few weeks - his number is XXXXXXXXX."*[24]

4 July 2020 to 5 July 2020 — The Tweed Hospital

30. RA was transferred to the Tweed Hospital, where she was admitted to the emergency department at about midday. She continued to express suicidal ideation and was allocated 1:1 nursing care in the ED.[25]

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[20] Exhibit 1, Volume 2, Tab 26A, Ambulance Electronic Record, pp. 59-60.
[21] T 11/12/23 16.16-20
[22] T11/12/23 17.35 onwards
[23] Exhibit 1, Volume 3, Tab 56, Medical Certificate under the Mental Health Act, pp. 3-6; Exhibit 1, Volume 3, Tab 56, Byron Central Hospital General Notes, pp. 16-17.
[24] Exhibit 1, Volume 3, Tab 56, Medical Certificate under the Mental Health Act, pp. 3-6; Exhibit 1, Volume 3, Tab 56, Byron Central Hospital General Notes, pp. 16-17.
[25] Exhibit 1, Volume 1, Tab 26A, Emergency Department Nursing Progress Notes, pp. 159-162; Exhibit 1, Volume 3, Tab 30, Statement of RN Paul Piccini-Lulham; Exhibit 1, Volume 3, Tab 31, Statement of RN Bini

31. At about 5pm, RA was assessed by Psychiatry Registrar Marc Greenhill. At the time of these events Dr Greenhill was in his second year of training.[26] His note in relation to RA was appropriately comprehensive.

32. Dr Greenhill's admission note records: *"says she would likely try again if discharged now"* and *"ongoing SI with plan to OD".* Dr Greenhill's plan included admission to the Kurrajong Low Dependency Unit with Care Level 3 (CL3), which requires nursing observations at least every 30 minutes. The plan also says, inter alia: *"Treating team to please liaise with private psychiatrist".*[27]

33. In oral evidence Dr Greenhill explained that given his review of RA occurred at the beginning of the weekend, it was unlikely that some of these steps would take place until the treating team reviewed the matter on the following Monday morning. He stated that he would have expected the following to occur:

> The team would probably try and make contact with her, RA's private psychiatrist and family, to just to get a better picture, overall picture, what was going on and then in consultation with the private psychiatrist they'd probably consider any medication changes they might feel would be appropriate. Maybe, you know, something, you know something's changed and maybe her medication mix wasn't quite right.[28]

34. Dr Greenhill's admission note is said to be *"in consultation with"* a consultant psychiatrist, Dr Navaratne. Although Dr Navarantne did not personally see RA, he recalled being consulted and had sufficient concerns about the risks involved to support her involuntary admission.[29]

35. At about 5.30pm, RA was transferred to the Kurrajong Unit. The Kurrajong Unit has a Low Dependency Unit (**LDU**) for up to 20 inpatients and a High Dependency Unit (**HDU**) for up to 5 inpatients.

Puthanpurackal Thomas; I note that the nursing progress notes also show that RN Justynne Tan cared for RA in the emergency department.

[26] T 11/12/23 24.30

[27] Exhibit 1, Volume 1, Tab 26A, Admission note, pp. 69-73.

[28] T 11/12/23 33.17-24

[29] Exhibit 1, Volume 3, Tab 51, Statement of Dr Navaratne.

36. RN Jennifer Sampson's statement says that she processed RA's admission to the Kurrajong Unit and that EN Helen Fyfe, who was allocated to care for RA, would have spent some time with RA to complete some of her admission forms.[30]

37. In her statement RN Sampson says that she recalls RA's belongings being searched, but she could not specifically recall who conducted the search. In oral evidence RN Sampson confirmed that she remembered RA's belongings being searched at the nurses' station.[31] She stated*:*

> So I – there was - it was happening around us. So there was, yeah, so I know it was being searched and I do recall with RA, yeah, things were removed from her room – removed from her bag. Some of them would be allowed in LDU but we took them, organised them to be taken away from – and not put into her room, yes"[32] .

38. RN Sampson said she remembered discussing *"cords from clothing and stuff not to be taken"* to RA's room. This discussion occurred with LDU staff and with EN Fyfe.[33]

39. EN Fyfe recalled the search of RA's property. In a statement provided to the Court she stated:

> On admission I recall being very thorough when searching her belongings to remove anything that I deemed to be a ligature risk. I cannot now recall every piece of clothing that RA had, but I removed any items that I felt were a risk, such as clothing with strings, belts and shoelaces.[34]

40. EN Fyfe also recalled removing RA's suitcase as it had straps to hold clothes down with.[35] In oral evidence she stated that while she could not recall specific items she recalled *"discussing that we would just remove all ties."*[36]

41. In oral evidence EN Fyfe could not remember what clothes or shoes RA was wearing.

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[30] Exhibit 1, Volume 3, Tab 36, Statement of RN Jennifer Sampson at [8]-[16].
[31] T 11/12/23 37.16.
[32] T 11/12/23 37.21 onwards.
[33] T 11/12/23 38.9.
[34] Exhibit 1, Volume 3, Tab 39, Statement of EN Helen Fyfe at [11].
[35] Exhibit 1, Volume 3, Tab 39, Statement of EN Helen Fyfe at [12].
[36] T 11/12/23 48.20

42. RN Sampson also says that RA would have been searched once she was taken to her allocated room.[37] However she was not present at the room search.[38]

43. Included in the Kurrajong admission records is an Admission Checklist and a Patient Property List. The Admission Checklist includes the item *"All belongings checked and hazardous items removed"*, which has been ticked as completed. The form was completed by EN Helen Fyfe.

44. EN Fyfe recorded observations of RA approximately every 30 minutes between 5.45pm and 9pm.[39] She also recorded administering diazepam at 7.10pm.[40]

45. RN Anita Duncan assumed care of RA when her shift commenced at 10pm. She recorded observations of RA approximately every 30 minutes between 10.06pm and 6.50am.[41]

Events of 5 July 2020

46. RN Cheryl Armstrong's statement records that sometime between 6.30am and 7am on 5 July 2020 RA came to the kitchen window (where RN Armstrong was making tea and coffee). RA was labile, angry and agitated and asking to be discharged. RN Armstrong told the Court that RA appeared *"driven, angry, very, very, angry and agitated."*[42] It was the first time she had met RA, apart from having seen her asleep overnight.

