STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Naomi WATSON LEY
Hearing dates:	19 – 22 February 2018
Date of findings:	3 May 2018
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Russell Deputy State Coroner
Catchwords:	CORONIAL LAW – suicide after discharge from hospital, diagnosis, decision to discharge, discharge process
File number:	2015/186664

Representation:	Counsel Assisting the Coroner: Ms Surya Palaniappan of Counsel Instructed by Ms Jessica Murty Crown Solicitor's Office Caroline Watson-Ley: Ms Helen Cooper Legal Aid NSW Northern Sydney Local Health District: Mr Steven Woods of Counsel Instructed by Ms Kate Hinchcliffe Curwoods Lawyers Dr Simon Cowap: Mr Sanjay Selvakumaran Makinson d'Apice Lawyers
Non publication order:	Pursuant to s75 (5) of the *Coroners Act 2009* I make an order permitting the publication of a report of the proceedings.
Findings:	I find that Naomi Catherine Fern Watson Ley died at 98 Boundary Street, Roseville, New South Wales on 24 June 2015. The cause of her death was hanging which was self-inflicted with the intention of taking her own life.

Recommendations:	I recommend to the Chief Executive of the Northern Sydney Local Health District that a policy be implemented to the effect that With respect to patients discharged from Mental Health Units (including Emergency Mental Health Units): in circumstances in which a discharge summary will not be available to be sent so that it is received on the day of discharge by a patient's GP and (i) where follow-up by a GP is recorded as part of that patient's discharge plan or (ii) where medications commenced by that GP are to be discontinued a member of the medical or nursing staff of the hospital should attempt to contact that GP to provide relevant information about the patient's presentation and discharge plan.

Table of Contents

Naomi Watson Ley died at the home she shared with her mother, Caroline Watson Ley, at 98 Boundary St, Roseville, on 24 June 2015.

Ms Watson Ley, in deference to her mother's wishes, was called by her first name throughout the proceedings and will, in what follows, be called Naomi. She was 33 years old when she died.

Naomi was born on 15 October 1981. She was the daughter of Caroline Watson Ley (who will hereinafter be referred to as Ms Watson Ley) and William Ley, sister of Leticia and niece and granddaughter of Peter Watson. She grew up in the family home in Roseville and was educated at Loreto Kirribilli where she was a very good student. She was accomplished at sport, in particular, tennis. She attended Sydney University and Macquarie University but did not complete a degree.

In 2010 she commenced work at the University of Technology Sydney as a student administration officer.

In 2011 Naomi's father and maternal grandfather died. She became engaged to her boyfriend. They separated, however, that year or in early 2012.

Ms Watson Ley gave to the inquest an eloquent description of her beloved, talented, generous and caring daughter and, as she spoke, allowed me to see photographs of a handsome young woman and of joyful occasions she shared with her mother.

She also provided a searing depiction of the terrible loss she has endured and of the dreadful moment she knew of that loss.

Functions of the Coroner

Section 81 of the *Coroners Act 2009* sets out the principal functions of a Coroner conducting an inquest. Those are to record the identity of the person who has died, the date and place of her death and the manner and cause of that death.

Findings as to identity, date and cause of death[1]

There is no issue in these proceedings that Naomi died on 24 June 2015. Her mother last spoke to her at about midnight on 23 June 2015 and found Naomi dead in the bathroom of the home they shared on the afternoon of 24 June.

There is no issue as to the cause of Naomi's death. Dr Van Vuuren, forensic pathologist records the cause of Naomi's death as hanging.

The evidence establishes that Naomi's death was self-inflicted with the intention of causing death.

Naomi's mental health

Naomi struggled with mental health problems for a number of years before her death. In 2010 or 2011 she was found on the cliff at Avoca and taken to the Mandala Mental Health Institute at Gosford Hospital.

In 2012 she was admitted to the Northside West Clinic, Wentworthville, and treated for depression.

In January 2013 she took a near lethal overdose of medications and required treatment in the Royal North Shore Hospital intensive care unit for approximately two weeks. Thereafter she spent further time in the hospital, suffering pneumonia and, on release, spent two weeks at the Northside West Clinic.

Dr Simon Cowap, the general practitioner who saw her frequently until 2012 and infrequently from that time, described her as 'a very vulnerable young woman with a highly unstable mood and prone to sudden and severe bouts of very low mood and thoughts of self-harm'. He said she 'had very long-standing problems with depression in the context of borderline personality disorder'.

Dr Edmund Lau, general practitioner, saw Naomi on a number of occasions in 2015. He said that she 'suffered from anxiety and depressive disorder for many years and her mood fluctuated regularly'.

---

[1] There was no transcript of evidence available. Extracts quoted from oral evidence are from my notes of that evidence.

Dr Mark Chan, consultant psychiatrist, who treated Naomi from January 2013 until July 2014 at Northside West Clinic both as an inpatient and an outpatient, said that her 'psychiatric diagnoses were Major Depressive Disorder, Generalised Anxiety Disorder and Borderline Personality Disorder '. He said the factors leading to her January 2013 suicide attempt 'were an undertreated depressive disorder, social isolation, ongoing issues with her ex-fiancé, and a strained therapeutic relationship with her treating psychiatrist at the time'.

In the first quarter of 2013 she had two further admissions to Northside West Clinic 'where she was trialed on several antidepressants (fluoxetine, duloxetine)'. In Dr Chan's opinion her depressive symptoms persisted and, in April 2013, she was readmitted to Northside West Clinic where she underwent a course of electroconvulsive therapy (ECT). In Dr Chan's opinion, 'her mood gradually improved and was euthymic (normal and stable…) on discharge in early June 2013'. On her discharge she was on the antidepressant fluvoxamine.

Dr Chan records that 'for the remainder of 2013 and the first half of 2014 she was relatively stable with some transient periods of mildly low mood and increased anxiety'.

The nature of Naomi's condition and, in particular, the diagnosis of that condition made in the Psychiatric Emergency Care Centre (PECC) at Royal North Shore Hospital in June 2015 have been a focus of this inquest. That has necessarily included a consideration of whether medical and, to a lesser extent, nursing staff had the opportunity to access, and accessed, sources of information which might have informed their diagnosis and, therefore, the treatment plan formulated for Naomi, and whether such a course would or should have led to a different diagnosis and, in a context in which Naomi was an involuntary patient, resulted in further inpatient treatment at Royal North Shore Hospital or transfer as a patient to a private clinic.

2013 Discharge from Royal North Shore Hospital

Naomi was discharged from the Royal North Shore Hospital to Northside West Clinic on 18 January 2013 into the care of Dr Tanveer Ahmed, psychiatrist. The discharge referral notes record a background of borderline personality disorder apparently diagnosed by Dr Ahmed. The plan sought a review of antidepressant medications.

June 2013 discharge from Northside West Clinic

Naomi was discharged from Northside West Clinic in January 2013. She was readmitted to that clinic on 30 April of that year. The discharge summary relating to that admission (and discharge on 7 June 2013), signed by Dr Chan on 14 June,

notes as Axis I diagnoses, Major Depression and Generalised Anxiety Disorder and an Axis II diagnosis of Borderline Personality Disorder. Dr Chan did not give evidence at the inquest but Dr Samuel Lim, in 2015 consultant psychiatrist at the Royal North Shore Hospital, explained that those classifications were conventions derived from DSM-IV. He said that Axis I conditions were more biological and Axis II conditions disorders of relation and personality and that the axes did not form a hierarchy.

The discharge notes indicate that Naomi was readmitted with 'persisting low mood and suicidal ideation. She had been trialed on Cymbalta (duloxetine) but this had failed to improve her mood and in fact may have been agitating her.' That discharge summary notes the ECT treatment. Medications on discharge included luvox (fluvoxamine) 50 mg nocte.

That discharge summary was neither sought nor obtained by those treating Naomi during her last admission to hospital.

Circumstances leading up to the admission to PECC in June 2015

Dr Chan records being told by Naomi's mother in the months following Naomi's death that she had ceased taking her antidepressant in early 2015 'on her own accord' and, indeed, that is what Ms Watson Ley thought. It is, however, difficult to determine with any assurance whether Naomi was taking any antidepressant in the months before 11 June 2015. It appears that Naomi told RN Starkey of the Community Mental Health Service that she had been taking Cipramal up until 11 June and there is, perhaps, some support for that in the clinical notes of Dr Jusuf[2], psychiatric registrar, in which she refers to medication changes.

In March and April 2015 Naomi saw Suzanne Randall, a counsellor, on four occasions and, at the end of April, moved to Darwin. She returned from Darwin after only three weeks. She told her mother that she had been the subject of unwanted advances from a housemate.

On 11 June she told her mother that she was feeling low and that she might need an antidepressant. On that day she saw Dr Lau at the Chatswood Medical Centre and, in response to her request, he prescribed Aurorix (moclobemide). It appears that Naomi took Aurorix for a period of about seven days. She told her mother that the Aurorix was making her feel worse. She said 'I am going into a dark place'. She went back to Dr Lau on 17 June and was advised that she could stop taking it. She did

[2] DrJusuf's record is 'medication change was instigated as she had become more flat'.

that and on 18 June started on citalopram, an antidepressant which is sold under the brand name Cipramil among others. Her mother said that she had taken citalopram before and it had lifted her mood.

