STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Matthew Wilson Leary
Hearing dates:	4 to 8 December 2017
Date of findings:	27 April 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – police operation, *Mental Health Act 2007*, mentally ill person, Prince of Wales Hospital, St Vincent's Hospital, communication with family members, discharge planning, observations, risk assessment, Marrickville Acute Care Service
File number:	2014/350742
Representation:	Ms D Ward, Counsel Assisting, instructed by Ms B Haider, Office of the General Counsel Mr B Bradley for St Vincent's Hospital, instructed by Holman Webb Mr P Coady for Richard Leary and Megan Wilson Mr R Coffey for the NSW Commissioner of Police Mr R Sergi for South Eastern Sydney Local Health District & Dr F Hume & Dr K Witheridge and Sydney Local Health District & Mr P Clenaghan, instructed by Curwoods Lawyers
Non-publication orders:	Pursuant to section 74(1)(b) of the *Coroners Act 2009*, the names and/or identifying information (including images) of any of the following persons is not to be published: 1. [redacted]; 2. [redacted].

Findings: I find that Matthew Wilson Leary died on 28 November 2014 in the waters off The Gap, Watsons Bay NSW 2020. The cause of Matthew's death was drowning. Matthew died as a consequence of actions taken by him with the intention of ending life.

Recommendations: ***To the Director of Medical Services, St Vincent's Hospital:***

I recommend that consideration be given to conducting a service delivery review to determine whether family members of mental health inpatients are provided with adequate information about the ways in which they may communicate information and concerns relating to a patient to clinical staff responsible for that patient's treatment and care. If such a review demonstrates that adequate information is not provided then I further recommend that consideration be given to the implementation of a robust and reliable system (including relevant staff training) that allows for such information to be provided.

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Introduction

1. Matthew Wilson Leary was an intelligent, passionate and empathetic young man with his life very much ahead of him. He had a loving, caring, and nurturing family and was himself a loving, caring and nurturing father to his own young son. Yet in the space of several months in 2014 Matthew was involved in a number of crises which placed his life at risk and resulted in a number of admissions to hospitals. Despite the love and support of his family and friends, Matthew could not be kept safe from the risk of harm that he posed to himself.

2. In the early hours of the morning on 28 November 2014, Matthew crossed to the incorrect side of the fence at The Gap in Watsons Bay. Police were alerted to the serious risk that Matthew was in and went there in an attempt to bring him back to safety. Tragically, they were unable to do so and Matthew ended his own life.

Why was an inquest held?

3. Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions about the identity of the person who died, when and where they died, and what was the cause and the manner of their death.

4. Due to the circumstances of Matthew's death on 28 November 2014, Matthew was regarded as having died in the course of a police operation. This meant that, according to the relevant section of the Act which applied at the time[1], an inquest into Matthew's death was mandatory. This does not suggest that there was any action taken by any police officer that should be subject to scrutiny or criticism. In fact, the evidence is to the contrary. Matthew's family have expressed their gratitude to the police officers who had interactions with Matthew for the way they did so, professionally and compassionately.

5. Although an inquest into Matthew's death is mandatory, there are also other reasons why an inquest was held. The death of a young man who had been admitted to two of Sydney's major hospitals three times in the month before his death, and who had the support of a loving and caring family and network of friends, raises the obvious question of how such a tragedy could occur. Whilst there is no simple answer to such a complex and troubling question, the inquest examined aspects of the circumstances leading up to Matthew's death.

6. The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify shortcomings not for the purpose of assigning blame or fault but, rather, so that hopefully lessons can be learnt from such shortcomings and so that, hopefully, these shortcomings are not repeated in the future. If families must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be hope for some positive outcome.

[1] *Coroners Act 2009*, section 23(1)(c) (since amended).

Matthew's life

7. Inquests and the coronial process are as much about life as they are about death. Recognising the impact that a death of person has had on their family of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that a death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Matthew's brief, but important, life.

8. Matthew was the first child of Ms Megan Wilson and Mr Richard Leary, born on Mother's Day 1989. His sister, Erin, was born a little over two years later. Because of their closeness in age Matthew and Erin developed an extremely close bond. Matthew also shared a loving relationship with both his parents and all of his grandparents.

9. Matthew's mother describes him as a vibrant little boy with brown eyes and a mop of curly red golden hair. At a very young age, Matthew's parents recognised that he had a sharp intellect and inquisitive nature. In year five Matthew was invited to attend an opportunity class in a public school. Matthew later attended a selective high school but dropped out of school shortly before his HSC. He later graduated from a TAFE tertiary preparation course and enrolled in the Bachelor of Arts degree at university.

10. Matthew had a lifelong passion for reading. He taught himself to read, before starting school, when he was only four. Ms Wilson has a fond memory that when Matthew was 14 years old he excitedly announced that he was reading a great book by a fabulous author he had discovered: *Crime and Punishment* by Dostoyevsky.

11. At a young age, Matthew's parents noticed his caring qualities and empathy for others. Mr Leary recalls that Matthew, as a toddler, would routinely help an elderly neighbour by bringing his newspaper to him so that the neighbour did not have to walk down his driveway himself. This sense of empathy led Matthew, throughout his life, to develop lasting connections and friendships with a diverse and eclectic range of people. Matthew's charming and engaging personality touched them all in some way.

12. Matthew was a thoughtful, inquisitive and intelligent person; indeed, one of Matthew's teachers describes him as one of the most intelligent students he ever taught. At times, Matthew's intellect baffled his parents. Ms Wilson recalls that on one occasion, when only five years old, Matthew walked into the bedroom holding his bunny toy to tell her about the Bosnia Herzegovina conflict and how awful it was.

13. Another one of Matthew's teachers described Matthew as a lovable misfit and Matthew's father says that Matthew regarded himself as a defiant nonconformist. Ms Wilson described Matthew as a hippie at heart who was born into the wrong age but who had the strength and resilience to live according to his own beliefs.

14. Matthew approached most things in life with a passion. He developed a keen interest in politics in his teenage years and was deeply concerned about issues of social justice and occasionally regarded himself as an activist. Matthew took these injustices to heart and at times it seemed that he carried the weight of the world on his shoulders. But Matthew never allowed this burden

to override his innate compassion for others. Matthew was a person who would, and on one occasion literally did, give his last dollar to help a person in need. Mr Leary observed that Matthew appeared to be happiest in his work life when given an opportunity to work for the underdog.

15. However, Matthew's greatest passion in life was his [redacted], who was born [redacted]. [redacted] brought enormous joy to Matthew's life, and Matthew to his. Ms Wilson recalls that Matthew and [redacted] spent many delightful weekends with her at her home in the Blue Mountains, building memories that will last a lifetime. Matthew was the most loving young father. It is heart-rending to know that [redacted], who was [redacted] when Matthew died, will grow up without Matthew in his life, except in his heart and memories.

16. The last few months of Matthew's life was a dark time. The person who Matthew was at this time was unrecognisable to those who loved him and knew him best. Gone was the vibrancy, spark, passion, and humour that was typical of Matthew and his life. It is hoped that the few brief words set out above, from someone who did not have the honour and privilege of meeting Matthew, does justice to the memories of those who loved and cared for him. The attendance of over 300 people, from all different walks of life, at Matthew's funeral is a testament to just how many people were left with lasting and positive impressions of the beautiful, caring, and vibrant young man that Matthew was, and how enormous and tragic a loss his death is.

Chronology of events

17. Much of the evidence heard during, and considered by, the inquest concerned the last month of Matthew's life. In order to better understand the events during that period, it is necessary to set out in some detail the background and chronology leading up to it.

Background and early 2014

18. Matthew met Alanna Audus when he was 19 years old. They later formed a relationship and started living together in 2011. [redacted] Ms Audus gave birth to Matthew's son, [redacted]. When [redacted] was about [redacted], Matthew and Ms Audus separated and Matthew moved out of their home.

19. Shortly after Christmas 2013 Matthew travelled overseas for the first time to New Zealand. He had a very enjoyable trip and when he returned Mr Leary noticed that Matthew appeared very settled.

20. Matthew met Ms Khye McCann on 13 March 2014 and they quickly became friends and formed a relationship shortly afterwards. During this period Matthew was frequently not attending work and had used up nearly all his leave, leading to concerns being raised by his manager. In late April 2014 Ms McCann broke her ankle and went to stay with Matthew for a couple of weeks whilst he cared for her. During this time, Ms McCann became aware that Matthew was having problems with alcohol; Ms McCann noticed that once Matthew started drinking, he did not appear to have the ability to stop at just one beer.[2]

21. The first half of 2014 was unremarkable but on 10 July 2014 Matthew's paternal grandfather, who he was very close to, passed away following a deterioration in his condition after surgery.

[2] Exhibit 1, page 423.

Shortly after his grandfather's funeral Matthew and Ms McCann travelled to New Zealand. Looking back, Mr Leary noticed that when Matthew returned he appeared to withdraw from his family, and that his appearance appeared to be declining. Ms McCann describes the return from the New Zealand trip as being the beginning of the end of her relationship with Matthew. She described Matthew as getting extremely jealous of things that didn't exist and causing arguments.[3]

22. Sometime in late August or early September 2014 Matthew and Ms McCann ended their relationship but remained friends. Ms McCann had been deeply affected by the passing of a close friend in August 2014 and she told Matthew that the difficulties in their relationship were having an adverse impact upon her studies.

23. Sometime in September 2014 Matthew developed a large rash which covered most of his torso and which his doctor told him was stress-related. During this time Matthew told Ms McCann that he hated his job but still had to work, and that he was behind in his studies. In mid-September, Matthew's employers wrote to him expressing concern that he may have a medical condition impacting his ability to attend work daily and offered to provide support, such as leave without pay, to him. On 3 October 2014 Matthew was caught drink driving and court proceedings were commenced against him.

Saturday, 11 October 2014

24. On 11 October 2014 Matthew, Ms McCann and [redacted] spent a wonderful afternoon together and in the evening went to Matthew's apartment for dinner. Earlier in the week Matthew had asked Ms McCann if she wanted to stay over that evening but Ms McCann had said that it was unlikely she would because she had a lot of study planned for the following day. After [redacted] went to bed Ms McCann received a call from a friend at around 9:00pm and told Matthew that she was going to call in on her friend on her way home. Matthew asked her not to leave and to instead stay the night. Ms McCann told Matthew that she didn't think that was a good idea as she did not want to complicate their friendship.

25. Matthew repeatedly asked Ms McCann not to go and she repeatedly said why she did not think it was a good idea for her to stay. At one point Matthew became angry at Ms McCann for answering the call during [redacted] bath and bed routine. Eventually Ms McCann went outside to leave and told Matthew that she would call him the next day and that they could spend the evening together. At this point Ms McCann said that Matthew "*completely snapped*".[4] Matthew told Ms McCann, "*Fine then, go, I'm going to kill myself*".

26. Matthew went inside his apartment and tried to close the door on Ms McCann. He repeatedly kept saying that he was going to kill himself. Matthew then began to fill the bathtub with water and went to get a toaster. Ms McCann intercepted him and had to physically restrain him from returning to the bathtub. Ms McCann attempted to reason with Matthew and reminded him to think of [redacted]. However Ms McCann described Matthew as having "*gone a bit wild*" and that her words "*seemed to have no impact*".[5] Ms McCann said that "*Matthew's irrationality and lack of*

[3] Exhibit 1, page 424.
[4] Exhibit 1, page 427.
[5] Exhibit 1, page 427.

ability to have my words sink in made me think that something quite unusual was happening for Matthew in that moment".[6]

27. Ms McCann eventually called 000 whilst Matthew was telling her to leave. When Ms McCann mentioned that [redacted] was at home the emergency operator expressed concern for his welfare. Although Ms McCann tried to explain that [redacted] was well and that it was Matthew who was at risk, the emergency operator indicated that the police would be called to attend.

28. Ms McCann told Matthew what had occurred and attempted to explain the implications of what would potentially occur if the police considered [redacted] welfare to be at risk. Matthew only responded by repeatedly saying that he didn't care and telling Ms McCann to go. Ms McCann made the decision to call 000 back and told the emergency operator that her earlier call had been in relation to an argument only, that [redacted] was fine, and to not send the police.

29. Ms McCann attempted to look up Ms Audus' number in Matthew's phone, planning to call Ms Audus to pick up [redacted] so that Ms McCann could then call for an ambulance. However she was unable to do so and eventually decided that the best solution was to tell Matthew that she would stay the night. By this time Matthew was no longer focused on putting the toaster in the bathtub and had taken a knife from the kitchen. Matthew pushed the point of the knife into his throat and told Ms McCann that she was going to leave and that he was going to kill himself. Fortunately, Ms McCann was eventually able to reason with Matthew so that he put the knife down and went to bed.

Sunday, 12 October 2014

30. The following day, 12 October 2014, Matthew went out and, by chance, ran into Ms Audus who took [redacted] with her. When Matthew returned Ms McCann said that she had to go home and Matthew promised that he would see a GP the next day and that he would tell at least one friend what happened.

31. After arriving home Ms McCann attempted to contact one of Matthew's friends. Later, Matthew called Ms McCann and told her that he was feeling unsafe. Ms McCann asked Matthew if he wanted her to return to his place and Matthew said that he did. When Ms McCann returned she and Matthew spoke about his suicidal thoughts. Ms McCann described Matthew as fairly lucid with none of the wildness that he had displayed the previous night. However at one point Ms McCann recalls that Matthew said something strange and out of context that she could make no sense of it.[7] She describes Matthew as sort of looking into space and also said that when she spoke to Matthew about the damage that would be caused to the important people in his life if he were to harm himself it did not seem to hit home.

32. Ms McCann stayed the night and left the following morning. Before Ms McCann left she made Matthew book an appointment to see a GP and once again made him promise to talk to a friend.

Other events in October 2014

33. Matthew went to see Dr Lucy Ballin, a general practitioner, on 13 October 2014. Matthew complained of being depressed for two weeks and told Dr Ballin that he felt suicidal on the

[6] Exhibit 1, page 428.
[7] Exhibit 1, page 431.

weekend as he was in debt and finding work difficult. Matthew refused to allow Dr Ballin to contact a local community health centre crisis team. Dr Ballin discussed Matthew's alcohol and cannabis use and he agreed to see a psychologist. Dr Ballin commenced Matthew on cipramil (an antidepressant).

34. Matthew returned to see Dr Ballin on 15 October 2014 and told her that he was feeling less depressed. Dr Ballin completed a GP mental health plan for Matthew to see Sarah Mithoefer, a clinical psychologist in his local area.

35. Matthew returned to see Dr Ballin on 16 October 2014 and complained of nausea and anxiety since being on cipramil. Matthew also said that he had arranged to see Ms Mithoefer the following Tuesday.

36. In mid-October there was a break-in at Matthew's home in Petersham and his computer was stolen. Mr Leary gave Matthew an old computer which belonged to his partner, Ms Kirsten Edwards, but when it was discovered that it was no longer working, he and Ms Wilson gave Matthew some money to buy a new computer.

Sunday, 19 October 2014

37. Matthew called Ms McCann during the evening of 19 October 2014 to apologise for his recent behaviour and to tell her that he was thinking of going to the hospital. Ms McCann told Matthew that was probably a good idea and Matthew later made two calls to 000. During the first call Matthew said that he could make his own way to Royal Prince Alfred Hospital (**RPAH**) but during the second call, made close to midnight, he asked for an ambulance. Police and paramedics later went to Matthew's house. The police records note that Matthew was possibly suicidal and that when asked if he needed to go to hospital, Matthew said that he would go.[8] Matthew was later taken to RPAH by ambulance.

38. At hospital Matthew was triaged but later told hospital staff that he was not willing to wait two hours to see a medical officer to be assessed. Matthew left RPAH at around 12:45am on 20 October 2014, telling hospital staff that he would go home, that he did not want to hurt himself, and that he would return to hospital later that morning.[9]

Wednesday, 22 October 2014 and first admission to Prince of Wales Hospital

39. On 22 October 2014 Ms Wilson called Mr Leary and told him that Matthew had sent her an email which was a kind of suicide note. Mr Leary had not checked his email at the time but when he did he also saw an email from Matthew which had been sent at 7:47pm. In the email Matthew spoke about his difficulties with his finances and study, and referred to drinking too much alcohol. He also referred to having no control and said, "*That's why I've decided to end it now*".[10] This was the first time that Mr Leary had ever heard of Matthew making threats to harm himself.[11] In another email sent to Ms Wilson at 7:36pm Matthew also referred to his financial problems, discontent with his job, and drinking too much alcohol. He also similarly referred to

[8] Exhibit 1, page 246.
[9] Exhibit 1, page 516.
[10] Exhibit 1, page 400.
[11] Exhibit 1, page 370.

losing control and wanting to act whilst he was still in control. Mr Leary tried to call Matthew without success.