47. RN Armstrong explained that the registrar would be starting his shift that morning and said that RA appeared to accept that and returned to her room, ostensibly to wait.[43] Shortly after 7am, RN Armstrong was doing a ward round when she noticed that the door to RA's ensuite was shut. RN Armstrong explained her process that morning:

> …Handover starts at seven so they started the handover. I did another round because that's when things happen as a rule. It's always during the handovers…And she was

[37] Exhibit 1, Volume 3, Tab 36, Statement of RN Jennifer Sampson at [13] and [17].
[38] T11/12/23 39.12
[39] Exhibit 1, Volume 1, Tab 26A, Level 3 Observation Chart, p. 98.
[40] Exhibit 1, Volume 1, Tab 26A, Medication Administration Record, p. 270.
[41] Exhibit 1, Volume 1, Tab 26A, Level 3 observation chart, p. 98; Exhibit 1, Volume 3, Tab 33, Statement of RN Anita Duncan at [7] and [15].
[42] T 12/12/23 2.46
[43] Exhibit 1, Volume 3, Tab 38, Statement of RN Cheryl Armstrong at [13].

> – partly to look at her as well because she was so upset. …as you walk into her bedroom, as you're facing it, there's a door on the left and that's the toilet door which is shut. And I yelled out to her and she didn't reply. So I went in and she's standing on top of the toilet, on the toilet seat, and she had her arms up and she was tying something around whatever it was. They were actually her laces. She – when I asked her to get down and what she was doing, I can't remember her reply.[44]

48. RN Armstrong's statement records that RA denied that she was attempting self-harm and was agitated and angry.[45] On the Level 3 observation chart, RN Armstrong documented *"Toilet standing on lid"* at 7.20am.[46]

49. RN Armstrong took RA to the nurses' station and advised her that she would need to go into the HDU. In her statement, RN Armstrong says that the cord that she found RA with was confiscated, but this does not appear to have been documented.[47] In oral evidence RN Armstrong recalled the "shoelaces" or cord being put in a plastic bag and told the Court the usual practice would be to put a hazardous item in a plastic bag, label it and store it securely.[48] She told the Court she would not have stored it herself as she was finishing her shift.

50. RN Armstrong described RA as having had two shoelaces in her hands.[49] If there were two cords it remains troubling and unexplained that only one cord appears to have been retained at this point.

51. The police brief of evidence includes photographs of the cord, which appears to be either a shoelace or a drawstring from an item of clothing.[50] The brief did not contain a photograph of the second cord, however the OIC, Detective Sergeant Sheehan brought two cords that were seized to court. One was in a plastic bag marked "first attempt" it was given the police exhibit number X0003823797 and the second was given exhibit number X0003824743 and was recorded as being the cord found on RA following the second incident, which I will come to shortly.[51]

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[44] T 12/12/23 3.5-9
[45] Exhibit 1, Volume 3, Tab 38, Statement of RN Cheryl Armstrong at [14].
[46] Exhibit 1, Volume 1, Tab 26A, Level 3 observation chart, p. 98.
[47] Exhibit 1, Volume 3, Tab 38, Statement of RN Cheryl Armstrong at [16].
[48] T 12/12/23 3.40
[49] T 12/12/23 4.27; Exhibit 1, Volume 1, Tab 18, Photographs taken by DSC Kajewksi pp. 1-4.
[50] Exhibit 1, Volume 1, Tab 18, Photographs taken by DSC Kajewski, pp. 1-4.
[51] These items were tendered as Exhibits at the hearing and marked as Exhibit 2 and 3 respectively.

52. Detective Sheehan gave evidence that both cords appeared to be drawstrings from a hooded jumper or the drawstring from a pair of tracksuit pants. He said he formed this view based on the length of the cords and also because "*the aglet at the end of the cord is a lot thicker than it would ordinarily be if it was a shoelace*".

53. I inspected the cords myself and while I see the force of the opinion expressed by Detective Sheehan, I am not able to make a firm finding, to the requisite standard, about whether the cords came from shoes or clothing.

54. Following RN Armstrong finding RA in the bathroom, RN Armstrong immediately reported the incident to the group handover, which included RN Lloyd.[52] In his statement, RN Lloyd says that, in order to move RA to the HDU, another patient had to be "stepped down" to the LDU.[53]

55. RN Lloyd was an extremely experienced nurse, assigned to the HDU that day. He made the decision to place RA on observation level CL2 when she came to the HDU.[54] He described RA as angry and dismissive when he tried to explain the reasons for the move. She was offered some PRN medication, which she refused stating "*Why are you trying to give me medication that I overdosed on?"*[55]

56. RN Lloyd gave evidence that his initial conversation with RA occurred in the patient lounge.[56] He gave candid evidence about the environment. He stated "*Okay, so our HDU unit is a horrible place. Sorry to have to say that. It's very – there's nothing there.*"[57] He explained that given it is a "*low stimulus area*" very little is allowed. The courtyard area has very high wire mesh and the overall feeling is claustrophobic.[58] He went on to explain that the foam furniture is uncomfortable and even the plants which were in the garden had been removed because patients had been known to sharpen twigs to use as weapons.[59] I have no doubt this environment would have increased RA's discomfort and anxiety level.

[52] Exhibit 1, Volume 3, Tab 38, Statement of RN Cheryl Armstrong at [18]; Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd at [14].
[53] Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd at [16].
[54] T 12/12/23 11.19
[55] T 12/12/23 12.6-8
[56] T 12/12/23 12.48
[57] T 12/12/23 12.20
[58] T 12/12/23 14.45
[59] T 12/12/23 15.1-8

57. RN Lloyd stated that on her arrival into the HDU area, RA was not wearing shoes and that:

> …Any drawstrings so that would have been taken from her before the night staff brought her on and that's what they told us, that they had searched her and then just brought her over. I think they had her turn out her pockets as well to bring her over to the high dependency unit.[60]

58. In his statement RN Lloyd says *"we searched RA's clothes and picked out items of clothing deemed safe for RA and the HDU environment."*[61] This appears to be a reference to a search conducted by RN Lloyd and RN Seckold. He told the Court that after some suitable appropriate clothing was chosen for RA to keep, the rest of her items were taken to the storeroom.