On Saturday, 20 June, Naomi told her mother that she didn't want to keep living. Ms Watson-Ley called Ms Randall and, on her advice, called the Community Mental Health Service. Ms Randall described the call from Ms Watson Ley as 'frantic'. RN Starkey spoke to both Naomi and Ms Watson Ley. Her clinical notes record that Ms Watson-Ley told her that there had been a gradual deterioration in Naomi's mood over the past two years but that since February she had become 'increasingly isolative and is now very depressed'. Her note records:

> *Past 1/52 has been refusing to eat, engage in ADLS [activities of daily life]. Tearful and crying throughout the day and night. Sense of hopelessness and despair.*
>
> *Highly agitated over past 2/7 and describes ruminating thoughts to suicide which she finds highly distressing. Thoughts include taking another OD, however client also describe[s] feeling disorganised in thought and unable to think clearly on how she would kill herself. States that if she could work out a way how to kill herself, she would.*
>
> *Reports feeling impulsive and unable to keep herself safe.*
>
> *Mother reports... Naomi has told her that as soon as she is left alone, she becomes highly distressed and anxious with an increase in thoughts to suicide. Has also told her mother that she would likely wait until she had gone to bed to kill herself.*

RN Starkey noted that Naomi had ceased her CipramiI 11 days ago. Her evidence was that that note reflected what she was told by Naomi.

RN Starkey advised Ms Watson Ley to take Naomi to Royal North Shore Hospital Emergency Department and alerted the psychiatric clinical nurse consultant at the hospital.

Admission to the Royal North Shore Hospital June 2015

20 June

Naomi was seen at the hospital, in the Emergency Department, by Registered Nurse Letticia Chalmers. Ms Chalmers had long experience in mental health nursing and had, until 2014 been a Clinical Nurse Consultant in mental health at the Royal North Shore Hospital Emergency Department. From January 2015 she has been working as a casual registered nurse across the North Sydney Local Area Health Service.

Ms Chalmers saw Naomi by herself and conducted a mental health assessment taking details of Naomi's past history, current history and performing a mental state examination. Naomi expressed to Ms Chalmers a desire to end her life and admitted to the existence of a plan but refused to state that plan. She was preoccupied with her facial features and believed that she was ugly and refused to leave the house for fear she may see someone she knew. She regretted being treated with Botox over the past three years. She reported poor sleep over the past three days and loss of appetite and was socially isolated with a low mood. It was clear to Ms Chalmers that Naomi was in crisis and required review by a psychiatric registrar. She assessed Naomi's suicide risk as high.

Ms Chalmers' note of that assessment, under the heading 'past psychiatric', was:

> *diagnosed depression*
>
> *borderline personality disorder*
>
> *body dysmorphia*
>
> *OCD traits.*

As I understood her evidence Ms Chalmers acknowledged that that information may have come from the hospital's electronic medical records. Ms Chalmers noted that, over the past 12 years, Naomi had been prescribed Pristiq, Aurorix, Cipramil and that she had previously been seen by Dr Chan and noted that was 18 months ago[3]. She noted no family history of suicide. The source of that information was unclear.

Ms Chalmers described her role as making a clinical determination as to whether a patient should be reviewed by a psychiatric registrar. In Naomi's case she expected that the psychiatric registrar would determine that Naomi required inpatient admission.

Naomi was next seen by Dr Sarah Challis who, at the time, was an intern in the Emergency Department. In accordance with section 19 of the *Mental Health Act 2007* Dr Challis assessed Naomi as a mentally disordered person and certified that in the form set out in Schedule 1 to the Act.

[3] It was in fact about 12 months before that Dr Chan had ceased seeing Naomi.

Naomi was then assessed, in the Emergency Department, by Dr Benjamin Hoadley, at the time the on-call psychiatric registrar. Naomi told Dr Hoadley that she had been 'feeling anxious over the past 3 days and that she ha[d] a significant concern that she had done herself harm with… cosmetic surgeries and botulinum toxin injections and that [that] worry was increasingly intrusive'. Dr Hoadley noted that Naomi had 'not been able to manage that anxiety [and] describe[d] the onset of ideas of suicide also over the past few days'. He noted that she denied 'acting on these ideas and denied planning, but is unable to deny intent'. Dr Hoadley noted that he was unable to 'identify [any] significant psychosocial precipitant to [the] period of anxiety' but did note medication changes 'of late which may have contributed'.

Naomi described to Dr Hoadley a low mood predating this period of anxiety 'for some months to years'.

He noted the prescription of Moclobemide which he noted she took for 7 days at 150 mg bd *i.e.* twice a day. She told him that she 'experienced sleep disturbance and a gradual increase in anxiety during [that] period and that she commenced taking citalopram – 30 mg a day for the past 3 days'.

Dr Hoadley noted that Naomi had 'a history of illness dating back to her teenage years at which time she struggled with anxiety deliberate self-harm and eating disorder. He noted that she had been managed intermittently for borderline personality disorder as an outpatient and an inpatient in the private sector (mostly out of Northside West) and he noted the history of brief involuntary treatment on the medical ward at the Royal North Shore Hospital in 2013 subsequent to a highly lethal polypharmacy overdose.

Dr Hoadley did not specifically remember accessing hospital records but said it was his practice to obtain information from all available sources.

Dr Hoadley noted that Naomi appeared 'distressed and anxious and acknowledge[d] the mood to be congruent with this'. He, too, noted that she had 'ideas of suicide but denied concrete plans'.

It appears that Dr Hoadley recommended that she consider admission to a private clinic following her stay at PECC. Dr Hoadley thought that Naomi was 'agitated and distressed in part due to sleep disturbance which ha[d] been potentially exacerbated by the medications which she ha[d] been prescribed in the past 10 days'. He noted that it was too difficult, in Naomi's distressed state, 'to get a better sense of the longitudinal history which might better explain the reason why she sought general practitioner help 10 days ago'. He noted that 'borderline personality disorder in part explained the maladaptive manner in which she ha[d] sought care'. He assessed 'her risk at present' as 'high' and noted 'the past history of a serious suicide attempt'. He noted that she was demonstrating 'a high level of distress'.

Dr Hoadley noted that he had discussed Naomi's case with Dr Samuel Lim, the on-call psychiatrist and, in addition to a psychiatric admission, recommended that she cease antidepressant tablets and try low-dose quetiapine for anxiolysis. He directed she be given 25 mg of quetiapine and 10 mg diazepam 'as required'.

Pursuant to the then section 27 (a) of the *Mental Health Act 2007* he certified that Naomi was a mentally disordered person and, he said, told Naomi of the implications of that certification should she try to leave the Emergency Department.

To a greater or lesser extent criticism has been made of each of those staff members by, and on behalf of, Ms Watson Ley for, *inter alia*, what is said to be their failure to consult her and gain the benefit of information she was in a position to supply.

Each was questioned about whether she or he had accessed hospital notes through the electronic medical records system.

I will return to those criticisms and that questioning.

Although it was the intention to admit Naomi to the PECC, there were no available beds and she was kept overnight in the emergency department on 20 June. She was given 25 mg of quetiapine and 10 mg of diazepam.

21 June

At 9.19 am on 21 June Clinical Nurse Consultant Jan Dass assessed Naomi to determine if there had been any change in her mental state overnight. She noted 'depression, bouts, all her life, in 2010 suicide attempt[4], nearly succeeded, was in coma for 10 days. This time Naomi says she wants it to be right.' She found Naomi to be 'very agitated and extremely anxious, very distressed with her appearance'. She reported to CNC Dass that she was 'tired of living like this'.

CNC Dass assessed Naomi as being at a 'high risk' of 'absconding and suicide'. She noted that she would need an acute bed because the risk was very high due to self-hatred 'and hopelessness, not wanting to be alive anymore'.

Naomi was given diazepam and quetiapine following her assessment by CNC Dass.

[4] The suicide attempt was in January 2011

CNC Dass spoke to Dr Lim and conveyed her view that Naomi required a high dependency unit bed because she was 'acutely suicidal'. She was, at that stage, being nursed one on one.

Naomi was recorded as being anxious at 1:44pm and was given a further 5 mg of diazepam.

At about 3pm she was seen by the on-call psychiatric registrar, Dr Wijemanne Karandana Vidanalage. He noted that her 'behaviour, eye contact and rapport [was] good. She spoke in normal rate and volume. Her mood is depressed and affect nearly flat… She denies suicidal thoughts.'

He notes his impression: 'BPD in crisis. Now improving. Can be managed in PECC'[5].

It is difficult to determine the extent to which Dr Wijemanne's impression that Naomi had a borderline personality disorder relied on the history he found in the notes.

In a phone call that afternoon Dr Wijemanne discussed with Dr Lim his impression that 'her presentation reflected an acute situational crisis in the context of a borderline personality structure'. Dr Lim 'recommended that given the acuity of her presentation' she required admission until further review the following day.

Naomi was transferred to the PECC at around 6pm on Sunday, 21 June. It was from the PECC that Naomi was discharged on 22 June.

Psychiatric Emergency Care Centre (PECC)

The Royal North Shore Hospital PECC is a purpose built 6 bed short stay assessment unit opened in 2014. As in Naomi's case, patients normally come to the PECC through the emergency department. It was designed to be a facility which provided a calm supportive environment in which to initiate treatments and to decide on the best disposition for the patient. It was designed for patients to stay about 24 to 48 hours with the intention that those requiring a longer stay would be transferred to the hospital's Mental Health Unit.