40. At around 8:30pm on 22 October 2014, Ms McCann saw that she had missed a text message from Matthew that had been sent at around 7:30pm. The message read, "*I'm so sorry I love you always xx*". Ms McCann sent a return text asking Matthew to call her which he later did. Matthew would not tell Ms McCann where he was, only saying that he was in a pub in the eastern suburbs. However, during the call Ms McCann heard some people in the background where Matthew was mention the Watsons Bay Hotel. Ms McCann sent a message to one of Matthew's friends telling him to go to the hotel.

41. Later, Matthew asked Ms McCann if she had checked her email. She said that she had not and when she asked if she should, Matthew said, "*No, not now, you'll find out soon enough*". Ms McCann checked her email and realised what Matthew's intentions were. She sent another message to Matthew's friend telling him to contact the police. Matthew later mentioned that he had watched the sunset at The Gap and that he had made a decision and it was for the best. Ms McCann repeatedly told him that she didn't think it was the day for making decisions and asked Matthew to come to her house in Alexandria. Matthew agreed and arrived there around 40 minutes later.

42. After he arrived the police called Ms McCann and told her that they needed to come to her house in order to sight Matthew because a call had been made by Matthew's friend out of concern for his welfare. In the time until the police arrived Matthew said that he had spent the afternoon, and the afternoon of the previous day, at The Gap contemplating. Matthew also said that he had made the decision to harm himself and had planned it on the night of 19 October 2014. He explained that that was why he had called the ambulance – because it shocked and scared him with how decided he felt about it.

43. A number of police officers and paramedics arrived a short time later. At the same time Matthew received calls from his parents and Ms Audus who by that time had read Matthew's email. Mr Leary later spoke to Matthew on the phone. Matthew said that he felt tired and didn't want to talk but promised to call his father the next day. Mr Leary later exchanged text messages with Matthew reminding him to call the next morning, to which Matthew agreed.

44. Matthew was later taken to the Prince of Wales Hospital (**POWH**) emergency department (**ED**) at 11:30pm and seen by a nurse. Matthew repeatedly told Ms McCann that he was going to run out of hospital and kill himself. At around 3:00am Matthew went out for a smoke with Ms McCann and became angry at her. He told her that as soon as he was released he was going to run and said that he would never forgive her for calling the police.

45. Matthew was later referred by the ED medical officer to Dr Jennifer Chan, a psychiatry registrar. Dr Chan took a history from Matthew in which he denied any plans or intention to suicide and reported feeling overwhelmed and wanting to sleep. Matthew said that he had a four-week history of low mood which had worsened in the past week. Matthew denied any anhedonia[12], said that he due to see a psychologist the following evening, and hoped that having some therapy would make him feel better. Matthew also told Dr Chan that he was willing to engage with the

[12] An inability to feel pleasure, or diminished interest, in normally pleasurable activities.

local community health care crisis team for follow up, and agreed to stay with Ms McCann that night.

46. Dr Chan diagnosed Matthew as having a Depressive Episode and believed that there were no grounds to involuntarily detain him.[13] The management plan was for Matthew to be discharged into Ms McCann's care and for him to be followed up by the Marrickville Acute Care Service (**ACS**), a team within the Marrickville Community Mental Health Centre (**MCMHC**). Dr Chan documented a request for the Marrickville ACS to contact Matthew the following afternoon. Before discharging Matthew, Dr Chan discussed the plan with the on call consultant psychiatrist who agreed with it.

Thursday, 23 October 2014

47. After not hearing from Matthew on the morning of 23 October 2014 Mr Leary spoke to Ms Wilson who gave him Ms McCann's contact details. Mr Leary was eventually able to speak to Matthew and they made arrangements for Matthew to go to Mr Leary's home later in the afternoon. During the day Mr Leary spoke to Ms Audus who said that she had also received Matthew's email. Ms Audus also told Mr Leary that it appeared to her that Matthew had almost no self-esteem at that time and that he was behind in his child support payments. This surprised and upset Mr Leary as Matthew had always been an attentive and loving father.

48. Ms Wilson later took Matthew to Mr Leary's house in the afternoon. Ms Edwards was also home at the time. Matthew confirmed that he had been to the Watsons Bay Hotel and that the reason he had been in the area was because he was considering taking his own life. Matthew also spoke about a number of other topics such as the fact that he had accumulated almost $5,000 in debt, that he was afraid of being evicted due to unpaid rent and that he was concerned about his pending court case. Richard also learned that Matthew had used the money he and Ms Wilson had given him for a new computer to buy a plane ticket to Melbourne on 17 October 2014. After running out of money Matthew caught a bus back to Sydney. During the return trip Matthew said that he felt miserable and set about "*plotting systematically how to kill myself*".[14]

49. Matthew also referred to the fact that he had been seen to see a doctor and been prescribed antidepressants, that he had gone to RPAH after being scared of his thoughts, and that he had been linked in with Marrickville ACS. Ms Wilson invited Matthew to stay with her but Matthew was adamant that he didn't want to do this. Matthew spoke about his fear of losing what he described as his "*autonomy*" and that his thoughts that he had to kill himself somehow related to this fear.[15] Matthew also said that he had not been going to work because he hated it and that because he had used up all his leave he had lost his pay and had no income.

Friday, 24 October 2014

50. On 24 October 2014 Ms McCann told Mr Leary about the incident involving the toaster on 11 October 2014. At around this time Mr Leary spoke to Ms Audus who expressed concern for [redacted] in the sense that if Matthew were to harm himself, [redacted] might also be inadvertently placed at risk of harm. Ms Audus indicated that she only wanted Matthew to see [redacted] when either Mr Leary or Ms Wilson was present and Mr Leary supported Ms Audus in this. However,

[13] Exhibit 1, page 529.
[14] Exhibit 1, page 372.
[15] Ibid.

when Matthew found out about Ms Audus' views he became upset and hurt, and for a time refused to see [redacted] at all. Eventually Ms Audus changed her position but Matthew's reaction was noticeably out of character to Mr Leary and was another factor which made him believe that Matthew was not well.

51. Later the same day Matthew saw Ms Edwards and Mr Leary. They both noticed that Matthew seemed very positive and expressed some concern that Matthew seemed too positive so soon after wanting to take his life. Mr Leary formed the view that Matthew may have been suffering from a bipolar condition.[16]

Saturday, 25 October 2014

52. Matthew, accompanied by Ms Wilson, went to see Ms Mithoefer for his first appointment on 25 October 2014. Matthew reported a history of depression which began in 2006 or 2007 and which had continued intermittently since then. Matthew told Ms Mithoefer that he had been depressed for two to three months and that he believed the initial trigger had been his job which he hated. Matthew also reported a number of other stressors that contributed to his low mood and feelings of hopelessness and suicidal ideation which included his financial difficulties, legal troubles, unstable accommodation, problems with studies and relationship problems.[17] Matthew also said that he was drinking alcohol daily, from 1 to 15 drinks with the latter occurring not more than twice weekly, that he frequently used cannabis, smoked a pack of cigarettes per day, and consumed various recreational drugs on the weekends.

53. Matthew also reported two previous incidents of contemplation or intentions of suicide, with one being on 19 October 2014 when he went to the ED at RPAH waited two hours but left without being seen.[18]

Sunday 26 October 2014 to Thursday, 30 October 2014

54. On Sunday 26 October 2014 a registered nurse from the Marrickville ACS contacted Matthew and made arrangements for a home visit later that day. During the visit Matthew spoke about his plans to continue seeing Dr Ballin and Ms Mithoefer, with an eventual referral to a private psychiatrist.

55. On 27 October 2014, Matthew saw Dr Ballin for the fifth and last time. Matthew said that he had been seeing Ms Mithoefer and had also been seen by the Marrickville ACS. Matthew said that he wanted to stop working and be on sickness benefits whilst having treatment for depression. Matthew also complained about the stress caused by his job, study debts and his pending court appearance. Matthew said that he was happy to see a private psychiatrist. Dr Ballin attempted to make some arrangements and eventually wrote a referral letter to a psychiatrist.

56. Matthew's criminal proceedings were finalised on 28 October 2014 at Newtown Local Court. In the days that followed Mr Leary and Ms Wilson attempted to contact a number of different organisations that might be able to assist Matthew.

[16] Exhibit 1, page 374.
[17] Exhibit 1, page 495.
[18] Exhibit 1, page 496.

57. Between 28 and 30 October 2014 Mr Leary and Ms Wilson spoke to Matthew about his financial issues, and in particular his rental arrears. When they suggested that Matthew tell the real estate agent that he was working on a solution Matthew engaged in what Mr Leary described as a "*verbal temper tantrum*" which Mr Leary saw as a possible symptom of mental illness. Mr Leary later discussed this with Ms McCann who described Matthew as "*acting like a brat*" which was, again, out of character for Matthew who was not known to be quick to anger and was rarely aggressive.[19]

58. On 30 October 2014 Matthew saw Ms Mithoefer for a second appointment and told her the outcome his court proceedings. On the same day Ms Wilson contacted Carer's Australia was told that they could provide six counselling sessions but that there would be a long wait.

Friday, 31 October 2014

59. On 31 October 2014 Matthew told Mr Leary that the real estate agent agency planned to commence proceedings in the NSW Civil and Administrative Tribunal against him. Mr Leary called Matthew several times to talk to him but Matthew did not answer the phone. Ms McCann describes Matthew as being really difficult to deal with and that he was being very distant and had refused to refill his prescription. Ms McCann called the Marrickville ACS for advice and help but they did not return her call.

60. Ms McCann and Matthew later spoke on the phone at about 5:00pm. Matthew said that he was on a bus on his way to the eastern suburbs to get to the water and watch the sunset. Ms McCann believed that Matthew had been drinking and told him to go to her house which he agreed that he would. Later that afternoon Ms McCann sent Mr Leary a message asking him to call her. When he did, Ms McCann told Mr Leary that Matthew said that he was going to the beach but Ms McCann believed that he may have been intending to go to the eastern suburbs again to harm himself. After obtaining contact details from Ms McCann, Mr Leary called both Dr Ballin and the Marrickville ACS and left messages for them to call him back. When Mr Leary's call was returned he mentioned Ms McCann's earlier attempt to speak to someone however the person who Mr Leary spoke to had no record of Ms McCann's call, but that arrangements would be made for someone to contact Ms McCann. Matthew later went to Ms McCann's house and Ms McCann informed Mr Leary that Matthew was with her.

Sunday, 2 November 2014

61. On 2 November 2014 Ms McCann spoke to Matthew and told him that she was not coping. She said that she had been on suicide watch for him for two weeks, that she was exhausted and that she needed him to reach out to some other people who were willing to support him. Matthew later left and around midnight he called Ms McCann and told her that he was at the cliffs at Watsons Bay. Ms McCann was eventually able to persuade Matthew to come to her house.

Monday, 3 November 2014

62. The next morning, Ms McCann told Matthew that she needed to ring Mr Leary. This angered Matthew and he left, saying that he would not go to his psychiatric appointment. During the morning Mr Leary called the Marrickville ACS to ask whether anyone had contacted Matthew and to seek information about his condition and treatment. Mr Leary was told that Matthew's

[19] Exhibit 1, page 376.

consent would be required before any information could be released. Later, Mr Leary received a text and spoke to Matthew during which time Matthew indicated that he was angry that Mr Leary had called the Marrickville ACS and that he had withdrawn his consent for the ACS to speak to Mr Leary about his treatment.

63. Matthew called Ms McCann during the day. He said he was at home but going out to nature, going out to the ocean soon. After not hearing from Matthew for a period of time, Ms McCann became concerned and later called the police. At 10:39pm on 3 November 2014 Matthew sent an email to Mr Leary, Ms Wilson and Ms McCann in which he spoke about funeral arrangements following his death.[20]

64. During the evening of 3 November 2014 Mr Leary spoke to Ms McCann who told him that Matthew was at an unknown location and would only say that he was "*east of Redfern*". Both Mr Leary and Ms McCann took this to mean that Matthew was heading towards The Gap. Mr Leary called Matthew a number of times and was eventually able to speak to him. Mr Leary describes Matthew as being quite morose, sobbing, distressed, and sounding intoxicated. Matthew did not tell Mr Leary where he was, only saying again that he was "*east of Redfern*". Mr Leary attempted to reassure Matthew, telling him that he loved him and how proud he was that Matthew was such a good father to [redacted].

65. Matthew ended the call to take a call from Ms McCann and Mr Leary later called him back. On this occasion Matthew told Mr Leary that he was at a bus stop somewhere near Rose Bay. Matthew seemed calmer to Mr Leary and he arranged for Matthew to stay where he was so that Mr Leary could pick him up. By this time, Matthew had also told Ms McCann where he was and she had notified the police.

66. On the way to Rose Bay Mr Leary received a call from Matthew who said that the police were with him. Mr Leary spoke to one of the police officers who assured him that Matthew was safe and gave him directions to their location. When Mr Leary arrived Matthew was placed in the back of an ambulance and handcuffed for his own welfare. Mr Leary described Matthew as being uncooperative with police and ambulance staff, dishevelled, intoxicated, and looking "*like a wounded animal who was striking out in pain*".[21] One of the police officers explained to Mr Leary that Matthew had attempted to flee and that the police had to restrain him. Mr Leary was also informed that Matthew would be detained under section 22 of the *Mental Health Act 2007* (**the MH Act**) and taken to POWH.

Tuesday, 4 November 2014 and second admission to Prince of Wales Hospital

67. Matthew was admitted at 12:59am. Due to concerns that Matthew posed a risk to himself he was placed in restraints and sedated. Between 3:00am and 3:30am Matthew was assessed by Dr Elaine Kwan, psychiatry registrar. Dr Kwan later took a history from Mr Leary during in which he told Dr Kwan of the two emails sent by Matthew on 22 October 2014 and 3 November 2014. Mr Leary also summarised Matthew's recent history, said that he was concerned that Matthew was mentally ill at the time, and said that he believed Matthew posed a serious danger to himself and required admission. Mr Leary recalls that he was told that Matthew would be observed over the next few hours and that Matthew might either then be discharged or admitted to the mental health ward (Kiloh Centre). Mr Leary expressed his concern about the possibility of Matthew

[20] Exhibit 1, page 409.
[21] Exhibit 1, page 382.

being discharged and was told that this would not occur without someone notifying him first. Mr Leary remained at hospital with Matthew for a period of time. At some stage Mr Leary heard Matthew say a number of times words to the effect of, "*I have learnt from this. I will not tell anyone what I am doing next time*".[22]

68. Dr Kwan later discussed Matthew with the on-call consultant psychiatrist and the management plan was for Matthew to be admitted to the Kiloh Centre for detoxification and further assessment when a bed became available. Matthew repeatedly tried to abscond from the ED and had to be placed in restraints for his own protection.[23] During his last attempt to abscond Matthew had to be restrained from jumping from a multi-storey car park.[24]

69. Matthew was later reviewed by a Drug and Alcohol Clinical Nurse Consultant (**CNC**), and by Dr Matthew Large, consultant psychiatrist. Dr Large's assessment was brief because he found Matthew to be uncooperative and uncommunicative and it was not possible to assess his mental state in any way. Dr Large noted that Matthew made repeated references to suicide and to his funeral arrangements. Dr Large was also aware that Matthew had been to The Gap repeatedly and that he could not, at that time, explain his conduct in any way.[25] Dr Large therefore concluded that Matthew was so irrational that he required care treatment and control for his protection from serious harm and no less restrictive care was reasonable. Matthew was subsequently detained as a mentally disordered person by Dr Large under s 27 of the MH Act. At 5:00pm Matthew was admitted to the Kiloh Centre.

Wednesday, 5 November 2014

70. On the morning of 5 November 2014 Mr Leary called the Kiloh Centre and was told that Dr Katherine Witheridge was the registrar involved in Matthew's treatment and that the consultant psychiatrist was Dr Frank Hume. Mr Leary later spoke to Dr Witheridge and made arrangements to see her later that day at 12:00pm. Dr Witheridge contacted Dr Hume at around 9:30am enquiring when he would be able to review Matthew. Dr Hume replied that he could do so later in the day.

71. Dr Witheridge reviewed Matthew at around 10:38am. An appointment was also made for Matthew to be assessed at the Langton Drug and Alcohol Centre (**the Langton Centre**) at Surry Hills on 12 November 2014.

72. Mr Leary later went to the Kiloh Centre as arranged and met with Dr Witheridge. He spoke to her about Matthew's recent history for a few minutes, noting that she did not take any notes, before Dr Hume joined the meeting. Mr Leary describes Dr Hume as doing most of the talking about Matthew's issues and that Dr Hume did not solicit any information from Mr Leary. Mr Leary recalls Dr Hume saying that whilst Matthew might have other issues he also had a serious issue with alcohol and that any other issues would not be resolved until the issue with alcohol was dealt with.