59. RN Lloyd thought it might be more productive if he left RN Seckold to engage with RA as he thought they might develop a better rapport. He gave the suggestion that with RA's "*significant history of trauma*", she might relate better to a woman and he noted that she appeared somewhat dismissive of him and his attempts to engage.[62]

60. RN Seckold and RN Lloyd recorded observations of RA approximately every 15 minutes between 7.30am and 12:45pm (noting that her care level had been changed to CL2 upon her admission to the HDU area).[63]

61. JB records receiving a phone call from RA at about 10am on 5 July 2020. He says that during this phone call, he spoke to a nurse who *"said that he had been doing this role for 40 years"*.[64] This may be a reference to RN Lloyd, who also refers to a call in his statement.[65] JB refers to RA saying *"I will kill myself"* during this call, which he understands RN Lloyd would have heard, but there is no reference to this in RN Lloyd's statement and it is not referred to in RN Lloyd's progress notes.[66] In oral

[60] T 12/12/23 14.16-20
[61] Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd at [20].
[62] T 12/12/23 16.35-45
[63] T 12/12/23 22.45- 23.44.
[64] Exhibit 1, Volume 1, Tab 23, Statement of JB at [67].
[65] Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd at [25].
[66] Exhibit 1, Volume 1, Tab 23, Statement of JB at [68]; Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd, Annexure A.

evidence RN Lloyd stated that rather than threatening to kill herself at this point RA was: "*doing the opposite. She was guaranteeing her safety to us*."[67]

62. JB also records that he told RN Lloyd that RA needed to see a psychologist and that RN Lloyd said that psychologists were only available on weekdays.[68]

63. At about 11.30am, Locum Psychiatry Registrar Nicholas Vitko reviewed RA. At the time of giving evidence he was in the final weeks of his specialist training. He impressed this Court as a conscientious doctor with a caring attitude.

64. Dr Vitko's notes record *"Her experience in MHU and HDU is triggering past memories of trauma in care"*.[69] This is a matter that is also stressed in his later statement. His notes record that he *"suggested"* that her care level be changed from CL2 to CL3 (decreasing the frequency of observations) and that *"Leave to the LDU in daytime hours may be appropriate at nurses' discretion".*[70]

65. Dr Vitko's statement emphasises that he had *"utmost faith"* in RN Lloyd and RN Stein, who was the nurse in charge of the unit on for the day shift on 5 July 2020.[71]

66. Dr Vitko's statement says that RA denied any thoughts of harming herself. That is consistent with his note *"At present is guaranteeing her safety"*.[72] Dr Vitko states that:

> …I formed the opinion that to remain in HDU would offer no benefit beyond containment of risk for the time that she remained in that environment, as medication strategies would not change her mental state. Any safety benefit of HDU would likely be lost at the point of transfer but the longer she remained traumatized in the HDU, the more her mental state would deteriorate, and the greater future risk she would present to herself.[73]

67. Dr Vitko's statement also emphasises that he was of the belief that RA had been searched and harmful objects had been removed from her possession. He records

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[67] T 12/12/23 17.15.
[68] Exhibit 1, Volume 1, Tab 23, Statement of JB at [67].
[69] Exhibit 1, Volume 3, Tab 46, Statement of Locum Psychiatry Registrar Nicholas Vitko, Annexure A.
[70]Exhibit 1, Volume 3, Tab 46, Statement of Locum Psychiatry Registrar Nicholas Vitko, Annexure A.
[71] Exhibit 1, Volume 3, Tab 46, Statement of Locum Psychiatry Registrar Nicholas Vitko at [14]-[15].
[72] Exhibit 1, Volume 3, Tab 46, Statement of Locum Psychiatry Registrar Nicholas Vitko at [25] and Annexure A.
[73]Exhibit 1, Volume 3, Tab 46, Statement of Locum Psychiatry Registrar Nicholas Vitko at [31].

a conversation with RA referring to the earlier incident in the LDU where she said that *"there is no way a drawstring on her pants could have hung her without breaking."*[74] This appears to have been RA trying to downplay the seriousness of what had occurred that morning. In oral evidence Dr Vitko confirmed he believed RA was not disordered in her thinking, but she was trying to "*minimise*" what had occurred. He said "*She was, I believe, genuinely terrified of being in the HDU any longer than she needed to be…RA [was trying to] advocate for herself to get out of there and, not wanting to take any chance that her care be continued in that restrictive environment.*"[75]

68. In relation to searching, it was Dr Vitko's clear assumption that RA would have been adequately searched after the events of the morning. In my view he was entitled to have confidence in that. He told the Court that he was essentially unaware that persons in the LDU were not searched for potential ligatures at that time (although they are now).[76] It follows that he would not have turned his mind to any specific hanging danger inherent in RA spending leave time back in the LDU.

69. Dr Vitko was visibly distressed when recalling the events of 5 July 2020 and had clearly reflected deeply on what had happened and the decisions he had made. He is to be commended for that. He gave compelling evidence about the factors he was called upon to balance. He was aware of RA's trauma background and understood how that history factored into the fear and distress she was now feeling in the extremely restrictive environment of the HDU. He identified "*regressed trauma type response behaviour.*"[77] He explained to the Court the difficulties involved in balancing the various risks involved:

> You have a couple of choices in that area – is that you can sort of keep doing the same thing. You can relinquish a little bit of your control over the patient at the risk that something might happen. Or you can up the ante with your treatment which is more severe, administer medications against a person's will, seclude them further, further restriction. All options are potentially problematic, all with potentially tragic outcomes…[78]

[74] T 12/12/23 31.20
[75] T 12/12/23 32.37-44
[76] T 12/12/23 33.28 onwards
[77] T 12/12/23. 35.19.
[78] T 12/12/23 35.22 onwards.

> So, you know, on the balance of those factors, on the balance of not exacerbating a trauma, on the balance of not protracting her illness or worsening it, on the balance of not increasing the probability of her suicide risk upon leaving hospital, on the balance of all these probabilities I took a different…[assessment of risk].[79]

70. On the Level 3 Observation Chart, RN Lloyd recorded "*Reviewed by RMO now CL3"* at 12pm.[80] RN Lloyd continued 30 minute observations of RA until 2pm when his shift finished. It appears from the Level 2 Observation Chart that RN Seckold also continued with 15 minute, care level 2 observations until 12:45pm and as such RN Lloyd and RN Seckold were simultaneously recording entries between 12 and 12:45pm. At 12:45 RN Seckold records that RA was "*Now care level 3 per DR*".[81]

71. At around 12.30pm, JB arrived at the Kurrajong Unit and was taken to see RA in the HDU. He persuaded her to take some diazepam, which was administered by RN Seckold at 12.40pm.[82]

72. RN Lloyd's statement says: *"I believe that [JB] had brought some items of clothing with him, which I also believe were searched by RN Seckold and would have been placed with her other things in the storeroom".*[83] JB's statement does not mention this, but it seems possible that he would have brought clothing given that it was his first visit to RA at the Tweed Hospital.

