CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of AP
Hearing dates:	16-19 December 2019, 25 February 2020
Date of findings:	1 June 2020
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	Coronial Law – Management of Risk to Child where Parent has Acute Mental Health Disorder – Child Protection File Closure Policy – Mental Health Care Coordination – Shared Care between General Practitioner and Local Health District Mental Health Team Case Care Coordinator– Mental Health Care Training
File number	2016/275557

Representation:	Mr M Johnston SC and Ms S Williams, counsel assisting, instructed by Mr J Pender and Mr A Nicholas, Crown Solicitor's Office
	Ms J Manuell SC for SP, instructed by Ms A Coultas-Roberts, Legal Aid Commission of NSW
	Mr R Sergi for Dr Don Ramjan, instructed by Ms G Peres da Costa, MDA National
	Dr P Dwyer for the Department of Communities and Justice, instructed by Ms E Hourigan, Maddocks
	Mr P Rooney for the South Western Sydney Local Health District, instructed by Ms O Sclavenitis, McCabe Curwood
	Mr B Bradley for Ms Sophie Schreuders, instructed by Ms K Hinchcliffe, Makinson D'Apice
	Ms L McFee for Dr Nadir Hafiz, instructed by Ms S Wallace, MDA National

Non-publication orders:

I make the following orders pursuant to section 74 *Coroners Act* 2009 (NSW)

1 A non-publication order is made with respect to the names of the following individuals:

a. AP;

b. SP;

c. [redacted]

d. [redacted]

e. [redacted]

f. [redacted]

g. [redacted]

h. [redacted]

i. [redacted]

j. [redacted]

k. [redacted]

l. [redacted]

2 A non-publication order is made over the entirety of the Internal Serious Case Review Report of November 2016, except as recorded in these findings. The non-publication order extends to any expert evidence that derives from that report.

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Introduction

1. This inquest concerns the death of AP who was just two years and seven months old when she died at her home in Miller, NSW on 10 or 11 September 2016.

2. AP was described by her mother, SP as "a beautiful baby, cheeky and intelligent." SP spoke candidly of her terrible loss and told the court of her ongoing love for her child. It is clear that AP will always be missed by SP and her family. No-one who observed the inquest or who was familiar with the evidence would have any doubts about SP's love for AP or for her profound and ongoing sorrow.

3. Tragically, AP died as a result of being drowned by her mother. At the time this happened SP was seriously mentally ill and suffering an acute relapse of her condition. AP's death occurred just a day or two after SP's mental health service provider failed to respond to an urgent notification from her general practitioner alerting it to a dangerous decline in SP's mental health. This grave omission occurred against the background of other failures of support which had occurred since AP's birth.

4. SP was found not guilty in relation to the murder of AP by reason of mental illness by Acting Justice Hidden in the Supreme Court of NSW on 14 September 2017

5. SP attended the inquest from custody each day. She was clearly motivated to honour the memory of her beloved child and to be part of a review which might strengthen support for other mothers with mental health needs. I thank her for her generous and dignified approach to participating in these proceedings.

The role of the coroner

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

[1] Section 81 *Coroners Act* 2009 (NSW).
[2] Section 82 *Coroners Act* 2009 (NSW).

7. In this case there is no dispute in relation to the identity, date, place or medical cause of AP's death. For this reason the inquest focussed on the manner and circumstances of her death and on questions about whether her death could have been prevented.

The evidence

8. The court took evidence over five hearing days, and heard oral testimony from some of those directly involved in SP's care, independent experts and departmental representatives.

9. The court also received extensive documentary material in over seven volumes. This material included witness statements, medical records, photographs, department records and policies and expert reports. While I do not intend to refer to all the material in detail in these findings, it has been comprehensively reviewed and assessed.

10. A list of issues was prepared before the proceedings commenced. The following questions arose in relation to AP's death:

a. The adequacy of steps taken by the Department of Family and Community Services (now the Department of Communities and Justice) to protect AP from harm;

b. The adequacy of care and treatment provided by Liverpool Community Mental Health Team to SP and, in particular, the appropriateness of the decision to discharge her on 9 September 2016, in light of her mental health history and the fact she had AP in her care;

c. The adequacy of the response of the Liverpool Community Health Team to Dr Ramjan's phone call and fax referral of 9 September 2016;

d. The adequacy of Dr Ramjan's actions in terms of compliance with section 27 of the *Children and Young Persons (Care and Protection) Act 1998*, and

e. The adequacy of the actions of the Liverpool Community Mental Health team, including the contact person, who received the phone call and fax from Dr Ramjan in terms of compliance with section 27 of the *Children and Young Persons (Care and Protection) Act 1998*.

f. The need for any recommendations in relation to the death.

11. These questions directed the focus of the evidence presented in court. However as is often the case, a hearing can tend to crystallise the issues which are really at stake. For

this reason, after dealing with the facts, I intend to distil my reasons under a small number of broad headings.

12. The focus of the inquest ultimately centred on the systemic challenges, rather than judging the conduct of specific individuals involved in the provision of care and support to AP and her family. At the end of the day, while no single individual is held out for any particular criticism of their actions at the time of AP's death, some of the systems in place were exposed as in need of review and improvement.

Fact Finding

13. Counsel assisting prepared a concise summary of the extensive documentary evidence obtained in relation to AP's death. The summary was circulated to interested parties during the course of the inquest for consideration and comment prior to finalisation. The summary is a careful synopsis of the salient facts leading up to AP's death and matters which were aired in SP's Supreme Court proceedings. Given that I was not alerted to any particular controversy, that document, which is now annexed to these reasons forms part of these proceedings as agreed facts. It accurately distills the tendered material.

14. As will be apparent, I have also relied heavily on the written submissions of counsel assisting in the preparation of the reasons.[3]

The support offered to SP

15. There were numerous organisations involved in providing services to both AP and SP, during AP's life. They included, but were not limited to professional health care services, mental health services in the St George, Liverpool and Blacktown areas, the My Health Medical Practice at Liverpool ("My Health"). Family and Community Services ("FACS") now known as the Department of Communities and Justice ("DCJ"), Charmian Clift Cottages, a women's refuge, Anglicare, Brighter Futures, Step by Step, a private psychologist and TAFE.

16. Despite this extensive involvement SP did not receive the support she needed at a critical time in the lead up to AP's death. As a result AP was placed at significant risk of harm. Tragically that risk eventuated. The evidence demonstrates starkly how services and professionals working in isolation, despite the best of intentions, can fail to grasp the complete picture of a person's needs.

[3] I thank Matthew Johnston SC and Sophie Williams, Angus Nicolas, and James Pender, solicitors, Crown Solicitor's Office for their detailed analysis of the evidence in this inquest and for their assistance in the production of these reasons.

Evidence concerning the involvement of Family and Community Services

17. SP had been in contact with DCJ[4] for a number of years prior to AP's birth. The history of that contact is essential to any understanding AP's family situation at the time of her death.

18. On 2 July 2010, SP had given birth to twins. SP's twins were subsequently removed from her care by DJC. The background of DCJ's involvement with SP and her children is outlined in the agreed facts at [7] to [20].

19. The focus of exploration of DCJ's involvement at the inquest was on the adequacy of steps taken by DCJ to protect AP, the decision made by DCJ to close SP's file in February 2015, and the adequacy and appropriateness of the communication between DCJ and health care professionals involved in SP's care. Attention was also paid to changes that have taken place at DCJ, and specifically within the St George CSC, since AP's death.

20. The inquest heard oral evidence from Professor Judith Irwin, who also provided an expert report in these proceedings. Professor Irwin is an Emeritus Professor of Social Work and Social Justice at the University of Sydney. She has over 45 years of experience as a social worker and academic. Her research and teaching covers subject matter including the links between domestic violence, child protection and mental health, community building and professional practice supervision.

21. The inquest also heard oral evidence from Ms Tracey Stokoe, Director of Community Services in Sydney, South Eastern and Northern Sydney District at DCJ. Ms Stokoe's evidence supplemented a letter on behalf of DCJ and a statement from Ms Stokoe, which form part of the brief of evidence.

22. The inquest was also provided with a copy of the Internal Serious Case Review ("ISCR") into the death of AP conducted by the Office of the Senior Practitioner in November 2016.

23. It is important to say at the outset that the court accepts that a proper internal investigation has taken place at DCJ. The ISCR is a rigorous document which demonstrates a thorough review of DCJ's involvement with SP and her family. I accept that DCJ properly identified inadequacies in the service it provided and in the years leading up to the inquest pursued reform and training aimed at minimising the risk of a similar tragedy. It is commendable that Office of the Senior Practitioner continues to work towards a reflective work culture where mistakes can be identified and acknowledged. The court was greatly assisted by the evidence of Ms Stokoe whose approach to proceedings showed candour and competence.

[4] These submissions adopt the acronym 'DCJ' when referring to the Department of Communities and Justice, including at times when it was known as Family and Community Services or 'FACS'.

Risk assessments made in relation to SP and AP

24. Mistakes made in the conduct of risk assessments using structured decision making tools had a negative impact on the service provided to SP and AP. Specifically, the following risk assessments were flawed.

25. On 6 December 2013, DCJ received a report that SP's mental health was not well-managed during her pregnancy with AP, that she was experiencing delusions, hallucinations and a degree of paranoia and that she had stopped taking her medication. SP was prescribed anti-psychotic and anti-depressant medication. The reporter said that there were no present concerns that SP would harm herself or others.[5] This report was assessed as non-risk of significant harm ("non-ROSH") because DCJ was aware of SP's pregnancy.[6]

26. The ISCR concludes that this report obtained new information about aspects of SP's mental health, which had not previously been reported as concerns during her pregnancy. The ISCR describes this as a "significant oversight which had a bearing on the assessment of risk going forward". Because this report was assessed as non-ROSH, it affected future application of the risk assessment tool for AP which counts screened-in reports only.[7]

27. On 6 February 2014, a caseworker visited SP at St George hospital, where she had given birth to AP four days prior. The caseworker assessed AP as being 'safe' with SP but developed a safety plan around concerns that SP would stop taking her medication, her mental health, and the possibility of domestic violence if she saw her former partner, [redacted][8]

28. The ISCR concluded that the documentation in the safety assessment of AP as safe was not accurate, and "failed to identify the concerns about SP's mental health and her stopping medication."[9] The ISCR identified a number of factors as contributing to this mistake: the caseworker had just returned from a three year secondment and had not been trained in use of the Safety, Risk and Risk Re-Assessment ("SARA") tools; the caseworker had little support to complete the safety assessment; and, further, the caseworker's manager did not approve the safety assessment for four weeks and did not provide feedback about the application of the tool.[10]

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[5] Agreed Facts at [27]; FACS, Internal Serious Case Review, November 2016, p. 13 (Brief, Vol 2, Tab 25).
[6] Agreed Facts at [27]; FACS, Internal Serious Case Review, November 2016, p. 14 (Brief, Vol 2, Tab 25).
[7] FACS, Internal Serious Case Review, November 2016, p. 14 (Brief, Vol 2, Tab 25).
[8] Agreed Facts at [37]; FACS, Internal Serious Case Review, November 2016, p. 17 (Brief, Vol 2, Tab 25).
[9] FACS, Internal Serious Case Review, November 2016, p. 17 (Brief, Vol 2, Tab 25).
[10] FACS, Internal Serious Case Review, November 2016, p. 17 (Brief, Vol 2, Tab 25).

29. On 5 March 2014, the DCJ caseworker completed a risk assessment for AP with SP. The risk of neglect was assessed as moderate and the risk of abuse was assessed as low.[11]

30. The ISCR identified that two previous reports for AP had not been screened-in by the Helpline and were not included in the assessment. This was in accordance with policy that applied at the time. Previous screened-in risk of harm reports for SP's twins were also not included in the assessment. This was an error. The ISCR states "[i]f AP's two previous reports had been screened in, and/or the previous reports for the twins considered, the risk assessment tool would have identified the risk to AP was 'high' rather than 'moderate'. This would have escalated the concerns the caseworkers held for SP and AP and may have meant different case planning for the risks to AP."[12]

31. On 18 April 2014, DCJ recorded a report alleging that SP had allegedly suffered abuse by a named person.[13] The report was screened by the Helpline as non-ROSH. The ISCR described the use of language in the report as "troubling". The report failed to capture the abusive nature of the alleged situation, and "minimised the role that FACS had to ensure that AP was safe". The ISCR concluded that this report should have been screened-in and sent to the CSC to consider the risk to SP and AP.[14]

32. On 11 May 2015, following the closure of the case file in February, DCJ received a report regarding concerns about AP. The reporter stated that SP had been staying in a women's refuge since 16 April 2015. She had recently been offered a Housing property in Miller. The reporter also stated that SP had continued "somatic delusions" and disturbed sleeping and eating patterns. SP was observed to stay in bed sometimes as late as 3 pm and was not feeding AP breakfast.[15] The report was assessed by the Helpline as non-ROSH and closed without further assessment.

33. The ISCR identified that because the caller had rung the Helpline through the 'NGO line', there was no requirement to apply the Screening and Response Priority Tool (SCRPT), a tool used to help practitioners decide if reported concerns meet the threshold for risk of significant harm. Further, there was no requirement to complete a history check and approval of a team leader was not required. The ISCR concluded that "The SCRPT should have been completed and this assessment should have been sent to the CSC for assessment of risk for AP. If caseworkers had received this report, particularly

[11] Agreed Facts at [47]; FACS, Internal Serious Case Review, November 2016, p. 20 (Brief, Vol 2, Tab 25).
[12] FACS, Internal Serious Case Review, November 2016, p. 20 (Brief, Vol 2, Tab 25).
[13] Agreed Facts at [53]; FACS, Internal Serious Case Review, November 2016, p. 21 (Brief, Vol 2, Tab 25).
[14] FACS, Internal Serious Case Review, November 2016, p. 21 (Brief, Vol 2, Tab 25).
[15] Agreed Facts at [83]; FACS, Internal Serious Case Review, November 2016, pp. 31-32 (Brief, Vol 2, Tab 25).

caseworkers who had worked with SP previously, they may have identified that SP sleeping late was a warning indicator for her declining mental health."[16]

34. The mistakes made above were acknowledged by DCJ in its response to the report of Professor Irwin[17]. DCJ identified the following changes that have been implemented since the death of AP and the ISCR report to improve screening and risk assessment processes:

a. The Helpline has changed its practice to ensure that all information received by a Helpline caseworker on the NGO line is screened using the SDM (Structured Decision Making) tool and that caseworkers complete a history check for the family to inform decision making;[18]

b. A Group Supervision model has been implemented at St George CSC which, in the opinion of DCJ, will better support caseworkers to understand and assess risk through supervisory input;

c. A Mental Health Kit has been introduced;

d. State-wide training has been conducted on the SDM Safety, Risk and Risk Re-Assessment (SARA) Policy and Procedures Manual over the last 12 months;

e. In 2017, an audit was conducted at St George CSC as to compliance and practice in relation to application of the SARA tool;

f. In 2018, St George CSC undertook a child protection training module called 'Protecting Our Kids', which reviewed the practice of completing safety and risk assessments across the CSC. [19]

35. In her oral evidence to the inquest, Professor Irwin acknowledged these improvements but emphasised the need for ongoing review and monitoring of the efficacy of these changes.[20]

Interagency co-ordination and co-operation

36. There was insufficient co-ordination and co-operation between agencies involved in supporting SP and AP.

[16] FACS, Internal Serious Case Review, November 2016, p. 32 (Brief, Vol 2, Tab 25).
[17] Letter from Normal Lucas, Maddocks, on behalf of DCJ dated 18 November 2019 (Brief, Vol 3, Tab 27).
[18] Letter from Normal Lucas, Maddocks, on behalf of DCJ dated 18 November 2019, p.6 (Brief, Vol 3, Tab 27).
[19] Letter from Normal Lucas, Maddocks, on behalf of DCJ dated 18 November 2019, p.7 (Brief, Vol 3, Tab 27).
[20] Transcript 16/12/19, p. 38 at L12-29.