73. The meeting had not gone for very long when both Dr Hume and Dr Witheridge received alerts on their pagers and were called away. Dr Hume took Mr Leary to Matthew's room so that he

[22] Exhibit 1, page 383.
[23] Exhibit 1, page 549.
[24] Ibid.
[25] Ibid.

could visit him. Mr Leary asked if they could continue the meeting at a later time but cannot recall whether he was given an answer. Due to the meeting being cut short, Mr Leary felt that he was unable to express his concerns for Matthew's safety.[26]

74. When Mr Leary went to see Matthew he saw that Matthew had improved from when he last saw him in the ED. Matthew said he expected to be discharged that day and planned to see his psychologist. Notwithstanding the improvement in Matthew's state Mr Leary could not understand how Matthew had switched from wanting to take his life, to having positive plans, in only a short space of time, and became extremely concerned when he heard of the discharge plan.[27]

75. During the course of the day Dr Witheridge reviewed Matthew and took a history from him. Dr Witheridge also contacted Dr Ballin, Ms Mithoefer and Marrickville ACS to take a collateral history. Finally, Dr Witheridge also spoke to Mr Leary. Dr Witheridge informed Mr Leary of a plan for Matthew to be discharged that day. Mr Leary said that he did not think Matthew ought to be discharged and that if this occurred Matthew would return to The Gap in a very short time. Mr Leary also gave Dr Witheridge copies of the two recent emails sent by Matthew along with a chronology of recent events, asking that they be placed with Matthew's progress notes. Mr Leary concluded by describing the various domains of Matthew's life (personal care, relationships, employment, finances, accommodation) that were in turmoil and expressing his belief that Matthew needed to be assessed. Mr Leary noted that Dr Witheridge seemed concerned by the information that he had given her and left to talk to someone. Whilst Mr Leary was comforted that his concerns for Matthew were being taken seriously, he was also concerned that it appeared that Dr Witheridge was receiving the information given by Mr Leary for the first time.[28]

76. Dr Hume, accompanied by Dr Witheridge, later reviewed Matthew during his afternoon ward rounds. At the time that he saw Matthew, Dr Hume's clinical impression was that Matthew "*was not suffering from any psychosis or pervasive mood disorder which would benefit from psychotropic medication or further hospitalisation*".[29] Further, Dr Hume was of the view that Matthew's frequent cannabis use and binge drinking were the likely explanation for his recent paranoid beliefs.

77. Dr Hume noted that Matthew had presented on 4 November 2014 when he was very intoxicated but had sobered up considerably over the following 36 hours. In that time his mental state improved and he became calmer and more rational. Dr Hume considered Matthew to be no longer psychotic or pervasively depressed and did not find there to be any persistence of depressive mood or affect, or Matthew to be tearful or actively suicidal. Dr Hume formed an opinion that Matthew did not have any underlying mood disorder, other than dysthymia. Dr Hume concluded that Matthew had "*overdosed on alcohol in the context of marked coexisting psychosocial stressors*".[30] Although Dr Hume's clinical impression was that Matthew was mentally disordered he could not be detained as an involuntary patient.[31]

[26] Exhibit 1, page 385.
[27] Ibid.
[28] Ibid.
[29] Exhibit 1, page 545-6.
[30] Ibid.
[31] Exhibit 1, page 545-7.

78. Sometime later Matthew approached Mr Leary and told him that he was not happy. This was because Matthew said that he had told he would be discharged that day but after Mr Leary had spoken to Dr Witheridge Matthew learned that he would be admitted for another night. Mr Leary told Matthew that he had only spoken to Dr Witheridge out of concern for Matthew. Ms Wilson arrived at the hospital around this time and she spoke to Mr Leary. When they returned inside the hospital they met with Matthew who told them that he would be asking for a review to hold him as an involuntary patient.

79. At some later time both Dr Hume and Dr Witheridge returned to Matthew's room. Dr Hume "*announced that it had been decided to keep Matthew in hospital for another night 'to monitor his withdrawal from alcohol*'".[32] Mr Leary was grateful that Matthew would not be released and hoped that Matthew would be properly assessed during his extended detention. However, Mr Leary described the reason given to detain Matthew as "*spurious*" because by this time Matthew had been in hospital for almost 40 hours and not consumed any alcohol.

Thursday, 6 November 2014

80. Matthew was discharged at around 10:40am the following morning 6 November 2014. Matthew went to see Ms Mithoefer for his third appointment with her. Later that day Ms Wilson made arrangements, through Carers Australia, for her and Mr Leary to receive some counselling to assist them to support Matthew. This appointment was made for 11 November 2014.

Sunday, 9 November 2014

81. On 9 November 2014 Mr Leary and Ms Wilson met with Matthew at his home to discuss his financial situation. They noted that Matthew's home appeared to be quite messy and discovered that Matthew had accumulated about $20,000 in debt. They discussed Matthew's upcoming tribunal hearing and realised Matthew could no longer afford to live in the flat. There was also some discussion about using the rental bond to account for the arrears and then finding Matthew some alternative accommodation.

Monday, 10 November 2014 and admission to St Vincent's Hospital

82. On the morning of 10 November 2014 Matthew began calling Ms McCann repeatedly from 4:30am. Ms McCann eventually answered and Matthew told her that he was at The Gap and that he was on the incorrect side of the fence and that the police were also there (after having received an alert notification from a local security service). Ms McCann repeatedly told Matthew not to do this and to cross back over the fence to safety. Ms McCann later sent a message to Mr Leary advising that Matthew was at The Gap. At 5:22am on 10 November 2014 Mr Leary received a text message from Ms McCann. They spoke on the phone shortly afterwards and Ms McCann told Mr Leary that Matthew was at The Gap and that they police had been called. Other police officers arrived at the scene at short time later with police negotiators arriving at around 6:15am. Mr Leary called the police and was eventually put through to a police officer at The Gap. Mr Leary passed on some information about Matthew's recent history and his own contact details.

[32] Exhibit 1, page 386.

83. Later that morning Mr Leary received a call from one of the police negotiators and passed on some further information about Matthew's recent history. Mr Leary asked if it would assist if he travelled to The Gap but was asked to remain where he was and told that he would be updated as things progressed. Despite this, Mr Leary felt that might be of assistance and drove to The Gap. Upon arrival Mr Leary identified himself and was asked by a police officer to move to a location where Matthew could not see him. It was explained to Mr Leary that his appearance might worsen the situation. Mr Leary agreed and asked the police, if they thought it appropriate, to tell Matthew that he was there, that he loved him, and to come back over the fence.

84. During the morning, Mr Leary was told that the police were still negotiating with Matthew, that he had asked for a drink, and that he had asked not to be taken back to the Kiloh Centre. As a result the police had contacted St Vincent's Hospital (**SVH**) and made arrangements for Matthew to be taken there if he came back over the fence.

85. The police continued negotiating with Matthew throughout the morning and Mr Leary kept in contact with Ms Wilson, Ms Edwards and Ms McCann to update them with what information he had. At some stage one of the police officers told Mr Leary that the negotiators had been speaking to a psychiatrist who thought that if Mr Leary wrote a message which could be given to Matthew it might assist the negotiations. Mr Leary wrote a brief message which he gave to a police officer to pass on to Matthew.

86. Eventually, at 2:36pm Matthew crossed back over to the correct side of the fence. Mr Leary was able to see him briefly before he was taken to an ambulance. Mr Leary drove to the ED at SVH and was met there later by Ms Wilson and Ms Edwards. They were advised that there was no psychiatrist available to speak to them and that Matthew would not be seen by a psychiatrist until the following morning. However, they were advised that they would have an opportunity to speak to someone after that. Mr Leary noted that Matthew appeared "*subdued and calm and positive*" in the ED and said that he expected that those treating Matthew would note the contrast between his presentation and actions at The Gap, and his presentation at hospital.[33]

87. Dr Candice Jensen, a registrar, interviewed Matthew when he was brought to SVH. At the time of presentation, Dr Jensen described Matthew as drug intoxicated and was at a high risk of suicide. She described Matthew as having mild to moderate depressive symptoms and that his symptoms indicated that he was psychotic and had anxiety.[34] Dr Jensen ultimately formed the view that Matthew was mentally disordered and required admission under the MH Act. As a result Matthew was later admitted to the Caritas unit, one of the mental health wards at SVH.

Tuesday, 11 November 2014

88. Dr Ramu Gopal Tulasi (known as Dr Gopal), psychiatry registrar, and Dr Matthew Cullen, consultant psychiatrist, reviewed Matthew at 11:45am on 11 November 2014. Dr Cullen noted that in that interview Matthew reported that his suicidal thoughts resolved and said that he was feeling better.[35] From a mental state examination Dr Cullen noted that Matthew's "*thoughts were logical and organised with no suicidal or homicidal ideas or ongoing thoughts of self-harm and there were no psychotic symptoms such as delusions or hallucinations*".[36] Dr Cullen also noted that

[33] Exhibit 1, page 391.
[34] Exhibit 1, page 677.
[35] Exhibit 1, page 687.
[36] Ibid.

Matthew's insight and judgment appeared appropriate but was impaired when under the influence of alcohol and other drugs. Dr Cullen concluded that given the improvement in Matthew's mental state, the fact that he was no longer intoxicated, and the lack of psychotic symptoms he was unable to detain Matthew under the MH Act.

89. Dr Cullen diagnosed Matthew as having mild to moderate depression in the context of various psycho-social stressors but noted that there was no evidence of psychotic or melancholic depression, and that his suicidal ideation was directly influenced by intoxication with various substances, with the other diagnosis being substance abuse disorder (primarily alcohol and cannabis).[37] Dr Cullen discussed with Matthew the plans that were in place to address his financial difficulties and substance abuse, noting that the plans seemed appropriate, but questioned Matthew as to whether he would be able to adhere to these plans.[38]

90. Sometime before midday, Mr Leary called Matthew who told him that he was likely to be discharged that day. Mr Leary described that he was "*horrified*" when he heard this, said that he was upset that no one had sought information from him, and that he could not understand how those treating Matthew would have had time to read the police notes and the notes from Matthew's previous admissions.[39] During the call Matthew mentioned going to the tribunal hearing on the Thursday, but Mr Leary expressed the view that he did not think that Matthew should be out of hospital at that time. Matthew ended the call but later rang Mr Leary back and said that he told the hospital that he did not consent to Mr Leary having any information about his treatment. Mr Leary and Ms Edwards, who was with Mr Leary at the time, became extremely concerned; Mr Leary felt that Matthew was "*trying to shut us out of the process so that he could be discharged and possibly carry through his suicidal intent*".[40]

91. Ms Edwards subsequently decided to write a letter to Matthew's treating team setting out her, and Mr Leary's, fears.[41] Ms Edwards explained her professional background as a barrister specialising in work within the coronial jurisdiction with significant experience of examining psychiatrists in the course of her professional work. In her letter Ms Edwards set out a recent chronology of events (including suicide messages sent by Matthew and the incident at Ms McCann's house on 11 October 2014), asked that her letter be attached to Matthew's file, and noted the following:

> "*I have no doubt that Matt genuinely believes he is in a constructive place today. He is understandably very reluctant to be detained against his will and his views should of course be given proper weight. But I am imploring his treating team to carefully review his history and explore his actual level of insight before making any decision*".[42]

92. Meanwhile, Mr Leary called Caritas a number of times in an attempt to find out who Matthew's treating doctors were. He was eventually told that Dr Cullen was the consultant and Dr Gopal was the registrar. Mr Leary asked to speak to either of them and was put through to Dr Gopal at around 2:00pm. Dr Gopal expressed his reluctance to speak with Mr Leary and referred to Matthew not giving consent for any information about his treatment being given to Mr Leary. Mr Leary told Dr Gopal that he was not seeking information, but was instead seeking to impart

[37] Exhibit 1, page 688.
[38] Ibid.
[39] Exhibit 1, page 392.
[40] Ibid.
[41] Exhibit 1, page 413.
[42] Exhibit 1, page 726.

information. Mr Leary also told Dr Gopal that he had grave concerns for Matthew's safety and was horrified that he was going to be discharged. Mr Leary said that "*in speaking to Dr Gopel [sic] I got the impression that he was not interested in my views and was doing his best to hang up the phone as soon as possible albeit in a courteous manner*".[43]

93. According to Gopal's recollection of the conversation, he noted that Mr Leary was very anxious and expressing his concerns about Matthew's recent behaviour. Dr Gopal told Mr Leary that whilst Matthew had not given his consent for Dr Gopal to provide information, he (Dr Gopal) was able to gather information from Mr Leary. When Mr Leary asked for Dr Gopal's email address Dr Gopal declined to provide it, explaining that because he was on six monthly rotations his email address would change in matter of weeks. Dr Gopal said that he wanted to ensure that anything that Mr Leary wrote would be placed in Matthew's file.[44] Dr Gopal recalls Mr Leary saying that he would attend the ward and provide a document in person which Dr Gopal said that he supported and encouraged. Dr Gopal also said that he asked the ward staff to provide a fax number to Mr Leary upon his arrival.[45]

94. Mr Leary's recollection of the conversation differs somewhat from Dr Gopal's. Mr Leary said that he told Dr Gopal that he had an important document which he wanted to forward to Matthew's treating doctors to consider and asked Dr Gopal if he could email it to him. Dr Gopal said that he could not. Mr Leary then asked for a fax number and, according to Mr Leary, Dr Gopal seemed reluctant to provide a number but eventually, at Mr Leary's insistence, transferred Mr Leary to another person. When Mr Leary repeated his request for a fax number he was initially not provided with one but was eventually given one.

95. As Mr Leary felt that he had received "*a run around from Caritas staff*" he decided to take the letter to hospital and personally give it to Dr Gopal as he had "*no confidence*" that if he faxed the letter it would make its way to Matthew's treating doctors or be read.[46] Mr Leary was aware that Ms Wilson was also going to the hospital that day and wanted to speak to her about his concerns.

96. At 2:20pm Dr Gopal had a lengthy family meeting with Matthew and Ms Wilson. When Mr Leary arrived at the Caritas unit he was shown into a room where the meeting, which he had not previously been told about, was taking place. Mr Leary was not told about this meeting because Matthew did not give consent to involve his father.[47] Matthew, Ms Wilson, Dr Gopal and at least two other Caritas staff were present. Dr Gopal told Mr Leary that Matthew could be discharged that day (11 November 2014) or that he could remain for one more night and be discharged the following day. According to Mr Leary the timing of discharge appeared to be at Matthew's discretion.[48]

97. Once told this Mr Leary became emotional and expressed the view that Matthew was being discharged without proper assessment, and that although Matthew said at times that he had no suicidal intention, his actions indicated that he posed a risk to himself. Mr Leary read from parts of Ms Edwards's letter and gave the letter to Dr Gopal and asked that he read and consider it. Mr Leary also asked that a copy of the letter be placed with Matthew's notes and shown to all

[43] Exhibit 1, page 392.
[44] Exhibit 1, page 678-2.
[45] Ibid.
[46] Exhibit 1, page 393.
[47] Exhibit 1, page 678-8.
[48] Exhibit 1, page 393.

involved in Matthew's care. According to Mr Leary, he did not see Dr Gopal read the letter.[49] Dr Gopal described Mr Leary as appearing anxious and talking over Matthew, especially about the contents of Ms Edwards' letter. Dr Gopal noted that Matthew was unsettled and, because of this, did not read the letter at the meeting. Dr Gopal said that Matthew rejected the contents of the letter and asked his father to leave the meeting. Dr Gopal said that Mr Leary eventually left after Ms Wilson asked that he do so.

98. Dr Gopal explained that during the meeting a plan was discussed for Matthew to remain overnight so that his mood, sleep, appetite, behaviour and risks could be observed. There was a plan for Matthew to have escorted leave with his family that day (11 November 2014) and that if that went well, for Matthew to have unescorted leave on 12 November 2014 to attend the Langton Centre for assessment.

99. Dr Gopal recalls that during the meeting Ms Wilson enquired about his diagnosis. Dr Gopal initially suggested that substance dependence was the issue but Ms Wilson did not accept this and requested a diagnosis. Dr Gopal went on to explain the risk to Matthew and that his risk escalated when under the influence of alcohol and/or recreational drugs, and said that both Matthew and Ms Wilson accepted this analysis.[50]

100. Mr Leary sent a message to Ms Edwards advising what had occurred and then waited to see Ms Wilson after the meeting finished. When it did Mr Leary saw Dr Gopal leave and walk towards a lift. Mr Leary saw that Dr Gopal was holding Ms Edwards's letter rolled up in his hand and asked Dr Gopal to read the letter. Dr Gopal said that he would and, according to Mr Leary, "*got very quickly into the lift as if to avoid further discussion*" with him.[51]

101. Mr Leary later met with Ms Wilson and Matthew whilst Matthew had a cigarette. Ms Wilson explained that it had been agreed that Matthew would stay one more night and would be given leave the next morning (12 November 2014) to see a drug and alcohol counsellor. Following that Matthew would return to the ward and be discharged and then spend one night with Ms Wilson.

102. Mr Leary said that whilst he was at Caritas on 11 November 2014 he was never provided with any diagnosis, there was no discussion about the appropriateness of Matthew's medication, and his input into Matthew's treatment was never sought.