73. In his statement, RN Lloyd says that he gave permission for JB and RA to leave the HDU to go together to the LDU courtyard.[84] This was also recorded by RN Lloyd on the Level 3 Observation Chart.[85] This permission was in accordance with Dr Vitko's note which allowed this type of supervised leave to the LDU at the discretion of a nurse.

74. RN Lloyd says that he recalls JB leaving sometime between 1.30 and 2pm, which is consistent with RN Lloyd's entries on the Level 3 Observation Chart (although

[79] T 12/12/23 35.36-40
[80] Exhibit 1, Volume 1, Tab 26A, Level 3 Observation Chart, p. 99.
Exhibit 1, Volume 1, Tab 26A, Level 2 Observation Chart, p. 100.
[82] Exhibit 1, Volume 1, Tab 23, Statement of JB at [69]-[75]; Exhibit 1, Volume 1, Tab 26A, Medication Administration Record, p. 270.
[83] Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd at [30].
[84] Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd at [31]-[34].
[85] Exhibit 1, Volume 1, Tab 26A, Level 3 Observation Chart p. 99.

JB's statement suggests that he left sometime later).[86] RN Lloyd and JB each record that they had a conversation just before JB left and RN Lloyd made a note of that conversation at 3.28pm.[87]

75. On the Level 3 Observation Chart, RN Lloyd recorded observations of RA in the LDU at 1.30pm and 2pm and RN Seckold recorded an observation of RA in the LDU at 2.30pm.[88] RN Seckold also made a detailed progress note, beginning it at 1.47pm and updating it several times up to 2.42pm.[89]

76. At about 7.30pm, RN McGreevy made a retrospective note that begins by recording that at the start of her shift, RN McGreevy and RN Tsadik introduced themselves to RA. She also recorded that: *"While on LDU RA initially presented settled and appropriate in behaviour, however started to display signs of irritability regarding minor matters. Moved over to HDU at 1535 hours to provide a low stimulus environment."*[90] That is also noted on the Level 3 Observation Chart (it is unclear who made that note, but it seems likely that it was RN Tsadik).[91]

77. RN McGreevy told the Court that from the commencement of her shift she was aware of what had occurred that morning and why RA had been moved to the HDU. She was "100%" aware that RA was a patient that she should keep "*a particular eye on.*"[92] She stated that when RA returned to the HDU she was wearing Ugg boots, leggings and a beige hoodie, but the hoodie didn't have any cord in it."[93]

78. RN McGreevy's retrospective note states:

> Once in HDU, RA was tearful, anxious and perplexed. Expressing that she didn't want to be here, stating that this place is making her worse…In the same conversation, RA was future focussed talking positively about impending birth of twin granddaughters… She settled quickly and requested to return to LDU at approx. 1550.[94]

[86] Exhibit 1, Volume 1, Tab 26A, Level 3 Observation Chart p. 99; Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd at [35]; Exhibit 1, Volume 1, Tab 23, Statement of JB at [81]-[84].
[87] Exhibit 1, Volume 3, Tab 41, Statement of RN Stephen Lloyd, Annexure A.
[88] Exhibit 1, Volume 1, Tab 26A, Level 3 Observation Chart, p. 99.
[89] Exhibit 1, Volume 1, Tab 26A, pp. 122-123.
[90] Exhibit 1, Volume 1, Tab 26A, pp. 170-171.
[91] Exhibit 1, Volume 1, Tab 26A, Level 3 Observation Chart, p. 99.
[92] T 12/12/23 40.1
[93] T 12/12/23 40.44-46
[94] Exhibit 1, Vol 1, Tab 26A, p. 171.

79. On the Level 3 Observation Chart, RN McGreevy recorded that 4.02pm, RA was in the LDU courtyard.[95] In her retrospective note she recorded: *"At 1600 hour check, RA in the courtyard of LDU, social and interacting with co-patients."*

80. RN McGreevy's retrospective progress note then records:

> At 1615 hours, I commenced a random check however was unable to locate RA in social areas. Myself and colleague Louisa Tsadik started to search for RA. Louisa Tsadik located a locked bathroom door with a shadow over the gap and proceeded to unlock the door, pushing it open, whilst at the same time I noted the cord note at the top of the door ledge. On door opening, RA's body fell to the floor, nursing staff immediately entered the bathroom, ligature was loosened from her neck…"

81. EN Flynn, RN Lovi and RN Keith Fyfe were alerted to the emergency by another Kurrajong patient and assisted in the emergency response. RN Lovi says that RN Snyder arrived and was asked to make a rapid response call.

82. CPR was commenced but RA did not regain consciousness. Several doctors and nurses responded to the rapid response call and later cared for RA in the ICU. Intensive care registrar Dr Oliver Stanbridge, responded to the rapid response call and later called JB to tell him what had happened.

83. RA remained in supportive care in ICU at Tweed Hospital. On 9 July 2020, Consultant radiologist Adelaide Wong, performed a CT scan and recorded an impression of diffuse hypoxic ischemic encephalopathy.[96]

84. JB was appreciative of the efforts of the ICU staff at Tweed Hospital but was distressed by the lack of information about what had happened on 5 July 2020.

85. JB says that he did not hear from anyone in hospital management or from the Kurrajong Unit until he mentioned this to an ICU nurse on 8 July 2020. The following day, JB reported receiving a phone call from "*the manager*"[97], but is not clear exactly who made this call (except that JB states that it was a man). There does not appear to be any record of the call in the medical records produced by the Tweed Hospital.

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[95] Exhibit 1, Volume 1, Tab 26A, Level 3 Observation Chart, p. 99.
[96] Exhibit 1, Volume 3, Tab 52, Statement of Dr Adelaine Wong.
[97] Exhibit 1, Volume 1, Tab 23, Statement of JB at [92].