37. As the agency responsible for protecting AP from harm, DCJ was best placed to play a co-ordinating role between agencies. Submissions made by counsel for DCJ properly acknowledge this fact.

38. The first DCJ caseworker involved with SP and AP held a planning meeting on 30 September 2014. SP, Step by Step (SBS), Community Mental Health and AP's childcare centre participated. The meeting served as a handover between DCJ caseworkers. A case plan was derived from the meeting and the new caseworker was to follow up with a referral to Brighter Futures and to continue to liaise with the services involved.[21]

39. The ISCR describes it as "disappointing" that this planning meeting was held two months after SP and AP left the Charmian Clift program, where SP had received a period of intensive parenting support. The ISCR observed that "a more timely planning meeting, which included workers from Charmian Clift, may have helped the services involved to understand the challenges SP had in their service, what supports she needed and how they could work more collaboratively to ensure SP had ongoing support to care for AP".[22] Professor Irwin concurs that the optimum time for a planning meeting would have been prior to SP leaving Charmian Clift, noting that staff there were "familiar with their needs and the challenges SP faced around the management of her mental health and the bonding and caring for AP".[23]

40. On 24 October 2014, an SBS worker emailed the DCJ caseworker seeking guidance as to how best to support SP "in light of her mental health". There is no evidence the caseworker responded to this email. The worker visited SP on the same day, and spoke with her about her difficulties with AP making a mess when feeding. The caseworker suggested to AP that she put a mat on the floor when feeding, to collect the mess. The ISCR identified that at this juncture, both the SBS worker and DCJ caseworker appeared to be lacking a clear understanding of SP's mental health, and how it impacted her care of AP. An opportunity was missed at that stage for DCJ to organise a meeting with the SBS worker and AP's mental health team to explore these issues. The ISCR observes "[t]he professionals involved with SP could then have developed joint goals and worked more collaboratively to address SP's ongoing mental health issues and minimise their impact on AP".[24]

41. The ISCR identifies that a further opportunity for inter-service collaboration was missed when SP changed to a new mental health worker in November 2014. The ISCR states "[t]his meeting would have provided an opportunity for the mental health worker to learn

[21] Agreed Facts at [69]; FACS, Internal Serious Case Review, November 2016, p. 27 (Brief, Vol 2, Tab 25).
[22] FACS, Internal Serious Case Review, November 2016, p. 27 (Brief, Vol 2, Tab 25).
[23] Report of Prof Judith Irwin, p. 4 (Brief, Vol 5, Tab 41).
[24] FACS, Internal Serious Case Review, November 2016, pp. 28-29 (Brief, Vol 2, Tab 25).

from FACS and SBS what their goals were and understand what they were trying to achieve for SP and AP".[25] Professor Irwin concurs that DCJ "could have been much more pro-active in planning, co-ordinating and communicating with Mental Health and the other services that were supporting SP and AP", concluding that the failure to do so exposed AP to the possibility of increased risk.[26]

42. Professor Irwin further observes that collaboration between DCJ caseworkers and the Liverpool Out of Home Care Service (OOHC) who had oversight of care of SP's twins would have been beneficial. The extent of SP's pre-occupation and stress around contact with and custody of her twins only becomes apparent from the notes of the LCMHT. (Professor Irwin is likely to be referring to the notes from St George Community Mental Health Team which are on the LCMHT file. The notes of the LCMHT do not in fact make extensive mention of this issue). Information sharing between the CSC and OOHC may have influenced the practice of each service with respect to SP and perhaps could have contributed to a reduction of SP's anxiety and tension.[27]

43. Perhaps most significantly, the decision to cease working with SP was made by DCJ in February 2015 prior to the caseworker contacting SP or other services with which she was engaged. At the time SP was informed of the decision to close her DCJ file, SP stated she would prefer to have the support of DCJ as it was a "safety net" for her. She declined a referral to Brighter Futures at that juncture. The decision to close the file was made at a time when funding for the SBS worker would shortly end, and SP's child care subsidy would end in a few weeks. No contingencies were made for these services to continue prior to closure. The ISCR observes that "the caseworker, who was not able to get in contact with mental health, did not have an understanding of SP's current mental health or of the support being provided to her".[28]

44. A meeting between services held at this time might have provided an opportunity for greater understanding of the importance of DCJ support as a 'safety net' for SP, and the reasons why she may have been wary of accepting a referral to yet another new service. It may have identified gaps in services which were likely to arise in the future and ensured adequate supports were in place to monitor SP's mental health and its impact on AP, going forwards.

45. The court is aware that there was some contact between DCJ and the relevant mental health service *after* the formal closure of her case file. A number of unsuccessful attempts were made to speak with Dr Duke at St George Mental Health to advise that the case had been closed. Contact was subsequently made with SP's mental health worker who

[25] FACS, Internal Serious Case Review, November 2016, p. 29 (Brief, Vol 2, Tab 25).
[26] Report of Prof Judith Irwin, p. 10 (Brief, Vol 5, Tab 41).
[27] Report of Prof Judith Irwin, p. 5 (Brief, Vol 5, Tab 41).
[28] FACS, Internal Serious Case Review, November 2016, pp. 30-31 (Brief, Vol 2, Tab 25).

apparently advised that SP was progressing well.[29] The mental health caseworker was advised to call the Helpline if necessary.

46. Ms Stokoe's evidence was that practice standards regarding collaboration which were in place at the time (such as the NSW Child Wellbeing and Child Protection Interagency Guidelines) would have required caseworkers to seek guidance from mental health partners and advice as to how the symptoms SP was experiencing may have impacted her ability to parent a child and keep her safe.[30] Ms Stokoe conceded that, due to the particular staff involved at St George CSC at the time, staff were not following best practice in that regard.[31] While Ms Stokoe was unsure whether SDM tools would prompt a caseworker to seek corroborative information about mental health from other agencies, she stated that the training given in application of the tools makes it clear that the advice of partner agencies should be sought where appropriate, such as in the areas of mental health or drug and alcohol issues.[32]

47. Ms Stokoe identified the introduction of Group Supervision as a further opportunity to involve casework specialists, consultants, partner organisations and families in a collaborative fashion. She acknowledged that the resources, priorities and work practices of other agencies, and of private providers in the health space, can inhibit their interest in and ability to engage in a co-operative approach to service provision.[33] She identified private GPs, psychologists and psychiatrists as particularly unlikely to attend Group Supervision meetings.[34] She noted that when invitations to attend group supervision or provide information are not taken up, DCJ is able to rely on Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to request information.[35]

Appropriateness of decision to close the case file

48. It is clear that SP and AP's file should not have been closed by DCJ in February 2015. Closure of the DCJ file resulted in a significant reduction of the amount of support being offered to SP, and a lack of oversight as to how SP's mental health was impacting upon AP's safety.

49. It is particularly noteworthy that SP herself referred to the involvement of DCJ as a "safety net." She did not want DCJ to close her case and would have preferred to know she had the option of DCJ support and monitoring available to her. There is no doubt that premature closure of her case file greatly increased the risk to AP and her family.

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[29] DCJ letter to Mr James Pender, 19 November 2019 at [49] p. 373.
[30] Transcript 17/12/19, p. 13 at L10.
[31] Transcript 17/12/19, p. 13 at L45.
[32] Transcript 17/12/19, p. 14 at L11.
[33] Transcript 17/12/19, p. 23 at L35.
[34] Transcript 17/12/19, p. 23 at L 39; p. 25 at L 24.
[35] Transcript 17/12/19, p. 24 at L34.

50. The following factors were identified in the ISCR as contributing to the erroneous decision to close the file:

a. Lack of understanding of the complexity of SP's mental health, including her symptoms;

b. Failure to develop a network of people and supports around SP and AP who were aware of SP's mental health and able to detect its decline; and

c. Failure to consider how SP's health impacted upon AP's safety in her care.[36]

51. These failures in understanding were compounded by the incorrect risk assessments discussed above, failure to consult with mental health services, a lack of curiosity about SP's trauma background, and the culture of isolation and lack of supervision which prevailed at St George CSC at the time.

52. Professor Irwin makes the observation that by the time AP was born, SP had experienced multiple past traumas: she had experienced domestic violence from the father of her twins, her twins had been removed from her care, she had been homeless, and she had reason to fear AP would be removed by DCJ. She had dealt with deteriorating mental health since the age of 15, experienced the separation of her parents and witnessed domestic violence and alcohol abuse within the home. Professor Irwin observes that throughout DCJ's engagement with SP "there appears to have been minimal acknowledgement of the existence of these experiences, and little recognition or understanding of how the interplay between them may have influenced SP's life and her capacity to look after both herself and AP".[37] Professor Irwin expresses the opinion that better understanding of these issues "may have led to a much broader network of services being involved in providing support, especially in relation to AP's care and safety."[38] [redacted]

53. Professor Irwin expressed the opinion that insufficient regard was had to the prior removal of SP's twins when making decisions about her case management. This was referred to as a "red flag", which should indicate concern and likely high support needs.[40]

54. Ms Stokoe agreed that SP's history was relevant to the assessment of future risk and should have been considered as a risk factor, but emphasised that people are capable of change, and their capacity to parent may vary over time as a result of multiple factors.

[36] FACS, Internal Serious Case Review, November 2016, p. 4 (Brief, Vol 2, Tab 25).
[37] Report of Prof Judith Irwin, pp. 2-3 (Brief, Vol 5, Tab 41).
[38] Report of Prof Judith Irwin, p. 4 (Brief, Vol 5, Tab 41).
[39] Report of Prof Judith Irwin, p. 9 (Brief, Vol 5, Tab 41).
[40] Transcript 16/12/19, p. 37 at L32.

The significance of prior child removal when making a risk assessment must be looked holistically with all other information available.[41]

55. Ms Stokoe made it clear that practice standards[42] already in place at the relevant time would have required caseworkers to seek guidance from mental health partners prior to such a significant decision being made. However there was a failure by the relevant caseworker to appreciate the risk involved and a failure to ensure adequate supervision identified and reviewed that omission. Ms Stokoe stated "Something that was highlighted quite clearly [in the ISCR] was the lack of supervision and support provided to staff at the time and the worries that there was a culture where caseworkers felt very much they were carrying risk on their own without being supported, and that the office was working in silo and not really had a culture to critique advice and support."[43] I commend Ms Stokoe for her candour and her readiness to identify where things went wrong.

56. Ms Stokoe expressed her confidence that a decision to close a file such at this would not be made at St George CSC today. Significantly, she spoke about work that had been undertaken to improve the work culture at St George CSC. She also pointed to the following changes which have been implemented since AP's death including:

a. A system has been implemented at St George CSC to ensure that no child protection case with a risk assessment of high or very high is closed without the Child Protection Case Work Specialist undertaking a review and their recommendation in support of the matter being closed;[44]

b. There would be an expectation that high or very high risk matters would come through Group Supervision, so that discussion could take place around the decision to close the file. [45] The prior removal of SP's twins would, under this model, result in the case being flagged as complex and appropriate for Group Supervision;[46]

c. Training in the application of SARA tools would help ensure that correct risk assessments were applied and SARA case reviews are occurring as needed in different CSCs to monitor compliance;[47]

d. Management changes at St George CSC have been made to address the situation in this case where a caseworker was working in isolation with inadequate training in applying SDM tools.[48]

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[41] Transcript 16/12/19, pp. 22-23.
[42] For example NSW Child Wellbeing and Child Protection Interagency Guidelines.
[43] Transcript 17/12/19, p 6.
[44] Statement of Tracey Stokoe, 20 September 2019 at [43] (Brief, Vol 3, Tab 26).
[45] Transcript 17/12/19, p. 7 at L42.
[46] Transcript 17/12/19, p. 8 at L 21.
[47] Transcript 17/12/19, p. 10 at L 10.

e. Steps have been taken to encourage and improve inter-agency collaboration, including attending local Safety Action meetings (SAM).

57. Ms Stokoe stated that different CSCs across the state have different priorities, strengths and weaknesses. She spoke of the particular issues which that arose specifically at St George CSC but also summarised the state wide reforms which had taken place since AP's death which deal with matters affecting CSCs across the state. In particular she spoke of the implementation of the NSW Practice Framework, the development of five evidence-informed Practice Kits to improve caseworkers' skills and development, the rollout of group supervision and the training and practice advice provided on the Casework Practice intranet site. The court accepts that these initiatives are significant improvements to the support offered to caseworkers on the ground and are likely to improve practise in the field. Nevertheless, the court remains concerned about the potential for inappropriate or premature case closure, given the risk it can create.

58. Submissions provided by DCJ accept that it may be useful to review existing policy and practice mandates to identify areas where guidance around case closure can be strengthened. I am heartened that DCJ intends to include a training package for caseworkers with a case study based on AP's case. This will serve to help alert workers to the particular risk issues that may be present when working with clients with serious mental health issues. I accept that DCJ is committed to learning from the tragedy of AP's death.

Evidence concerning care and treatment provided by Dr Ramjan

59. SP was treated by her general practitioner, Dr Don Ramjan, on 14 occasions from 28 July 2015 to 9 September 2016. Dr Ramjan saw SP, sometimes with AP, at My Health Medical Practice in Liverpool ("My Health").

60. Aspects of this treatment are summarised in the Agreed Facts at [105]-[109].

61. Dr Ramjan has provided two statements in this matter, dated 19 November 2016 and 9 December 2019. He also gave oral evidence at the inquest.

62. It was clear that Dr Ramjan had genuine concern for his patient and that he tried to assist the court to the best of his ability, given his sometimes incomplete memory of the relevant events. The court specifically acknowledges that Dr Ramjan made sincere and appropriate efforts to assist SP as soon as he became aware of her acute relapse on 9 September 2016.

[48] Transcript 17/12/19, p. 10 at L 10.

63. Dr Ramjan appeared surprised that the available records did not always accord with what he referred to as "his invariable practice". Nevertheless the court recognises that practices are rarely "invariable" and that any person working in high volume situations may from time-to-time depart from their usual practice. It is certainly clear that Dr Ramjan was working at capacity. Like many general practitioners working in the fee-for-service model, Dr Ramjan saw a large number of patients each day. At the relevant time Dr Ramjan was working full time from 9am to 6pm each day seeing about 40 patients, as well as carrying out occasional procedures and emergency consultations.[49] Working at that rate, it is hardly surprising that his clinical records are often brief. He explained "Unfortunately, you know, in an ideal world, documenting every single thing that happens would be, would be easy to do. But unfortunately I'd probably spend two hours after work still writing notes and, and not have the ability to document every single thing that was said in a consult, or every single phone call that I've made. Yesterday I made 15 calls to try and establish another psychotic patient's medication, you know, including to the psychiatrist and, and to the, family members. And, you know, there's only so many hours in the day that I can do that."[50] I accept the veracity of this account but am somewhat troubled by the conditions under which he worked.