Wednesday, 12 November 2014

103. In the morning Matthew went to an appointment at the Langton Centre. Dr Gopal, Dr Cullen, Dr Parthasanath (a junior medical officer) and two nurses later attended on Matthew at 2:30pm. Dr Gopal noted that Matthew was exhibiting mild to moderate symptoms and had been denying active suicidal thoughts or ideations, or thoughts of self-harm. Dr Gopal also recorded that Dr Cullen had noted the letter from Ms Edwards which had been provided by Mr Leary.[52]

104. On review Dr Cullen found no change in Matthew's mental state compared to the previous day. Dr Cullen described Matthew's mood as remaining "*fundamentally unchanged other than a mild degree of depression associated with some reduced energy and motivation, but no anhedonia*".[53] Dr

[49] Exhibit 1, page 393.
[50] Exhibit 1, page 678-3.
[51] Exhibit 1, page 394.
[52] Exhibit 1, page 678-3.
[53] Exhibit 1, page 688.

Cullen encouraged Matthew to remain as in involuntary patient but Dr Cullen said that Matthew "*firmly declined this offer indicating that he had broader psychological support than previously and linking his relapses to substance abuse*".[54] Dr Cullen also ceased citalopram (due to side effects) with a view to commencing Matthew on different antidepressant, venlafaxine.

105. Dr Gopal recorded that Dr Cullen provided detailed psycho-education, the rationale behind changing medication, and detailed explanation of the risks to Matthew. Dr Gopal said that the risk was currently low but that the risk escalated due to Matthew's poor coping skills to stressors, and his drug and alcohol use. Dr Gopal notes that Matthew accepted this assessment as being accurate.[55]

106. A discharge plan for Matthew was formulated which comprised the following: (a) Follow up with the Langton centre; (b) Psychologist review on Friday that week; (c) Acute care follow up by the Marrickville ACS; (d) Discharge into Ms Wilson's care; (e) Attend Rental Review Tribunal with Ms Wilson on 13 November 2014; (f) Review with Dr Gopal at O'Brien Centre at 3:00pm after the Tribunal review; (g) Matthew prescribed Venlafaxine; (h) Matthew and Ms Wilson's mobile numbers, and Ms Wilson's address, were all noted; (i) Matthew to follow up with a private psychiatrist with a referral from his GP.[56]

107. Mr Leary's and Ms Edwards' daughter [redacted] and, after being told the news by Mr Leary, Matthew expressed his joy [redacted]. In the afternoon Matthew sent Mr Leary a message advising that he had been discharged and was going to Ms Wilson's home.

Thursday, 13 November 2014

108. Matthew attended the tribunal hearing on 13 November 2014 with the result being that he had until the following Thursday to move.

109. Late at night on 13 November 2014 or early in the morning on 14 November 2014 Ms Wilson called Mr Leary to let him know that she had been contacted by Ms McCann and told that Matthew had gone missing again.

110. Dr Gopal notes that Matthew and Ms Wilson did not attend the scheduled appointment at the O'Brien Centre at 3:00pm on 13 November 2014 and that Matthew may instead have had an appointment with Ms Mithoefer (his fourth appointment) at that time.

Monday, 17 November 2014

111. During the afternoon of 17 November 2014 Matthew went to Mr Leary's home to visit [redacted]. He did not stay for long and Mr Leary described him as being unkempt and distracted. Mr Leary discussed briefly whether Matthew's property could be moved to Ms Wilson's home but Matthew became angered by this and said that he was not up to making any decisions. During this time, Matthew received a number of messages about possible short term accommodation in Dulwich Hill.

[54] Exhibit 1, page 689.
[55] Exhibit 1, page 678-3.
[56] Exhibit 1, pages 678-3 to 678-4.

Tuesday, 18 November 2014 to Tuesday, 25 November 2014

112. On 18 November 2014 Matthew was discharged from Marrickville ACS. Attempts had been made by the Marrickville ACS to arrange a home visit with Matthew on 16 November 2014 without success. The plan to discharge had been discussed with Matthew who agreed with it, indicating that he would continue to see Ms Mithoefer.

113. Matthew later moved into the Dulwich Hill home on 19 and 20 November 2014. On 20 November 2014 Matthew saw Ms Mithoefer for the fifth time and did not attend an appointment at the Langton Centre. On 21 November 2014 Matthew, Ms Audus, [redacted] and some friends went for a bushwalk and Matthew and [redacted] stayed with Ms Wilson over the weekend of 22 and 23 November 2014. On 25 November Matthew had his sixth and final appointment with Ms Mithoefer and again failed to attend an appointment at the Langton Centre.

Wednesday, 26 November 2014

114. On 26 November 2014 Matthew visited Mr Leary at home to spend time with [redacted] and Ms Edwards, and have dinner. Matthew appeared very quiet, subdued and sad to Mr Leary but he stayed longer than expected and he, Ms Edwards and Mr Leary spent an enjoyable evening watching TV with Matthew commenting that he was looking forward to spending Christmas with Ms Audus and [redacted] at Mr Leary's and Ms Edwards's home.

Thursday, 27 November 2014

115. Matthew saw Ms McCann at a social event on 27 November 2014. At 11:43pm Matthew sent Ms McCann a Facebook message which said, "*I can't deal with the heart ache any more in all senses of the world. I love you always x*". Shortly before midnight, Matthew called a friend, Katherine Sassoon, and told her that he was at Watsons Bay. Ms Sassoon, aware of some of Matthew's recent history, became concerned and asked Matthew to meet her. Matthew declined and Ms Sassoon decided to make her way to Watsons Bay.

Friday, 28 November 2014

116. Ms Sassoon arrived at The Gap at around 12:20am. She called Matthew from her phone in an attempt to find him. Matthew said that he wanted some time alone, that he just wanted to watch the waves, that he hadn't jumped to the incorrect side of the fence and wasn't thinking like that, told Ms Sassoon to go home and that he would call her in the morning.

117. At around 1:07am an on-site security officer on duty at Watsons Bay received an alert that the perimeter fence at The Gap had been breached and notified police. At 1.08am Matthew sent a text message to 26 people, including family and friends, which read, "*Love you always x*".

118. Police officers arrived on the scene at 1:10am and began looking for Matthew. At 1:17am they found Matthew between Jacobs Ladder and Jacobs Ladder North, on the incorrect side of the fence and sitting on the cliff edge. As he saw the police officers approaching, Matthew stood up and walked towards the fence. Matthew recognised one of the police officers to be Constable Kim Vanderzanden, who had previously met Matthew, including on 10 November 2014. Constable Vanderzanden said to Matthew, "*How are you going, Matthew, what's happened today? What brings you up here?*", and asked him to come to the correct side of the fence. Matthew

walked away from the fence and sat back down again. Constable Vanderzanden again asked Matthew to come back to the correct side of the fence. Matthew did not respond and, after about a minute, he stood back up and came towards the fence. Matthew said, "*I'm really sorry, I'm really sorry*", and then turned and ran off the cliff at 1:20am.

119. Police from the Aviation Unit and Marine Command were despatched to the scene. With the assistance of a police helicopter, Matthew's body was located in the waters below The Gap about 10 metres from the shoreline at about 1:47am. Water police recovered Matthew from the water a short time later and found that he was unresponsive with no signs of life.

What was the cause of Matthew's death?

120. Matthew was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Istvan Szentmariay at 9:15am on 28 November 2014. Dr Szentmariay found that there was a small amount of white frothy material around the nostrils which was a strong indicator of drowning. Dr Szentmariay also noted that multiple x-rays showed a noticeable deviation of the vertical axis of the cervical spine, which may represent cervical spinal damage, and that toxicological testing returned a blood alcohol level of 0.187 g/100mL. Dr Szentmariay eventually concluded in his autopsy report dated 8 April 2015 that the cause of death was drowning.[57]

What was the manner of Matthew's death?

121. Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence. Taking into account Matthew's history of persistent suicidal ideation, his past threats of self-harm, his repeated visits to The Gap, the assessments conducted during his hospital admissions, and his witnessed actions on 28 November 2014, I conclude that the evidence is sufficiently clear, cogent and exact[58] to allow a finding to be made that Matthew died as a consequence of actions taken by him with the intention of ending his life.

What issues did the inquest consider?

122. Prior to the inquest, a list was sent to the interested parties outlining the issues which the inquest would consider (**the Issues List**). Those issues are:

    (1) Communication between treating professionals involved in Matthew's care (Kiloh Centre, Prince of Wales Hospital; Caritas, St Vincent's Hospital; Marrickville Community Mental Health) and Matthew's family and significant others including:

        (a) Desirability of obtaining relevant information from family and significant others (including the type of support they were able to offer);

        (b) Whether concerns around maintaining patient confidentiality dissuaded treating professionals from listening to family and significant others;

        (c) In circumstances where Matthew's family and significant others were supporting him through his illness, what supports were available to them.

[57] Exhibit 1, page 9.
[58] *Briginshaw v Briginshaw* (1938) 60 CLR 336.

(2) Efforts to diagnose Matthew's illness, to establish an appropriate treatment plan and the adequacy of discharge planning (assuming treatment in the community) relating to Matthew's admissions at:

(a) Prince of Wales Hospital commencing 3 November 2014;

(b) St Vincent's Hospital commencing 10 November 2014.

(3) Arrangements for ongoing treatment in the community including:

(a) Coordination and communication between Prince of Wales Hospital, St Vincent's Hospital, Langton Clinic, Marrickville Community Health and Matthew's general practitioner and psychologist;

(b) Matthew's level of engagement with these services and whether information about his engagement (or lack thereof) was shared with other services;

(c) Communication with the family and significant others on the type of support they were actually able to provide, how to encourage Matthew to pursue treatment in the community and where to turn if Matthew refused to engage whilst his mental health further deteriorated.

123. In order to investigate some of the matters raised in the Issues List, a number of reports were obtained from experts in the field of psychiatry. The Office of General Counsel, on behalf of the Coroner's Court, instructed Dr James Telfer, consultant psychiatrist and senior staff specialist in psychiatry at Royal North Shore Hospital, to provide several independent expert reports. Following receipt of Dr Telfer's reports, SVH instructed Dr Tanya Ahmed, consultant psychiatrist and clinical director and inpatient Visiting Medical Officer at the South East Regional Hospital psychiatric unit, to also provide a report. Similarly, the South Eastern Sydney Local Health District (**SESLHD**), on behalf of POWH and its clinicians, instructed Dr Christopher Ryan, consultant psychiatrist and director of consultant liaison psychiatry at Westmead Hospital to provide a report. Each of these experts gave evidence during the inquest.

124. At the conclusion of the evidence in the inquest, the matter was adjourned and a timetable fixed for the interested parties to prepare written submissions. Submissions were received from Counsel Assisting, Mr Leary and Ms Wilson, SVH, and SESLHD (including Dr Frank Hume and Dr Katherine Witheridge) and Sydney Local Health District (**SLHD**) (including Mr Paul Clenaghan).

125. I acknowledge that the submissions prepared by Mr Leary and Ms Wilson have been made on behalf of Matthew's immediate and extended family, and Ms McCann. For convenience, I will respectfully refer to the submissions from Mr Leary and Ms Wilson as the submissions from Matthew's family.

126. In their submissions, Matthew's family contend that that there were three major failures in Matthew's care and that three corresponding findings should be made. Matthew's family submit that the **First Failure** was:

> *Doctors at both hospitals failed to properly engage with Matthew's family and therefore failed to properly assess the risk that Matthew faced. This failure occurred on both of*

Matthew's presentations to the Prince of Wales Hospital, and on the single presentation to St Vincent's Hospital.[59]

127. On this basis, Matthews's family submit that the following finding should be made:

> *Treating staff at Prince of Wales and St Vincent's Hospital failed to adequately take account of family observations, experience and concerns in relation to Matthew's illness. This failure prevented those same doctors from taking adequate account of risk factors relating to Matthew's condition and risk. A specific finding is sought in relation to a failure by St Vincent's Hospital to provide a realistic avenue for family members to communicate with doctors*.[60] (**Proposed Finding One**)

128. Matthew's family submit that the **Second Failure** was:

> *Treating doctors also failed to obtain highly relevant information that could have been provided by Matthew's treating GP, Dr Ballin, and clinical psychologist, Sarah Mithoefer. Both professionals had seen Matthew on multiple occasions, had become extremely concerned about his mental health, and in the case of Ms Mithoefer, had made a diagnosis of a moderate to severe Major Depressive Episode. Ms Mithoefer was qualified to make this diagnosis. It was ignored by treating doctors at Prince of Wales and St Vincent's*.[61]

129. On this basis Matthew's family submit that the following finding should be made:

> *Treating staff at St Vincent's Hospital failed to adequately investigate and take account of other medical and psychological views, specifically the views of Dr Ballin and Ms Mithoefer, in coming to a decision to provisionally discharge Matthew on 11 November 2014. Both Dr Ballin and Ms Mithoefer were qualified to make the observations and diagnosis that they did make. They had information relevant to Matthew's condition and risk, but no effort was made to obtain those professionals' views*.[62] (**Proposed Finding Two**)

130. Finally, Matthew's family submit the **Third Failure** to be:

> *The Third Failure: Doctors at St Vincent's failed in their obligations to Matthew in coming to a decision to provisionally discharge him on the morning of 11 November 2014 and to communicate this decision to him. The decision to discharge him on 12 November 2014 was also a failure*.[63]

131. On this basis Matthew's family submit that the following finding should be made:

> *Doctors at St Vincent's Hospital, in making a conditional discharge of Matthew on the morning of 11 November 2014, acted prematurely and without properly taking a corroborative history. Communicating this decision to Matthew that morning increased the risk of Matthew surreptitiously working toward gaining his own discharge and undermined any possibility of using Matthew's close relationship with his family and psychologist to*

[59] Submissions on behalf of Matthew's family, page 2.
[60] Ibid.at [9].
[61] Ibid., page 3.
[62] Ibid.at [9].
[63] Ibid., page 3.

fashion a treatment plan best suited to his needs and risk factors.[64] (**Proposed Finding Three**)

132. Matthew's family submit that there are a number of evidentiary bases that would allow the making of each of the proposed findings referred to above. Firstly, as there is considerable direct overlap between these evidentiary bases and the Issues List, I propose to consider each of these bases individually. Secondly, as there was also a degree of overlap between the evidentiary bases themselves I have attempted below to separate and summarise them into discrete categories so that they may be individually considered for clarity.

Should Proposed Finding One be made in relation to Prince of Wales Hospital?

133. Matthew's family submit that Proposed Finding One should be made because:

    (a) There was an insufficient degree of communication between Ms McCann and treating clinicians on 22 October 2014;

    (b) Treating clinicians did not take an appropriate history on 4 November 2014;

    (c) Dr Hume did not take a comprehensive history from Matthew on 5 November 2014;

    (d) The fears and observations of Ms Wilson and Mr Leary were discounted and disregarded by treating clinicians.

    (e) Dr Hume's evidence was unreliable and should be rejected; and

    (f) The treating clinicians failed to properly assess the risk that Matthew faced.

134. I will consider each of these matters in turn below.

Was there a sufficient degree of communication between Ms McCann and treating clinicians on 22 October 2014?

135. Matthew's family submit that on 22 October 2014 Ms McCann was not given the opportunity to speak with clinicians at POWH in Matthew's absence and when she did attempt to communicate her concerns to staff, her attempts were ignored.[65] Matthew's family point specifically to the interview that Dr Jennifer Chan conducted with Matthew. The clinical records from that interview note that Matthew "*denied any plan/intent of selfharm (sic) or suicide*"[66], that there were "*no past suicide attempts*"[67] and that Ms McCann was "*happy to have Matthew home with her tonight*". Matthew's family submit that what is documented in the clinical records is in direct contrast to Ms McCann's experience of the attendance at POWH. It is submitted that this contrast was due to Ms McCann not being given an appropriate opportunity to raise any concerns that she had about Matthew and his care.