[5] I note the initials BPD are routinely used throughout the notes to refer to borderline personality disorder. Dr Wijemanne, in the statement he signed in February of this year, expands the initials to bipolar disorder. That expansion appears to be a mistake in his statement and does not accord with Dr Wijemanne's assessment at the time.

22 June

Just after midnight on 22 June Registered Nurse Arishma Devi observed Naomi to be anxious. She gave her 10 mg of diazepam to help her sleep. The medication, she observed, had a good effect.

Dr Lim saw Naomi, in company with Dr Sandy Jusuf, a junior Psychiatric Registrar and Cindy Manalansan, a Registered Nurse whose employment in the PECC was on a casual basis, at sometime between 9am and 10am on 22 June. Thereafter Dr Lim, again accompanied by Dr Jusuf, spoke with Ms Watson Ley.

Before he spoke to Naomi, Dr Lim reviewed the electronic notes, in particular the notes relating to the mental health assessments of Drs Challis, Hoadley and Wijemanne. He saw references in the notes to her previous admission in 2013 but did not have access, or ready access, to the full documentation of that admission because, at the time, the records of medical and surgical wards were not available, or fully available[6], on the electronic medical records system but existed in paper form only.

Dr Jusuf acted, as she described it, as 'scribe' at those consultations with Naomi. Dr Lim made no notes on the clinical record. The notes available are those of Dr Jusuf (although it was Dr Lim's evidence that he checked Dr Jusuf's 'original entry'). The notes record the history obtained from Naomi:

> *Naomi felt embarrassed about how she presented to the ED. She was overwhelmed, agitated and talked about suicide though did not have any plans. She felt this might have been caused by the change in medications. She developed secondary insomnia and nightmares which worsened her mental state.*
>
> *She was afraid she might hurt herself again as well as she had a background of high lethality suicide attempt in past.*
>
> *She felt better now. She was able to sleep better since admission and felt more relaxed.*
>
> *Medication change was instigated as she had become more flat… She had been applying for jobs and became despondent that things weren't going as well as expected, hence became more flat. Otherwise there were no other triggers.*

[6] The electronic records have progressively been updated and, from this vantage point, it is not possible to say exactly what notes would have been available to Dr Lim at the time.

Dr Jusuf recorded that the 2013 suicide attempt followed the death of her father and the breakup of her engagement. She also noted the admissions to Northside West in what she noted was 2012 and 2013.

She recorded Naomi's mood on mental state examination as 'ok' and explained, in her oral evidence, that that was Naomi's description. Dr Lim's evidence was that he found her 'euthymic, pertaining to normal'.

Dr Jusuf noted Naomi's plans 'to find a job to improve her self-esteem and earn enough to move out of her mother's place'.

Dr Jusuf recorded what, it appears, was Dr Lim's assessment, that Naomi exhibited

> *emotional dysregulation, agitation and suicidal ideation likely exacerbated by recent change in medications on background of BPD and body dysmorphic disorder. Chronic risk of impulsivity and emotional dysregulation leading to accidental suicide in future.*

Dr Jusuf notes that they discussed DBT (dialectic behavioural therapy) and options for further follow-up. Dr Lim's evidence was that Naomi expressed an interest in re-engaging with a private psychiatrist at Northside West Clinic.

Dr Lim formed a plan to discharge Naomi but told her he would need to speak to her mother before making a final decision to discharge her.

The 'plan' recorded in the progress notes at this point is:

1. *D/C*
2. *Advised not to restart antidepressant until one week but start gradually (10mg citalopram)*
3. *F/U GP for referral to private psychiatrist*
   Dr Edmund Lau, Chatswood Medical Center, Victoria Ave
4. *F/U CMHT*
5. *F/U Northside Greenwich for potential DBT in future.*

Dr Lim, again in the presence of Dr Jusuf, spoke to Ms Watson Ley, who had been called back to the hospital. The clinical progress notes contain a short record of the discussion with Ms Watson Ley. The record notes that Ms Watson Ley is a nurse practitioner at Royal Prince Alfred Hospital and that she recognised Dr Lim from Naomi's 2013 admission. It continues:

'presentation, prognosis and plan explained. Mother is agreeable to same.

Alternative of DBT through CMHT explained as well.

Plan:

1. *D/C into mother's care*
2. *F/U as per previous entry*
3. *Prn quetiapine*

Naomi was discharged from the PECC shortly after midday. Registered Nurse Sarah Bowes completed the discharge procedure. Her entry in the clinical record notes that Naomi was seen by Dr Lim and Dr Jusuf 'with collateral collected from her mother Caroline'. She noted that Naomi would be discharged to her mother's home. She observed that Naomi made a good eye contact but engaged with nursing staff 'only when spoken to'. The entry continues:

Discharge completed as per transferred checklist. Handed over to Feleena at LNS [Lower North Shore]CMHT who will provide support calls to Naomi tomorrow. Naomi aware of same… Provided with contact details for LNS CMHT and the Mental Health Line.

Encourage[d] to call either if she feels as though she is in crisis.

Provided with 3 x 25mg quetiapine tablets to be used PRN as per Dr Jusuf's instruction.

Caroline will escort Naomi to an appointment with her GP this afternoon at 17:00 hours. Dr Simon Cowap at Fountain Street Medical Practice, Alexandria.

RN Bowes gave evidence that it was her practice to provide to patients who are being discharged cards which have contact details for the Community Mental Health Team and the Mental Health Line and encourage them to call if they were in a crisis. RN Bowes was, in her evidence, unable to recall whether she gave those cards and those numbers to Ms Watson Ley or just to Naomi.

RN Bowes' did not have available to her a discharge summary. She faxed to Dr Cowap a medical certificate for Ms Watson Ley and, in doing so, noted that she was awaiting the discharge summary and would fax it 'as soon as possible'.

Dr Jusuf did not complete the discharge summary until 25 June.

Events following discharge from PECC

Appointment with Dr Simon Cowap

Ms Watson Ley attended the appointment scheduled with Dr Cowap that afternoon. Naomi did not accompany her mother. Ms Watson Ley's best recollection was that Naomi said she was tired and that she needed to remain at home to take the call from the Community Mental Health Team[7].

Dr Cowap's notes of that appointment record what he perceived as the 'agonising situation' facing Ms Watson Ley. He recorded a discussion he had with Ms Watson Ley about 'disengaging from micromanaging Naomi's life and being her primary - only source of support'. In what appears to be a reflection of his conversation with Ms Watson Ley about the situation she was in, Dr Cowap recorded:

> *At one level is facilitating Naomi, enabling, on the other hand Naomi is so lacking in judgement [and] insight that would do very poorly alone and is a significant risk of suicide.*

He recorded a history given by Ms Watson Ley which culminated in her taking Naomi to the Royal North Shore Hospital, that Naomi was admitted 'under schedule', that she, Naomi, was 'very angry - but has now been discharged'.

23 June

At about 6.30pm on 23 June 2015, RN Starkey rang Naomi. The purpose of that call, as she described it, was to follow-up, determine the extent to which aspects of the discharge plan were put in place and assess Naomi's current risk level in relation to her suicidality, so far as a telephone call made possible.

Ms Starkey noted in the clinical record that Naomi was 'pleasant, bright and friendly when engaging'. She was told by Naomi that her mood remained flat but had definitely improved since her admission to the PECC. She denied 'any further SI [suicidal ideation] 'other than fleeting thoughts which are less frequent [than] during admission. No plan or intent to act upon these.'

Naomi told her that she has not arranged an appointment with her GP and that she does not have a regular GP. She said she would discuss an appointment for a GP with her mother. Ms Starkey recorded a plan:

[7] That call was in fact scheduled for the following day.

1. *Naomi to arranged (sic) for appt with GP*

2. *Support call on Friday 26/6 to check outcome of this.*

At midnight Ms Watson Ley wished her daughter a good night, told her that she loved her and acknowledged that she was still feeling low. Naomi replied ‘it’s just a washout from the medication’ and told her mother she loved her.

24 June

On the morning of 24 June Ms Watson Ley left for work leaving her daughter to sleep. She did not disturb her to say goodbye.

She tried to call Naomi at 11am and again at 1pm. On neither of those occasions did Naomi answer nor did she respond to text messages asking her to call her mother.

Her mother drove home at about 4pm. She called out to Naomi without response and frantically looked through the house. She found her daughter in the ensuite bathroom, lifeless, with a belt around her neck hanging from the towel rail.

Prescription drugs taken post discharge

Femoral blood, taken post-mortem, revealed the presence of citalopram at 0.09mg/L, diazepam 0.03 mg/L and nordiazepam 0.04 mg /L. Those results were analysed by Professor Alison Jones, a specialist physician and clinical toxicologist, whose opinion was that Naomi had taken 30 mg of citalopram at least within 24 hours of her death but had not taken diazepam in the 24 hours before her death.

What was the diagnosis in the PECC?

Dr Lim’s opinion was that Naomi’s acute distress and suicidal ideation were the result of the physical consequences of recent medication changes on a background history of borderline personality disorder with associated problems of impulsivity and emotional dysregulation.

Dr Lim had spoken to Dr Hoadley on 20 June and to CNC Dass and Dr Wijemanne on 21 June. He had access to all clinical notes, including the notes of RN Starkey,

taken since 20 June and to parts of the Royal North Shore Hospital record with respect to Naomi.