64. Aspects of Dr Ramjan's care were considered by Professor Christopher Ryan in his expert report, and elaborated upon in his oral evidence before the inquest. Professor Ryan is a Clinical Associate Professor at the University of Sydney and a Consultation-Liaison Psychiatrist at Westmead Hospital. Consultation-Liaison Psychiatry is the subspecialty of psychiatry that provides care and treatment for people who present to the general hospital with psychiatric and psychological problems. His role includes assessing and treating patients and making judgements as to their diagnosis, and management, including decisions about whether they should be treated coercively under the provisions of the *Mental Health Act 2007*.

65. The focus of attention on Dr Ramjan's care at the inquest was on two issues:

a. The exchange of information (or lack thereof) between Dr Ramjan and the LCMHT, in particular regarding the prescription of mental health medications; and

b. The actions taken by Dr Ramjan on 9 September 2016, following a consultation with SP in which he became concerned about the deterioration of her mental health.

[49] Transcript 18/12/19 at p. 56 at L 18 onwards.
[50] Transcript 18/12/19 at p. 43 at L30 onwards.

66. Overall, Professor Ryan regarded the psychiatric history and documentation taken by Dr Ramjan as minimal but adequate.[51] Professor Ryan observes that Dr Ramjan appears to have acted on the assumption that SP's diagnosis was post-partum psychosis, perhaps relying on information SP gave to him,[52] while in fact SP's diagnosis was more in keeping with a long standing schizophrenia-like psychosis. Professor Ryan's view was that this would have had minimal impact on her management, however I wonder whether it contributed to his acceptance that her condition was gradually improving. Professor Ryan further notes that Dr Ramjan misused some mental state terms, and his belief that SP's concern about her weight was evidence she was "of sound mind" was suboptimal. However these factors fell short of "inadequate" care in his opinion.[53]

67. Dr Ramjan's evidence was that he was not familiar with the anti-psychotic medication triflouperazine (also referred to by the trade name Stelazine), having not prescribed it before treating SP or since. In the opinion of Professor Ryan, the fact that Dr Ramjan was not familiar with trifluoperazine was not, of itself, concerning or unusual. As generalists, GPs are regularly called upon to prescribe medications which they do not have experience with. This was not an issue which Professor Ryan expected should necessarily have been raised by Dr Ramjan, or impacted upon his care.[54]

68. Professor Ryan's major criticism of Dr Ramjan's care was that, despite having limited experience with psychiatric treatment, he made no effort to speak to the community mental health team. As noted above, this included making no effort to liaise with them in relation to medication dosage.[55] He stated in oral evidence "I think my criticism really was when he was making… important treatment decisions, that he would have every reason to think that he wouldn't have expertise in making, then you would have expected as standard practice that he would speak to the psychiatrist who's also involved in the care".[56]

69. Professor Ryan's expectation as a psychiatrist was that if a GP felt treatment or a medication dosage should be decreased, they would first make contact with the prescribing psychiatrist. The conflicting evidence as to whether Dr Ramjan did, in fact, decrease SP's dosage of anti-psychotic medication without consulting the LCMHT is discussed below.[57]

70. Professor Ryan acknowledged that the lack of communication went both ways: Dr Ramjan had not been provided with information from the LCMHT about its treatment plan

[51] Report of Prof Christopher Ryan, p. 43 (Brief, Vol 5, Tab 44).
[52] Report of Prof Christopher Ryan, p. 43 (Brief, Vol 5, Tab 44).
[53] Report of Prof Christopher Ryan, p. 44 (Brief, Vol 5, Tab 44).
[54] Transcript 18/12/19, p. 20 at L40.
[55] Transcript 18/12/19, p. 20 at L40.
[56] Transcript 18/12/19, p. 21 at L31.
[57] Transcript 18/12/19, p. 22 at L 7.

for SP, nor did he seek out this information.[58] Dr Ramjan was effectively co-managing his patient with the LCMHT, and that required communication.

71. Despite Dr Ramjan's evidence to the inquest that the usual practice of My Health was for reception staff to seek records from community mental health services in relation to new patients, there is no evidence to suggest that, in fact, occurred in this case.[59] Dr Ramjan observed that at the time of these events, contacting the LCMHT often did not result in obtaining any useful records.[60] Given the lack of documentation I am not satisfied that reception staff sought collaborative records in relation to SP. Dr Ramjan's contact is more difficult to assess.

Circumstances in which dose of triflouperazine was reduced

72. A clinical note made by Dr Ramjan on 27 November 2015 and time stamped 15:38 states:

> "Dose of Stelazine 2 mg Tablet changed from 2 in the evening As directed to 1 in the evening As directed [sic]."

73. In a subsequent consultation on 25 February 2016, Dr Ramjan documented in his clinical notes that SP felt "tired all day – everyday". The clinical notes state "Trial reduction in dose" and record once again that the dose of trifluoperazine had changed from 2 mg to 1 mg, even though this apparently occurred during the earlier consultation.[61]

74. A separate document which forms part of the My Health records is headed 'Patient Health Summary'. It contains a list of SP's prescriptions. It records that on 27 November 2015, Dr Ramjan prescribed "Stelazine 2 mg Tablet" at a dose of "2 Tablet In the evening As directed". Nil repeats were ordered.[62] If this notation were taken on face value, it would suggest that Dr Ramjan in fact increased SP's dosage of triflouperazine to 4 mg per evening, despite what is recorded in the clinical note for that consultation.

75. On 25 February 2016, it is recorded in the Patient Health Summary that Dr Ramjan prescribed "Stelazine 1 mg Tablet" at a dose of "1 Tablet In the evening As directed". Five repeats were ordered.[63]

76. In the opinion of Professor Ryan, the apparent decision by Dr Ramjan to decrease SP's dose of trifluoperazine from 2 mg for 1 mg, even though she was clearly psychotic on 1 mg, without consulting a member of the LCMHT, was an inadequate aspect of his care.[64]

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[58] Transcript 18/12/19, p. 23 at L 5.
[59] Transcript 18/12/19, p. 37 at L30.
[60] Transcript 18/12/19, p. 40 at L31.
[61] Consultation note by Dr Ramjan, 25 February 2016, p. 632 (Brief, Vol 2, Tab 22); Report of Prof Christopher Ryan, p. 39 (Brief, Vol 5, Tab 44).
[62] Annexure A to the supplementary statement of Dr Ramjan, 9 December 2019 (Brief, Vol 1, Tab 18A).
[63] Annexure A to the supplementary statement of Dr Ramjan, 9 December 2019 (Brief, Vol 1, Tab 18A).
[64] Report of Prof Christopher Ryan, p. 44 (Brief, Vol 5, Tab 44).

77. Dr Ramjan's evidence on this issue evolved in the following manner.

78. In his first statement dated 19 November 2016, Dr Ramjan stated regarding the 27 November 2015 consultation:

> "SP came in with AP regarding a repeat script of Cymbalta and well as an anti psychotic medication called Stelazine 2 mg tablet [sic]. SP had informed me that she had been prescribed Stelazine by her Psychiatrist at COMET (Community Mental Health Emergency Team)."[65]

79. In relation to the consultation on 25 February 2016 he stated:

> "There was no change and her mental health was stable. At that time, she was having a trial reduction in her dose of Stelazine from 2 mg to 1 mg. I cannot remember whether I organized this trial or whether it came from COMET."[66]

80. It is noted that there is no evidence that Dr Hafiz, or anyone at LCMHT, had decided to trial a reduced dosage of triflouperazine at that time. Rather, at the most recent consultation with Dr Hafiz on 11 December 2015, he had recorded "?? relapse of psychotic [symptoms]" and "Suggest [increase] in Stelazine dose to 3-4 mg".[67]

81. In his supplementary statement dated 9 December 2019, Dr Ramjan states that he has no recollection of the circumstances that gave rise to him making the consultation note on 27 November 2015. He notes that the prescription in fact given to SP was a repeat prescription for trifluoperazine at the existing dose of 2 mg.

82. Dr Ramjan states that it was his "invariable practice" at that time never to provide a patient with a lower dose of antipsychotic medication than had been prescribed by a psychiatrist, without first seeking confirmation of the reduction from the prescriber. He notes that this practice was particularly relevant to his consultation with SP on 27 November 2015, as prior to that he was not familiar with trifluoperazine and was not confident in his knowledge of its side effects and interaction with other drugs.[68]

83. Dr Ramjan records in his supplementary statement that when he saw SP again on 25 February 2016, he provided her with a prescription for triflouperazine at the reduced amount of 1 mg. He was unable to recall this consultation and could recall no reason why he would have departed from his usual practice of seeking confirmation and advice regarding a reduction of the antipsychotic before completing the prescription.[69]

84. In oral evidence before the inquest, Dr Ramjan was taken to his consultation notes regarding the consultation on 25 February 2016. He was asked "At this point in time,

[65] Statement of Dr Ramjan, 19 November 2016 at [23] (Brief, Vol 1, Tab 18).
[66] Statement of Dr Ramjan, 19 November 2016 at [23] (Brief, Vol 1, Tab 18).
[67] LCMHT medical records, 11 December 2015, p. 479 (Brief, Vol 2, Tab 23).
[68] Supplementary statement of Dr Ramjan, 9 December 2019 at [18]-[22] (Brief, Vol 1, Tab 18A).
[69] Supplementary statement of Dr Ramjan, 9 December 2019 at [23]-[25] (Brief, Vol 1, Tab 18A).

when you were reducing the antipsychotic medication, did you actually contact Dr Hafiz?" He responded:

> "No. But prior to this, as would be my practice, from the previous consult where she had told me that she had, was on a reduced dose of, of the Stelazine, and I attempted a reduction and then decided not to do it. Because I couldn't contact anyone at that consult, I decided not to do it. But between then and this consult there would have been some contact."[70]

85. This answer appears to be inconsistent with his evidence in his supplementary statement that he had no recollection of the circumstances in which he made the consultation note on 27 November 2015. Dr Ramjan was insistent in his oral evidence that there "would have been a phone call" to the community mental health team. He stated he "would not have spoken to Dr Hafiz" and "would have spoken to one of the nurses".[71] He denied the possibility that he could have reduced SP's medication without consulting the community mental health team.[72] He acknowledged that while in his supplementary statement he stated it was his invariable practice to consult the *prescriber* of antipsychotic medication before lowering the dose, his evidence now was that he in fact would have spoken to someone else at LCMHT, perhaps a nurse or a social worker.[73]

86. When questioned further about the circumstances in which SP's dose of Stelazine appeared to have been changed on 27 November 2015, Dr Ramjan gave a detailed answer as follows:

> "So, it, it's simply a matter of the way that the software's designed. So SP's presented and advised me that she's on a 1 milligram dose from the mental health team. I can't confirm that so initially I've then changed it to 1 while I'm on the telephone probably, then unable to establish that she definitely is on that lower dose, I've returned her back to her original dose, and now that the medication's at 1 milligram, I've then said take two tablets in the evening, I'm not changing your dose until I can confirm that's the case…"

87. The detail given in this answer may be an honest attempt at reconstructing what had occurred, but is difficult to rely upon when his supplementary statement states that he could not recall the circumstances in which the notation on 27 November 2015 was made.

[70] Transcript, 18/12/19, p. 42 at L 41.
[71] Transcript, 18/12/19, p. 43 at L 5.
[72] Transcript, 18/12/19, p. 43 at L 25.
[73] Transcript, 18/12/19, p. 44 at L 1.

88. At the end of the proceedings counsel assisting submitted that the court would not be satisfied that Dr Ramjan consulted with any member of the LCMHT in relation to this medication change. The more likely conclusion is that he did not. This is because:

a. There is no note in the My Health records of any contact between Dr Ramjan and any community mental health service in relation to SP prior to April 2016;

b. There is no note in the LCMHT records of any contact with Dr Ramjan at all;

c. Had Dr Ramjan contacted the LCMHT in relation to a potential reduction in SP's anti-psychotic medication, it is implausible that a staff member would have supported that change, given that Dr Hafiz's most recent recommendation was to increase SP's Stelazine dose;

d. The way in which Dr Ramjan's evidence on this issue has evolved over time appears more consistent with him reconstructing events in an effort to make sense of the patient records, than with him having a genuine recollection of these matters.

89. A contrary interpretation of the evidence was urged by counsel for Dr Ramjan. Counsel for Dr Ramjan submitted that the court would have found Dr Ramjan a credible witness and could properly accept his explanation of his "invariable practice" of never reducing an anti-psychotic medication prescribed by a psychiatrist without first seeking confirmation from the prescriber. Counsel submitted that Dr Ramjan was clearly a conscientious practitioner, evidenced by the fact that he had been unfamiliar with the particular medication and had taken the trouble to look it up. Further it was submitted that, given the prescribing records, the court would readily accept that Dr Ramjan's initial decision to reduce the Stelazine dose, during the consultation on 27 November 2015 was revised *because* no contact could be made with a prescriber. This was in accordance with his evidence of his usual practice.

90. Against this background counsel for Dr Ramjan submitted that the court should not make a finding that his decision to reduce the dose on 25 February 2016 was made without appropriate consultation. Counsel stated that the appropriate starting point was that Dr Ramjan was a credible witness who told the court that, given his invariable practice, reducing the dose "was not possible" without confirmation from the LCMHT.[74] He asked the court to accept Dr Ramjan's oral evidence which was that "between [27 November 2015] and this consult [25 February 2016] there would have been some contact [with

[74] Transcript 18/12/19, p. 43 at L 39-43.

LCMHT]."[75] In oral evidence Dr Ramjan stated that he would not have spoken to Dr Hafiz, but may have spoken to a mental health nurse or social worker.[76]

91. The trouble is there is no record of that kind of contact in Dr Ramjan's My Health record or in the LCMHT record. Dr Ramjan conceded his omission and in reflecting on his own practice, stated that he was now far more cautious with his documentation, "in particular verbal communications with people in the community."[77]

92. If Dr Ramjan made contact with the LCMHT it is extremely unlikely, even implausible that a nurse or social worker would have confirmed a reduction in specific anti-psychotic medication when there was no notation from a prescribing doctor to that effect on file. One wonders whether Dr Ramjan spoke to someone or whether he remained unable to get in touch with anyone at LCMHT and so, against his own usual practice, made a decision to reduce the medication in the context of SP presenting well and her self-reporting a reduction in dose by the psychiatrist.

93. At the end of the day, without a supporting record, while I accept it was his *usual* practice I cannot be satisfied that Dr Ramjan made appropriate contact with a psychiatrist prior to reducing SP's dose in February 2016. However, I note that in the particular facts of this matter little may turn on the precise dose prescribed, given that it is likely as the year wore on SP became non-compliant even with the lesser dose.

94. It is clear that SP developed some rapport with Dr Ramjan over the period of her attendance at his clinic. When she attended on 9 September 2016, he was immediately aware that there had been a significant decline in her mental health. Initially he suggested she attend the hospital, but she walked out of the room.[78] He acted quickly recording in his consultation notes, "…CoMET team contacted for urgent review as she has a 2 year old. Spoke to MH team at comet and faxed letter."[79] Dr Ramjan recognised the acute risk to AP and made appropriate attempts to get the family help. Unfortunately as is discussed below, his efforts proved futile.