136. Ms McCann was present when Dr Chan interviewed Matthew. Ms McCann said that during the interview the "psychologist" (I have taken this to be a reference to Dr Chan) never asked her

[64] Submissions on behalf of Matthew's family at [9].
[65] Ibid.at [12].
[66] Exhibit 1, page 629.
[67] Ibid.

what she thought of the situation concerning Matthew. Ms McCann also said that she attempted to communicate non-verbally to Dr Chan, by shaking her head out of Matthew's line of sight, that Matthew should not be released and that what he was saying to Dr Chan should not be accepted.[68] This is because Ms McCann was of the view that "*of course Matthew said what he needed to say to be released*" and that it was "*pretty straight forward to work that out*"[69]. However, Ms McCann says that Dr Chan took no notice of this.[70] Specifically no mention was made by Matthew of the events of 11 October 2014 and Ms McCann says that she had no opportunity to raise it during the interview.[71] This is understandable as Ms McCann described the situation as "*fragile and tense*" and that she "*didn't want to do anything that would make it worse*".[72]

137. Dr Chan provided a statement[73] describing her interaction with Matthew, although she was not called to give evidence. Prior to the inquest, further questions were posed to Dr Chan and she responded to them in writing.[74] Dr Chan was asked whether, if she had been aware of certain information (such as the fact that Matthew had sent suicide notes to his parents on 22 October 2014) which had not been made known to her at the time of interviewing Matthew, there would have been a need to critically evaluate what Matthew was telling her. Dr Chan said that her assessment of Matthew involved "*developing a rapport with him and to explore information about mood, content of thinking, suicidal ideation, and psychiatric symptoms*". Dr Chan explained that at the time of her assessment "*Matthew's account was consistent with an honest statement of experience*".[75] Further Dr Chan was specially asked whether she was able to have a discussion with Ms McCann, in Matthew's absence, to assess Ms McCann's capacity to care for Matthew in the short term. Dr Chan's answer was, "*Yes, it is my usual practice*".[76]

138. **Conclusion:** Clearly, there is a direct conflict as to whether Ms McCann ever had an opportunity to speak to Dr Chan in Matthew's absence. On the evidence available it is not possible to resolve this conflict. What is clear though is that Dr Chan did not have available to her information about Matthew's threats of self-harm on the evening of 11 October 2014. I infer that the discrepancy between the clinical records documenting that "*Khye is happy to have Matthew home with her tonight*"[77] and Ms McCann's evidence that Matthew being released into her care was "*beyond [her] capacity*"[78], appears to be due to the fact that there was simply no other option available at the time. Ms McCann said that if Matthew was to be released she "couldn't risk angering him because it was my responsibility to keep him safe through the night"[79] and "*if they were to release him, I felt like he – definitely shouldn't be alone*".[80]

139. The evidence at inquest established as a general principle of clinical practice that it is of assistance to take collateral histories from other health professionals involved in a patient's care, as well as from family members and significant others. This issue will be discussed in further detail below. In relation to the events of 22 October 2014 it is not known why there is a direct

[68] Exhibit 1, page 438.
[69] Ibid.
[70] 5/12/17, T60.17.
[71] 5/12/17, T60.40.
[72] 5/12/17, T60.7.
[73] Exhibit 1, page 526.
[74] Exhibit 1, page 530.
[75] Exhibit 1, page 531.
[76] Exhibit 1, page 533.
[77] Exhibit 1, page 557.
[78] 5/1/217, T60.17.
[79] Exhibit 1, page 438 at [43].
[80] 5/1/217, T60.3.

factual conflict regarding whether Ms McCann ever had an opportunity to speak to Dr Chan in Matthew's absence. Although such an opportunity was not documented in the clinical records, other than obliquely, Dr Chan's statement is to the effect that she formed the view that Matthew was providing an honest account of his intentions. On this basis, even though the available evidence does not positively confirm that there was sufficient communication between Dr Chan and Ms McCann, it appears that Dr Chan performed a critical assessment of the information provided by Matthew.

Was an appropriate history taken by treating clinicians on 4 November 2014?

140. Matthew's family submit that on 4 November 2014 only a limited history was taken from Ms McCann (which included the events of 11 October 2014[81]) and that few other observations were made by clinicians who reviewed and assessed Matthew.

141. A review of the clinical records revels the following interactions between Matthew and clinical staff on 4 November 2017:

(a) a history was taken by a registered nurse at around 1:27am;[82]

(b) an examination was performed by Dr Elaine Kwan (registrar) at around 7:00am;[83]

(c) a history was taken by Dr Adam Skinner (resident medical officer) at around 9:18am;[84],

(d) a history (including collateral histories taken from Ms McCann, Mr Leary and Ms Wilson) was taken by CNC Simon Llewelyn at about 9:56am;[85]

(e) following Matthew's transfer to the Kiloh Centre, a history was taken by a drug and alcohol CNC at around 10:56am;[86] and

(f) a history was taken by a registered nurse at around 5:06pm on 4 November 2014.[87]

142. Also contained within the clinical records is a summary contained in the determination made by Dr Large that Matthew was a mentally disordered person.[88]

143. **Conclusion:** It appears that part of the difficulty in making detailed clinical observations was due to Matthew's presentation, which in turn made it difficult to take a reliable history from him. Dr Kwan recorded that she was "*unable to obtain consistent history from patient – currently intoxicated on alcohol +/- other substances*"[89] and that "*Matthew is currently intoxicated on review and needs re-assessment of his mental state when sober*".[90] Dr Skinner also noted, "*Patient not co-operative with discussion or assessment. Intermittently replying 'nope' to all questions" and "psychiatry registrar unable to assess due to intoxication*".[91] At the time of Dr Large's review it

[81] Exhibit 1, page 646.
[82] Exhibit, page 634.
[83] Exhibit 1, pages 639-643.
[84] Exhibit 1, page 644.
[85] Exhibit 1, pages 646-648.
[86] Exhibit 1, page 650.
[87] Exhibit 1, page 652.
[88] Exhibit 1, pages 580-590.
[89] Exhibit 1, page 641.
[90] Exhibit 1, page 643.
[91] Exhibit 1, page 644.

was noted, "*Continues to offer limited engagement with limited not able (sic) to offer any reasonable explanations*".[92]

144. However by the following morning, when Matthew was assessed by Dr Witheridge, his condition had improved markedly and Matthew was noted to be "*pleasant and cooperative*".[93] This meant that Dr Witheridge was able to take a history from Matthew, as well as a collateral history taken from Marrickville ACS, Dr Ballin, Ms Mithoefer and Mr Leary, and record detailed observations.[94] Therefore, although detailed observations were not recorded on 4 November 2014 several attempts were made to do so. The absence of observations appears to have been due to Matthew's presentation rather than any shortcoming in clinical practice.

Did Dr Hume take a comprehensive history?

145. Matthew's family submit that the history provided by Ms McCann about the pervasive nature of Matthew's mental health and the risk that he posed to himself should have been uncovered if a careful and corroborated history was taken by Dr Hume on 5 November 2014. Matthew's family also submit that Dr Hume's position that this information may not have changed his approach to Matthew in any way cannot be accepted.

146. Dr Hume could not recall whether Ms McCann's account of Matthew "*discussing suicide*"[95] was ever given to him at any time during 4 to 6 November 2014.[96] Whilst agreeing that such information would have been useful[97] Dr Hume said that it "*probably*" would not have, in retrospect, changed his approach to Matthew in any way.[98] When asked why, Dr Hume explained that he thought Matthew had enduring suicidal ideation, numerous psychosocial stresses, and a major problem with binge alcohol.[99] Matthew's family submit that Dr Hume's position cannot be accepted and that these were relevant matters to Matthew's eventual diagnosis.[100] Matthew's family submit that if a careful history had been taken relevant information such as Matthew's sense of absolute hopelessness, his inability to abstain from alcohol, and the rapid onset of suicidality would have been uncovered.

147. **Conclusion:** As Dr Hume made no record of his meeting with Matthew on 5 November 2014 (this was a task delegated to his junior doctor, Dr Witheridge) it is not possible to determine what relevant history he elicited from Matthew. The questions posed to Dr Hume regarding Ms McCann's evidence that Matthew previously discussed suicide did not go into precise detail. It is therefore difficult to gauge whether Dr Hume gave appropriate consideration to the pervasive nature of Matthew's suicidal thoughts that Ms McCann was aware of.

148. However Dr Hume did give consideration to this matter in other ways.[101] Dr Hume said that he was aware of the two emails that Matthew had sent to his parents and that Matthew had minimised their significance. Although Matthew told Dr Hume that he was not suicidal on 3 November 2014 Dr Hume formed the view that Matthew was in fact suicidal at the time. Finally,

[92] Exhibit 1, page 647.
[93] Exhibit 1, page 656.
[94] Exhibit 1, pages 656-659.
[95] 5/12/17, T95.36.
[96] 5/12/17, T95.42.
[97] 5/12/17, T95.46.
[98] 5/12/17, T95.49
[99] 5/12/17, T96.2.
[100] Submissions on behalf of Matthew's family at [17].
[101] Exhibit 1, page 545-5 at [42].

Dr Hume was aware that Matthew had told Mr Leary of his intention to conceal any suicidal intent in the future and noted that that type of comment "*is not out of the ordinary for someone presenting as Matthew did earlier that day*".[102]

149. Although Dr Hume had no specific regard to the history which Ms McCann gave evidence about, it is clear that Dr Hume did give consideration to certain matters in assessing Matthew's mental state. These matters – namely Matthew's enduring suicidal ideation, his numerous psychosocial stresses, and his problems with alcohol – are the very matters that Matthew's family submit Dr Hume ought to have had regard to.

Were the fears and observations of Mr Leary and Ms Wilson discounted and disregarded by clinicians during Matthew's admission from 4-6 November 2014?

150. Ms Wilson's impression was that she did not feel that the meeting on 5 November 2014 with Dr Hume and Dr Witheridge was an inclusive one. Ms Wilson gave evidence that she felt that it was more the case that she and Mr Leary were being told what was going to happen with Matthew[103], rather than being allowed to have any constructive input. Further, Ms Wilson notes that no clinician asked to see her or Mr Leary separately without Matthew present.[104]

151. Mr Leary describes a similar experience concerning both of his meetings with Dr Hume on 5 November 2014. In the first meeting Mr Leary said that there was only a very short conversation where his impression was that "*the take home message was, 'Your son is a drunk, he might have some mental health issues, but we'll never get to the bottom of them unless he stops drinking'*".[105] In the second meeting Mr Leary describes Dr Hume as doing most of the talking about Matthew's issues, without soliciting any information from Mr Leary.[106] Mr Leary said that he had no opportunity to raise any concerns that he had with Dr Hume.[107]

152. There is no dispute that Dr Hume's first meeting with Mr Leary and Ms Wilson was unexpectedly cut short when Dr Hume and Dr Witheridge were called away after receiving a page to attend to another patient. Dr Hume gave evidence that, prior to the meeting, it had been his intention "*to spend quite a lot of time with Mr Leary, to say what – well this is our assessment to date of Matthew*"[108] and to elicit information from Mr Leary.[109] Dr Hume also said that Dr Witheridge told him that that there may have been an opportunity to speak with Mr Leary later that day, and that he intended to do so, but that unfortunately it was a busy afternoon.[110] In this regard, counsel for the SESLHD submits that regard must be had to Dr Hume's competing clinical obligations on the day which included seeing up to 12 patients plus, as already noted, emergencies.[111]

153. Counsel for the SESLHD also points to a recognition made by Dr Witheridge in her statement that she specifically recalled thinking that Matthew had a good level of family support, and was impressed by Mr Leary as a committed and caring parent. Dr Witheridge found these factors to

[102] Exhibit 1, page 545-5 at [42].
[103] 5/12/17, T34.20.
[104] 5/12/17, T34.37.
[105] 4/12/17, T58.41.
[106] Exhibit 1, page 385.
[107] 4/1/217, T58.48.
[108] 6/12/17, T10.13.
[109] 6/12/17, T10.21.
[110] 6/12/17, T10.24.
[111] 6/12/17, T16.17.

be atypical for patients in the Kiloh Centre.[112] On this basis it is submitted that Dr Witheridge's observations demonstrates that the important role of Matthew's family was accepted and recognised, and not discounted or disregarded.

154. **Conclusion:** Receipt of information that a family member of a patient may wish to provide to a clinician treating that patient is a delicate issue. There is the potential that such communication may be viewed by the patient as a breach of trust, thereby undermining any beneficial therapeutic alliance that may have been built between clinician and patient. This matter is explored further below.

155. It is unfortunate that Dr Hume's first meeting with Mr Leary and Ms Wilson was unexpectedly cut short. It is of course impossible to know what may have transpired had Dr Hume and Ms Wilson not been paged away to attend to another patient. There is no evidence to contradict Dr Hume's evidence that he intended to spend quite a lot of time with Mr Leary (and, I infer, Ms Wilson). However, there is also no evidence that Dr Hume attempted to carry through with this intention after the meeting was cut short or, at the least, conveyed this intention to Mr Leary and Ms Wilson.

156. The point to be made here is not that if Dr Hume had received relevant information and concerns from Mr Leary and Ms Wilson it would have necessarily altered Matthew's diagnosis or treatment plan. Indeed the evidence from Dr Hume is that it probably would have made little to no difference to his approach to Matthew. Instead, the point is that Mr Leary and Ms Wilson felt that the care and treatment provided to Matthew was not inclusive in the sense that they were not afforded an opportunity to raise their concerns in a way that still protected Matthew's desire for confidentiality. This meant that Mr Leary and Ms Wilson felt that they were "*sidelined*", and that their views were not taken seriously.[113]

157. Counsel for the SESLHD submits that perhaps the differing views between the treating clinicians and Matthew's parents is simply due to perception. I think that there is some force to this submission. It seems to me that the conduct of comprehensive clinical practice would suggest that the family members of a patient in Matthew's situation should not be left in a situation where they could reasonably form such a perception.

Should Dr Hume's evidence be rejected?

158. Matthew's family submit that in giving evidence Dr Hume commonly made "*sweeping statements of Matthew*" and observations of his personality, suicidality and relationship with his parents which could not have, in all likelihood, been gathered from his meetings with Matthew on 5 November 2014.[114] In this regard Matthew's family submit that it is "*more likely that Dr Hume's evidence was a combination of some recollection, as well as post fact reconstruction and hypothesis*" and, as a result, much of it should be rejected.[115]

159. In support of this submission, Matthew's family point to three factors. Firstly, attention is drawn to questions asked of Dr Hume about his review of Matthew on 5 November 2014 during his ward rounds. Dr Hume agreed that he did not document anything, at any stage, in Matthew's

[112] Exhibit 1, page 541-5.
[113] Submissions on behalf of Matthew's family at [40].
[114] Ibid at [31].
[115] Ibid at [32].

file.[116] Dr Hume also agreed that the four lines documented by Dr Witheridge in the clinical records about the second meeting constituted the only note made by her regarding his interaction with Matthew that day. The lines read[117]:

> *Reviewed by Dr Hume*
> *Depressive episode with concurrent alcohol abuse*
> *Needs to cease alcohol use to get to the root of his anger and grief*
> *Doesn't need to be an inpatient for this*

160. Dr Hume agreed that Dr Witheridge was a fairly detailed note taker[118], as demonstrated by the balance of her entries in the clinical records. When asked if the brevity of Dr Witheridge's documentation of his interaction with Matthew, compared against her other notes, caused Dr Hume to think that his interaction was shorter than he recalled, Dr Hume said that it did not.[119] Instead Dr Hume described Dr Witheridge's notes as a "*pithy summary*" which did not go into detail and which did not reflect the length of time spent, nor the issues discussed, with Matthew.[120]

161. While acknowledging that his memory about the day had dimmed over time, Dr Hume said that it was his recollection that the interview lasted around 40 minutes which he described as "*a fairly typical time frame*".[121] Dr Hume gave evidence that he spent "*a substantial period of time*"[122] with Matthew and that it "*was not a brief interview*"[123] as "*there were clearly lots of issues that needed to be discussed and they were discussed with Matthew*".[124] Dr Witheridge described Dr Hume's usual practice of reviewing a patient's progress notes prior to making his own assessment of the patient and that such consultations typically take around 30 to 45 minutes.[125]

162. Secondly, Matthew's family relies upon Matthew's report to Ms Mithoefer (on 6 November 2014) that a "*consultant*" spent "*only a couple of seconds*" with him, that the consultant "*didn't give [Matthew] the time of day*", and that this made Matthew feel "*dehumanized*".[126] The content of Ms Mithoefer's notes were raised with Dr Hume in evidence. Dr Hume said that the only other consultant who saw Matthew on 4 November 2014 was Dr Large and that that was only a very brief assessment.[127] Dr Hume rejected the possibility that Matthew was referring to him in the notes taken by Ms Mithoefer.[128]

163. Thirdly, Matthew's family points to the discrepancy between the discharge summary written by Dr Witheridge and Dr Hume's diagnosis. In the discharge summary Dr Witheridge noted: "*Matthew has been suffering from an acute depressive illness for about 2 months on a background of chronic depression first diagnosed in 2007*", and, "*Matthew has an acute on chronic depressive illness and situational crisis that is exacerbated by his excessive alcohol and cannabis use*".[129] Dr

[116] 6/12/17, T14.4.
[117] Exhibit 1, page 659.
[118] 6/12/17, T15.47.
[119] 6/12/17, T15.25.
[120] 6/12/17, T15.43, T16.13.
[121] Exhibit 1, page 545-5.
[122] 6/12/17, T15.13.
[123] 6/12/17, T16.8.
[124] 6/12/17, T16.12.
[125] Exhibit 1, page 541-5.
[126] Exhibit 1, page 506.
[127] 6/12/17, T17.1
[128] 6/12/17, T17.10.
[129] Exhibit 1, page 665.

Hume's diagnosis was that Matthew had a situational crisis and was acutely distressed or dysphoric, which he later termed to be an adjustment disorder during evidence.