RN Starkey recorded a history of overdose and borderline personality disorder. Ms Chalmers had noted, *inter alia*, borderline personality disorder and diagnosed depression. Dr Hoadley noted the intermittent management for borderline personality disorder as an outpatient and inpatient, thought that borderline personality disorder in part explained what he recorded as 'the maladaptive manner in which she has sought care'. Dr Hoadley's diagnosis, as noted in the clinical record, was

> *borderline personality disorder*
>
> *medication side-effects.*

Dr Wijemanne's 'impression' was recorded in the notes as

> *BPD in crisis. Now improving*.

Although Dr Lim had been one of Naomi's treating doctors during her admission to Royal North Shore Hospital in 2013, he did not, at the time he initially spoke to Naomi, have any independent recollection of that admission. Prior to speaking to her he saw, in the notes, references to, but did not have access electronically to, the full documentation relating to, that admission.

Naomi told Dr Lim that she had started seeing a private psychiatrist at Northside West Clinic, that she had continued to see him for about 2 years[8] and that she required two further admissions to a private psychiatric facility to manage her depression. She told him that she had found her engagement with her private psychiatrist extremely positive and felt that he had helped her recover from her depression.

The fact that Naomi had previous involvement with Northside West Clinic was also available to Dr Lim through Dr Hoadley's notes, as was the fact that she had previous involvement with Dr Chan, through Ms Chalmers' notes. I will return to Naomi's involvement with Northside West Clinic and Dr Chan.

A period of two years from the Northside West admission would, if it were accurate, put Naomi's engagement with a private psychiatrist much closer to the time of her June 2015 admission than, for example, Ms Chalmers' notes would suggest. She had, in fact, not seen Dr Chan for about 12 months.

[8] Naomi's information to Dr Lim in that respect was not accurate.

Naomi told Dr Lim, he said, that on her return from the Northern Territory some weeks ago she intended to continue looking for a job but found the prospect overwhelming. She told him, he said, that the reason she saw her GP for 'review of her antidepressant medication' was the thought that 'she might need a stronger antidepressant to help her avoid a relapse of her depression during this period'. Dr Jusuf's clinical notes record that Naomi told Dr Lim

> *she had been applying for jobs and become despondent that things weren't going as well as expected, hence became more flat. Otherwise, there were no other triggers.*

She told him, he said, about the increase in her level of anxiety and agitation on moclobemide and the recommencement of citalopram and thought her symptoms may have been caused by the changes in medication.

She did not present, he said with any 'hopelessness and helplessness' and was oriented toward the future.

In coming to his diagnosis Dr Lim took into account the fact that Naomi had taken citalopram at a dose of 30mg immediately after ceasing moclobemide and that the usual starting dose for citalopram was 10mg. He took into account the background history of borderline personality disorder.

Borderline Personality Disorder

Dr Lim was aware of the history taken by Dr Hoadley and the note of Dr Wijemanne referencing borderline personality disorder and had available to him nursing notes to the same effect.

Dr Lim, however, stressed, a number of times in his evidence, that it was his task to base any diagnosis on what he observed during her current admission. Despite that fact neither the progress notes nor the discharge summary reflect clinical reasoning justifying a diagnosis of borderline personality disorder, a situation to which I will return.

As has become apparent from statements and other documents obtained the purposes of this inquest, the history, taken, or referenced, during Naomi's admission in June 2015, reflected what was in fact the case, namely, that Naomi had been diagnosed with borderline personality disorder, if not before, then in 2013 and that, in the second half of 2013 or the first half of 2014, she had been referred for dialectic behavioural therapy, a therapy for borderline personality disorder which she did not continue.

Dr Michael Giuffrida, forensic psychiatrist, who has a significant history as staff specialist and visiting psychiatrist within the New South Wales mental health system, reviewed *inter alia* the hospital records. He acknowledged the diagnostic history, said that he did not discount borderline personality disorder as an appropriate diagnosis, but, it was his opinion, that the observations of Naomi on the June 2015 admission, reflected in the hospital records, did not offer evidence that Naomi suffered from a borderline personality disorder.

Dr Christopher Ryan, psychiatrist, who is Senior Staff Specialist and Director of Consultation-Liaison Psychiatry at Westmead Hospital and Clinical Associate Professor, Westmead Clinical School also reviewed *inter alia* the hospital records. He thought that 'many of the features' described in the DSM 5 as present in borderline personality disorder were 'evident in the documentation available, such as identity disturbance, recurrent suicidal behaviour and instability of mood'. He thought that, on balance, Naomi did have borderline personality disorder.

It does appear that there was some significant reliance by treating doctors at the Royal North Shore Hospital in June 2015 on the history of a borderline personality disorder diagnosis. I am unable to determine the extent to which Dr Lim relied on that history or formed an independent assessment but I note that Dr Lim's evidence was that a diagnosis of borderline personality disorder required a longitudinal assessment. In that context some reliance on the notes of previous admissions might be expected.

Taking into account the diagnostic history, including that of Dr Chan, the fact that Dr Giuffrida would not discount it and the opinion of Dr Ryan, I cannot conclude that Dr Lim's diagnosis, so far as it related to the existence of a borderline personality disorder, was unwarranted.

Adverse serotonergic effects of medication

On 11 June 2015 Naomi was prescribed moclobemide, which is sold *inter alia* under the brand name Aurorix. It appears that she stopped taking that on 17 June and, on 18 June, commenced on citalopram, a drug which she had taken, her mother said, previously without ill effect.

Moclobemide is a monoamine oxidase inhibitor. Citalopram is a selective serotonin uptake inhibitor. Although their operations are different both are used clinically as antidepressants. Professor Jones explained that the biochemical effect of antidepressants is to raise 5HT (serotonin) in the brain.

Depending on individual susceptibility in a patient, adverse serotonergic effects can occur as a result of taking a single agent but are more likely from taking two agents together. Professor Jones said that, for that reason, a 'washout' time is recommended between drugs whose side-effects might combine. Although she deferred to psychiatric opinion on the appropriate 'washout' period for moclobemide, as I understood her evidence, she thought the washout period would be in the order of 10 to 14 days. In answer to a specific question she said that 36 hours was too short a time.

Dr Giuffrida thought the effective washout period would probably be a maximum of 48 hours. Dr Ryan agreed that Moclobemide had a short half life but said its effects may remain beyond that.

Professor Jones described the potential adverse serotonergic effects as existing along a spectrum from life-threatening toxicity to effects which only the most careful clinician would be able to discern.

Dr Ryan was of the opinion that the fact that Naomi had started, or restarted, citalopram at a 30 mg dose, together with the timing of the onset of her most severe symptoms, 'strongly suggest that serotonergic effects were contributing to her disturbed mental state in the days leading up to her presentation on 20 June 2015'.

Dr Giuffrida gave reasons in his report for excluding serotonergic toxicity but, addressing serotonergic effects in his evidence, accepted that it was possible that Naomi was exhibiting some serotonergic effects. He said, however, that it is very difficult to differentiate those effects from the changes in mental state brought about by anxiety and distress.

Those opinions suggest that there was a proper basis for Dr Lim's opinion that serotonergic effects of medication changes were a factor in Naomi's presentation. A central issue in this inquest is whether he should have been of the opinion that those effects, on a background of borderline personality disorder, represented the critical issue in her presentation.

Major depression

Whether or not Naomi had a borderline personality disorder, Dr Giuffrida's opinion was that the 'major issue was almost certainly…. that she had suffered a relapse of a major depressive episode'. Dr Giuffrida considered that symptoms displayed, or reported, by Naomi during her time at the Royal North Shore Hospital in June 2015 were consistent with a diagnosis of a recurrent episode of major depressive disorder. Those symptoms included decreased appetite, insomnia and an increasing sense of

effort in activities. Dr Giuffrida also pointed to observations in the nursing notes, including those of CNC Dass, which noted Naomi's 'self-hatred and hopelessness'.

Dr Giuffrida's opinion that Naomi was suffering a recurrence of an episode of major depressive disorder was also based very significantly in Naomi's medical history to which I will return.

Dr Ryan, too, thought that major depression 'is certainly an important differential diagnosis to consider in the context of any suicidal patient'.

Effects of diazepam and quetiapine on assessment

Dr Ryan set out, in his first report, the reasons why he regarded it as unlikely that Naomi suffered a major depression:

> *The feature most opposed to a Major Depression hypothesis is [Naomi's] rapid return to a positive mood state by 22 June, when she described her mood as 'ok' and was noted to be smiling. This rapid return to a normal mood was also seen… during the 2013 admission, where she was noted to be 'positive in mood' the day after she was intubated a mood state that continued until her discharge. It was also notable that [she] had apparently relatively recently enjoyed a holiday in Darwin… suggesting that she was unlikely to have been suffering a depression then at least.*

In addressing the fact which Dr Ryan considered argued most strongly against a major depression, Dr Giuffrida was of the opinion that the quetiapine and the diazepam given to Naomi during her admission to the Royal North Shore Hospital

> *'would have… given her very considerable relief of her agitation and anxiety and would have in all likelihood given the impression that Naomi's symptoms at least in relation to agitation and anxiety had improved at the time of discharge. That of course would be a false impression.*

Dr Giuffrida said that the effect of diazepam varies as to tolerance but in a person not routinely on benzodiazepines it is likely to have a very significant anxiolytic and sedating effect which may serve to disguise and suppress symptoms that precipitated the presentation.