Evidence concerning Liverpool Community Mental Health

95. SP was referred to Liverpool Community Mental Health Team (LCMHT) for mental health care and case management in May 2015. Background to SP's mental health condition and treatment prior to this referral is set out in the agreed facts at [21]-[83].

[75] Transcript 18/12/19, p. 43 at L 43 onwards.
[76] Transcript 18/12/19, p. 44 at L 6 onwards.
[77] Transcript 18/12/19, p. 66 at L 27.
[78] Statement of Dr Ramjan, 19 November 2016 at [33-40].
[79] Medical records from My Health Medical Centre, Liverpool, Consultation notes, 9 September 2016.

96. While a patient of LCMHT (referred to by that organisation as 'consumers'), SP had two Clinical Case Co-ordinators (CCCs) assigned to her. Both provided statements which are included in the brief of evidence. The inquest also heard oral evidence from Mr Ghimire, who was SP's CCC from 16 May 2016, up until a decision was made to discharge SP from LCMHT on 9 September 2016.

97. SP's treating psychiatrist at LCMHT was Dr Hafiz. The inquest received a statement and oral evidence from Dr Hafiz.

98. Patrick Parker, Director of Community Health and Partnerships at South Western Sydney Local Health District (LHD) provided a response to the report of Professor Ryan. A supplementary statement of Mr Parker was provided, addressing issues that had arisen during the course of the inquest. Mr Parker gave oral evidence on the final day of the inquest.

99. It was appropriately conceded by the LHD at the outset that there were significant and systemic shortcomings in the care offered to SP and AP. In particular the LHD conceded that it was not appropriate to discharge SP in September 2016.

Role and function of Care Co-Ordinators ('CCCs')

100. Mr Ghimire commenced employment with the LCMHT on 16 May 2016. It was his first employment in mental health, after completing a Masters of Social Work.[80] He was given no specific training for the role of CCC, prior to commencing his job.[81] The evidence indicates that the handover process at LCMHT was poorly executed and Mr Ghimire did not receive adequate supervision in his new role.

101. About a week after commencement he was allocated approximately 24 to 26 patient files. Many of those patients had been under the care of SP's previous CCC, who had gone on maternity leave in mid-April. He did not receive any formal handover, either oral or written.[82] Mr Parker's evidence was that the policy on clinical handovers requires a verbal handover to occur. If this couldn't occur between Mr Ghimire and SP's previous CCC, the verbal handover should have been conducted by the Acting Team Leader, Mr Raymond Finch.[83] Further, as a new starter, Mr Ghimire should have been given a shared caseload with a more experienced practitioner. This would have allowed for the gradual transfer of files from the more experienced to the less experienced person. Given this was Mr Ghimire's first job as a CCC, that process of mentoring should have taken up to six months.[84]

[80] Statment of Bikash Ghimire, 10 February 2020 at [2] (Brief, Vol 6, Tab 45).
[81] Transcript, 25/2/20, p. 5 at L 46.
[82] Transcript, 25/2/20, p. 6 at L 35; p. 8 at L 7.
[83] Transcript, 25/2/20, p. 66 at L 15.
[84] Transcript, 25/2/20 p. 66 at L 25.

102. Instead, Mr Ghimire commenced a process of independently reviewing the progress notes on the clients' electronic files, and prioritising those who needed to be followed up first. In doing so, he distinguished between those with "acute needs", who had priority, and those were "stable". He was informed by Mr Finch, that patients on Community Treatment Orders should be followed up first.[85]

103. It is clear that Mr Ghimire was inadequately resourced and supported in his role. For this reason, the process of review undertaken by Mr Ghimire was flawed. It is apparent from his evidence that he focussed on recent entries in the progress notes, made by previous SP's CCC. From these he gleaned that SP was "presenting cheerful" and "requesting for a discharge with her GP". He took no steps at that time to establish contact with SP's GP. He concluded that following her up was a low priority.[86] Had Mr Ghimire delved further back into SP's progress notes at an early stage, he would have identified that SP's anti-psychotic medication had been increased at her most recent psychiatric review, and that follow up within one month had been requested. Instead, he was unaware of these issues when he took over SP's care.[87]

104. Mr Ghimire explained this narrow approach to assessing SP's needs in terms of providing "continuity of care" with the care the previous CCC was providing. The phrase "continuity of care" was used repeatedly throughout his oral evidence. There were several limitations with this approach. First, it assumed that the plan formulated by SP's previous CCC was appropriate at the time it was developed. Secondly, it assumed that the plan to consider discharge to the care of her GP remained appropriate, and didn't allow for a potential deterioration in SP's mental state. Thirdly, it didn't motivate Mr Ghimire to exercise curiosity about SP's history and her broader psychosocial needs, or to develop the rapport with SP that might have allowed him to better understand those needs. As an example of this lack of curiosity, while Mr Ghimire believed he would have spoken to SP briefly about AP, there are no notes to indicate Mr Ghimire spoke with SP about the children removed from her care.[88] Finally, it was not based on any attempts to corroborate SP's self-reported "stability", or any consultation with the other supports understood to be in SP's life. The lack of corroboration appears to extend to a failure to check with SP (or at least document) what medications she was taking, whether she had an adequate supply, and whether she was getting medications from her GP.[89] Mr Ghimire's willingness to accept, on face value, that she was well engaged with other services is particularly surprising in the face of her repeated failure to attend appointments with the LCMHT.

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[85] Transcript, 25/2/20, p. 7 at L 5; p. 8 at L 1.
[86] Transcript, 25/2/20, p. 8 at L 17.
[87] Transcript, 25/2/20, p. 12 at L 20.
[88] Transcript, 25/2/20, p. 36 at L 36.
[89] Transcript, 25/2/20, p. 47 at L 39.

105. Mr Ghimire's first contact with SP occurred on 29 June 2016 when he telephoned her to "check with her wellbeing" and to advise of her next case review.[90] At that point, SP had not been spoken to by anyone at LCMHT since 5 April 2016, and had not been seen by a psychiatrist in the team since 11 December 2015. SP denied "any concerns at this stage" and stated she "thought she was already discharged" from the service. She stated she was seeing a private psychologist and a general practitioner.

106. On 13 July 2016, SP failed to attend a psychiatric review that had been scheduled with Dr Jacobi. Mr Ghimire did not have contact with SP to follow up the missed appointment until 21 July 2016, when she in fact called him to enquire about the date of her next appointment. In oral evidence, Mr Ghimire was taken to the LCMHT's Missed Appointment Policy in operation at that time. He conceded that he was aware at the time that the guideline was in place, but was not aware of the timeframe in which follow up was required to occur.[91] Although the policy required all consumers who missed appointments to be followed up by telephone from the treating doctor of clinical on the day of the appointment, Mr Ghimire's evidence was that he was not notified of SP's nonattendance on that day.[92] It was his expectation that the CCC would follow up further only if the psychiatrist had been unable to contact the consumer, and he was notified of this fact by the psychiatrist or administrative staff.[93]

107. Mr Ghimire's evidence was that this aspect of practice has improved at LCMHT since AP's death. CCCs now sit in on consultations that occur between psychiatrists and consultants. CCCs are accordingly immediately aware if an appointment is missed, and if the consumer isn't able to be reached by the psychiatrist on the phone during the appointment period.[94]

108. Mr Ghimire gave evidence that the next time anyone from the LCMHT had face to face contact with SP was in August 2016. He stated that he discussed his difficulties engaging with SP with Mr Finch, who volunteered to conduct a home visit with SP. He recalls later having an informal conversation with Mr Finch in which Mr Finch confirmed he had seen SP at home and reminded her to attend an upcoming appointment on 2 September 2016. Mr Ghimire stated that "[Mr Finch] indicated that there were nil current acute risks regarding her mental state identified at the time of contact".[95]

109. There is no record on SP's file of this home visit occurring. If Mr Finch did attend he made no record. Mr Ghimire's evidence was that he did not complete a progress note as

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[90] LCMHT medical records, p. 495 (Brief, Vol 2, Tab 23).
[91] Transcript, 25/2/20, p. 16 at L 37.
[92] Transcript, 25/2/20, p. 18 at L 23.
[93] Transcript, 25/2/20, p. 19 at L 14.
[94] Transcript, 25/2/20, p. 20 at L 35.
[95] Statement of Bikash Ghimire, 10 February 2020 at [21]-[22] (Brief, Vol 6, Tab 45); Transcript, 25/2/20, p.25 at L 29.

he expected Mr Finch to do so.[96] He conceded that in spite of his recollection of these conversations with Mr Finch, he was not in a position to say whether Mr Finch did, in fact, conduct a home visit to SP.[97] Mr Parker gave evidence that the LHDs investigations into this incident turned up no mention of Mr Finch conducting a home visit.[98]

110. Failure to record a visit of this importance, with a client who had previously been difficult to engage, is surprising. I am not satisfied the visit occurred or if it did that it could have had any useful therapeutic value.

111. When next spoken to by Mr Ghimire on 1 September 2016, SP again stated she "thought she was discharged from the service" and complained that she "did not get much support" from LCMHT. She stated she was seeing a counsellor from TAFE and would prefer to be discharged.[99]

112. Mr Ghimire was asked what support, in his view, the LCMHT had in fact given SP over the previous year. He responded:

> "Mainly to monitor her mental state and… to support if she has any psychosocial needs, such as, you know, to explore about TAFE course and – and these things; and to have access to social activities. And when I spoke to SP at that time, and also review from the previous notes that she was having regular contact with her father and a regular contact with friends, attending TAFE - and so there was no current needs for psychosocial input required…."[100]

113. When it was suggested to Mr Ghimire that little had been done to monitor SP's mental state in a number of months he pointed to his initial phone call to SP and his prompt to her to attend a psychiatrist review as demonstrative of his efforts. He again emphasised that he was providing "continuity of care" by prompting SP to attend a psychiatric review so that a determination could be made if she was suitable for discharge to her GP.[101]

114. It was during his phone call with SP on 1 September 2016 that Mr Ghimire obtained the contact details for her GP and psychologist for the first time. He did not make contact with those persons because, in his view, there was no obvious reason to do so.[102] Mr Ghimire's attention was directed to the Care Coordination Case Management policy in place at the LCMHT at the time. With reference to that policy he was asked if he saw it as his role to make contact with the GP and psychologist. He denied this, repeating that

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[96] Transcript, 25/2/20, p. 25 at L 45.
[97] Transcript, 25/2/20, p. 51 at L 40.
[98] Transcript, 25/2/20 p. 66 at L 45.
[99] LCMHT medical records, at p. 499 (Brief, Vol 2, Tab 23).
[100] Transcript, 25/2/20, p. 25 at L 38.
[101] Transcript, 25/2/20, p. 25 at L 12.
[102] Transcript, 25/2/20, p. 31 at L 4.

there were no acute risks or obvious reasons do to so.[103] He stated that if there were concerns, he would expect other services involved to contact the LCMHT.[104] He did not identify anything he would do differently with the benefit of hindsight, in the absence of other services bringing to his attention any concerns or indications of deterioration of SP's mental state.[105]

115. The court accepts that Mr Ghimire, who was new to the role of CCC, was poorly supervised and supported. What is concerning is his continued lack of insight given that years have now passed since he faced these issues as a newly employed worker.

116. Mr Parker agreed it was concerning that Mr Ghimire did not see a need to communicate with SP's GP or psychologist. However, he emphasised that such contact should have been made at a much earlier point in time, prior to Mr Ghimire assuming the role of CCC. He stated:

> "So the role of the case manager, which I think we understood to be pretty clear around coordination and bringing services together around a consumer, should happen from the beginning of somebody's episode of care, particularly in circumstances where somebody has a good relationship with a GP".[106]

117. In Mr Parker's view, Mr Ghimire's actions and singular focus on discharge are explicable as a worker "coming in new to the team, and not necessarily having a lot of experience in the role, I think he's picked that up and thought this person's for discharge, and that's why he describes his prioritisation going towards other consumers."[107]

Role and function of treating psychiatrist

118. At the time that SP was a patient of LCMHT, Dr Hafiz was employed by that service as a consultant psychiatrist, two days per week. The LCMHT employed a second consultant psychiatrist at that time. There were no regular meetings held between the psychiatrists at the practice.[108]

119. Dr Hafiz confirmed that from when he first saw SP on 14 August 2015, he understood by reference to records from St George Community Mental Health Team that she suffered from delusional symptoms which worsened when she ceased taking her medication. At the time of this first consultation, SP was suffering from mild delusions, but was not preoccupied with them.[109]

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[103] Transcript, 25/2/20, p. 32 at L 40.
[104] Transcript, 25/2/20, p. 33 at L 18.
[105] Transcript, 25/2/20, p. 33 at L 18.
[106] Transcript, 25/2/20, p. 71 at L 18.
[107] Transcript.
[108] Transcript, 19/12/19, p. 5 at L 4.
[109] Transcript, 19/12/19, p. 7 at L 33.

120. Dr Hafiz agreed that as part of a normal mental state assessment, a person with a child in their custody would be assessed as to their interactions, beliefs and care for the child. His notes of his first consultation with SP record that SP stated "I love her", referring to AP, and denied any concerns regarding AP's safety.[110] He acknowledged that the fact that SP was sleeping 12 hours per night was a concern, as it would impact on her ability to look after AP. His response to that concern was to change the timing of SP's duloxetine dose to the morning.[111]

121. Dr Hafiz's next contact with SP occurred during a consultation on 11 December 2015. During the intervening period, a number of appointments were cancelled and rescheduled (see agreed facts at [91]-[92]). Dr Hafiz initially acknowledged in his oral evidence that the length of time which elapsed between these two consultations was a concern to him.[112] However, when questioned further on this issue, Dr Hafiz clearly regarded the scheduling and follow up of appointments as a responsibility that rested with the CCCs. He also regarded it as the responsibility of CCCs to bring it to his attention if a more urgent review was required. In response to a question by counsel assisting the Coroner, he gave the following evidence:

> Q. Did you think there was any urgency at this point in time to bring her back before December 2015, to review the medication?
>
> A. Considering how she was there was no concern at that time. When, when a case manager has concern about some patient they do discuss with the consultant psychiatrist and they are advised to bring the appointment sooner, bring it forward and, depending on the urgency of the case [sic].[113]

122. During the consultation on 11 December 2015, Dr Hafiz observed that SP was experiencing an increase in potential delusional thoughts that warranted an increase in her dose of triflouperazine. He recorded in his notes the need to review SP within the next month.

123. As things transpired, SP did not attend any further reviews with Dr Hafiz. When asked about SP's failure to attend subsequent appointments, Dr Hafiz again emphasised that making and follow up of appointments was the responsibility of CCCs. When asked if he was concerned about SP's failure to attend, he stated "… [a]t the time the appointments are made by the clinical care coordinator so we see the patient when they make an appointment."[114] He went on to note that he did not take part in multi-disciplinary team

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[110] Transcript, 19/12/19, p. 8 at L13.
[111] Transcript, 19/12/19, p. 8 at L44.
[112] Transcript, 19/12/19, p. 9 at L31.
[113] Transcript, 19/12/19, p. 10 at L 11.
[114] Transcript, 19/12/19, p. 10 at L 11; See also Transcript, 19/12/19, p. 15 at L 26.

meetings at the LCMHT, so he was not aware of the progress of patients, unless a CCC came to talk to him about them.