164. Dr Hume explained that it was possible that Dr Witheridge's "*summary was a misrepresentation of what I'd thought about Matthew*".[130] Dr Hume described Dr Witheridge's conclusion as an incomplete formulation and due to a difference in terminology[131], and that the more correct technical term for Matthew's diagnosis would be adjustment disorder with depressed mood.[132] Dr Hume agreed that the phrase adjustment disorder was not contained in his statement[133] but that it was contained in Dr Ryan's report which he read within two weeks of giving evidence at the inquest. In this regard, Dr Hume acknowledged that Dr Ryan's report made him "*more aware of the correct terminology*"[134] and that his diagnosis of Matthew having what he initially termed as a situational crisis was "*sort of the same as an adjustment disorder*".[135] Counsel for the SESLHD submits that Dr Hume's explanation for the apparent discrepancy being due to misinterpretation should be accepted and, in any event, nothing turns on it.[136]

165. **Conclusion:** The brevity of Dr Witheridge's notes pertaining to Dr Hume's review of Matthew is difficult to reconcile with Dr Hume's own recollection of the event. It is clear, as Dr Hume acknowledged, that Dr Witheridge appears to have been a detailed note-taker. Certainly, Dr Witheridge recorded the collateral histories that she took from Mr Leary, Dr Ballin, Ms Mithoefer and Marrickville ACS in some detail.

166. Dr Hume gave evidence that there were many issues that needed to be discussed with Matthew. However there is no clear evidence as to the detail of these issues or what was actually discussed. Certainly, anything that might have been discussed was not documented in detail by Dr Witheridge contrary to, it would seem, her other note-taking. Neither Dr Hume nor Dr Witheridge have a specific recollection as to how long the meeting with Matthew took. Instead, the evidence given in their statements and during the inquest is based on what was their understanding of their usual practice and how long a review of that kind typically took. Counsel for the SESLHD submits that in the absence of direct evidence to the contrary, it is more than likely that Dr Hume followed his usual practice on 5 November 2014.[137]

167. The brevity of Dr Witheridge's record of Dr Hume's review of Matthew, and Matthew's recounting to Ms Mithoefer of his review by a consultant do not amount to direct evidence contrary to Dr Hume's usual practice. However, in my view, they provide in combination an evidentiary basis upon which I infer that Dr Hume did not spend as much time in his review of Matthew as his evidence suggests. The discrepancy between Dr Hume's diagnosis and Dr Witheridge's record in the discharge summary does not assist in this regard. I agree with counsel for the SESLHD that nothing turns on it and that the discrepancy can reasonably explained by misinterpretation. However, the evidence of Dr Hume's competing clinical obligations due to the ward being busy on 4 November does provide assistance in drawing such an inference.

[130] 5/12/17, T93.9.
[131] 5/1/217, T89.33.
[132] 5/1/217, T89.6.
[133] 6/1/217, T7.5.
[134] 6/12/17, T7.17.
[135] 6/12/17, T7.19.
[136] Submissions on behalf of SESLHD at [54].
[137] Ibid at [48].

168. From that evidentiary basis it is more difficult to draw the further inference suggested by Matthew's family: that is, to infer that Dr Hume's evidence, or at least much of it, should be rejected. I have concluded that Dr Hume's recollection of how much time he spent with Matthew was less than what he believed to be the case, and less than what his usual practice was regarding patients. This may have been due to mistake or lack of recollection on the part of Dr Hume. To conclude further that Dr Hume's evidence should be rejected in its entirety would require, I think, evidence that Dr Hume deliberately embellished his account of the time spent interviewing Matthew. I can no find no evidence that this occurred.

Did the treating clinicians fail to properly assess the risk that Matthew faced?

169. Matthew's family submit that regardless of the clarity or otherwise of Dr Hume's evidence and regardless of how long Dr Hume might have spent with Matthew, the fact remains that Dr Hume undertook little to no investigation of the concerns raised by Matthew's parents.[138] Matthew's family also submit that Matthew's statements were taken at face value and Dr Hume did not "*reality test*" a reference in the discharge summary to Matthew expressing no further suicidal ideation and being positive about his mental health support network[139] by speaking to Mr Leary about these issues.[140]

170. Counsel for the SESLHD submits that the competing factors in Matthew's care were carefully weighed by Dr Hume.[141] On the one hand, Dr Hume formed the opinion that Matthew's mental state was stable and that he did not need further hospitalisation. Dr Hume considered that Matthew could be safely discharged and noted that Matthew had a good management plan which included discharge and treatment in the community, a plan to live with his father, an appointment with a psychologist, a GP management plan, community Crisis Team follow up, a drug and alcohol appointment, an appointment with a psychiatrist, and good family support.

171. On the other hand, Dr Hume explained that consideration had to be given to the potential negative effects of keeping Matthew in a psychiatric ward. He explained that many patients in the Kiloh Centre are very ill and have confronting behaviours. He explained that mentally disordered people such as Matthew should be protected from truly mentally ill people and that, in his opinion, exposing Matthew to such an environment was not the best option when Matthew had a good management plan on discharge.[142] Dr Hume gave evidence that involuntary admission carried the risk that Matthew would be exposed to what Dr Hume described as "*not a good place to be*"[143] particularly when Matthew himself had described it as a "*distressing experience*"[144] in circumstances where he was getting better by the hour but other involuntary patients were either fluctuating or not necessarily getting better.[145]

172. Dr Hume formed the view that Matthew was genuine in his positivity toward the management plan and support networks that were put in place. However he explained that it is not uncommon for patients to not tell the truth and that is a factor that clinicians must have regard

[138] Submissions on behalf of Matthew's family at [39].
[139] Exhibit 1, page 666.
[140] 5/12/17, T93.47.
[141] Submissions on behalf of the SESLHD at [51].
[142] Exhibit 1, page 545-6.
[143] 6/12/17, T20.45.
[144] Exhibit 1, page 577.
[145] 6/12/17, T21.25.

to. Dr Hume noted that it was possible that Matthew was lying about his future intentions, but noted that not telling the truth would not allow for a patient to be detained in hospital.[146]

173. In any event, it is submitted that Dr Witheridge said that the interventions and services which were planned for Matthew were no different to those which he would have been able to access as an involuntary patient.[147]

174. **Conclusion:** The evidence indicates that Dr Hume appropriately took into account the risks that Matthew faced. The evidence indicates that he was aware of the possibility that Matthew may not have been truthful regarding his positive intention to comply with a treatment plan. Although the evidence establishes that Dr Hume did not personally undertake any investigation to determine the reliability of Matthew's stated intention, it is evident that Dr Witheridge undertook an investigation including obtaining relevant collateral histories. In any event, as Dr Hume noted, even if Matthew had not been telling the truth, this would not have provided a basis to involuntarily detain him.

175. In this regard Dr Hume was aware of his legal obligations under the MH Act. He gave this evidence:

> "*…what do I think that Matthew has got wrong with him and is the environment in which he has been detained involuntarily is that a benefit to his mental state and condition or can we come up with a less restrictive option which is fair to Matthew? It may not – not everyone might agree with it but it – Matthew was the centre of our attention. What is going to be the best option for Matthew and what are we able to do within the conditions imposed by the Mental Health Act?*".[148]

176. On the basis of the above, I accept that the risks that Matthew faced were considered and that Dr Hume acted in accordance with his obligations under the MH Act.

Should Proposed Finding One be made in relation to St Vincent's Hospital?

177. Matthew's family submit that Proposed Finding One should be made because:

(a) Dr Gopal did not give appropriate consideration to the letter written by Ms Edwards;

(b) Dr Gopal was an unreliable witness;

(c) Dr Cullen did not give appropriate consideration to the letter written by Ms Edwards;

(d) The treating clinicians did not critically evaluate Matthew's self-reporting that he would not harm himself;

(e) Matthew's family were not included in the treatment process;

178. Again, I will consider each of these matters in turn below.

[146] Exhibit 1, page 545-6.
[147] Exhibit 1, page 541-5.
[148] 6/12/17, T20.16.

Was appropriate consideration given to the letter written by Ms Edwards by Dr Gopal?

179. Much of the submissions made by Matthew's family revolves around Mr Leary's attempt to convey Ms Edwards' letter to the clinicians at SVH and have it appropriately considered. In general terms, Mr Leary's evidence is that he was being given the "run around" during his phone call with Dr Gopal and that following the call, he decided to take Ms Edwards letter to the hospital to deliver it personally to ensure that Matthew's treating doctors would receive it and read it. Mr Leary's recollection of the conversation is that it was he who indicated that he was not seeking information about Matthew; rather he was attempting to impart information to Dr Gopal.

180. Dr Gopal made a contemporaneous record of that phone call.[149] In his note, Dr Gopal records that whilst Matthew had not given consent for information to be provided to Mr Leary, Dr Gopal was able to gather information from Mr Leary whilst still protecting Matthew's wish for confidentiality. It was suggested to Mr Leary that regardless of whether his, or Dr Gopal's recollection, was correct, Dr Gopal's record indicated that he was willing to receive any information that Mr Leary wished to share. Mr Leary did not appear to accept this and indicated that his feeling, as indicated in his statement, was that Dr Gopal wanted to get him off the line as quickly as possible, albeit in a courteous manner.[150]

181. Mr Leary's recollection is that he only made the decision to go to SVH after his call with Dr Gopal ended and when he was given the hospital's fax number in a subsequent call. Mr Leary said that when he was given the fax number he formed the view that if he simply faxed Ms Edwards latter it might not make its way to Matthew's treating doctors.[151] However, Dr Gopal's record notes that Mr Leary said during the phone call with him that he would come to the ward. Although Mr Leary said that this was not his recollection he fairly conceded that Dr Gopal's note caused him to doubt his recollection and that he may have been mistaken.[152]

182. **Conclusion:** There is no dispute that Dr Gopal declined to give his email address to Mr Leary. Dr Gopal said that he did not do so because his email address was going to change as he was on a six-monthly rotation, and because of some past incidents of unauthorised access to emails due to computers being situated in publicly accessible locations. Dr Gopal's explanation for not providing Mr Leary with his email address appears, on at least one basis, to be difficult to accept. Whilst any concern that Dr Gopal may have had about the security of other people accessing any email that might be sent to him appears to be reasonable, it is difficult to understand why a prospective change of email address might have prevented him from providing his current email address to Mr Leary. It is clear that Mr Leary was conveying an intention to send an email to Dr Gopal immediately. If this is accepted then the fact that Dr Gopal would be rotating to a different discipline sometime in the future appears to be an irrelevant one. Further, Dr Cullen said that it was his understanding that "*on multiple occasions, particularly my Registrars, would interact with family members via various media including telephone, email, or fax*".[153]

183. Despite this, Dr Gopal's contemporaneous note indicates a willingness to receive information which Mr Leary wanted to provide. Further, Dr Gopal said that when Mr Leary said that he

[149] Exhibit 1, page 796.
[150] 5/1/217, T3.45.
[151] 5/12/17, T4.18.
[152] 5/12/17, T4.10; T4.23.
[153] Exhibit 1, page 696.

would come to the ward and provide the document in person this was supported and encouraged.[154] Mr Leary's fair concession that he might have been mistaken about when he decided to take the letter to St Vincent's supports the conclusion that Dr Gopal intended to give appropriate consideration to any concerns that Mr Leary might raise, in writing or otherwise.

Was Dr Gopal an unreliable witness?

184. The progress notes record that on 11 November 2014 Dr Gopal recorded the following: "*Mother was initially very entitled and demanded a diagnosis*"[155], "*parents trying to take control of Matthew's situation & Matthew is not willing & relationship enmeshment between parents & Matthew*".[156]

185. Matthew's family submit that Dr Gopal's labels are demonstrative of the dismissive attitude which he and other members of the treating team displayed towards Matthew's family. It is also submitted that Dr Gopal's explanations for these terms was unconvincing and "*most probably a lie*"[157], which affects assessment of his overall credibility in an adverse way.

186. Dr Gopal was asked about the use of these terms in evidence. He explained that by using "*entitled*" he was referring to Ms Wilson wanting a diagnosis and wanting to know what the problem was, not meaning to be critical or convey that she was being rude or difficult.[158] By "*enmeshment*" Dr Gopal said that he was trying to convey that Matthew and his parents wanted to be together and support each other, his parents wanted to be involved in his care, but that they had a difference of opinion as to how to reach that goal.[159] Dr Gopal agreed with Counsel Assisting that the term enmeshment, in a psychiatry context, can have another meaning suggesting over-involvement between people. However, Dr Gopal explained that whilst the term is "*very well used in child and adolescent psychiatry*" it is not so in adult psychiatry.[160]

187. Dr Gopal went on to explain that his notes were being recorded for medical professionals, that the terms could be interpreted in another way by non-medical professionals, and that the notes would be referred to during a handover the following morning and that if there was any confusion it would be clarified at handover.[161]

188. **Conclusion:** It should be acknowledged, as noted in the submissions from Counsel Assisting[162], that Dr Gopal's notes were drafted as medical notes, and were not made with the expectation that Matthew's family would read them in the context of a coronial investigation. It is accepted that medical practitioners need to be frank in their record keeping.

189. An initial reading of the notes does give the impression that the terms used by Dr Gopal were a negative, rather than a positive, characterisation. However Dr Gopal indicated that he was simply trying to record an observation, and not draw a conclusion or judgment, to allow for consistency of observations to be checked in the future if required.[163]

[154] Exhibit 1, page 678-2 at [17].
[155] Exhibit 1, page 798.
[156] Exhibit 1, page 801.
[157] Submissions on behalf of Matthew's family at [77].
[158] 7/12/17, T37.32.
[159] 7/12/17, T39.18.
[160] 7/12/17, T39.41.
[161] 7/12/17, T37.49.
[162] Submissions of Counsel Assisting at [76].
[163] 7/12/17, T38.37.

190. However, the evidence established that it was intended for the notes to be discussed at handover the following morning and for any clarification, if needed, to be provided at that time. Ms Wilson fairly acknowledged in evidence that during the meeting Dr Gopal might have been left with the impression that Matthew's parents were "*trying to take control*".[164] However Ms Wilson drew a distinction between control as opposed to considering all available options to keep Matthew safe.

191. Dr Gopal agreed that he could have written his observations in a different way.[165] On this basis it is difficult to understand why Dr Gopal chose to use terms such as "*entitled*" and "*enmeshment*" if he did not intend for them to carry their usual meanings in the language of psychiatry. It would have been simpler, and avoided the need for potential clarification at a later time, if Dr Gopal had simply written what he meant (as noted above) rather than use the terms that he did. Looked at in this way, I conclude that the explanations given by Dr Gopal were unconvincing. However, I do not think that the explanations amounted to a deliberate lie so as to adversely affect Dr Gopal's overall credibility. Rather, it appeared that Dr Gopal was attempting to avoid having any negative characterisation attached to the observations which, it would appear, were made for clinical reasons.

192. Even if I am mistaken about the veracity of Dr Gopal's explanations, the evidence does not establish that Dr Gopal's note taking is demonstrative of a dismissive attitude which he (or any other member of the treating team) displayed towards Matthew's parents. It is to be remembered that the meeting in which the notes were taken was the occasion where Dr Gopal, with the assistance of Ms Wilson, was able to secure Matthew's agreement to remain as a voluntary patient in preparation for a staged discharge.

Was appropriate consideration given to the letter written by Ms Edwards by Dr Cullen?

193. Ms Edwards' letter was not read prior to the meeting on 12 November 2014 at 2:30pm with Dr Gopal noting that he had no time to use the letter to test anything that Matthew might have told the doctors.[166] Matthew's family submit that an inference can be drawn (because Dr Gopal was an unreliable witness and his credibility was adverse affected) that he was being untruthful about Ms Edwards' letter being read by Dr Cullen before the meeting.

194. Dr Gopal said that he read Ms Edwards' letter after the family meeting and that he gave a nurse a copy so that it could be included in Matthew's file.[167] Dr Gopal also said that he remembered very well giving the letter to Dr Cullen before the meeting, telling him that Mr Leary's concerns were contained within it, and asking him to read it.[168] Dr Cullen said in evidence that he distinctly recalled reading Ms Edwards' letter[169] but initially said that he could not recall whether he did so on the afternoon of 11 November 2014 or the following morning.[170] However, in later evidence Dr Cullen clarified that he read Ms Edwards' letter and chronology on 12 November 2014.[171]

[164] 5/12/17, T27.1.
[165] 7/12/17, T39.31.
[166] 7/12/17, T42.17.
[167] 7/12/17, T36.12.
[168] 7/12/17, T41.9.
[169] 6/12/17, T91.13.
[170] 6/12/17, T91.19.
[171] 6/12/17, T93.13.

195. The contemporaneous record of the meeting on 12 November 2014 records this entry by Dr Gopal: "*Add on. Dr M Cullen noted the letter provided by Matthew's father*".[172] In evidence Dr Gopal was asked whether the reference to "*Add on*" meant that Ms Edwards' letter was only considered by Dr Cullen after the meeting. Dr Gopal said that this was not the case, that Dr Cullen had read the letter before the meeting[173], that he personally did not document in the notes that Dr Cullen read the letter because a junior medical officer was responsible for documenting it[174], and that as part of his responsibility for ensuring the quality of the notes he reviewed the notes at the end of the meeting and considered that they needed to be supplemented with the add on entry.[175]

196. **Conclusion:** I have already concluded that no finding can be made that Dr Gopal was an unreliable witness and therefore do not take the submission made by Matthew's family in this regard into account. Looked at in this way, the evidence given by Dr Gopal and Dr Cullen regarding the circumstances in which it is asserted that Ms Edwards' letter was provided to Dr Cullen is consistent. The explanation by Dr Gopal for the "*Add on*" to the clinical record appears to be a reasonable one. Accordingly there is no basis to infer that either Dr Gopal or Dr Cullen were being untruthful in relation to considering Ms Edwards letter.