Dr Ryan, too, thought that those medications were 'undoubtedly partly responsible for her improvement in mental state and should have been factored into [Dr Lim's]

considerations'. He said that the extent to which it may be playing a part in her being so much better is a judgment a clinician has to make.

It was Dr Lim's evidence that he took the effect of those medications into account in assessing Naomi. That is a difficult assertion to assess.

There is no mention in the clinical notes of Dr Lim's opinion as to the possible effect of the doses of quetiapine and diazepam on Naomi's mental state during her stay at the hospital. There was a difference of emphasis between Dr Ryan and Dr Giuffrida as to what might be expected in clinical notes. This is a matter to which I will return but I accept the proposition that not everything that goes through a clinician's mind will, or should, be reflected in the notes.

Dr Lim's evidence was that he was alive both to that possibility and to the possibility that Naomi was masking her symptoms. He said that psychiatrists are not lie detectors but he looked for, and could not detect, inconsistencies in her responses. She was warm and reactive and her manner did not demonstrate anything which was contrary to her responses to questions.

Consideration by Dr Lim of an alternative diagnosis major depression

It is clear that Dr Lim knew, if for no other reason than because he was told by Naomi, that she had a history of depression for which she was treated by a psychiatrist and which necessitated stays at the Northside West Clinic.

He also had access to the clinical notes, including those of CNC Dass noting that Naomi had 'depression bouts, all her life' and RN Chalmers' note that she had a history of 'diagnosed depression' and he had access to the clinical notes of RN Starkey.

Dr Lim made specific reference to reviewing the notes of Dr Challis which 'described very low mood, a lack of interest in food, ruminating thoughts and difficulties with sleep in the past 2 days' and Dr Hoadley's notes which described a history of low mood over 'months to years'.

It was Dr Lim's evidence that he considered a differential diagnosis of major depression and rejected it. In coming to that view he said he noted 'the absence of a

major life event precipitating the admission'[9], the relatively quick resolution of the depressive symptoms, that the reported symptoms occurred within a relatively short timeframe and that the development of the more distressing symptoms was coincident with the changes in medication.

With respect to the relatively quick resolution of symptoms Dr Lim said that major depression is more sustained. He discerned, in Naomi, he said, a sense of hope when she could identify the problem as medication changes.

While it is true that the extremity of the symptoms occurred within a relatively short timeframe, the information provided to RN Starkey by Ms Watson Ley, and to Dr Hoadley by Naomi, referenced a longer period during which symptoms were evident. RN Starkey noted a history of gradual deterioration in mood over the past two years and increasingly isolative behaviour since February and, seemingly in that context, Ms Watson Ley's opinion that Naomi was 'now very depressed'.

There is no specific reference in the clinical notes of Dr Lim's assessment of Naomi or in the discharge summary to a serious consideration of an alternative diagnosis of major depression. Dr Lim responded derisively to the suggestion put to him in cross examination that one would expect to see, in the progress notes [and discharge summary], reference to a seriously considered alternative diagnosis by referring to the absence, in the notes, of any reference to conditions, which he listed and which were not relevant to Naomi's presentation.[10]

He responded positively to the propositions enunciated in his counsel's detailed questions, including, that, as Mr Woods put it, typically, as an interview with the patient progressed, differential diagnoses would be opened up and shut down without their being articulated.

Dr Ryan, Dr Giuffrida and Dr Nicholas O'Connor, Senior Staff Specialist psychiatrist and Clinical Director of the North Shore Ryde Mental Health Service, each said that he would expect to see a significant alternative excluded diagnosis in the discharge summary. Dr Giuffrida and Dr O'Connor would also have expected to see clinical reasoning justifying the diagnosis of borderline personality disorder reflected in the discharge summary.

---

[9] After Naomi's death her mother learnt of renewed contact by Naomi's ex-fiance in the weeks leading up to her death, a fact not disclosed by Naomi during her admission.

[10] The conditions Dr Lim listed were bipolar disorder, overdose of methamphetamines and schizophrenia. To the extent to which submissions on behalf of Dr Lim suggested that Dr Lim regarded those alternative diagnoses with the same level of seriousness that he did major depression those submissions would appear to contradict at least the tenor of the evidence of Dr Lim.

There was some difference of opinion between Dr Giuffrida and Dr Ryan as to whether a significant alternative excluded diagnosis would be expected in the progress notes. Dr Ryan suggested that 'relevant negatives' are not, or 'not necessarily', written up in the electronic notes 'anymore' and he would not be particularly concerned if that information were not in the progress notes.

The extent to which the absence of any reference to a major depression as an alternative diagnosis in the progress notes and discharge summary of itself grounds an inference that a serious consideration of major depression was absent from Dr Lim's diagnostic reasoning is to be considered in the light of the circumstances operating in the PECC on the morning of 22 June and the role of Dr Jusuf.

The discharge summary was the work of Dr Jusuf, a first-year registrar in the first 6 months of training. It was not completed until 25 June by which time Dr Lim was no longer in the PECC.

The progress notes, on the other hand, although the work of Dr Jusuf, were notes in which she said she acted as a scribe. It was her evidence that she discussed Dr Lim's opinion with him after he spoke to Naomi and before he spoke to Ms Watson Ley. It was Dr Lim's evidence that he read the initial progress note written by Dr Jusuf and that she asked him for some words.

Dr Lim's substantive position was, at the time, inpatient consultant in the Acute Mental Health Unit of Royal North Shore Hospital. He was nevertheless rostered to cover an absence in the PECC on the morning of 22 June while maintaining all of his responsibilities in the Acute Mental Health Unit, a situation which Dr O'Connor, described as usual staffing practice but unsatisfactory in that it places those doctors managing two patient loads under 'considerable pressure'.

This considerable pressure may well have been reflected in a less than comprehensive consideration of the progress notes of Dr Jusuf. I cannot conclude on the evidence of the progress notes and discharge summary alone or in combination with the fact that his diagnosis was otherwise, that Dr Lim did not, in some part of his reasoning, consider and discard the alternative diagnosis of a major depressive episode.

However, the seriousness with which such an alternative diagnosis would be considered might be expected to increase with an awareness of information that Naomi's diagnosed depression had been severe. There was information potentially available which, if he had accessed it, might have informed Dr Lim that Naomi had been diagnosed with severe treatment resistant depression and had undergone ECT. That information was potentially available from Naomi and her mother, the discharge summaries from Northside West Clinic and her treating clinicians outside the Royal North Shore Hospital.

Information sources potentially available

Naomi and Ms Watson Ley

Dr Lim relied on the clinical notes of his registrars and Dr Challis but it is unclear that any of them took a history from Ms Watson Ley. Their notes do not reference her as a source of their information. RN Starkey did specifically acknowledge Ms Watson Ley as a source of significant information but the extent to which Dr Lim relied on, or reviewed, RN Starkey's notes is unclear. His oral evidence was that he had regard to them.

Dr Ryan notes that 'there is no evidence that either [Naomi] or her mother told any member of the treating team that she had had ECT or that she had been previously diagnosed with a severe treatment resistant major depression.'

Indeed, although Ms Watson Ley thought that Naomi would have told anyone who asked about that history, it is apparent that Naomi did not give medical or nursing staff that history. I can be satisfied that a note would have been made of such a significant matter if medical or nursing staff had been told of it. It is also apparent that her mother did not give that history to medical or nursing staff.

Caroline Watson Ley

Ms Watson Ley's evidence was that she would have mentioned major depressive disorder and ECT if she had been asked but that she was not consulted or given the opportunity to give doctors or nursing staff a history known to her.

RN Starkey

RN Starkey spoke to both Naomi and Ms Watson Ley in circumstances of crisis. Naomi was very upset and crying quite heavily and it was from Ms Watson Ley that she obtained the bulk of the information.

Ms Watson Ley was, as might be expected, upset, fearful and agitated by her daughter's condition. RN Starkey's role was to assess Naomi's immediate needs, including whether she needed hospitalisation. In such circumstances it was not realistically available to RN Starkey to take, or Ms Watson Ley to give, a full history.

RN Starkey did, however, obtain a limited history from Ms Watson Ley.

RN Chalmers

RN Chalmers' practice was to speak to the patient alone first. The purpose of that, she said, was to build up a better rapport. She said that patients are not always forthcoming in front of family or friends. To the extent that RN Chalmers first spoke to Naomi alone and then called in Ms Watson Ley, her evidence agrees with that of Ms Watson Ley.

There is some dispute between RN Chalmers and Ms Watson Ley over what happened thereafter. RN Chalmers denies Ms Watson Ley's recollection that she was called away by a pager. Her evidence was that she does not use a pager and does not answer a mobile phone if she is with a patient or patient's family member. RN Chalmers did agree, however, that it was possible that she did not take a history from Ms Watson Ley and, indeed, there is no specific reference in RN Chalmers' clinical notes to the source of any history being Ms Watson Ley.

RN Chalmers said that, having assessed Naomi and come to the view that she needed to be assessed by a psychiatric registrar she would have handed over to the psychiatric registrar and he would do the full assessment including speaking to Ms Watson Ley.

Dr Challis

Dr Challis was, at the time, an intern in the emergency department of the hospital. Ms Watson Ley has no recollection of having spoken to her and it is likely she did not.

Dr Hoadley

Ms Watson Ley's evidence was that she identified herself to Dr Hoadley as 'Naomi's mother, her primary carer, and her advocate'. She said she asked him if she could give him some background before he went in to see Naomi and says that he replied 'no I don't need it. Any information I'll get from your daughter.'