124. One of the issues impacting upon the quality and urgency of follow up appears to be the way that files were physically managed at LCMHT at the time. Dr Hafiz explained that he would have a patient's physical file before him on the day when a patient was expected to attend his clinic. If the patient did not attend, he would make a note to that effect and the file would be returned to the CCC for follow up. In the absence of an approach by the CCC, there was nothing to bring a patient's situation back to the attention of Dr Hafiz, prior to their next clinic appointment.[115] By way of example, Dr Hafiz was taken to his notes for SP's scheduled appointment on 29 January 2016. SP did not attend the appointment. The clinical notes recorded by Dr Hafiz simply read "DNA" (did not attend).[116] Dr Hafiz agreed when questioned that more should have been recorded to communicate the urgency of rescheduling an appointment with SP.[117]

125. When SP did not attend a further appointment on 31 March 2016, Dr Hafiz wrote in the clinical progress notes "DNA, Please rebook".[118] When taken to this entry, Dr Hafiz again emphasised the responsibility of the CCC, stating "The case manager generally follow-up the patient. So it's understood that the case manager is following-up with the patient, and if there's concern they will come and discuss it with me."[119] It should be noted that Dr Hafiz's evidence on this issue contradicts the expectation of Mr Ghimire, in line with the Missed Appointments Policy in place at the time, that treating doctors or clinicians would follow up consumers on the day of a missed appointment (see above at [98]).

126. Overall, Dr Hafiz described the responsibility for patient care as being shared between the CCC and treating psychiatrist. He stated:

> "The responsibility is shared, shared responsibility I would say. As a, in terms of decision-making regarding her medications and her ..(not transcribable).. management and stuff, I was the primary person more. But in terms of other psychiatric treatments, such as psychotherapy, the case manager is also involved. The allocation of the patients to the case manager is according to the needs of the patient, according to the social worker, psychologist and others…. I would say it's a shared responsibility."[120]

127. Dr Hafiz was asked about his expectations regarding liaison with general practitioners involved in his patients' care. He stated that GPs would usually contact them (presumably

[115] Transcript, 19/12/19, p. 12 at L 16.
[116] LCMHT Medical Records, p. 480 (Brief, Vol 2, Tab 23); Transcript, 19/12/19, p. 13 at L 34.
[117] Transcript, 19/12/19, p. 13 at L 49.
[118] LCMHT Medical Records, p. 480 (Brief, Vol 2, Tab 23).
[119] Transcript, 19/12/19, p. 51 at L 9.
[120] Transcript, 19/12/19, p. 51 at L 10; See also p. 60 at L 31.

referring to the LCMHT) to ask what medication they were prescribing. Contact would usually be made with a CCC or on call staff member, who would convey the message to him.[121] He would "definitely" expect to be contacted if a GP was considering reducing the medication dose of a person engaged with a community mental health service.[122] His preference was for patients to get their medication from the LCMHT.[123] In SP's case, he stated that he was never contacted by Dr Ramjan or anyone from the My Health practice.[124] He was not aware that SP had been receiving scripts for triflouperazine from Dr Ramjan,[125] and would have been concerned had he been aware that her dose had been lowered.[126]

128. A particular issue of concern arising from the evidence is that, at the time SP was a patient of LCMHT, psychiatrists were not included in the multi-disciplinary team ("MDT") meetings conducted at the service. Dr Hafiz stated that he asked to be included in those meetings when he commenced working at the service, and was told that was not necessary.[127] This decision to exclude psychiatrists from MDT meetings appeared to contribute to the dysfunctional decision making around SP's discharge from the service, an issue which is discussed further below. Dr Parker clarified that the exclusion of psychiatrists from MDT meetings was contrary to LHD policy and should not have occurred. No adequate explanation was given as to why this occurred. Dr Hafiz gave evidence that since AP's death the approach of the LCMHT has changed, and he is now included in MDT meetings.[128]

Failure to build adequate rapport and foster engagement

129. In the opinion of Professor Ryan, clinicians of the LCMHT did not put appropriate time and effort into building rapport with SP and this represented an inadequacy in her care.[129] I accept his view. Professor Ryan acknowledged that providing care and treatment to SP would have proved a challenge, primarily due to her strong reluctance to engage. He observed that such reluctance is not uncommon in people who suffer from psychiatric illnesses, who might not see themselves as unwell and might find treatment to be burdensome. Other factors can contribute to an individual's reluctance to engage, and prior removal of children by DCJ was identified as a relevant example of such a factor in this case.[130]

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[121] Transcript, 19/12/19, p. 19 at L 35.
[122] Transcript, 19/12/19, p. 18 at L 26.
[123] Transcript, 19/12/19, p. 16 at L 26.
[124] Transcript, 19/12/19, p. 17 at L 21.
[125] Transcript, 19/12/19, p. 17 at L 40.
[126] Transcript, 19/12/19, p. 18 at L 6.
[127] Transcript, 19/12/19, p. 22 at L 37.
[128] Transcript, 19/12/19, p. 61 L 6.
[129] Report of Prof Christopher Ryan, pp. 11, 22 (Brief, Vol 5, Tab 44).
[130] Transcript, 18/12/19, p. 3 at L 39 – p. 4 at L 10.

130. This process of rapport building can take months or even years.[131] Activities that may contribute to rapport building may include regular phone calls, reminders of appointments, picking people up to attend appointments and home visits.[132] As Professor Ryan stated, "when efforts of this sort are successful, these patients may willingly tread down therapeutic avenues that they would certainly have rejected otherwise".[133]

131. Professor Ryan described the very few contacts between LCMHT and SP from November 2015 to March 2016 as "surprising given her clinical state".[134] Phone calls were made infrequently. Only two home visits were documented between December 2015 and April 2016. Although SP was usually reminded about upcoming appointments with Dr Hafiz, staff made no effort to go to her home to accompany or assist her to attend. There was no mention of SP's boyfriend – a potential ally in her care – in the clinical notes until Dr Hafiz recorded her distress at their breakup on 2 September 2016.[135]

132. Mr Parker agreed that SP's personal circumstances, including her history of having children removed by DCJ, were relevant factors that should have been considered by those responsible for her care. However he expressed the view that those factors should have been addressed more assertively at an earlier time in her care, "rather than in the period after a decision had been essentially made to start proceeding with a discharge," which occurred in around April 2016.[136] He fell short of criticising Mr Ghimire for his singular focus on discharge, once he assumed the role of CCC. Leaving aside individual responsibility, there was, In my view, a systemic failure to build rapport and foster engagement with SP.

Should Dr Hafiz have considered using coercive powers under the Mental Health Act?

133. Professor Ryan observes that when rapport building fails as a strategy to support engagement in treatment, clinicians must frequently fall back on coercive powers under the *Mental Health Act* to secure mandated treatment. He points to two factors which, in his view, caused the clinicians involved in SP's care to overlook the option of using these coercive powers:

a. Firstly, it was not appreciated that SP and AP needed protection from serious harms, within the meaning of that term in the *Mental Health Act*. Those harms were ongoing and ever present, but there was a risk of them becoming extremely severe. Those harms included the distress SP experienced when her symptoms were not well controlled, the possibility of AP being removed from

[131] Report of Prof Christopher Ryan, p. 23 (Brief, Vol 5, Tab 44).
[132] Transcript, 18/12/19, p. 4 at L 18.
[133] Report of Prof Christopher Ryan, p. 23 (Brief, Vol 5, Tab 44).
[134] Transcript, 18/12/19, p. 4 at L 43.
[135] Report of Prof Christopher Ryan, pp. 23-24 (Brief, Vol 5, Tab 44).
[136] Transcript, 25/2/20, p. 68 at L 4.

SP's care as a result of her declining mental health, as well as the harms that could flow to AP as a result of her primary caregiver being very unwell;

b. Secondly, and related to the first issue, it was not appreciated that to the extent that SP was refusing to engage in treatment, she was doing so without decision making capacity.[137]

134. Expanding upon the failure to appreciate the serious harms AP was exposed to, Professor Ryan observes that "[a] child growing up in a household where her only caregiver is either depressed and frequently distressed by her delusional ailments is likely to suffer significant development and psychological detriment." Professor Ryan notes that only superficial consideration was given to the possibility of harm to AP. When the issue was addressed at all, LCMHT staff relied upon assurances given by SP, or "brief and inexpert" observations of SP's parenting skills. As an example of this, Professor Ryan observes that SP twice told clinicians at LCMHT that she was unable to get out of bed and was sleeping 12 hours per day. This was incompatible with her responsibilities as the carer of a toddler, however the responses of clinicians were "inappropriately muted".[138]

135. Expanding on the second issue noted above, in the opinion of Professor Ryan, active consideration should have been given to use of coercive powers when it became apparent she was not engaging with treatment, and particularly when it appeared she was becoming actively unwell. He agreed that when SP informed Dr Hafiz on 2 September 2016 that she had stopped taking antipsychotic medication, that should have been a trigger to consider further action, given that historically her health had deteriorated after discontinuing medication.[139] He regarded it as highly likely that her decision to cease taking trifluoperazine was made without decision-making capacity.[140] He explains "if a person lacks decision-making capacity around a particular decision, this robs the decision of its validity as a meaningful decision of the individual and in cases where the decision is likely to cause the individual serious harm, the state, in this case through the actions of mental health clinicians who are provided powers to intervene by mental health legislation, is obligated to act".[141]

136. I think it very likely, as Professor Ryan suggests, that SP's decision to stop taking medication was made without proper capacity. Equally I accept that a psychiatrist who had previously developed a strong rapport or understanding of SP would have realized on 2 September 2016 that it was time to at least consider coercive measures available under

[137] Transcript, 18/12/19, p. 5 at L 39 – p. 6 at L 27; Report of Prof Christopher Ryan, p. 25 (Brief, Vol 5, Tab 44).
[138] Report of Prof Christopher Ryan, p. 27 (Brief, Vol 5, Tab 44).
[139] Transcript, 18/12/19, p. 11 at L 1.
[140] Report of Prof Christopher Ryan, p. 27 (Brief, Vol 5, Tab 44).
[141] Report of Prof Christopher Ryan, p. 28 (Brief, Vol 5, Tab 44).

the *Mental Health Act* such as long acting injectable anti-psychotic medication via depot preparation. However, it should be remembered that Dr Hafiz actually had very limited history with SP, having only seen her on two prior occasions. The last being many months before, in December 2015. Despite his view to the contrary, Dr Hafiz does not appear to have developed a strong rapport with her or to have delved into her background or obtained any great knowledge about her prior acute relapses over time. As we have seen, he had not even been present at multi-disciplinary (MDT) meetings where her case and her non-attendance was discussed.

137. When Dr Hafiz spoke to SP by telephone on 2 September 2016 and was informed that she was not taking her Stelazine medication, he did not think she seemed preoccupied with psychotic symptoms and she agreed to attend on 9 September 2016 for further review. In those circumstances and against that background I understand why he was not triggered to consider coercive action under the MHA at that time. Nevertheless, the later decision to go ahead with discharge remains inexplicable.

Mandatory reporting obligations

138. The obligation on health professionals to make a mandatory report to the Secretary of DCJ in relation to a child, pursuant to s. 27 of the *Children and Young Persons (Care and Protection) Act 1998* arises where the clinician has "reasonable grounds to suspect the child is at risk of significant harm." It will not always be obvious if this threshold is met, and Professor Ryan makes the observation that involving government agencies with a child has the potential itself to give rise to harm.[142] Given the wide discretion vested in professionals by s. 27, Professor Ryan did not conclude there had been a failure on behalf of LCMHT staff to make a report to the Secretary in relation to AP.[143]

139. However, he observed that the LCMHT records overall showed a lack of regard for the serious harms that could befall, and were in fact befalling AP. Only superficial assessment of that issue was documented. He could not rule out that, had staff been more attuned to this issue, a notification to DCJ might have been made.[144]

Decision making regarding discharge from the Service

140. I accept the evidence of Professor Ryan that there was never a proper reason to consider discharging SP from the LCMHT. Her mental health was not stable for any length of time, and she had AP in her care. There was no evidence that SP's decision making capacity was reviewed when consideration was given to discharge.[145] The record keeping around the decision to discharge SP was poor and reflected apparent contradictions between

[142] Transcript, 18/12/19, p. 8 at L 25.
[143] Transcript, 18/12/19, p. 9 at L 1.
[144] Transcript, 18/12/19, p. 9 at L 22.
[145] Transcript, 18/12/19, p. 12 at L 9; Report of Prof Christopher Ryan, p. 32 (Brief, Vol 5, Tab 44).

those documenting the process, further adding to the impression that a clear and orderly process of discharge was not in place.[146]

141. The first reference to the possibility of discharging SP from the LCMHT appears in a clinical progress note made by her then CCC, Ms Schreuders, on 5 April 2016. The note begins "[phone call] to SP to gauge how she has been and to discuss discharge? [sic]"[147] It must be remembered that at this time, SP had not been seen by a psychiatrist since December 2015, and had not attended two scheduled follow up reviews. There is nothing in the progress notes to shed light on why it was thought appropriate to raise the issue of discharge with SP at that time. The note states that SP was "agreeable to discharge back to her GP", and records an intention to discuss at an upcoming multi-disciplinary team meeting on 8 April 2016.

142. Dr Hafiz's evidence was that he was made aware of this progress note when he was asked to consider discharging SP from the service. He stated that contact should have been made with SP's GP to confirm she had a good relationship with them, and that it was "clearly" the CCCs responsibility to make that contact.[148]

143. A further progress note dated 8 April 2016 records that the option of discharging SP was discussed between her CCC and Dr Hafiz. It records "Dr Hafiz requests above to be discussed in MDT – he feels unable to make appropriate decision regarding discharge as he has not been able to assess SP's MSE – she failed to attend the last two dr's reviews".[149] Dr Hafiz gave evidence that he would not necessarily have been provided with SP's file when asked to consider discharging her at that time. Such discussions could happen informally between consultants and CCCs.[150]

144. Professor Ryan was of the view that a home visit should have been conducted prior to discharge.[151] I accept his evidence. A progress note made by SP's CCC on 8 April 2016 records the intention to "conduct home visit for MSE and risk assessment" before potential discharge. The note records the intention for this to be done by the "on call" in the week of 11 April 2016.[152] SP's case was discussed at a MDT meeting on 12 April 2016, and the plan to conduct a home visit was endorsed. A home visit was attempted by a social worker on 13 April 2016, however SP was not home.[153]

145. Between 13 April 2016 and September 2016, there is no further record of SP's case being discussed at a MDT meeting, or of further home visits being attempted. As

[146] Report of Prof Christopher Ryan, p. 33 (Brief, Vol 5, Tab 44).
[147] LCMHT medical records, p. 481 (Brief, Vol 2, Tab 23).
[148] Transcript, 19/12/19, p. 21 at L 17.
[149] LCMHT medical records, p. 485 (Brief, Vol 2, Tab 23).
[150] Transcript, 19/12/19, p. 50 at L 19.
[151] Transcript, 18/12/19, p. 14 at L 25; Report of Prof Christopher Ryan, p. 34 (Brief, Vol 5, Tab 44).
[152] LCMHT medical records, p. 487 (Brief, Vol 2, Tab 23).
[153] LCMHT medical records, p. 493 (Brief, Vol 2, Tab 23).

previously stated I do not accept that there is sufficient evidence to establish a home visit by Mr Finch occurred in August 2016.