86. On 10 July 2020, several members of RA's family attended a meeting at the hospital. This included JB, RA's sons, the partner of one of his sons, and JB's sister and brother in law. Also in attendance were social worker Anna Chisholm, Mary Campbell (described by JB as being *"from the organ donation unit"*), an *"ICU doctor"*, a nurse and a medical student.[98] It is unclear which doctor this refers to, but it does not appear to have been Dr Stanbridge or surgical registrar William Harrison, who have each given statements but were not involved in RA's care on 10 July 2020.[99]

87. JB's description of that meeting is very different to the impression given by Ms Chisholm's progress note. JB said that: *"The meeting was poorly run"* and *"the only one that was professional in this situation was Mary Campbell."* Ms Chisholm's note records some particulars of the meeting and concludes, *"At this time it would appear no further inpatient SW involvement required however happy to be available for support if family wish. SW to provide follow up phone call to husband in 2 weeks and/or handover to SW at Newcastle Coroners Court."*

88. JB did not receive any further contact from social workers at the hospital, but did receive assistance, which he praised, from a social worker from *"the forensic office in Newcastle"*.[100]

89. Overall, JB reports a dearth of support from the Tweed Hospital.

90. On 11 July 2020, RA underwent surgery for organ donorship, during which she was pronounced life extinct at 11.20am.[101] JB says that Ms Campbell kept in contact with him through the organ donation process.[102]

Cause and manner of death

91. Forensic pathologist Hannah Elstub conducted an external autopsy on 16 July 2020. She found that the direct cause of RA's death was hypoxic ischaemic

[98] Exhibit 1, Volume 1, Tab 23, Statement of JB at [94]; Exhibit 1, Volume 1, Tab 26A, progress note made by Anna Chisholm, p. 162.
[99] Exhibit 1, Volume 3, Tab 54, Statement of Physician Dr Oliver Stanbridge at [31]; Exhibit 1, Volume 3, Tab 54, Statement of Surgical Registrar William Harrison at [16]-[17].
[100] Exhibit 1, Volume 1, Tab 23, Statement of JB at [102].
[101] Exhibit 1, Volume 3, Tab 28, Organ Donation Documentation; Exhibit 1, Volume 1, Tab 4 Life Extinct Form.
[102] Exhibit 1, Volume 1, Tab 23, Statement of JB at [96]-[97].

encephalopathy with antecedent causes being neck compression and hanging. I accept her opinion.

92. RA's death was intentionally self-inflicted. It was her second attempt to kill herself in less than 24 hours. She had expressed the desire to kill herself on multiple occasions in the days before.

Brief Summary of changes made by NNSWLHD following RA's death

93. Ms Deidre Robinson, the Director of Mental Health and Alcohol and other drugs service for NNSWLHD gave evidence at the inquest on behalf of NNSWLHD.[103] Ms Robinson states that following RA's death, areas for clinical improvement were identified and steps were taken by NNSWLHD to address these areas. NNSWLHD identified that there were inadequate search procedures in the Kurrajong Unit at the time of RA's death and a misunderstanding of the items that were allowed on the unit.

94. Ms Robinson gave evidence that as at July 2020, there were two different search procedures which had conflicting information about items allowed to be brought into mental health units. The corporate search procedure required the removal of prohibited items which may be a ligature risk from all patients being admitted to an acute mental health unit (such as the Kurrajong Unit), whereas the Mental Health Services procedure allowed the unit discretion to determine whether or not to search a patient, based on the acuity of the patient, and also to determine what items could be brought onto the premises.

95. That policy specified that items such as ribbons and shoelaces would be removed from patients admitted to observation areas, which in this case meant the HDU. The Court heard evidence from a number of nurses that as at July 2020, there wasn't a consistent practice of confiscating potential ligatures, such as shoelaces and clothing cords, from patients who were being admitted in the LDU at the Kurrajong Unit.[104]

96. Ms Robinson stated that since July 2020, the following changes have been

[103] T 13/12/23 2.13-25.1; Exhibit 1, Volume 3, Tab 60, Statement of Deidre Robinson; Exhibit 1, Volume3, Tab 61, Supplementary Statement of Deidre Robinson.
[104] See e.g: T 11/12/23 38.16 and T 11/12/23 42.9.

implemented:

- NNWLHD mental health units are now all using the same search procedure, being the corporate search procedure.

- The search procedure now requires the removal of all prohibited items which may be a ligature risk for all patients across all NNSWLHD acute mental health units.[105]

- Ongoing education has been provided to staff at the Kurrajong Unit regarding search procedures, including to casual, relief and agency staff. The education included informing staff of the list of prohibited items in mental health units.[106]

- Additional information on search procedures has been inserted into the Kurrajong Unit orientation manual as well as the mental health units in Lismore and Byron. A flow chart has been inserted to provide visual guidance for nursing staff directing the flow and process of searching of patients on admission to the ward.

- The orientation booklets provided to patients have also been updated to include a list of the prohibited items and signage has been placed at the entrance of the Kurrajong Unit to inform patients and visitors of the prohibited items.[107]

- The search procedure now mandates that shoelaces must be removed from all patients. Spot audits were conducted for six months since the implementation of the search procedure and education to monitor compliance. Ongoing audits now continue as routine practice using a search audit tool. Storage lockers have been purchased for each inpatient as it was identified that the Kurrajong Unit lacked a safe, secure and organised storage space for a patient's belongings.

97. Other areas of improvement Ms Robinson identified in her statement, and in her evidence included the following:

- NNSWLHD identified that there may have been an underestimated observation

[105] Exhibit 1, Volume 3, Tab 60, Statement of Deidre Robinson at [9] - [13].
[106] Exhibit 1, Volume 3, Tab 60, Statement of Deidre Robinson at [17] - [21].
[107] Exhibit 1, Volume 3, Tab 60, Statement of Deidre Robinson at [25]-[30].

level for RA. When assessing RA's risk of suicide, the risk assessment tool set out in *Clinical Care of People Who May Be Suicidal Policy Directive* was not considered in isolation by the treating team to form the treating decisions. The Policy was updated to identify the strong link between the quality of the therapeutic relationship and the therapeutic outcomes and reinforces that screening tools alone must not be used to assess risk or determine treatment.