Dr Hoadley denied that he would have expressed himself in those terms, agreed that Ms Watson Ley asked to speak to him alone and that he may have told her it was his practice to see the patient first. Dr Hoadley explained, in oral evidence that it was his

practice to see a patient or the patient together with her carer first and not, first, to speak to the carer alone.

Ms Watson Ley said she then left the hospital but Dr Hoadley said that she was present when he went to speak to Naomi and that he took a history from both. He could not recall details of the conversation. The details of the assessment were contained in his extensive clinical notes. Those notes do not specifically cite Ms Watson Ley, as they do Naomi, as the source of any part of that clinical history but do record Dr Hoadley's difficulty in getting 'a better sense of the longitudinal history which might better explain the reason why she sought general practitioner help 10 days ago'.

It may well be that, Dr Hoadley having declined to speak to her first, Ms Watson Ley left the hospital when Dr Hoadley commenced his consultation with Naomi. It is not a matter that I can determine. I can, however, be satisfied that Ms Watson Ley did not provide Dr Hoadley with any substantial history. If she did indeed leave while he was speaking to Naomi that might provide some explanation for the lack of history sourced to Ms Watson Ley in Dr Hoadley's notes.

CNC Dass and Dr Wijemanne

It is unclear what, if any, opportunity was available for Ms Dass or Dr Wijemanne to speak to Ms Watson Ley. Ms Watson Ley has no memory of speaking to either of them.

Dr Lim and Dr Jusuf

It is not disputed that Ms Watson Ley did not tell Drs Lim and Jusuf about the diagnosis of major depression in 2013 and the ECT treatment.

There is a very significant difference on the evidence of Drs Lim and Jusuf on the one hand, and Ms Watson Ley on the other, as to what opportunity was given to Ms Watson Ley to provide a relevant history and an input into the decision to discharge.

Dr Lim said that, after speaking to Naomi, he arranged to speak to Ms Watson Ley on her own because that was 'an environment more conducive to obtaining a collateral history' and that he and Dr Jusuf then spoke to Naomi and Ms Watson Ley together. Although Ms Watson Ley disputes a great deal about Dr Lim's version of her interaction with him, she did not dispute that she spoke to Dr Lim in the presence of Dr Jusuf.

Dr Jusuf said that the purpose of speaking to family members is to get any further information, to ask the family about any stressors and triggers and then ask some clarifying questions, to summarise the information from the patient which would allow the family member to qualify that information or to disagree, then to discuss the plan and obtain the family member's opinion on that plan. The implication of Dr Jusuf's evidence was that that was what was done in this case.

Although she was mistaken about when it was that Dr Lim remembered Naomi, Dr Jusuf remembered, she said, that the history Ms Watson Ley gave to Dr Lim accorded with his recollection.

That history was given in a context in which Dr Lim had formed, at least, a preliminary opinion that Naomi should be discharged. It is not clear whether that context militated against Dr Lim gaining, from Ms Watson Ley, a more comprehensive history but, it is also not clear whether, at the time, Ms Watson Ley thought the 2013 admissions were relevant.

When asked whether she had told Dr Lim that the breakdown in Naomi's engagement was a stressor in 2013 she said 'I do not know what I would have told him. I do not think it was discussed. I have no recollection of that…I cannot see what relevance it would have…2013 to 2015. It was not a continuum.'

Ms Watson Ley's evidence appears to suggest that she would not necessarily have thought to tell Dr Lim about Dr Chan's diagnosis and treatment of Naomi.

Ms Watson Ley did acknowledge that Dr Lim may have asked her opinion about Naomi's presentation. I understood that to be an acknowledgement that she may have given it.

Northside West Clinic and/or Dr Chan

Dr Lim makes no reference to his accessing the January 2013 discharge summary from Northside West Clinic. He did not have and did not seek the discharge summary for Naomi's admission to Northside West Clinic ending in June 2013.

Dr Giuffrida was very critical of Dr Lim's and his registrars' failure to obtain 'at the very least a discharge summary' from Northside West Clinic and preferably to speak to Dr Chan. Dr Giuffrida notes that those doctors 'had the opportunity to review the circumstances of Naomi's previous admission to RNSH in 2013 which would have recorded that she had been transferred to that clinic'.

It is Dr Giuffrida's opinion that had Dr Lim had the June 2013 discharge summary he would have formed the view 'that Naomi was likely to have relapsed into an episode of major depression with all the attendant risks'.

The discharge summary from Northside West Clinic dated 14 June 2013 and signed by Dr Mark Chan, consultant psychiatrist, includes, as one of the diagnoses, major depression and generalised anxiety disorder. It notes that Naomi had been trialed on duloxetine (Cymbalta) which 'had failed to improve her mood and in fact may have been agitating her'. Duloxetine is used in the treatment of depression.

The discharge summary records that she was 'commenced on RUL (ultra-brief pulse-width) ECT. Her mood gradually improved with this…. In total she had 10 ECT treatments.'

Naomi was discharged on fluvoxamine (Luvox) 50 mg po nocte. Fluvoxamine is an antidepressant medication.

Dr Ryan's first report was written before he had access to that Northside West discharge summary. In that report he was firmly of the view that, while

> *it remained possible that [Naomi] did suffer a Major Depression (in addition to her Borderline Personality Disorder) during her to June 2015 admission…on balance that was unlikely.*

Dr Ryan's opinion as to the unlikelihood of Naomi having suffered a major depression in June 2015 underwent some revision when he became aware of the information recorded in the Northside West discharge summary.

Dr Ryan confessed himself to be very surprised when it became apparent to him that Naomi had had a course of ECT because 'neither ECT nor a severe treatment resistant major depression is mentioned in the notes'. He said that, although he still thought it was unlikely she was suffering from a major depression, the fact that Naomi had had ECT made it 'more likely' than the information he had hitherto had done.

Significantly, Dr Ryan said that that information would have made him speak to Dr Chan.

It is clear that were the treating doctors aware of the fact that Naomi had undergone ECT for what must have been regarded as a severe, intractable major depression

that would or should have led, at the very least, to a reappraisal of the working diagnosis.

Should Naomi's treating doctors have made enquiries which would have elicited that information?

Dr Giuffrida was of the opinion that, what he regarded as, the uncertainty of the June 2015 diagnosis together with the seriousness of the almost lethal suicide attempt in 2013 would have warranted extra effort in those treating Naomi satisfying themselves as to the underlying presentation.

Dr Ryan, on the other hand, thought that there was nothing in Naomi's presentation or the facts known to Dr Lim which suggested that his diagnosis was 'looking shabby' and, that Dr Lim thought that the last time Dr Chan had seen Naomi was 18 months before. However, as noted above, while that is what RN Chalmers recorded, it is not what Naomi, on the evidence of Dr Lim's statement, told him. That would have put her involvement with Dr Chan much closer to the June 2015 admission. In oral evidence Dr Lim said he thought she said 20 months had elapsed since she had seen Dr Chan.

Dr Chan had left Sydney and was working in a mental health facility in Goulburn. There was some evidence about potential difficulties in contacting Dr Chan. Those anticipated difficulties may have militated against contacting, or attempting to contact, Dr Chan in circumstances in which the treating doctors had no specific knowledge of a diagnosis of major depression and treatment with ECT. However, the content of the June 2013 discharge summary, had it been obtained, was sufficiently challenging to the working diagnosis to have, in that event, made contacting Dr Chan the more important.

Dr Ryan clearly thought, as did Dr Giuffrida, that the fact that Naomi had been treated with ECT, signifying, as it did, that she had been treated for intractable depression, was highly relevant.

Dr Ryan's opinion was that whether or not a psychiatrist should have sought further discharge summaries from the later Northside West admissions 'was a matter on which reasonable minds could differ'. Naomi's treating doctors, he said, had no reason to suspect she had been treated with ECT or had had depression of such severity as would have warranted such treatment.

While Dr Giuffrida did not suggest that the treating doctors had reason to suspect Naomi had been treated with ECT his opinion was that the treating doctors had reason to make further enquiry.

Dr Giuffrida's evidence with respect to the June 2013 discharge summary was that it would have been 'relatively easy' to obtain. He said that a consent form faxed to the hospital would usually result in the discharge summary being received the same day. I did not understand Dr Ryan to demur from that proposition.

I accept Dr Ryan's observation that each attempt to get more information comes with a cost in delay and that 'there has to be an end to seeking new information'. However, particularly in circumstances in which Dr Hoadley and Dr Lim refer to the importance of, and difficulty in obtaining, a longitudinal history, I am satisfied that it would have been prudent on the part of the registrars and/or Dr Lim to access at least the June 2013 discharge summary. That information would, or should, at least have led to a reassessment of the diagnosis.

Should that information, had it been accessed by Dr Lim or the other medical staff at the Royal North Shore Hospital, have changed the diagnosis?

Dr Lim, in his oral evidence, stressed that he had to assess Naomi as she presented in June 2015. He said that had he known that Naomi had been treated for intractable major depression with ECT he would not have altered his diagnosis. That is a difficult matter to assess.

Dr Ryan, on balance, thought the diagnosis, at which Dr Lim arrived, was correct even with the additional information, which Dr Lim did not access, but it was clear that the seriousness with which Dr Ryan regarded the possibility that Naomi suffered from a major depression had changed. Dr Ryan, with that knowledge, would have called Dr Chan.