146. On 2 September 2016, SP's case was discussed in an MDT meeting. The progress note made by Mr Ghimire records that SP reported regularly seeing Dr Ramjan and her psychologist, Michelle[154]. She was also seeing a TAFE counsellor. The note records that SP asked to be discharged from the LCMHT. The note states that "Team decided to d/c her to the GP's care".[155] At face value, this note strongly suggests that discharge decisions were treated as a matter for the MDT, rather than for the treating psychiatrist. While Dr Hafiz agreed when questioned that the "Team actually agreed to discharge her", he stated that discharge could not occur without his recommendation.[156]

147. The evidence as to how Dr Hafiz arrived at his recommendation to discharge SP is a troubling aspect of this case. In my view, no satisfactory explanation was ever given for the decision making process that occurred.

148. Dr Hafiz stated that he was not concerned that SP did not want follow up from the LCMHT. He pointed to a number of factors in support of his view: he had been informed by the CCC that she was with friends when contacted, she was attending TAFE regularly, she had been in touch with her father, and she had been engaging with her GP.[157] There is little evidence of curiosity by the CCC or Dr Hafiz as to how these factors constituted strong evidence that SP's mental health was stable.

149. Dr Hafiz was informed by SP over the telephone on 2 September 2016 that she had stopped taking her triflouperazine as it was "a small dose anyway" and she felt she didn't need it. SP refused to comment on her persecutory thoughts during that phone call. SP agreed to attend an appointment with Dr Hafiz on 9 September. Dr Hafiz noted that he would consider discharging her after this appointment.[158]

150. When questioned about his reaction to the phone call on 2 September 2016, Dr Hafiz agreed that he was concerned that SP had stopped taking her medication, however she was not preoccupied with psychotic symptoms, and he was reassured that she agreed to come and see him.[159] At that stage he still wanted to see SP in person before making a decision relating to discharge.[160] He was of the view that if SP could be engaged by the

[154] Records show the contact with her psychologist was minimal.
[155] LCMHT medical records, p. 500 (Brief, Vol 2, Tab 23).
[156] Transcript, 19/12/19, p. 32 at L 43.
[157] Transcript, 19/12/19, p. 33 at L 32.
[158] LCMHT medical records, p. 501 (Brief, Vol 2, Tab 23).
[159] Transcript, 19/12/19, p. 34 at L 10.
[160] Transcript, 19/12/19, p. 35 at L 16.

service, she would continue taking her medication orally as she had been reliable in doing so in the past.[161]

151. Despite these intentions, following SP's failure to attend her appointment on 9 September, Dr Hafiz formed the view that there was "no imminent risk at this stage" and it was "reasonable to discharge her from case management".[162]

152. When questioned as to how he formed the view that there was no imminent risk present at that stage, Dr Hafiz pointed to the content of his phone call with SP on 2 September 2016. This is somewhat troubling, given the content of that call. As Professor Ryan stated "[t]he ill-judged nature of the decision to discharge [SP] on 9 September 2016 is underlined by the fact on the last face-to-face contact Dr Hafiz had with her on 11 December 2015, he had suggested that she was possibly relapsing and on his telephone contact with her on 2 September 2016 she had told him that she had stopped taking her trifluoperazine, which given her history, was likely to result in a relapse".[163]

153. Dr Hafiz pointed to other details of that conversation as providing him with reassurance. He stated that she had referred to AP being unwell - she had laughed as AP thought it was her grandfather on the phone (Dr Hafiz took this as evidence SP had been in touch with her father); she had informed him she had missed TAFE to look after AP, which he took as evidence she was prioritising the care of her child.[164] While Dr Hafiz conceded that after speaking to SP on 2 September 2016 he still wanted to see her before considering discharge, he pointed to the conversation as giving him the reassurance he required to make the recommendation to discharge. The circularity of this reasoning is apparent and the matters relied upon are superficial and show a misguided approach to the decision.

154. Communication between the LCMHT team, Dr Ramjan and the private psychologist involved in SP's care should have taken place before any decision was made to discharge SP.[165] Professor Ryan described this sort of contact as an uncontroversial part of clinical care, that usually takes place via telephone.[166] Dr Hafiz agreed that reliance on SP's self-report that she was engaging with a GP was inadequate, stating "I would like to talk to the GP to confirm it". In further questioning, he clarified that he would expect the CCC to make that contact with the GP before discharge of a patient was considered.[167] Dr Hafiz emphasised in his oral evidence that his recommendation to discharge SP was not *in fact* a discharge, and that the CCC would have been required to contact her family

[161] Transcript, 19/12/19, p. 35 at L 39.
[162] LCMHT medical records, p. 505 (Brief, Vol 2, Tab 23).
[163] Report of Prof Christopher Ryan, p. 32 (Brief, Vol 5, Tab 44).
[164] Transcript, 19/12/19, p. 37 at L 39.
[165] Transcript, 18/12/19, p. 14 at L 37.
[166] Transcript, 18/12/19, p. 16 at L 1.
[167] Transcript, 19/12/19, p. 25 at L 24.

and GP before discharge occurred.[168] However the progress note made by Dr Hafiz on 9 September clearly contemplated informing SP's family and GP of the discharge, rather than consulting with them as to their views on that course of action. It merely stated "it is important to provide her and her family with all the relevant contact details" and "please advise the GP to contact our service if there is deterioration in the mental state."

155. I accept the opinion of Professor Ryan, that while the views of the MDT should have been of interest to Dr Hafiz in making a decision as to discharge, as the treating psychiatrist responsible for SP's care, the decision rested with him.[169] When asked about the decision making process around discharge, Dr Hafiz stated "it's a team recommendation. It's a general joint team decision but it requires consultant's approval".[170] This suggests a degree of reliance on the input of the MDT which goes beyond the approach endorsed by Professor Ryan. In Professor Ryan's view, the discussion of the decision to discharge at multi-disciplinary team meetings, without the treating psychiatrist or any consultant psychiatrist present, would not have provided an opportunity to "properly weigh all the elements that should be considered in such a condition…including the legal powers open to the team as alternatives to discharge".[171] I accept his view.

156. Mr Parker's evidence was that the MDT, as a whole, has the responsibility for making treatment decisions, including the decision to discharge.[172] However, this approach is based on the assumption that all psychiatrists within a team will attend the MDT meetings. Mr Parker states that it is not known why the manager of the LCMHT at the time conducted the MDT meetings without Dr Hafiz in attendance. Mr Parker advises that since AP's death the LHD became aware of this issue and has followed up to ensure that medical staff are attending MDT meetings in all community mental health teams across the LHD.[173]

157. Mr Parker properly conceded on behalf of the LHD that it was not appropriate to discharge SP from the service.[174] He told the court that procedures around discharge have been strengthened since AP's death. He told the court that while the former policy mandated 48 hours for the completion of a discharge summary, the current policy does not specify a time that the discharge summary will be completed by because it is understood as a *process* which involves engaging with GPs and other providers as well as family.

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[168] Transcript, 19/12/19, p. 36 at L 26.
[169] Transcript, 18/12/19, p. 16 at L 39.
[170] Transcript, 19/12/19, p. 23 at L 21.
[171] Report of Prof Christopher Ryan, p. 33 (Brief, Vol 5, Tab 44).
[172] Supplementary statement of Patrick Parker, 10 February 2020 at [29] (Brief, Vol 6, Tab 47); see also 'Mental Health Transfer of Care/ Discharge Procedure' produced by Mr Parker at attachment 7.
[173] Supplementary statement of Patrick Parker, 10 February 2020 at [30]-[31] (Brief, Vol 6, Tab 47).
[174] Statement of Patrick Parker, 19 November 2019, p. 2 (Brief, Vol 2, Tab 21).

Evidence as to referral from Dr Don Ramjan on 9 September 2016

158. On 9 September 2016, SP visited Dr Ramjan without her daughter. She requested a drug screen in order to regain custody of her twins. Dr Ramjan was already concerned about SP's mental health, but immediately realised there had been an escalation in her condition. She spoke in a tangential manner and focussed on religious themes. To his credit Dr Ramjan acted quickly, telephoning and then faxing the local mental health service where he knew she was a patient.

159. SP's LCMHT file contains no record of contact with Dr Ramjan on 9 September 2016, or of receipt of the fax referral. This remains a disturbing and unexplained feature of the investigation. It is impossible to understand how the LHD was not able to shed more light on an omission of this magnitude.

160. In January 2020, having become aware of certain evidence during the course of this inquest, further investigations were undertaken by the LHD to determine who took the call and received the facsimile sent by Dr Ramjan on 9 September 2016. The practice at LCMHT at the time was that staff were allocated to cover phone calls/ faxes on an *ad hoc* basis at the beginning of a shift. Due to staff changes throughout the shift, there was not a single person responsible for taking an actioning calls during each shift.[175] Based on Dr Ramjan's recollection that he spoke with a female, all female staff on duty that day at LCMHT were spoken to. These investigations did not identify the person who took the call.[176]

161. Curiously, the investigation revealed that a male staff member accessed SP's electronic record at 8.45 pm on 9 September 2016. That staff member was spoken to and denied accessing the record himself. The staff member suggested that one of his colleagues could have used his computer to access SP's records.[177]

162. In relation to the receipt of faxes, the practice at the time was that individual clinicians who received a fax would either enter it onto a consumer's medical record, or create a triage if it was a new referral. There was, and is, no separate log maintained of incoming faxes.[178]

163. Mr Parker conceded on behalf of the LHD that there was inaction on the part of the Community Mental Health Emergency Team (CoMHET) staff members who took the calls and received the fax from Dr Ramjan.[179] Because of that inaction, it was never identified that SP had in fact missed a psychiatric consultation that day, and the concerns raised by Dr Ramjan were never brought to the attention of Dr Hafiz. No person was ever deputed

[175] Supplementary statement of Patrick Parker, 10 February 2020 at [16] (Brief, Vol 6, Tab 47).
[176] Supplementary statement of Patrick Parker, 10 February 2020 at [7]-[8] (Brief, Vol 6, Tab 47).
[177] Supplementary statement of Patrick Parker, 10 February 2020 at [10] (Brief, Vol 6, Tab 47).
[178] Transcript, 25/2/20, p. 59 at L 18.
[179] Supplementary statement of Patrick Parker, 10 February 2020 at [14] (Brief, Vol 6, Tab 47).

to go and check on SP. The real reason for this failure of communication remains an unresolved issue at the heart of this tragedy. In spite of the mystery, it is important to acknowledge that the failure to act promptly on Dr Ramjan's concern is a grave omission with tragic consequences.

164. When taken to the contents of the facsimile sent by Dr Ramjan, Dr Parker agreed that the communication should have elicited an urgent response in the form of a mental health review[180]. Tragically, Dr Ramjan's sincere attempts to get help for SP were somehow lost or ignored. It is clear that had SP received the assistance she needed on 9 September 2016, medical staff would have become aware of the imminent risk facing AP and been able to properly assess it and take the necessary action. In my view AP's death was preventable, had the appropriate systems been operating correctly.

165. Mr Parker gave evidence that the following changes to practice and procedure have been put in place at CoHMET which address this failure:

a. CoMHET staff are now assigned duties for a shift on an allocation system. Records of these duties are retained by the LHD. Mr Parker explained that "This system improvement means that there is an audit trail and clear accountability for taking calls on the intake phone".[181]

b. CoHMET staff who perform triage duties are expected to undertake the State Mental Health Telephone Triage Training, a 2-day training course which addresses practice standards for mental health telephone triage services and "supports the development of skills and confidence in collecting information, assessing need and in clinical decision making".[182]

Response of the LCMHT to AP's death

166. Mr Parker conceded on behalf of the LHD that the care provided in this case was substandard.[183]

167. In his supplementary statement at [33]-[87], Mr Parker outlines changes that have been made at the LHD and within the LCMHT, since AP's death. In summary, these include:

a. Review and enhancement of certain policies and procedures that were in place at the time of AP's death;

b. Implementation of a new clinical records auditing system in 2016. This was further updated in 2019 to include 9 new questions relating to child protection;

[180] Transcript, 25/2/20, p. 57 at L 1.
[181] Supplementary statement of Patrick Parker, 10 February 2020 at [17] (Brief, Vol 6, Tab 47).
[182] Supplementary statement of Patrick Parker, 10 February 2020 at [18]-[19] (Brief, Vol 6, Tab 47).
[183] Transcript, 25/2/20, p.65 at L 50.

c. A caseload review tool was implemented in the LCMHT in 2017 to ensure compliance with team procedures and mandatory documentation, and to ensure consumers are being seen regularly and appropriately. Child protection is a standing item in case reviews;

d. Team leaders are required to complete monthly reports to their senior service managers which measure team members against a number of metrics;

e. Fax machines have been phased out of the LHD and replaced with email inboxes;

f. Staff within the mental health service are expected to complete mandatory child protection training;

g. The 'Mental Health Child Protection in Your Hands' (CPiYH) strategy has implemented a number of changes including development of a training package for adult mental health services, development of a child protection reference guide for managers, and creation of CPiYH Advocates in the Adult Community Mental Health teams to support the implementation of the CPiYH initiative;

h. An initiative called Health Pathways has been developed in collaboration between the LHD and Primary Health Networks. It provides GPs with an online clinical and referral information portal where they can access information about management and treatment options, local services and referral processes;

i. Clinical supervisors were identified for all members of the LCMHT, to ensure staff had access to appropriate supervisors outside of the team and within their area of professional expertise; and

j. A system has been implemented to identify circumstances where a consumer has not had a recorded activity in their electronic medical record for 90 days or more. Monthly reports are prepared and distributed to senior managers and team leaders.

168. Finally, a NSW Mental Health Line has been introduced, which is a state-wide mental health telephone service operating 24 hours a day, 7 days per week, staffed by mental health professionals.[184] Calls to the service are triaged and, aside from any immediate action, a triage form is sent to the relevant CoMHET by email for follow up. All calls to this line are auditable, and an audio recording of the call is kept. It is to be hoped that, had this system been in place as at 9 September 2016, appropriate action would have been

[184] Supplementary statement of Patrick Parker, 10 February 2020 at [51] (Brief, Vol 6, Tab 47).

taken in response to Dr Ramjan's enquiry. Certainly, documentation of the making and triaging of that enquiry would be available.

169. Investigations conducted by the LHD also revealed some systems and performance issues around the way the LCMHT was functioning at the time that SP was in its care. At a clinician level, it was identified that the assertiveness, regularity and quality of follow up with consumers varied. In the context of these findings, Mr Parker stated he was not surprised that Mr Ghimire was not familiar with some of the policies in place at the time.[185] These shortcomings were addressed through use of the caseload review tool, which allows managers and CCCs to review electronic medical records to ensure they are being adequately updated. The caseload review tool also reviews frequency of contact.[186] The tool was implemented at LCMHT in 2017, and rolled out across the LHD in early 2019.