- It was identified that design modifications could be made to inpatient unit doors to minimise the risk of them acting as a ligature point. The new Tweed Valley Hospital has doors with anti-ligature hardware and a gap at the top and bottom of the door to minimise the risk of the doors being used as ligature points.

- The NNSWLHD Clinical Procedure has been rescinded and now follow the NSW Health Policy Directive which mandates the practice of assessments by medical officers to provide direction to nursing staff regarding the level and purpose of observation required for individual patients. The level of observation, its rationale and reviews must be clearly documented by the responsible medical officer so clinicians may easily identify the level of observation and the ongoing targeted nursing assessments required.

- Prior to RA's death a quality improvement project had been commenced to improve the documentation of patient visual observations within the Kurrajong Unit. Audits have been ongoing since October 2020 and results show improvements in compliance with the engagement and observation policy and medical officer and nurse unit manager review of observation levels. An action plan was formed to sustain compliance, including regular education and monitoring.

- Removal of curtain rods and brackets to eliminate ligature points and twice yearly environmental safety audits which identify obstructions to the observation of high-risk patients and structures which could be used as ligature points.

98. Importantly, NNSWLHD acknowledges that its policies at the time did not prompt further searches of the unit to enable it to identify and confiscate the cords. Since the hearing, NNSWLHD has also implemented the following additional changes:[108]

- The template used to document patient searches in the eMR entitled "Patient Search and Belongings" has been revised to prescriptively list items that should be removed from patients as well as to include a section where hazardous items removed from patients should be particularised and include a note as to where they have been stored.

- A memorandum has been issued to all mental health inpatient staff regarding the documentation of patient searches setting out the relevant policies, templates and staff responsibilities.

- Clinical Nurse Educations have commenced training staff with the revised Patient Search and Belongings template.

- Audits of the use of the Patient Search and Belonging template are being undertaken on a weekly basis for three months following its implementation.

99. The Court also heard about the proposal to redesign the HDU and LDU, rendered images of which were tendered by the NNSWLHD.[109]

100. Ms Robinson explained to the Court that a key priority in redesigning the mental health inpatient unit is the intention to establish a more therapeutic environment. The HDU where RA had been placed was described by an experienced RN as a "*horrible*" environment.[110] Ms Robinson spoke of community and consumer engagement in the process of designing the new space with a focus on colour, art and building safe outdoor spaces which may assist in making the environment more pleasant for patients. I note that in his statement RA's husband, JB raised concern regarding the state and condition of mental health facilities and recommended work

[108] Letter from Francesca Menniti, McCabes dated 22 December 2023.
[109] Exhibit 4, Rendered images of the Mental Health Unit.
[110] T 12/12/23 12.20

be done to make them more welcoming, comfortable and less institutional and sterile environments.[111]

101. I note the photos I have been shown of the new facility depict a number of gardens and courtyards both in the LDU and HDU and spaces with ample windows and natural light. I consider the redesign is a great improvement. Creating a more positive environment is not just window dressing, it has the capacity to impact a patient's therapeutic experience.

102. The Court was informed that the new building should be open by 14 May 2024.[112]

The issues

The care provided on RA's last admission

103. At the conclusion of the evidence, Counsel Assisting submitted that the Court could find that there had been reasonable clinical record keeping about decisions which had been made, with the clear exception of the search records. Further she submitted that the Court would accept the evidence of Dr Sullivan in relation to the appropriateness of RA's medical care in the period shortly before her death.

104. Dr Sullivan expressed the opinion that the mental health care offered to RA in the community in 2020 was generally adequate. He noted that anxiety disorders rarely meet the threshold for inpatient assistance except when accompanied by suicidality. He was not critical of the way her GP managed her care, describing it as *"patient-centred"* and appropriately including psychological and pharmaceutical approaches. He noted that RA had undergone thyroid function testing and there did not appear to have been an underlying physical cause for her anxiety. He stated that there were "*documented efforts made to develop collaborative plans, encourage adherence, and promote therapeutic engagement*." He did not consider that there were strong grounds to detain RA for longer under the *Mental Health Act* on either of the two admissions to Currumbin Clinic. Further he stated that "*it was not clear that she had significant depressive symptoms which warranted ongoing detention*."

[111] Exhibit 1, Volume 1, Tab 23, Statement of JB, p. 29 at [123].
[112] T 13/12/23 20.40.

105. In relation to RA's final admission, Dr Sullivan gave evidence that both Dr Greenhill and Dr Vitko made appropriate assessments between 4 July 2020 and 5 July 2020 at Tweed Hospital. They both clearly understood that she posed an ongoing suicide risk and there was no suggestion of discharge. Both understood the need to balance "*the need for supervision and monitoring to reduce the potential for suicide, with the detrimental effects of involuntary admission and restriction on RA*." In oral evidence he confirmed the view that he had expressed in his report that it was appropriate for Dr Vitko to adjust the care level without consulting his consultant psychiatrist, particularly when he had a clear rationale for his decision.

106. Dr Sullivan was asked to comment specifically on the step down from CL2 to CL3. He understood the decision was based on the level of distress shown by RA in the HDU, as was the decision to allow leave to the LDU. While stating that "*with the benefit of hindsight"* the decision may have been too hasty, he was not critical of Dr Vitko, who he said "*exhibited appropriate judgement*" in making these decisions. I accept his view. In particular, Dr Sullivan agreed with Dr Vitko that it was important to take into account the effect of RA's trauma background on her presentation in the HDU, noting that "*all of those experiences at some level resonated with her unpleasant and horrible experiences as a child and caused her significant distress. And that was very relevant to her unfortunate suicide.*"[113]

107. In oral evidence Dr Sullivan made it clear that one must remember that we review these decisions with the benefit of hindsight. While he thought the decision may have been hasty, he placed that opinion in context, telling the Court "*I can understand why Dr Vitko weighed up those choices and determined that placing her in a lower level of restriction may have improved her amenability to intervention and assisted her to reduce her distress. Now that's… it's a subjective call. One can't predict the future. But I thought it was made on a sensible rationale, even if it proved to be the wrong choice*."[114] I accept his view. I also note the submission of counsel for the NNSWLHD who correctly states that notwithstanding Dr Vitko's note, RA remained under restrictive conditions for over five hours and that for much of the time that she was in the HDU she was under fairly constant observation from the nurses' station.