Dr Giuffrida's opinion was that that information should have led to a primary diagnosis of a relapse of a major depression.

Had major depression been the principal diagnosis, it is Dr Giuffrida's opinion that Naomi would or should have been detained in the hospital to establish and monitor the appropriate drug regime and should not have been released without appropriate antidepressant cover. I accept that that would have been the likely outcome of a diagnosis of major depression.

If in fact a recurrence of a major depression did, in whole or in part, cause Naomi's symptoms leading up to her admission then releasing her without antidepressant

cover for a week may well have, as Dr Giuffrida thought, made her very vulnerable to medicating herself with antidepressants with all the attendant risk.

I cannot say what the final diagnosis would have been had Dr Lim accessed the June 2013 discharge summary but, if he had done so, I am satisfied that it is much more likely that major depression would have figured more strongly than it did in his analysis of Naomi's presentation.

Although the evidence raises a very clear question about whether a recurrence of major depressive disorder should have been the principal diagnosis, the evidence is not such that I can conclude positively that such a diagnosis should have been made.

Decision to discharge[11]

Effect of diagnosis

The consequence of the diagnosis that Naomi's acute distress and suicidal ideation were a result of the serotonergic effects of medication changes on a background of borderline personality disorder was the decision to discharge Naomi and to discharge her with a plan that she not restart any antidepressant until one week had elapsed.

Dr Lim's opinion, which is supported by both Dr Ryan and Dr Giuffrida, is that patients with borderline personality disorder, as a general group, do not do well with long stays in psychiatric units. Dr Lim said that prolonged hospitalisation might be detrimental to self-esteem in such patients.

Dr O'Connor explained that it was 'important for the long-term recovery' of patients 'with an underlying diagnosis of Borderline Personality Disorder to foster autonomy of the patient and to promote the patient's sense of agency'.

Dr Giuffrida's opinion, nonetheless, was that, even if Dr Lim's formulation was correct, there would have been benefit in detaining Naomi for a relatively short period of time so that the treating team had the opportunity to deal with the crises that precipitated the suicidal ideation and to determine if an alternative pharmacological treatment was warranted.

[11] The operation of this section 27 of the *Mental Health Act 2007* (NSW) was raised in the course of the inquest in the context of a question of whether a second Form 1 should have been completed by Dr Lim. This was not identified as an issue prior to inquest and it is not a matter on which I need to form a concluded view.

Dr Giuffrida's opinion was that the experience of suicidal ideation in such patients is often related to precipitating crises which are resolvable and often, of their nature, passing, or even fleeting.

Naomi clearly wanted to be discharged. Dr Ryan, in that context, pointed to the legislative framework which would allow a patient who expressed a competent desire for discharge to be detained but only where there were strong reasons to detain her, reasons which, he said, were not present in this case. He noted that Dr Lim had formed an opinion that care of a less restrictive kind was available.

I accept that, on the basis of the diagnosis made, the decision to discharge was a proper exercise of clinical judgement.

Input of Ms Watson Ley

Ms Watson Ley's evidence was that she had vehemently opposed any decision to discharge Naomi.

Dr Lim and Dr Jusuf adamantly rejected the evidence of Ms Watson Ley that she strongly opposed Naomi being discharged. Dr Lim said that if a carer were very opposed to a discharge it would be unlikely to occur and that he would not have discharged Naomi against a firm objection by her mother. Dr Jusuf said that if Ms Watson Ley had voiced an objection to Naomi's discharge she, Dr Jusuf, would have recorded it.

The discussion between Dr Lim and Ms Watson Ley had, as its context, the preliminary decision by Dr Lim with respect to discharge but also Ms Watson Ley's awareness of Naomi's attitude to being detained in hospital. When Ms Watson Ley saw Naomi on the day of discharge she said to her mother 'I've got to get out of here'. Naomi, Ms Watson Ley said, was extraordinarily distressed about being 'scheduled' which she described as a 'frightening, terrifying experience'. She said it was 'distressing for Naomi and frightening for me'. Ms Watson Ley's concern about Naomi's reaction to being detained in hospital was related to Dr Cowap who noted that Naomi was very angry about that.

Ms Watson Ley thought it highly unlikely that she would have said to Dr Lim that a longer admission might have an adverse impact but did not actually deny saying it.

Ms Watson Ley was in an extremely difficult position because she was, she said, being blamed by Naomi for taking her to the hospital. For that and other reasons Dr

Cowap described Ms Watson Ley's situation as 'agonising'. Keeping Naomi in hospital beyond 22 June would have involved a decision to continue her involuntary detention.

Ms Watson Ley's recollection that she strenuously opposed Naomi's discharge is conscientiously held but I accept the evidence of Drs Lim and Jusuf that Ms Watson Ley did not express to them any significant opposition to Naomi being discharged.

Citalopram post discharge

The evidence of Professor Jones establishes that Naomi did, in contravention of the advice given on discharge, take citalopram, at least within 24 hours of her death and at a dose of 30 mg.

If the diagnosis of Naomi's anxiety and distress leading up to her admission were correct it may well be that the taking of citalopram at that dose had a seriously adverse effect on her well-being. Naomi had been exposed to Moclobemide until 17 June. She would still, on 23 and 24 June, be within the washout period identified by Professor Jones but not the period identified by Dr Giuffrida.

Citalopram had been stopped on her admission to hospital on 20 June. The recommended starting dose for citalopram is 10 mg per day. Dr Ryan said while he would not ignore the continuing effects of Moclobemide, he thought it more likely that the citalopram itself at a re-starting dose of 30 mg may have had serotonergic effects and increased her anxiety. Dr Giuffrida agreed that that was a possibility.

Dr Giuffrida explained, an explanation with which Dr Ryan agreed, that antidepressants such as citalopram have no effect on borderline personality disorder but persons with such conditions are prone to mood disturbances and an antidepressant, where it is prescribed to such persons, is prescribed for its impact on depression which might accompany borderline personality disorder.

On Dr Lim's formulation the citalopram to which he referred in the discharge consultation must have been, in his view, for that purpose. Consistent with his diagnosis, Dr Lim must have regarded the need to delay taking citalopram and to recommence at a dose of 10 mg as very important. In that context, there was a need to ensure that both Naomi and her mother clearly understood the importance of the plan with respect to citalopram.

Discharge process

Information provided to Naomi and Ms Watson Ley

Ms Watson Ley was very critical of the information she was given on discharge, in particular the information given to her by Drs Lim and Jusuf.

Ms Watson Ley accepted, in her oral evidence, that she was told by Dr Lim about all of the items recorded as the 'plan' in the progress notes *viz*:

> *not to restart citalopram for one week and then at 10 mg;*
>
> *to follow up with GP for referral to private psychiatrist;*
>
> *to follow up with the Community Mental Health Team;*
>
> *to follow-up with Northside West for potential DBT in the future*.

Ms Watson Ley, however, said that what she was told was vaguely expressed and non-specific. Dr Jusuf emphasised that both Ms Watson Ley and Naomi were intelligent women and Dr Lim thought that both Naomi and her mother had understood the plan and the risks post discharge. Ms Watson Ley is clearly an intelligent woman and one versed in the health system but, in this situation, she was also the mother of a young woman who had been hospitalised in a context of extreme agitation and thoughts of suicide and who now blamed her for that hospitalisation. She was described by Dr Cowap that afternoon as being in an 'agonising situation'.

Ms Watson Ley did not take a great deal of understanding away from the discharge conversation with Dr Lim.

Citalopram

Particularly in the light of the diagnosis there was an identified risk associated with the resumption of citalopram, a risk which led Dr Giuffrida to say that he did not understand the clinical reasoning which would have her resume, following discharge, a medication which was implicated in her presentation. Dr Ryan, too, noted the risk and thought it would be mitigated by waiting up to 10 days and recommencing on a dose of 10 mg.

In accordance with the diagnosis made it was a very important that both Naomi and Ms Watson Ley understood the need for Naomi to abstain from taking citalopram for the specified period and, presumably, to be aware that there were specific risks for Naomi attendant upon the taking of citalopram.

A further benefit of a clear discussion about citalopram and the reasons for abstaining would possibly have elicited further information about the reason Naomi or her mother understood that she was taking the medication.

Increased risk of suicide

The policy document in force at June 2015 Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004) notes, at page 27:

> *people who have been at risk of suicide require close follow-up when discharged from hospital. The first 28 days after discharge from hospital has been identified as a period of elevated risk of suicide*.

Dr Ryan disputes the accuracy and efficacy of such a statement and there appears to be some considerable debate in the profession on this topic. The merits of either side of that argument are not ones which I can determine beyond observing that reference to such a risk was, and is, in the relevant policy framework.

There is, however, as I understood the evidence, general agreement that persons with borderline personality disorder have an increased risk of suicide.

Dr Lim said that he did tell Naomi and Ms Watson Ley about an increased risk of suicide in the days and weeks following Naomi's discharge. Ms Watson Ley denies that that was what she was told.

It is likely that the information from Dr Lim was not expressed in those terms. Dr Jusuf, a psychiatric registrar who was present and taking notes, did not, herself, following that meeting, appreciate that there was, or was considered to be, such an increased risk.

Dr O'Connor stressed that he would not advise the patient about suicide risk in stark terms and that that information has to be personalised and individualised. Dr O'Connor would convey what was necessary in the context of advising the patient and her carer about accessing the Community Mental Health Team and other services.