170. Mr Parker conceded that a review of SP's file did not demonstrate a proper appreciation by those involved in her care about the needs of AP or any risk to AP. He stated that the investigations following AP's death revealed some deficits in the treating team's consideration of child protection issues more broadly. In SP's case, engagement with this issue should have commenced within the first few weeks after the LCMHT assumed responsibility for SP's care. Moreover it would have been appropriate to have engaged with SP's previous community health team, and the issues they raised, at an early point in time.[187] Mr Parker pointed to the CPiYH program as the core of LHD's response to this shortcoming.[188]

171. At the conclusion of proceedings, counsel assisting, while conceding that some improvements had taken place at the local level, suggested two recommendations directed to SWSLHD arising directly out of the evidence. The first aimed at strengthening communication between mental health staff within SWSLHD and general practitioners involved in the care of patients/consumers. The other at improving training for CCCs both in relation to strategies for engaging with outside stakeholders and in relation to improving skills and techniques in rapport building and strengthening relationships with patients/consumers. I note that these recommendations were broadly supported by counsel for AP's mother, SP. In addition counsel for SP urged specific consideration of a recommendation mandating the provision of direct telephone contact numbers of CCCs (and the team leaders) to known GPs involved in a patient's ongoing care and a policy which details clear lines of responsibility for the care of consumers. Further, counsel for SP urged that the importance of these issues necessitated that any recommendations

[185] Transcript, 25/2/20, p. 64 at L 44.
[186] Transcript 25/2/20, p. 65 at L 14.
[187] Transcript, 25/2/20, p. 80 at L 4.
[188] Transcript, 25/2/20, p. 80 at L 30; See also Statement of Patrick Parker, 19 November 2019, Annexures 5-7 (Brief, Vol 2, Tab 21).

should be applied to all NSW Local Health Districts, rather than just SWSLHD. While I would normally feel constrained, by considerations of fairness, in making recommendations to a party that had not been present at the proceedings, I note that counsel for SWSLHD helpfully sought a response from the Ministry of Health and for that reason I do not feel constrained in considering the proposal.

172. SWSLHD did not support making the recommendations, in light of the changes already made at the LHD, as outlined above. The Ministry also resisted the recommendations, primarily on the basis that existing policy and training exists which would make the recommendations largely redundant.

173. The LHD did not accept that an additional policy related to the interface between the mental health services and GPs would add any benefit to current policy. It pointed to nine extensive policies which it stated "already address the need for collaboration". These included Care Coordination/Case Management Policy (MH_Proc2019_003), Discharge and Transfer of Care Procedures (MH_Proc2019_011) and Missed Appointments (MH_GL2019_005) among others.

174. The LHD also referred the court to new initiatives which include the use of integrated clinics where LHD staff are based in GP Clinics and the use of the Health Pathways information portal. It stated that the interface between LHD staff and GPs is audited as part of the Mental Health Audit framework.

175. The Ministry of Health did not support the making of recommendations. It considered the Discharge Planning and Transfer of Care Policy ("the TOC Policy") already in place, as providing adequate guidance to mental health staff involved in the assessment, care, discharge planning or transfer of care of mental health consumers. The Ministry stated that this policy which came into effect on 26 September 2019 is due for review on 26 September 2024. It was submitted that the policy adequately supports LHDs to develop written procedures to address and manage key aspects of mental health discharge planning and transfer of care. It includes a requirement that mental health services identify a key contact/coordinator from the multidisciplinary team who is responsible for ensuring that each step of the discharge planning process is completed.

176. In addition to this, it was submitted that the NSW Health Policy directive "Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals" provides LHDs with the necessary guidance directing that "discussions between the patient and their family/carers/s, GPs, community health and service providers should occur early, for effective care planning." This 2011 policy applies to all of Health, not just to the mental health sector.

177. In relation to training aimed at CCCs. The court was informed that NSW Health runs a mandatory Care Coordination training module through HETI. The Ministry stated "the module uses a process framework that facilitates communication during admission and transfer of patient care. It promotes effective communication with the multidisciplinary team in planning for care transitions."[189]

The need for recommendations

178. DCJ accepted the intent of the draft recommendation circulated in relation to case closure. I accept the matters put by counsel for DCJ and have adjusted the original recommendation accordingly.

179. Draft recommendations directed to health providers were not supported.

180. In my view the evidence in these proceedings clearly demonstrates the significant risk involved for a patient who is co-managed by a GP and a LHD when care is not properly coordinated and shared. I accept the submission put by SP's counsel that "the evidence at this inquest highlighted the absolute necessity for clear, documented lines of communication between mental health staff at a Local Health District and a treating general practitioner in respect of their co-managed patient."[190] Further I accept the issue is one of general importance and is unlikely to be an issue at a single health service.

181. There were real gaps in the background known by Dr Ramjan in relation to SP's diagnosis, complex mental health history and past treatment, among other issues, which was readily available on the LHD file. Equally there were significant gaps in SWSLHD's knowledge of her relationship with her GP, her social history, her non-compliance with medication and her lack of engagement with a psychologist. As counsel for SP correctly states, "communication was tragically lacking".

182. Submissions put by SWSLHD and the Ministry of Health suggest that adequate policy is now in place to safeguard against this kind of communication failure occurring in the future, rendering the need for recommendations nugatory. The court was directed to many such policies comprising of hundreds of pages. Many of those policies are robust in their formulation and positive in their intent. However, the court needs to balance that against somewhat disturbing evidence from the CCC involved in SP's care. Even in retrospect, in late 2019 he appeared to have little insight into the great failure of communication that had occurred or indeed the risk involved in the premature discharge process. I have of course considered that it is possible this lack of insight is isolated.

[189] Submissions on behalf of the SWSLHD at [59].
[190] Submissions on behalf of SP at [7].

However, when I reviewed Dr Ramjan's testimony he also gave evidence of very recently having real difficulty in contacting a mental health provider in relation to a patient's mental health medication. Dr Hafiz's evidence of the reliance a psychiatrist must have on the CCC in the public health sector also underscores the need for further training and support.

183. Excellent policies are useless unless they are well understood and properly observed. The court is aware that recommending new policy can contribute to policy overload and make no positive impact. Nevertheless, I am not confident that the communication issues that arose in this inquest are already solved and I request further consideration of the recommendations outlined below.

Findings

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

Identity

The person who died was AP

Date of death

She died on the evening of 10 September 2016 or early morning on 11 September 2016.

Place of death

She died at her home, [redacted]

Cause of death

She died from drowning.

Manner of death

AP was drowned by her mother, who had recently relapsed into an acutely psychotic mental state. Her mother was mentally ill and not responsible, at law, for her actions. There were significant failures by both SWSLHD and DJC to provide adequate care to AP and her mother in the lead up to AP's death.

Recommendations pursuant to section 82 *Coroners Act 2009*

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

Department of Communities and Justice

That DCJ implement a policy whereby open child protection cases with a risk assessment of "high" or "very high", involving a parent(s)/carer(s) with a known and current diagnosis of a severe acute or persistent mental health disorder, are not closed prior to consultation about the closure with key mental health services involved in the client's care, and the recommendation of those services being documented. This policy will be supported by case based training to practitioners which targets work with open "high" and "very high" risk child protection cases, including cases involving a parent/carer with a known and current diagnosis of a severe acute or persistent mental health disorder.

That DCJ conduct a review of existing policy and practice mandates to identify additional areas where guidance around case closure can be strengthened in order to emphasise the need to consult with relevant services and develop clear policy on which role can approve closure of cases where there has been a risk assessment of "high" or very "high".

Ministry of Health

That the Ministry of Health give consideration to conducting a review of the adequacy of existing policies to identify where guidance can be strengthened to emphasise the need for clear and regular communication and clear lines of responsibility between Local Health Districts and general practitioners where a consumer's mental health care is shared. Further, that an overall policy is reduced to a simple formulation and supported by ongoing training.

That the Ministry of Health give consideration to reviewing the current mandatory training offered to Case Care Coordinators (through HETI or in other forums), in the light of the evidence presented at this inquest. Consideration could be given to including these facts in a de-identified case study to highlight the need for enhanced communication between those sharing care and for the need to prioritise rapport building with consumers.

That the Ministry of Health, in line with current policy, ensure LHDs are reminded of their responsibility to provide known general practitioners involved in the care of consumers with the direct contact telephone numbers of the Case Care Coordinator and Team Leader responsible for the care of the consumer, where shared mental health services are provided.

South Western Sydney Local Health District

That SWSLHD conduct training for all CCCs directed towards developing understanding of their role in case coordination, strategies for engaging with stakeholders in patient care and techniques in rapport building and maintaining consumer relationships.

Conclusion

186. Finally, I offer my sincere thanks to counselling assisting, his solicitor advocate and both his instructing solicitors. I appreciate their very great assistance in the preparation of these reasons.

187. Once again, I offer my sincere condolences to SP and her family. I acknowledge that the pain of losing a loved child in these circumstances is profound and that their grief is ongoing. I am so sorry that SP was not given the help she needed at this critical time. There were numerous failures in the care and support offered to SP and her family in the lead up to AP's death, most significantly the failure to make contact with her on 9 September 2016.

188. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
June 2020
NSW State Coroner's Court, Lidcombe

Annexure A – Statement of Agreed Facts

NAME, PLACE, DATE OF DEATH

1. The deceased is AP [redacted]). AP was aged 2 years and 7 months at the time of her death.

2. AP died at her home, at [redacted]

[redacted] AP died sometime in the evening of 10 September 2016 or early morning of 11 September 2016.

4. The cause of death was a result of being drowned by her mother, SP.

BACKGROUND

SP – History and previous children

5. SP was born on 29 May 1989.

6. She suffered from depression and anxiety from around the age of 14. She had over many years described an olfactory delusion that she emitted a "fishy odour" that made other people sick.[191]

7. On 19 March 2010, Family and Community Services ("FACS") received a risk of significant harm report ("ROSH report") when SP was approximately 5 months pregnant with twins. She had previously been diagnosed with depression, had previously self-harmed and had recently been diagnosed with an "atypical psychotic illness", believing her body let off strange smells that could cause harm to people around her.[192] SP was also worried she would make the children sick when they were born. SP had ceased taking her medication during her pregnancy.

8. SP was living with her mother, [redacted] but there were frequent arguments between [redacted] and her partner [redacted] at the time where [redacted] was verbally abusive and [redacted] would hit [redacted] over the head. The lease was due to end in a few months. There were concerns that SP may soon be homeless.[193]

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[191] Mental Health records of SP from Liverpool Hospital (SWSHS), p. 555.
[192] FACS, Internal Serious Case Review, November 2016, p. 9.
[193] FACS, Internal Serious Case Review, November 2016, p. 9.

9. FACS received two further reports on 26 March 2010, describing physical violence against SP by her partner, [redacted] This followed an argument in which [redacted] said that he did not want SP to have the children.[194]

10. On [redacted], SP gave birth to twins.

11. On 9 July 2010, FACS received a report that SP may have been suffering from schizophrenia and was "slightly delusional". SP believed that the food in the hospital was poisoning her, that the twins had sore throats because of this, and that she should feed them water instead of milk. She stopped taking her medication and left the hospital without the twins. The twins were taken into care and initially placed with [redacted] and her partner [redacted]

12. On 13 July 2010, [redacted] told caseworkers that SP had been staying at her home and had physically stopped her from caring for one of the babies who was crying. She stated that SP had told the baby to "shut up".[196]

13. On 16 July 2010, FACS assessed the twins' paternal grandparents and placed the twins in their care. [redacted] was assessed as unsuitable to care for the twins because he was violent towards SP and lacked suitable accommodation.[197] SP was also assessed as unsuitable due to her "obvious mental health problems that compromised her parenting and her ability to bond with them".[198]

14. SP was voluntarily admitted to the mental health unit at St George Hospital from 15 July 2010 to 26 July 2010.[199]

15. In a letter to the Cremorne Community Mental Health Centre, dated 28 July 2010, Dr Andrew Kall of St George Hospital Perinatal Mental Health stated that after the twins were born, SP "was non-compliant with her antipsychotic medication as she did not want to be sedated so she could be awake for the children".[200] Though Dr Kall stated that SP "seemed confident that she would never harm her babies…[and] denied any suicidal ideation during her pregnancy", she was at a "relatively high risk of suicide" due to "her past multiple impulsive suicide attempts".[201]

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[194] FACS, Internal Serious Case Review, November 2016, p. 10.
[195] FACS, Internal Serious Case Review, November 2016, p. 10.
[196] FACS, Internal Serious Case Review, November 2016, p. 10.
[197] FACS, Internal Serious Case Review, November 2016, p. 10.
[198] Department of Family and Community Services, Internal Serious Case Review, p. 3.
[199] Mental Health Records of SP from Liverpool Hospital (SWSHS), pp. 572-574.
[200] Letter from Dr Kall of Perinatal Mental Health, dated 28 July 2010.
[201] Letter from Dr Kall of Perinatal Mental Health, dated 28 July 2010.

16. On 10 March 2011, the Parramatta Children's Court made final orders placing the twins in the care of the Minister for 12 months, to allow the children to be restored to SP following completion of a program at Charmian Clift Cottages, an organisation which provides a residential support service for women living with a mental illness and their dependent children.

17. On 30 May 2011, FACS restored the twins to SP's care and SP entered the program at Charmian Clift Cottages. Over the following months, SP demonstrated a strong bond with the children and that she could meet their needs.

18. On 27 August 2011, SP and the twins left Charmian Clift Cottages to live with SP's father.

19. On 15 September 2011, FACS received information that SP and [redacted] had resumed their relationship. The report contained concerns that one of the twins was sick and that SP had not sought medical care for him, that SP had hit one of the twins on the forehead with the palm of her hand, that one night [redacted] shook one of the twins violently and that [redacted] had put his hands around SP's neck and tried to choke her. The twins were removed to the care of their paternal grandparents again.[202]

20. On 17 February 2012, the Parramatta Children's Court made final orders placing the twins under the care of the Minister until the children attained the age of 5 years. All aspects of parental responsibility for the children were allocated to the Minister for a period of 12 months after which parental responsibility (except contact) was given to the twins' paternal grandparents. The Minister was to retain parental responsibility for contact until the twins were 5 years old (i.e. until 2 July 2015).[203]

Pregnancy and birth of AP

21. On 21 November 2013, when SP was 28 weeks pregnant with AP, a mental health assessment was undertaken by Registered Nurse (RN) Michelle Batton at the Women's and Children's Health Centre.[204]

22. On the assessment form, RN Batton stated SP's mood was "alright" but that she had poor appetite, insomnia and anxiety due to concerns that FACS will remove her child after birth.[205]

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[202] FACS, Internal Serious Case Review, November 2016, p. 12.
[203] FACS, Internal Serious Case Review, November 2016, p. 12; Order of the Children's Court dated 17 February 2012 (page 350 – 352 of the Bundle of documents referred to in Maddocks' letter dated 18 November 2019).
[204] Mental Health Records of SP from Liverpool Hospital (SWSHS), pp. 561-8.

23. SP denied thoughts of self-harm or suicide but reported "feelings of hopelessness".[206] Strengths recorded on the form included that SP "refuses to give up" and has a "good relationship" with her father.[207]

24. Under "initial management plan" it was recorded that SP would like to commence medication and had an appointment scheduled for 6 December 2013 with Dr Margot Phillips.

25. On 27 November 2013, FACS received the first report about SP in relation to her pregnancy with AP. The report alleged that one of the twins was trying to kick SP in the stomach. Due to the earlier removal of the twins, a ROSH report was sent to St George Community Service Centre ("St George CSC").