197. It is evident that the reading of Ms Edwards' letter did not prompt Dr Cullen to speak to either Mr Leary or Ms Edwards about the contents of the letter. Dr Cullen reasonably explained that he and the treating team at SVH viewed Ms Wilson, rightly or wrongly, as the representative of the family. From the interviews the team had had with Ms Wilson, they felt comfortable that they had a good holistic picture from the family's perspective.[176]

Did the clinicians critically evaluate Matthew's self-reporting that he would not harm himself?

198. Matthew's family submit that that there was no "*reality check*" of what Matthew was saying in circumstances where Matthew was known to be charming, very good at telling people what they wanted to hear, and so desperate that he would have said anything to get out.[177]

199. Dr Cullen said that he critically evaluated Matthew's self-report via two lengthy interviews, reviewing nursing observations, and interviewing Ms Wilson.[178] Dr Cullen also said that it was incorrect to assert that Mr Leary's statements about the risk that Matthew posed to himself were not approached with a high index of suspicion.[179] He said that the treating team were aware of Matthew's multiple suicide attempts but that Matthew's "*inter-episode functioning was much higher between these suicide threats which appeared to occur in the context of substance abuse*".[180]

200. Dr Cullen was asked specifically about whether, as noted in Ms Edwards' letter, the danger Matthew posed to himself was disguised by the positive and constructive manner in which he engaged with health care professionals immediately following a crisis and whether Dr Cullen was on notice to be careful of such conduct. Dr Cullen explained that he weighed all this up was open and not stubborn to change his mind in light of further evidence.[181]

[172] Exhibit 1, page 805.
[173] 7/12/17, T41.9.
[174] 7/12/17, T41.14.
[175] 7/12/17, T43.13-32.
[176] 6/12/17, T96.37.
[177] 5/12/17, T36.44.
[178] Exhibit 1, page 692.
[179] Exhibit 1, page 697.
[180] Ibid.
[181] 6/12/17, T94.16.

201. Dr Cullen was specifically asked about whether he took any steps to critically assess Matthew's stated intention not to kill himself in the future. Dr Cullen answered by saying that he recognised that Matthew was at risk in the future.[182] Earlier in evidence Dr Cullen explained that there were always risks that Matthew would not take his antidepressant medication[183] and that he would not follow through with the treatment plan.[184] However, Dr Cullen summarised by saying that although the treating team could facilitate certain things, it was ultimately Matthew's decision as a 25 year old adult to make his own decisions about what he does in terms of his health care.[185]

202. **Conclusion:** The evidence indicates that the treating team at SVH, and Dr Cullen in particular, were alive to the risk that Matthew may not have been truthful when expressing a positive intention in relation to the proposed treatment plan for him. The clinicians had available, and utilised, clinical tools to discount any "*performance effect*". The evidence indicates that a review was conducted of the information available to the treating team, including the records from POWH, observations of Matthew, and discussions had at multidisciplinary meetings.

Were Matthew's family included in the treatment process?

203. Similar to their experience at POWH, Matthew's family submit that they were not made to feel included in the treatment process. In particular Ms Wilson gave evidence that she was not invited to participate in a conference with a doctor in Matthew's absence and did not ask for one because she felt that the doctors had already made up their mind, because Mr Leary had already provided Ms Edwards' letter and that if it was not going to persuade the doctors to change their minds then Ms Wilson believed that she had little chance of doing so, and because she did not think the doctors would take notice of her.[186]

204. In evidence Dr Cullen was asked whether there was an avenue for Ms Wilson to volunteer information, which she was not comfortable volunteering in Matthew's presence, Dr Cullen referred to nursing staff, social workers, and junior doctors on the ward being available for family members to speak to in order to convey information.[187] Dr Cullen said that whilst he would think that there is some channel by which family members are provided with information regarding how they can do this, he explained that he was unware of any such protocol.[188]

205. Dr Telfer was asked whether he would take any further steps such as attempted to see a family member by themselves. Dr Telfer said that would be usual practice but qualified that by noting a downside where a patient might be alienated if they felt that their family was conspiring to lock them up against their wishes. Dr Telfer noted that this would have been an important consideration in Matthew's case.[189]

206. Dr Ahmed agreed that gathering collateral information to support a diagnostic formulation, or to be certain about what is happening, is important. However, Dr Ahmed noted that there are many

[182] 6/12/17, T96.25.
[183] 6/12/17, T95.19.
[184] 6/12/17, T95.23.
[185] 6/12/17, T95.10.
[186] 5/12/17, T36.9.
[187] 6/12/17, T72.22.
[188] 6/1/217, T72.42.
[189] 8/12/17, T40.25.

issues to consider and that a lot of potential damage could be caused by meeting a family member against a patient's will.[190] Dr Ahmed gave this evidence:

> "*But at the core of that is the fact that the – your engagement is with the patient, not with the family, and whatever can be done to enhance that engagement, build up trust and rapport, is key. And sometimes that does mean keeping family at some distance. It's hard to put ourselves in the shoes of the Caritas commissions [as transcribed] but it – it does appear that the family certainly expressed their views quite clearly, either directly or by letter, and not – so those views were heard by the team. And I – I'd – and again, difficult to say in retrospect, I don't know that meeting with family members individually would have influenced any of the decision making because they were already aware of the concerns as they were expressed*".[191]

207. Both Dr Ryan[192] and Dr Telfer[193] agreed with Dr Ahmed's evidence.

208. **Conclusion:** The fact that Matthew's family were not made to feel included in the treatment process is highly regrettable. It is understandable in such circumstances that they felt that they were being ignored, disregarded and sidelined. Whilst the evidence established that there are often sound clinical reasons why a clinician will not speak to the family member of patient in the absence of a patient, it does not appear from the evidence that a conscious decision was made in this regard in Matthew's case. Certainly, if it was, it was not communicated to Matthew's family.

209. The conduct of comprehensive clinical practice would seem to indicate that, firstly, it could have at least been indicated to Matthew's family that Ms Edwards' letter had been read. Secondly, if it was felt that there were no clinical reasons to explore the contents of the letter further, or if having a meeting in the absence of Matthew would be counter-productive, this also could have been indicated to Matthew's family. The evidence indicates that it was well-recognised by the treating clinicians at SVH that Matthew had a caring and concerned family who wanted to be engaged with his treaters and with his care. This recognition ought have been acted upon.

210. Further, as already noted, there was conflicting evidence given by Dr Gopal and Dr Cullen regarding the use of email as a means by which family members of patients are able to communicate with clinical staff. Dr Cullen gave evidence that whilst he assumed that family members are provided with information about the ways in which they might be able to convey relevant information to clinical staff, he was unware of the mechanism by which this occurs. From this it appears that there is a lack of available information, or at least a lack of clarity, for family members of patients at the Caritas unit at SVH as to how they may communicate concerns and information to a patient's treating team. The evidence given at inquest is that such concerns and information are useful and should be considered in the assessment of patient and that patient's treatment plan. Accordingly, I conclude that is both necessary and desirable pursuant to section 82(1) of the Act for the following recommendation to be made.

211. **Recommendation:** I recommend to the Director of Medical Services, St Vincent's Hospital that consideration be given to conducting a service delivery review to determine whether family members of mental health inpatients are provided with adequate information about the ways in

[190] 8/12/17, T58.4.
[191] 8/12/17, T58.11.
[192] 8/12/17, T58.25.
[193] 8/12/17, T58.40.

which they may communicate information and concerns relating to a patient to clinical staff responsible for that patient's treatment and care. If such a review demonstrates that adequate information is not provided then I further recommend that consideration be given to the implementation of a robust and reliable system (including relevant staff training) that allows for such information to be provided.

Should Proposed Finding Two be made?

212. Matthew's family submits that in their haste to discharge Matthew the clinicians at SVH lost a significant opportunity to speak with qualified clinicians who could provide them with valuable information.[194] In doing so Matthew's family point in particular to the valuable input that could have been provided by Ms Mithoefer who, amongst all of Matthew's treatment providers, had built the strongest therapeutic alliance with him.

213. Ms Mithoefer opined that Matthew's presentation was consistent with a moderate to severe major depressive episode.[195] In evidence Ms Mithoefer confirmed that she was referring to Matthew as suffering from a major depressive episode according to the definition in the DSM-IV.[196] Ms Mithoefer said that she reached that conclusion during her first session with Matthew[197], that she was not dissuaded from this diagnosis during her subsequent five sessions with him[198], and that Matthew was on the more severe end of the spectrum relative to other people in the community.[199] Ms Mithoefer did not believe that the major depressive episode was caused by Matthew's drug and alcohol use.[200] Although the treating team had available to them Ms Mithoefer's contact details at least by the conclusion of the family meeting on 11 November 2014[201], there is no evidence that any of the St Vincent's staff contacted her. Certainly, Dr Ahmed said that she could find no evidence that this had occurred.[202]

214. Matthew's family point to Dr Telfer's evidence in which he said that he would look at the reasons why a clinical psychologist (who was qualified to do so) might make a diagnosis of depression and seeing whether those reasons fit with his understanding of the diagnostic criteria.[203] In Matthew's case, Dr Telfer noted that Ms Mithoefer's reasons did fit.

215. However it should be remembered that Dr Telfer acknowledged that whilst he placed some weight on Ms Mithoefer's conclusion that Matthew's presentation was consistent with a moderate to severe major depressive episode, he did not have regard to it exclusively.[204] Further, Dr Ahmed explained that whilst a psychologist would often make a structured questionnaire-based diagnosis of depression, a psychiatric assessment involves more than merely applying the DSM-IV criteria. Dr Ahmed explained that saying that a person has depression based on meeting DSM criteria is not a full comprehensive diagnostic formulation and that a psychiatric assessment is a very complex process of gathering information.[205]

[194] Submissions on behalf of Matthew's family at [106].
[195] Exhibit 1, page 497.
[196] 7/12/17, T22.13.
[197] 7/12/17, T24.1.
[198] 7/12/17, T24.5.
[199] 7/12/17, T32.33.
[200] 7/12/17, T24.25.
[201] Exhibit 1, page 801.
[202] 8/1/217, T39.18.
[203] 8/12/17, T11.9.
[204] 8/12/17, T11.1.
[205] 8/12/17, T11.21.

216. Dr Telfer, Dr Ahmed and Dr Ryan all agreed that as Ms Mithoefer was the only professional that Matthew would see and he felt that he had a good rapport with her, that it was important to give consideration to her opinion[206], that the longitudinal history that she took would have been helpful[207], and that it would have assisted the St Vincent's staff to contact her.[208] However, Dr Ahmed explained that whilst it is important to take such a collateral history it would not on its own be determinative of an assessment of a patient in front of a psychiatrist on a particular day.[209] Dr Ahmed explained that the assessment of patient's mental state is a complicated process and that the doctors at SVH would not find that Matthew had a picture consistent with an earlier assessment if they did not see something consistent with that assessment at the time.[210]

217. **Conclusion:** This issue does not appear to have been addressed directly with either Dr Gopal or Dr Cullen in evidence. Counsel for SVH submits that the issue is not whether the treating team took any steps to contact Dr Ballin or Mithoefer directly, but whether SVH took reasonable steps to obtain an understanding of Matthew's relevant and recent medical history.[211] In support of this, SVH submits that the treating team were aware of Matthew's admission to POWH four days before his presentation to SVH and had obtained the clinical notes of that presentation. In those notes were recorded contact that Dr Witheridge had made with both Ms Mithoefer and Dr Ballin.[212] On this basis SVH submits that it had access to contemporary information from both health care professionals, along with the clinical notes of Dr Hume.

218. Whilst this might have been the case the expert evidence at the inquest established that, even allowing for the qualifications highlighted by Dr Ahmed, it would have been of assistance to contact Dr Mithoefer, the person with whom Matthew had developed the closest rapport and built the strongest therapeutic alliance amongst his treatment providers. Further, the contact that Dr Witheridge made with Ms Mithoefer (and Dr Ballin) occurred six days before Matthew's admission to SVH. In that period Matthew had attended another appointment with Ms Mithoefer. This is not to suggest that the failure to contact Ms Mithoefer might have led to any difference in outcome. Rather, it represented a missed opportunity to gather current and collateral information. It should be remembered that Dr Cullen drew a distinction between a patient possibly having different mental states when reviewed by clinicians at different points in time[213], and that it was important to explore useful strands of information to see whether they should be discounted.[214] Looked at in this way, optimal clinical practice would suggest that contact should have been made with Ms Mithoefer and Dr Ballin to at least verify, as Dr Ahmed described above, that the clinical picture in the minds of the SVH clinicians was consistent with an earlier assessment.

Should Proposed Finding Three be made?

219. Matthew's family submit that the decision on 11 November 2014 to provisionally discharge Matthew was premature, as was Matthew's eventual discharge on 12 November 2014. Matthew's family also submit that the communication of the provisional discharge decision to

[206] 8/12/17, T12.6
[207] 8/12/17, T39.24.
[208] 8/12/17, T39.10.
[209] 8/1/217, T39.1.
[210] 8/1/217, T38.39; T39.4.
[211] Submissions on behalf of St Vincent's Hospital at [68].
[212] Exhibit 1, page 735.
[213] 6/12/17, T60.45.
[214] 6/12/17, T83.1.

Matthew was also a failure in that it gave him incentive to "*perform well*" to be discharged and that it undermined the therapeutic relationship between Matthew and his father that had kept Matthew alive, and prevented the hospital from receiving information and placing sufficient weight on it.[215]

220. I have already considered whether Matthew's treating clinicians performed a critical evaluation of Matthew's self-reporting that he would not harm himself. I will consider the other matters raised by Matthew's family below.

Was Matthew's provisional discharge, and his eventual discharge, premature?

221. Consideration of whether Matthew was discharged prematurely requires examination of the issue of Matthew's diagnosis. Various diagnoses were provided by the senior clinicians who treated Matthew and by the experts who provided a report for the purposes of the inquest. Their opinions may be summarised as follows:

    (a) Dr Hume formed the opinion that Matthew did not have an underlying mood disorder, other than dysthymia[216] (a type of low grade depression, always persistent in the background[217]). He opined that Matthew had overdosed on alcohol in the context of marked coexisting social stressors.[218] Dr Hume did not believe that Matthew had a mental illness and explained that whilst Matthew may have met the criteria for major depression at times over the last three months of his life, this was not sustained.[219] In evidence Dr Hume referred to the term "adjustment disorder" becoming aware of it after reading Dr Ryan's report. Dr Hume explained that his view that Matthew had a situational crisis and that he was acutely distressed or dysphoric was the same as an adjustment disorder, just a difference in terminology.[220]

    (b) Dr Cullen diagnosed Matthew as having mild to moderate depression in the context of various psycho-social stressors but noted that there was no evidence of psychotic or melancholic depression, and that his suicidal ideation was directly influenced by intoxication with various substances, with the other diagnosis being substance abuse disorder (primarily alcohol and cannabis).[221] Dr Cullen found no evidence of Matthew having melancholic depression[222] or psychotic symptoms[223] and did not think that Matthew met the criteria for major depression.[224]

    (c) Dr Ryan opined that Matthew's mostly likely diagnoses were adjustment disorder with depressed mood, alcohol use disorder, cannabis use disorder, and stimulant and/or hallucinogen disorder.[225] Dr Ryan did not believe that it was likely that Matthew suffered a major depression but conceded that the possibility of a moderate to major depression was left open by the data available.[226]

[215] Submissions on behalf of Matthew's family at [118].
[216] Exhibit 1, page 545-6 at [46].
[217] 5/12/17, T79.17.
[218] Exhibit 1, page 545-6 at [46].
[219] 5/12/17, T80.37.
[220] 6/12/17, T7.21.
[221] Exhibit 1, page 688 at [15].
[222] 6/12/17, T60.5.
[223] 6/12/17, T81.19.
[224] 6/12/17, T67.38.
[225] Exhibit 1, page 23-28.
[226] 8/12/17, T9.43.

(d) Dr Ahmed believed that Matthew had a number of diagnoses including adjustment disorder with depressed mood, alcohol use disorder, cannabis use disorder, and nicotine dependence.[227] Dr Ahmed believed that the decline in Matthew's functioning was due to his "*long standing psychological vulnerability, poor coping skills and interpersonal difficulties in crisis following a series of linked psychosocial stressors, complicated by alcohol and polysubstance misuse*"[228] rather than a major depression. However, Dr Ahmed also acknowledged that the possibility of major depression could not be excluded[229] although she believed that Matthew's low mood was in keeping with dealing with a large stress load and his intermittent alcohol use.