[113] T 13/12/23 27.36-39.
[114] T 13/12/23 37.39-42.

108. Dr Sullivan was asked whether in his opinion RA should have been "*specialled*" or given 1:1 care (CL1) on the morning of 5 July 2020. He explained that the staff appeared to understand that RA was at high risk of suicide, but they were faced with weighing up whether such a highly intrusive form of intervention would compromise rapport to such an extent that long term risk would be increased. In his view the decision not to special RA was appropriate. He also gave evidence that using CL1 restrictions was very unusual.

109. I note that neither Dr Sullivan nor Ms Swanton were surprised or critical of the fact that RA's private health providers were not contacted on the weekend. Further both expressed the view that in the initial period of an admission, the emphasis must be on settling the patient, providing appropriate medication and building rapport. There is nothing in the records to suggest that had RA got to the stage of discharge planning, that appropriate arrangements would not have been made with her community providers.

110. I accept Dr Sullivan's opinion on these issues and also note the governance and risk issues raised by Ms Robinson. Ms Robinson gave oral evidence that whilst it is standard practice to engage with a patient's treating psychologist or psychiatrist in order to gather collateral information about a patient, it is not usual practice to make contact over the weekend. Ms Robinson stated that this is because the process is slower over weekends with less staff rostered on. Ms Robinson also noted that involving a patient's treating practitioners can pose challenges in relation to clinical risk and governance in that it involves external practitioners, not employed by the LHD introducing treatment in an acute facility where a treating team are already trying to treat the patient. Accordingly, Ms Robinson said calling a private psychiatrist or psychologist on the weekend would not be considered by any public sector service.[115]

111. Ms Robinson also gave evidence that most of NNSWLHD's procedures reference the need to engage family and carers where possible.[116] Ms Robinson stated that the NNSWLHD has a mental health forum for consumer family and carer engagement which provides an opportunity for the NNSWLHD to hear the voice of families and carers about ways in which they can improve processes. Ms Robinson

[115] T 13/23/23 23.35.-24.43
[116] T 13/12/23 23.42.

also explained that the NNSWLHD have increased the number of peer workers, who engage both patients and families and act as a bridge between them and the clinicians.[117]

112. Ms Swanton was critical of the decision to allow RA back into the LDU. She gave evidence that if she had been present on the ward she would have strongly advocated for RA to remain in the HDU. She stated "*She was still presenting with some volatility, obviously impulsivity at the time and she was quite labile. And I think there wasn't a sustained period between her admission into…the HDU ….and then being downgraded or allowed some leave out onto the LDU*." I accept this may be correct, with hindsight. Nevertheless, I am of the view that Dr Vitko could not have known that RA would have had such easy access to a hanging cord. I note that he told the Court that he is only now aware that ligatures were not necessarily removed from all patients in the LDU.

The search process and procedures

113. Counsel Assisting submitted that there remained real difficulties for the Court in relation to understanding how RA had been able to access two cords, the one used for the morning attempt and the one RA used later that afternoon. This is because there were insufficient records kept, firstly as to what RA was wearing and secondly in relation to the searches of her and her property which apparently took place at various times, including when she moved between units and when clothes were brought in by JB. It is impossible to know with any certainty what was confiscated or where it was stored. The fact that other patients in the LDU may also have had shoelaces or cords only further confuses the issue.

114. While EN Fyfe had completed an admissions checklist to confirm that hazardous items had been removed, there is no specific documentation to explain exactly what was removed or where it was put. Counsel Assisting drew the Court's attention to the evidence of RN Sampson that what was removed in the LDU would depend on the specific patient and on an assessment of the particular risks involved. It was also submitted that while the Court might be comforted that the policy had now

[117] T 13/23/23 23.35.-24.43

changed in the LDU and that training had been commenced, further improvements to the way searches are documented may be required.

115. It is troubling that at the conclusion of the evidence I remain unable to make a firm finding about how RA accessed both cords. While RN Armstrong described what was used on the first occasion as shoelaces, the OIC, Detective Sheehan said that the cords used on both occasions are more likely the type of cords that are commonly found in tracksuits or "hoodies" (as a drawstring). Ultimately, whether RA had two cords in the morning and managed to hide one, or whether she obtained another or was given another one later or found one when she was allowed back into the LDU, I am unable to say. I accept that it must be very frustrating for family members to be no clearer about exactly what happened at the end of these proceedings.

116. NNSWLHD appropriately conceded that overall search practices were inappropriate at the time RA was an inpatient at the Kurrajong Unit. Counsel for NNSWLHD identified the problem as primarily one of inconsistency, as RA's movement between the LDU and the HDU may have provided for a number of opportunities for her to get access to a cord. I have referred to some of the changes made following RA's death and I note that both medical and nursing staff who gave evidence appeared aware of the crucial change which now brings search procedures for ligatures in the LDU in line with those for the HDU.

117. Counsel Assisting explored with a number of witnesses whether the new electronic medical record template[118] to be used for searching was now adequate or whether it should be amended to be more prescriptive regarding the items that should be removed from the patient and also whether it should specifically require the itemisation of what hazardous items have actually been removed and where they have been stored.

118. It was pleasing that the LHD was immediately amenable to considering the issue and to exploring whether there were ways to improve electronic documentation for patients in NNSWLHD Mental Health Inpatient Units. At the conclusion of evidence, the Court was provided with a new pre-completed note or electronic template which

[118] Exhibit 1, Volume 3, Tab 60, Statement of Deidre Robinson, Annexure K.

might assist in ensuring safer and more consistent searches take place and are documented electronically. I have attached a copy of the new template to these findings as **Annexure A**. The document is to be completed at each search, including when moving between low acuity and high acuity areas. It provides room for items to be recorded and if removed, the location where they have been stored. It is an improved document.

119. The NNSWLHD also provided information, which I have already referred to, about a memorandum to staff alerting them to the new template, training which has commenced and the existence of an audit process.

120. In view of this response, there is no need to make a recommendation on this issue.

Notification of NSW Police

121. Counsel Assisting submitted that some of the difficulties the Court experienced in trying to understand what had occurred were exacerbated by the fact that the NSWPF were not notified of the event until 10 July 2020.