There is obviously an element of clinical judgment in determining how best, and when, to convey such information but it is clear that Ms Watson Ley, like Dr Jusuf, did not take away from her meeting with Dr Lim an understanding of any increased risk of suicide in the period post discharge.

Phone call to GP

No telephone call was made to Naomi's GP by Dr Lim, Dr Jusuf or RN Bowes. Dr Lim acknowledged that it would have been better if such a call had been made. RN Bowes accepted that, in the absence of a discharge summary, someone from PECC should have called the GP to alert him to the discharge and the plan.

The importance of informing a general practitioner that medications he had prescribed were considered to have precipitated Naomi's admission is clear.

Dr Lim explained, an explanation supported by Dr O'Connor, that there are often practical difficulties in gaining ready access to a GP, particularly on a Monday morning, and an appropriate discharge may well be delayed if it had to await contact with a GP. Nonetheless, no such contact by the PECC was attempted.

Both Dr Ryan and Dr Giuffrida considered that such a call should have been made.

Dr Lim understood, from Naomi, that her GP was Dr Lau but the appointment made, by her mother, on the afternoon of 22 June was with Dr Cowap. The appropriate contact, at least from Dr Lim's point of view, would have been Dr Lau. While it is clear that Naomi's GP should have been contacted I cannot find that the fact that Dr Lau was not contacted had any effect on the tragic outcome.

Dr Lim acknowledged that Ms Watson Ley may well have mentioned Dr Cowap to him and RN Bowes, at least, was aware that an appointment had been made with Dr Cowap.

Ms Bowes called the Community Mental Health Team, which had access to the hospital notes, to advise that service of the discharge so that follow-up procedures could be put in place, as indeed, they were.

No discharge summary was available to be sent to either Dr Lau or Dr Cowap and one was not sent over the subsequent days. It was in fact only completed late on 25 June.

Whatever the situation the time of discharge when a patient has been brought in two days before, distressed and with serious thoughts of suicide, is a time when the patient and, perhaps particularly, her carer are likely to be under considerable stress. What doctors and nurses think they are telling the patient and her carer and what the patient and her carer hear are in many cases likely to be different things, if not in content, then in emphasis. Care needs to be taken to ensure that instructions about when and how to take medication, the urgency of seeing other professionals, the

resources available in the community, the ways such resources could be accessed and the desirability of accessing them are clearly set out and effort taken to ensure that they are understood.

That process would have been significantly assisted by an easy to understand written formulation. It would also have been assisted by a phone call to the treating GP, particularly in circumstances where a discharge summary had not been sent and was not likely to be sent before a scheduled appointment. That phone call need not have been made by treating doctors but by the discharge nurse.

A GP in Dr Cowap's position, receiving such a call, may well have been in a better position to form a view as to the significance of Naomi not attending an appointment with him and to advise at least Ms Watson Ley accordingly. Dr Cowap would have been in a position to emphasise the advice with respect to citalopram to Ms Watson Ley.

Apart from printed information about the Community Mental Health Team and other contact details neither Ms Watson Ley nor Naomi were given information in a written form.

Lessons learned

Dr O'Connor attended every day of the inquest and has reflected, and continues to reflect, on the lessons which should be learned from Naomi's death.

Involvement of family members

Dr O'Connor's opinion about the importance of autonomy in patients with an underlying diagnosis of borderline personality disorder did not, he said, 'mean that important information such as historical information is not obtained from family members. Family members should be informed about, and where the patient consents involved in, the development of management decisions, such as discharge planning.'

He noted changes made to the *Mental Health Act 2007,* which became effective in August 2015, enabled patients to nominate carers who can access relevant information. Dr O'Connor noted:

> *In the past carers have often reported feeling isolated and unsupported by the mental health system, including feeling excluded from treatment and*

discharge planning. These changes are a step forward in recognizing family and carers as an important part of the recovery process and the benefit of providing carers with the information they need to effectively support the [patient]. Staff are required to adhere to this legislation.

Those changes underscore the important role of a person in Ms Watson Ley's position and will facilitate such a person's involvement in the patient's care while in hospital and post discharge.

Contact with the GP after decision made to discharge

While it is true that staff at the Royal North Shore Hospital were told different things by Naomi and her mother as to the identity of any treating GP, there were compelling reasons to contact one if not both of the nominated persons.

The diagnosis of Naomi's condition on presentation made it important to contact the GP who had prescribed medications which the hospital had ceased or suspended, a fact that Dr O'Connor acknowledged.

It was clear to Royal North Shore Hospital staff, at least at the time of discharge that an appointment had been made with Dr Cowap that afternoon.

Dr O'Connor agreed that contacting a GP or treating psychiatrist should be done. He did, however, lend support to the evidence of Dr Lim that the availability of GPs and psychiatrists can make that very difficult to achieve.

I accept the submissions on behalf of the Local Health District that

it would be unduly burdensome upon patients ready for discharge if discharge were to be delayed where practical impediments existed in relation to contacting the GP prior to discharge.

I adopt, with some amendment, the recommendation proposed by Counsel Assisting, accepted by the Northern Sydney Local Health District and supported by Naomi's mother, that a policy be implemented to the effect that:

With respect to patients discharged from Mental Health Units (including Emergency Mental Health Units):

in circumstances in which a discharge summary will not be available to be sent so that it is received on the day of discharge by a patient's GP and

(i) where follow-up by a GP is recorded as part of that patient's discharge plan or

(ii) where medications commenced by that GP are to be discontinued

a member of the medical or nursing staff of the hospital should attempt to contact that GP to provide relevant information about the patient's presentation and discharge plan.

Discharge summary

Dr O'Connor recognised that 'the discharge summary was not completed in an appropriate timeframe'. He described a system which has since been put in place:

> *A mental health service wide audit is now conducted of the timelines of Discharge Summary completion after mental health admissions. These audits are now continuous and performance tracked weekly via the transfer of care meeting. The Transfer of Care Meeting involves a review of discharge summary completion for patients discharged from PECC and MHIPU. Any outstanding discharge summaries are referred to the treating Psychiatric Consultant for immediate follow-up and action.*

Discharge plan to patient/carer

Dr O'Connor accepted that a comprehensible discharge plan should be given to a patient and her carer on discharge. He explained that a number of attempts have been made to produce such a document in the past but that those attempts had been defeated by the processes involved in approval of medical forms.

In the light of his reflections on the situation of Naomi and her mother on discharge he, nonetheless, committed to having patients discharged from the PECC and their carers given a written plan in a form they can comprehend.

The Northern Sydney Local Health District has given support to Dr O'Connor's commitment and itself committed to ensuring that a simple, one page discharge plan is provided to patients and their carers on discharge[12]. In view of that commitment it is not necessary to make a recommendation to that effect.

[12] Paragraph 82 of submissions on behalf of the Local Health District

Suggestions with respect to recording and auditing of clinical records

I note the submissions of Counsel Assisting proposing a suggestion to the Northern Sydney Local Health District that it 'consider implementing a standardised policy for the practice of recording and auditing notes'.

Health practitioners giving evidence in this inquest have accepted that it is consistent with good practice that the source of a history given be recorded in clinical notes and I note the undertaking given by Local Health District to review its policy.

In the absence of having heard direct and detailed evidence on the implications of any suggestion with respect to the auditing of discharge summaries, I am not in a position to make any suggestion to the Local Health District in that regard.

Consideration

Some significant doubt has been cast on the diagnosis at which Dr Lim arrived, particularly in the light of further information (from Northside West Clinic) which was available to him had he sought it (and some information[13] which was not available to anyone but Naomi).

The treating doctors should, in my opinion, have accessed the June 2013 discharge summary which would have informed them of highly pertinent facts which should have informed their diagnosis. I cannot, however, positively conclude that Dr Lim's diagnosis was wrong.

While there may have been reason for Naomi to remain in hospital to establish her medication regime, particularly in circumstances in which she had no antidepressant cover for some days, clinical judgments were made in the context of a diagnosis of borderline personality disorder and what that signified with respect to prolonged stays in hospital. Those judgments were also made in the context of a legislative regime which would have required strong reasons to detain her against her will. I cannot, with comfortable satisfaction, conclude that those clinical judgments were wrong.

[13] That Naomi had had recent contact with her ex-fiancé. Ms Watson Ley did not know of that until after Naomi's death.

This was a terrible tragedy and one from which Naomi's mother will never fully recover. Her statement at the conclusion of the inquest compellingly described the devastation she continues to experience.

I hope that she can take some small comfort from the fact that changes will be implemented as a result of her and Naomi's experience.

Findings

Naomi Catherine Fern Watson Ley died at 98 Boundary Street, Roseville, New South Wales on 24 June 2015. The cause of her death was hanging which was self-inflicted with the intention of taking her own life.

Recommendations

I recommend to the Chief Executive of the Northern Sydney Local Health District that that a policy be implemented to the effect that:

> *With respect to patients discharged from Mental Health Units (including Emergency Mental Health Units):*
>
> *in circumstances in which a discharge summary will not be available to be sent so that it is received on the day of discharge by a patient's GP and*
>
> *(i) where follow-up by a GP is recorded as part of that patient's discharge plan or*
>
> *(ii) where medications commenced by that GP are to be discontinued*
>
> *a member of the medical or nursing staff of the hospital should attempt to contact that GP to provide relevant information about the patient's presentation and discharge plan.*

I close this inquest.

Magistrate P Russell

Deputy State Coroner

Glebe

Date