(e) Dr Telfer considered the likely diagnosis for Matthew to be major depression, with a secondary diagnosis of intermittent alcohol and cannabis use in the context of multiple psychosocial stressors.[230] In reaching this diagnosis Dr Telfer noted that the diagnosis of major depression was confirmed by assessments of mental state performed by Dr Ballin (together with prescribing antidepressant medication), Ms Mithoefer, and Dr Witheridge.[231] Dr Telfer did not think that a diagnosis of adjustment disorder with depressed mood was sufficient as he did not accept that without situational distresses there would be no depressed mood.[232]

(f) Ms Mithoefer believed that Matthew's presentation was consistent with a moderate to severe major depressive episode[233] which she did not believe was caused by Matthew's drug and alcohol use.[234]

222. It is clear that no diagnostic consensus was reached amongst a number of qualified and experienced mental health care professionals. This in itself demonstrates the complexities involved in Matthew's case. It also demonstrates that, as a number of the professionals themselves acknowledged, reasonable minds may legitimately differ as to Matthew's diagnosis.

223. Matthew's family acknowledge that there is little point in evaluating Matthew's actual diagnosis and whether he was a mentally ill person under the MH Act.[235] However, Matthew's family submit that the submission made by Counsel Assisting[236] that the issue of Matthew's detention is an issue where expert minds can legitimately differ should be rejected.[237]

224. Consideration of this submission requires an examination of the relevant provisions of the MH Act and the corresponding evidence. Section 14 of the MH Act provides:

> **14 Mentally ill persons**
>
> (1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

[227] Exhibit 1, page 23-553.
[228] Exhibit 1, page 23-558.
[229] Ibid.
[230] Exhibit 1, pages 23-2 and 23-3.
[231] Exhibit 1, pages 23-2.
[232] 8/12/17, T17.35.
[233] Exhibit 1, page 497 at [20].
[234] 7/12/17, T24.25.
[235] Submissions on behalf of Matthew's family at [108].
[236] Submissions by Counsel Assisting at [57].
[237] Submissions on behalf of Matthew's family at [112].

(a) for the person's own protection from serious harm, or
(b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

225. Section 4 of the MH Act defines mental illness as a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) delusions,
(b) hallucinations,
(c) serious disorder of thought form,
(d) a severe disturbance of mood,
(e) sustained or repeated rational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).

226. Dr Telfer concluded that Matthew had a continuing condition of depression and that the likely effects of deterioration included suicide attempts.[238] In evidence it was confirmed (by Dr Ryan) that the MH Act does not insist on a diagnosis in order to trigger the application of section 14.[239] In that regard Dr Telfer was asked what symptom, for the purposes of establishing mental illness as defined in section 4, he relied upon. Dr Telfer indicated that he believed Matthew had a severe disturbance of mood.[240] Dr Telfer gave evidence that someone with an adjustment disorder with low mood or depressed mood could still fit the definition of mental illness, explaining that adjustment disorder is a causal statement which does not exclude a person as having a severe disturbance of mood.[241] From there, Dr Telfer indicated that even if Matthew did have an adjustment disorder it was still open to detain him involuntarily if there were severe aspects to that mood disturbance which caused a danger to himself or others.[242]

227. Dr Ahmed described a severe disturbance of mood to be a persistent low mood characterised by symptoms that would accompany a diagnosis of a severe depression.[243] Dr Ahmed said that there was significant evidence that Matthew had significantly fluctuating mood[244] and that whilst at times Matthew could be seen to have low mood she found that there was no evidence of severe disturbance of mood through his admission.[245]

228. Dr Ryan was of a similar view to Dr Ahmed. He said that "*by overlooking, or not having access to, the variety of assessments that took place, Dr Telfer has not taken into account the variability of [Matthew's] presentations including his fluctuating mood*".[246] Dr Ryan agreed with Dr Ahmed that Matthew's presentation was inconsistent with a severe disturbance of mood and that therefore there was no basis to detain him under the MHA.[247]

[238] Exhibit 1, page 23-4.
[239] 8/12/17, T19.42.
[240] 8/12/17, T20.20.
[241] 8/12/17, T44.15.
[242] 8/12/17, T44.25.
[243] 8/12/17, T20.42.
[244] Exhibit 1, page 23-557.
[245] 8/12/17, T20.33.
[246] Exhibit 1, page 23-47.
[247] 8/12/17, T56.50.

229. Further, Dr Ryan noted that one of the factors that raises the possibility that a reasonable person might form a different opinion as to diagnosis was:

> "*The fact that diagnoses in psychiatry depend crucially on careful history and clinical examination that derive data from interview and observation that is then matched with clinical patterns that one as seen over the course of one's career. While an expert writing a report has the advantage of reviewing extensive documentation, he or she has not had a chance to meet the patient and gather all the data that was not included in, or cannot be communicated easily in, the notes or via statements. (It is for this reason that I usually put great stead in the opinions of the most experienced clinicians that had the opportunity to meet a patent in person)*".[248]

230. **Conclusion:** All the clinicians agreed that the question of involuntary detention was one where expert opinion can legitimately differ. With this in mind, and accepting the evidence of Dr Ryan above in particular, it cannot be said that the mere fact that Dr Telfer reached a different conclusion regarding the ability to detain Matthew means that Dr Cullen was wrong in his decision. Dr Cullen reached a considered conclusion that Matthew did not have a severe disturbance of mood and therefore could not lawfully be detained involuntarily. Dr Cullen himself acknowledged that in a clinical setting it is possible that like minds may differ. However it remained his opinion that he would not have been acting in good faith, nor adhered ethically to the care and treatment principles outlined under the MH Act, if he had detained Matthew.[249] As Dr Ryan acknowledged, Dr Cullen was the most experienced clinician that had the opportunity to meet Matthew in person. On this basis it cannot be said that SVH failed in its obligations to provisionally discharge Matthew on 11 November 2014, and discharge him on 12 November 2014.

231. However, if I have understood the core of the submissions made by Matthew's family correctly, the prematurity of Matthew's discharge was not related to the issue of whether he could lawfully be detained involuntarily, but whether a proper corroborative history was taken before that decision was reached. In this regard, Matthew's family submits that the differences in opinion between the experts demonstrates that the question of Matthew's detention under the MH Act was a complex one which warranted further investigation and corroboration.

232. In support of this submission Matthew's family point to the opinion expressed by Dr Telfer that the time available to observe Matthew from about 4:00pm on 10 November 2014 to about 11:45am on 11 November 2014 was "*not sufficient time to make an evaluation of the adjustment disorder or situational crisis and the suicidal risk*".[250]

233. In contrast, Dr Cullen said that his assessment of Matthew, and his ultimate decision to discharge him, was made following a "*professional and comprehensive ongoing assessment of Matthew's presentation*" and included observations of Matthew's mental state, relevant recent history, interviews with Matthew and Ms Wilson, Ms Edwards' letter, and nursing staff observations.[251] Having done that Dr Cullen explained that in weighing up the information contained in the letter, in light of all the other information that was available, nothing in it caused him to change his perspective or change his plan.[252]

[248] Exhibit 1, page 23-49.
[249] Exhibit 1, page 710-6.
[250] 8/12/17, T50.29.
[251] Exhibit 1, page 710-6.
[252] 6/12/17, T94.25, T94.43.

234. Dr Telfer was invited to comment on what level of care should have been considered by St Vincent's in terms of a treatment plan. Dr Telfer said:

> "*Well in my opinion every effort should've been made to persuade him to stay in hospital voluntarily, and I believe that happened. The antidepressant treatment needed to be continued and reviewed, which did happen. The family needed to be involved, which to some extent did happen and there was a meeting documented by Dr Gopal with the family. The history available from Prince of Wales was used in the assessments made at St Vincent's. So all that was comprehensive and competently done, but my belief is that he should have been detained as a mentally ill person, rather than discharged from hospital*".[253]

235. Counsel for SVH points to the fact that Dr Ahmed's and Dr Ryan's concessions that it was possible that Matthew suffered a Major Depression, although that was not their preferred diagnosis, did not mean, as Matthew's family submit, that the issue of detention under the Mental Health Act was open for further investigation and corroboration.[254] Instead, counsel for SVH submits that it was appropriate for the experts to acknowledge that an alternative view may be held as to diagnosis. What was clear is that it was their view that Matthew did not present with a severe disturbance of mood so as to justify detention under the MHA.

236. **Conclusion:** I do not think that the concessions made by Dr Ryan and Dr Ahmed as to the possibility of a diagnosis different to their own being open means of itself that the further investigation regarding Matthew's detention was warranted. The concessions are an appropriate recognition that reasonable minds may differ when evaluating a complex diagnostic issue.

237. The real question is whether there is another basis upon which it could be said that further investigation or corroboration, prior to Matthew's discharge was warranted. Dr Cullen's evidence is that he performed a comprehensive assessment of Matthew's presentation, taking into account all relevant information. Dr Telfer also describes the assessment performed at SVH as comprehensive and competent. However, Dr Telfer qualifies this assessment somewhat by noting that whilst Matthew's family needed to be involved, they were only involved "*to some extent*".

238. I have already noted above that the treating team correctly recognised that Matthew's family were concerned about, and engaged in, his care and desirous of imparting information to ensure that every relevant matter could be considered in Matthew's assessment and treatment. Further, as I have also already noted above, there was a reasonable basis to consider that it would have been appropriate for the treating clinicians at SVH to have at least made contact with Ms Mithoefer. Seeking the views of Matthew's family prior to discharge, explaining the decision to discharge Matthew, and contacting Ms Mithoefer were all final, confirmatory steps in the preparation for discharge which could have, it would appear, been easily undertaken. Looked at in this way, the decision to provisionally discharge Matthew, and his eventual discharge, can be regarded as being premature. However I would not characterise the fact that these steps were not taken as demonstrating that the treating team at SVH "*displayed a callous, indifferent and dismissive view*" of Matthew's family and their distress.[255] Rather, it represented a missed opportunity.

[253] 8/12/17, T31.39.
[254] Submissions on behalf of Matthew's family at [111] to [114]; Submissions of behalf of St Vincent's Hospital at [91].
[255] Submissions on behalf of Matthew's family at [119];

Should Matthew have been told of his provisional diagnosis and discharge?

239. Matthew's family submit that being told of the provisional discharge plan gave Matthew incentive to perform well to guarantee his discharge. This issue has already been dealt with above. Further it is submitted that it ruined the therapeutic alliance between Matthew and his father.

240. **Conclusion:** Once the view was reached that Matthew could not be lawfully detained, Matthew was entitled, as a competent adult, to be included in the decision-making concerning his care. This meant that he was entitled to know his diagnosis and the plans for his discharge. The regrettable consequence of this is that it had an adverse impact upon the therapeutic alliance that Mr Leary had forged with Matthew.

241. However, there was no proper basis to withhold this information from Matthew. To restrict information from being given to Matthew would have undermined the therapeutic trust which had provided the basis for Matthew's agreement to voluntarily stay for further observation and treatment, and to a staged release.

Issues in relation to Marrickville Community Mental Health Care

242. Aspects of the involvement of MCMHC and the Marrickville ACS in Matthew's care arose during the course of the inquest. For completeness, these issues will be discussed below.

243. It was conceded by the SLHD that the record keeping relating to Matthew's discharge from the Marrickville ACS was not as good as it could have been.[256] It was conceded by Mr Paul Clenaghan (Community and Partnerships Manager, Mental Health Services for SLHD) that the discharge summary should have been completed before nine days had passed since Matthew's discharge on 18 November 2014.[257] However, Mr Clenaghan gave evidence that this was identified as a problem in 2015 and that data is now collected by MCMHC. This data allows an analysis to be performed to determine whether patient clients of MCMHC have discharge summaries completed on the day of their discharge. The aim of the analysis is to strive for compliance with a performance indicator of zero clients discharged with an incomplete discharge summary.[258] Mr Clenaghan said that the data analysed to date demonstrated that this has been "*dramatically improving*".[259] Importantly in Matthew's case, there is no evidence to conclude that if the documentation surrounding discharge had been completed on the day of Matthew's discharge rather than nine days later that this would have altered the outcome for Matthew.

244. During the course of the inquest Mr Clenaghan was asked questions about the ACS care model and whether an alternative to the team-based structure would be therapeutically more beneficial to clients of the ACS if an individual care coordinator, or "go-to" person was identified. For example, there is evidence that Ms McCann and Mr Leary had difficulty contacting an ACS team member on 31 October 2014 when Matthew was in crisis. Mr Clenaghan explained that the ACS operates a team approach (2 shifts per day with 2 team members, and 1 member on shift overnight) to the coordination of care which is required due to the intensity and short-term

[256] Submissions on behalf of the SLHD at [65].
[257] 6/12/17, T54.28.
[258] 6/12/17, T55.11.
[259] 6/12/17, T55.23.

contact of the ACS with its patient clients. The team approach means that a client of the ACS usually does not have a nominated care coordinator.[260] The objective of the team approach is to liaise with various treatment providers and ensure the best possible access to the ACS. In this way any member of the team can action care plans and respond to referrals.

245. The disadvantage of this approach is that no single person is appointed as a case worker or care coordinator with coordination being shared by the ACS team.[261] In evidence Mr Clenaghan expressed some concern with a model of having a "dedicated go-to person" as the point of contact for a client.[262] Mr Clenaghan explained that the crisis team model is based on virtually daily contact and trying to resolve immediate crisis issues. He explained that having a nominated person would cause chaos in the sense that trying to allocate a person to a patient would overcomplicate things due to the need to take into account things like different experience levels, part time and full time staff, as well as staff absences due to leave and sickness.[263]

246. Both Dr Ryan and Dr Telfer acknowledged that the team approach had some disadvantages and in some ways was unsatisfactory[264], for example when too many handovers are required for a person in urgent need or in severe crisis. However, Dr Telfer acknowledged that he could see no better way of dealing with the situation than the way described by Mr Clenaghan.[265] While also acknowledging that the model was not ideal Dr Ahmed pointed to her understanding (as a previous director of an equivalent mental health community team) that there is extensive cross shift communication where information is shared.[266] In this way Dr Ahmed explained that "*there is a constant observation of each patient by the team even though there are different contacts from different team members over a period of time*".[267] A further consideration in Matthew's case was that he would never have been considered for case management because he had access to private services and his preference was to use them.[268]

247. The ACS and care coordination services are separate teams within MCMHC. The former provides short-term intensive interventions whilst the latter provides longer term intensive or non-intensive interventions. Matthew would not fall within care coordination services which, in 2014, was usually reserved for people with severe enduring mental illness[269] with the highest diagnostic group of people in care coordination being people with schizophrenia.[270] Mr Clenaghan explained that in Matthew's case the ACS worked as a support system for Matthew's GP and psychologist, and as a contact point for the family, rather than a coordinator of care.[271]

Findings

248. Before turning to the findings that I am required to make, I would like to express my gratitude to Ms Donna Ward, Counsel Assisting, and her instructing solicitor, Ms Benish Haider. I am extremely appreciative not only of their tireless efforts and valuable assistance (both before and during the inquest), but also for the compassion, sensitivity and empathy that they have shown

[260] Exhibit 1, page 865-4 at [19], [20].
[261] Ibid at [23], [24].
[262] 6/1/217, T47.10.
[263] 6/1/217, T47.13, T47.40.
[264] 8/12/17, T52.34, T53.15.
[265] 8/12/17, T53.14.
[266] 8/12/17, T53.46.
[267] 8/12/17, T54.1.
[268] 8/12/17, T54.4, T54.33.
[269] 6/12/17, T35.2.
[270] 6/12/17, T36.23.
[271] 6/12/17, T38.36.

throughout the coronial investigation and inquest process. I also thank Detective Sergeant Steven Giles for his efforts during the investigation into Matthew's death and for compiling the comprehensive initial brief of evidence. In doing so I would also like to recognise, and echo Mr Leary's expression of gratitude to, the various police officers who dealt with Matthew in his moments of crisis in a professional, caring, and respectful manner.

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

Identity
The person who died was Matthew Wilson Leary

Date of death
Matthew died on 28 November 2014.

Place of death
Matthew died in the waters off The Gap, Watons Bay NSW 2030.

Cause of death
The cause of Matthew's death was drowning.

Manner of death
Matthew died as a consequence of actions taken by him with the intention of ending life.

Epilogue

250. The turmoil and distress that surrounded much of Matthew's last month of life have, without question, left his family with indelibly painful memories of this time. However, amidst the darkness of this period were three moments in which, I hope, it is fitting to best remember Matthew by: the first time he met [redacted] on 17 November 2014; the weekend that he and [redacted] spent with Ms Wilson on 22 and 23 November 2014; and the quiet evening spent with Mr Leary, Ms Edwards and [redacted] on 26 November 2014 enjoying the simple pleasure of each other's company.

251. I am most conscious of the fact that these findings are being delivered at a time approaching what would have been Matthew's 29th birthday. The anguish and sorrow felt collectively by Matthew's family is, no doubt, immense. On behalf of the Coroner's Court, and the counsel assisting team, I offer my deepest and most respectful condolences to Ms Wilson; Mr Leary; Matthew's son, [redacted]; Matthew's sisters, Erin and [redacted]; Ms Audus; Ms McCann and Matthew's extended family and friends for their tragic and devastating loss.

252. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
27 April 2018
NSW State Coroner's Court, Glebe