122. The OIC, Detective Sheehan, gave evidence that police should have been called earlier in a situation such as this where a very serious suicide attempt had been made in a hospital. He explained that it could have protected the evidence later available to the coroner. Not only are recollections clearer at the time events occur but witness evidence is less likely to be contaminated if statements are taken early. Forensic evidence may also be collected and documented accurately.

123. I note that NSW Health were not a party to these proceedings and I accept that there may be delicate policy issues at play in requiring LHDs to call for NSWPF attendance after a suicide attempt. Whether the current policy needs review is a matter beyond the scope of the evidence in this inquest and I do not intend to make a recommendation in this regard. Nevertheless, I intend to send a copy of these findings to NSW Health to alert them to the issues revealed in this investigation. It may be that there should be a formal policy change to direct immediate notification to police if there's a reasonable likelihood that a serious suicide attempt will result in death. It is a matter I will leave for their ongoing consideration.

124. The family were concerned about the poor communication they received from NNSWLHD staff representing mental health following RA's death. JB gave evidence that the first contact they received following RA's death was from the ICU registrar, Dr Stanbridge[119] In Ms Robinson's statement dated 15 February 2023 she states that the NNSWLHD Clinical Procedure for open disclosure was updated in December 2021. The policies distinguish between clinical disclosure and formal open disclosure. At the hearing, Ms Robinson gave evidence that the open disclosure policy requires a treating clinician make contact with the family, and at that time for RA that would have been the ICU consultant or registrar. However, Ms Robinson said her expectation would have been that one of the senior treating clinicians from the mental health team should also have made contact with RA's family following her death. Ms Robinson acknowledged that there was a missed opportunity to engage with the family and carers at a critical point.[120]

125. Ms Robinson also gave evidence that a team of senior nurses are now available out of hours and on weekends to act as a conduit for nursing staff across the mental health service and that in the case of a critical incident, this additional resource could assist with ensuring contact with families following a critical incident is managed appropriately.[121] I came to the view that Ms Robinson understood the family's concern and accepted that the NNSWLHD could have done better.

126. Having considered the evidence, I make no specific recommendations in relation to this matter.

Findings

127. For reasons stated above I make the following formal findings pursuant to section 81 of the Coroners Act:

Identity

The person who died was RA.

[119] T 13/12/23 11.1 – 12.44.
[120] Ibid.
[121] T 13/12/23 13.26- 14.20.

Date of death

RA died on 11 July 2020.

Place of death

RA died at Tweed Hospital, Tweed Heads NSW.

Cause of death

RA's cause of death was hypoxic ischemic encephalopathy caused by neck compression and hanging.

Manner of death

RA's death was intentionally self-inflicted and occurred during a period of involuntary care at Tweed Hospital. Her death occurred in the context of inadequate processes in relation to inpatient searches.

Conclusion

128. I offer my sincere thanks to counsel assisting, Ms Laura Thomas and her instructing solicitor, Rebecca Campbell for their assistance in this matter. Thanks also to Bridget Dawson.

129. Thank you to the OIC, Detective Sergeant Gary Sheehan, for his assistance in these proceedings.

130. Finally, once again, I offer my sincere condolences to RA's family and I thank them for their participation in these difficult proceedings and for sharing their memories of the woman they loved so much. JB brought a different photograph of RA to court each day of these proceedings. RA was a radiant woman. Her poetry filled our courtroom. I have no doubt that RA's experience of trauma in childhood made some of her adult life extremely difficult, but hearing from her son and seeing her beautiful and playful grandchild on the video screen gave me a glimpse into her loving family and the joy she also knew. I can see RA has had a profound impact on those around her and I express my sincere condolences to her family and friends.

131. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
NSW State Coroner’s Court, Lidcombe
6 March 2024

Mental Health, Alcohol & Other Drugs

Health
Northern NSW
Local Health District

Our purpose is to support people as they find solutions towards living well

Patient Search and Belongings template

Copy and paste template into eMR as an Auto-text pre-completed noted. "A"

Patient Search and Belongings

Reason:

[_] New Admission
[_] Return from leave.
[_] Moving between low acuity and higher acuity area.
[_] Identified risk or reasonable suspicion that patient is in possession of prohibited item.
[_] Additional belongings brought in by family or carer.

Search Type:

[_] Ordinary
[_] Frisk *(includes use of wand)*

Patient Consent:

[_] yes [_] no (*if no, please provide comment on legal status and actions taken)*

Comment: _

Search conducted with *(staff members name)*: _

Property List & Location stored: *(Provide detailed description of items brought in by patient and the location of where they have been stored or whether they are retained by the patient)*

Item / Description	Location stored
Bags/ suitcases: _	_
Clothes/ toiletries: _	_
Wallet/ purse: _	_
Car keys/ house: _	_
Mobile phone/ electrical devices: _	_
Personal care devices *(i.e. hearing aids, dentures)*	_
Other: _	_

Medications *(S4D & S8 to be signed into drug register)*

_

Prohibited items removed & Location stored:

(Prohibited items may encompass any item with the potential to inflict harm to the person or others either in its original form or when modified. Please refer to Search, Patient and Staff Safety procedure for a comprehensive list of dangerous and prohibited items on the unit)

[_] No items removed

Prohibited item removed	Location Stored
_	_
_	_
_	_
_	_

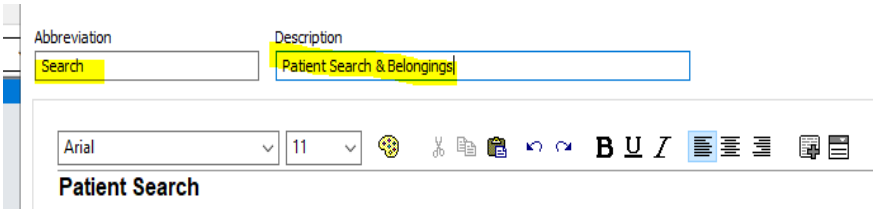
Debrief and education with consumer:

[_] yes [_] no

Comments: _

QRG – Creating Auto-text in eMR

1. Copy & Paste Patient Search documentation template into eMR progress note.
2. Highlight text.
3. R) Click on mouse and select option Save As Auto-Text…
4. Enter Search in Abbreviation text box.
5. Enter Patient Search in Description text box.



6. Save Auto-text.
7. Progress notes are to be Titled Patient Search
8. The Auto-text function will prompt user of template availability when user starts typing Abbreviation term [Search].