26. On 29 November 2013, St George CSC sent a High Risk Birth Alert ("HRBA") to St George Hospital requesting that, when born, the baby's urine and meconium be tested for substances.

27. On 6 December 2013, FACS received a report that SP's mental health was not well-managed during her pregnancy with AP, that she was experiencing delusions, hallucinations and a degree of paranoia and that she had stopped taking her medication. SP was prescribed anti-psychotic and anti-depressant medication. The reporter said that there were no present concerns that SP would harm herself or others.[208] This report was assessed as non-risk of significant harm ("non-ROSH") because FACS was aware of SP's pregnancy. The non-ROSH report was forwarded to St George CSC for its information as there was a current open case plan.[209]

28. On 9 December 2013, St George CSC sent a letter to the reporter acknowledging that they had received the report and explaining that the report had been closed as St George CSC was not able to respond.[210]

29. On 10 December 2013, FACS and health workers discussed SP's case at a "peri-natal high risk meeting". They noted that SP had schizophrenia and was not always compliant

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[205] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 561.
[206] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 561.
[207] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 561.
[208] FACS, Internal Serious Case Review, November 2016, p. 13.
[209] FACS, Internal Serious Case Review, November 2016, p. 14.
[210] FACS, Internal Serious Case Review, November 2016, p. 13.

with her medication. Other than this meeting and the HRBA, FACS had no active engagement with SP during her pregnancy.[211]

30. On 2 February 2014, AP was born at St George Hospital and FACS was alerted about the birth.

31. SP said that the father was unknown and that she became pregnant from a one-night stand. It appears this information was untrue and was an attempt to avoid FACS intervention. SP denied having recent contact with [redacted]

32. On 3 February 2014, a caseworker at St George CSC was informed that SP was "relatively stable" following AP's birth due to the medication she had been on since December 2013.[212]

33. On 4 February 2014, two caseworkers from St George CSC were allocated to the report. The caseworkers visited St George Hospital and met with nursing staff. The caseworkers then met with SP. SP stated that she would not mind returning to Charmian Clift Cottages if she was offered a place. The caseworkers informed SP that she was going to stay in hospital for a few days so they could talk with Charmian Clift Cottages and look for support services if SP decided to go directly home from hospital.[213]

34. On 5 February 2014, a new FACS caseworker was assigned to SP and AP. The caseworker visited and assessed SP's father's home. The caseworker contacted Charmian Clift Cottages, and was informed that they would not have any placements for a number of months.[214]

35. The caseworker also contacted Catherine Villa, which provides supported accommodation in a communal setting for young pregnant women and young mothers under the age of 25 and their babies and children. However, there were no placements at that time. [215]

36. On 6 February 2014, FACS was informed that SP and AP were to be discharged from St George Hospital on that day. The perinatal nurse told SP's caseworker that SP "will always have some residual psychosis and anxiety" and that this would impact her skills as a mother, but that she was doing well at that time.

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[211] FACS, Internal Serious Case Review, November 2016, p. 14.
[212] FACS, Internal Serious Case Review, November 2016, p. 15.
[213] FACS, Internal Serious Case Review, November 2016, p. 15.
[214] FACS, Internal Serious Case Review, November 2016, p. 16.
[215] File Note Record dated 5 February 2014.

37. That same day, the FACS caseworker met with SP at the hospital. SP told the caseworker that she had stopped taking her anti-psychotic medication because she "felt better". The caseworker emphasised the importance of continuing to take her medication. The caseworker developed a safety plan around concerns that SP would stop taking her medication, her mental health, and the possibility of domestic violence if she saw [redacted].[216] The caseworker and SP also discussed engaging a number of services to assist SP including a referral to Community Mental Health and a possible referral to the Step By Step Progressive Parenting program. SP was open to accepting these referrals.[217]

38. On 7 February 2014, the FACS caseworker, the perinatal nurse and the psychiatrist visited SP at home. At SP's request, the psychiatrist increased her anxiety medication and changed her anti-psychotic medication to assist with sleeping. The file note of this visit made by the FACS caseworker does not record the caseworker discussing with SP the possible sedative effect of SP's medication, and its possible effect on her ability to care for AP.[218]

39. On 7 February 2014, the FACS caseworker made a referral for a Step By Step worker to work urgently with SP. The caseworker asked the Step by Step worker to see SP twice a week and help her establish routines.[219]

40. On 10 February 2014, SP rang the FACS caseworker and said she was not coping and needed to go to Charmian Clift Cottages that day. The caseworker immediately visited SP at home. SP said she was not "thinking right" and had not been eating or sleeping properly. The caseworker brought SP and AP to St George CSC. The caseworker sought a placement for SP at Charmian Clift Cottages, but was told that there was no availability. The caseworker also contacted Catherine Villa but was told there was a substantial waiting list and contacted Red Cross Young Mothers but was told that it did not have a residential service for mothers over 18 and its intake for outreach services ceased at age 23.[220]

41. SP signed a temporary care arrangement meaning that AP would stay with foster carers until a place at Charmian Clift Cottages became available. The initial temporary care

[216] FACS, Internal Serious Case Review, November 2016, p. 17.
[217] File Note Record dated 6 February 2014.
[218] FACS, Internal Serious Case Review, November 2016, pp. 17-18.
[219] FACS, Internal Serious Case Review, November 2016, pp. 17-18.
[220] File Note Record dated 10 February 2014.

arrangement was for a period of 6 weeks. The caseworker organised for SP to see AP three times a week and to give expressed breast milk during contact visits.[221]

42. On 11 February 2014, the caseworker followed up with the perinatal nurse and community health workers who had visited SP. The caseworker was informed that SP was "teary" but that they did not have concerns for her immediate mental health and that the acute mental health team would be visiting that night. [222]

43. On 17 February 2014, SP was voluntarily admitted to St George Hospital. She was assessed by RN Beth Tovey and reported feeling numb and empty. SP expressed suicidal thoughts but no present intentions. RN Tovey noted that she was "future oriented to be well to take care of baby". At the time of the assessment, SP was recorded as taking Cymbalta (an anti-depressant) and Zyprexa (an anti-psychotic).[223]

44. On 17 February 2014, the FACS caseworker visited SP in the hospital and informed SP that she would organise contact with AP at the hospital.[224]

45. On 21 February 2014, the FACS caseworker contacted the social worker from the hospital who confirmed that SP was doing "really well and had a lovely visit from the baby today".[225]

46. On 27 February 2014, the hospital advised the FACS caseworker that SP would be in hospital for at least another 2 weeks.[226]

47. On 5 March 2014, the FACS caseworker completed a risk assessment for AP with SP. The risk of neglect was assessed as moderate and the risk of abuse was assessed as low. [227]

48. On 11 March 2014 a place became available at Charmian Clift. However, SP was not ready to be discharged due to a medication set back.[228]

49. On 21 March 2014, SP agreed to a further temporary care arrangement allowing AP to remain with her foster carers until SP entered the program at Charmian Clift Cottages.[229]

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[221] FACS, Internal Serious Case Review, November 2016, p. 18.
[222] FACS, Internal Serious Case Review, November 2016, p. 18; File Note Record dated 11 February 2014.
[223] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 554.
[224] FACS, Internal Serious Case Review, November 2016, p. 19.
[225] FACS, Internal Serious Case Review, November 2016, p. 20.
[226] FACS, Internal Serious Case Review, November 2016, p. 20.
[227] FACS, Internal Serious Case Review, November 2016, p. 20.
[228] FACS, Internal Serious Case Review, November 2016, p. 20.

50. On 25 March 2014, SP was discharged from hospital to Charmian Clift Cottages. The discharge notes identify her diagnosis as schizoaffective disorder with "poor insight, somatic preoccupation, enduring psychosis and depressive cognition and concerns about the care of the baby".[230]

51. On 27 March 2014, AP was returned to the care of her mother. The hospital discharge plan included continuing SP's depot injections and requiring ongoing monitoring of her compliance with medication.[231]

52. On 3 April 2014, Charmian Clift Cottages informed the FACS caseworker that SP had settled in well and was parenting independently. The FACS caseworker also spoke with SP who said that the program was easier than she thought it would be and she was proud she had not needed any help with AP yet.[232]

53. On 18 April 2014, FACS recorded a report [redacted][233] [redacted][234] On 24 April 2014, a worker from Charmian Clift Cottages contacted the Manager Casework at St George CSC regarding the report that had been made to FACS. [redacted] The Manager Casework stated that they would not raise these concerns with SP because of her mental health and suggested a planned response between the two agencies would be more appropriate. The Charmian Clift Cottages worker did not agree with this suggestion. The Manager Casework requested that the psychiatrist at Charmian Clift Cottages speak to SP [redacted][235]

54. That same day, the Manager Casework spoke with the Manager Client Services at St George CSC and then contacted SP and informed SP that she could not have any contact with [redacted] over the weekend as [redacted] was living with [redacted] and he could pose a risk to AP. [236]

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[229] Temporary Care Arrangement signed 21 March 2014.
[230] Mental Health Records of SP from Liverpool Hospital (SWSHS), pp. 552-553.
[231] FACS, Internal Serious Case Review, November 2016, p. 21.
[232] FACS, Internal Serious Case Review, November 2016, p. 21.
[233] FACS, Internal Serious Case Review, November 2016, p. 21.
[234] FACS, Internal Serious Case Review, November 2016, p. 11-12.
[235] FACS, Internal Serious Case Review, November 2016, p. 22.
[236] FACS, Internal Serious Case Review, November 2016, p. 22.

55. [redacted][237]

56. On 28 April 2014, the FACS caseworker contacted Charmian Clift Cottages. Staff at Charmian Clift Cottages provided additional information about [redacted] and SP being in a relationship and [redacted] residing with [redacted]. The Charmian Clift Cottages workers were also concerned about [redacted] bringing alcohol when he visited and being left unsupervised with AP. The FACS caseworker was informed that Police had gone to Charmian Clift Cottages to speak to SP but that Charmian Clift Cottages had not allowed them to speak to SP because of her declining mental health.[238]

57. On 28 April 2014, the FACS caseworker contacted the person who provided the information in the report to FACS on 18 April 2014. The person declined to meet with the FACS caseworker. The FACS caseworker documented that she had concerns that the person may not be telling the truth.[239]

58. On 2 June 2014, SP contacted St George CSC and stated that she felt overwhelmed and asked if SP's father could care for AP for a few days.[240]

59. On 3 June 2014, the FACS caseworker informed SP that SP's father could not care for AP as he and his partner had not been assessed by FACS.[241]

60. On 4 June 2014, SP contacted the FACS caseworker and said she felt depressed and overwhelmed by parenting AP and wanted to "run away". SP agreed to voluntarily place AP with foster carers under a temporary care arrangement until 10 June 2014.[242]

61. On 10 June 2014, the FACS caseworker contacted SP to see if she wanted AP returned to her care. SP said she had missed AP and the caseworker arranged for AP to be returned to SP that afternoon.[243]

62. On 2 July 2014, FACS, Charmian Clift Cottages and Bankstown mental health staff met with SP about leaving Charmian Clift Cottages. FACS agreed to organise child care and parenting support services. Bankstown mental health staff agreed to refer SP to the local

[237] FACS, Internal Serious Case Review, November 2016, p. 22.
[238] FACS, Internal Serious Case Review, November 2016, p. 23.
[239] FACS, Internal Serious Case Review, November 2016, p. 23.
[240] FACS, Internal Serious Case Review, November 2016, p. 23.
[241] FACS, Internal Serious Case Review, November 2016, p. 23.
[242] FACS, Internal Serious Case Review, November 2016, p. 23.
[243] FACS, Internal Serious Case Review, November 2016, p. 24.

mental health service. SP asked about respite care and the FACS caseworker offered monthly respite if needed.[244]

63. On 8 July 2014, the FACS caseworker visited SP's father and his partner to discuss SP and AP coming home. SP's father said that he thought SP would need childcare which the caseworker agreed to arrange.[245]

64. Notes from Charmian Clift Cottages record that, during her time there, SP experienced poor mental health, depression, boredom, poor memory and vision problems. She said that her obsessive-compulsive disorder made her anxious about mess, and staff reminded her that attending to AP was a priority over cleaning. SP displayed some insight with regard to her mental health and its effect on her parenting. On at least two occasions, she stopped taking medication without medical advice, with staff noting a decline in her mental health and instability in her moods as a result.[246]

65. On 22 July 2014, SP and AP left Charmian Clift Cottages to live with her father.

66. On 28 July 2014, the FACS caseworker organised two days of childcare a week for AP.

67. On 8 August 2014, the caseworker introduced SP to the Step by Step worker ("the SBS worker") who was to work with her two days a week. [247]

68. On 22 August 2014, the SBS worker visited SP again.[248]

69. On 30 September 2014, the FACS caseworker held a planning meeting with SP, Community Mental Health, SBS and AP's childcare centre. SP reported significant improvements in her mental health since February 2014, which the services confirmed. The services all indicated that SP had made improvements and engaged well with their services. The meeting identified ongoing strategies to assist SP with parenting and served as a transfer or handover meeting between FACS caseworkers.[249]

70. The SBS worker visited SP on 16 and 24 October 2014. The SBS worker observed that SP felt a compulsive need to avoid mess when feeding AP and was defensive when discussing certain matters. The SBS worker sought guidance from FACS about how to

[244] FACS, Internal Serious Case Review, November 2016, p. 27.
[245] FACS, Internal Serious Case Review, November 2016, p. 24.
[246] FACS, Internal Serious Case Review, November 2016, p. 25.
[247] FACS, Internal Serious Case Review, November 2016, p. 27.
[248] FACS, Internal Serious Case Review, November 2016, p. 27.
[249] FACS, Internal Serious Case Review, November 2016, p. 27.

interact with SP in light of her mental health, but there is no documented response from FACS.[250]

71. On 24 October 2014, the FACS caseworker visited SP and AP. The FACS caseworker noted that AP was happy and playful and AP and SP had a good bond. The FACS caseworker talked to SP about her difficulties with AP making a mess when she ate and recommended that SP put a mat on the floor when she fed AP to contain the mess. The caseworker also spoke to SP about co-sleeping, identifying that SP's medications may pose a risk to AP in this context.[251]

72. On 29 October 2014, the FACS caseworker rang SP to obtain further details about SP's planned trip to the Cook Islands. SP gave permission for the caseworker to speak to her psychiatrist. SP said things were going well and she was trying to settle AP in her cot at night.[252]

73. On 3 November 2014, the FACS caseworker spoke to the SBS worker to discuss the next two planned sessions.[253]

74. On 2 December 2014, the FACS caseworker spoke with SP's new mental health worker and was informed that SP's medication had been changed, however, SP remained on anti-depressant and anti-psychotic medication. The FACS caseworker also had a cultural consultation about safe sleeping practices in the Cook Islands and discussed how to raise co-sleeping in a culturally sensitive manner with SP.[254]

75. Also on 2 December 2014, the FACS caseworker met with SP and they discussed co-sleeping. The FACS caseworker spoke about possibly ending FACS involvement.[255]

76. On 17 December 2014, the FACS caseworker spoke to SP over the phone. SP confirmed that she and AP would be in the Cook Islands from 20 December 2014 to 23 January 2015.[256]

77. On 16 February 2015, the FACS caseworker documented a Case Plan Review/Closure record. On 17 February 2015, the caseworker visited SP to discuss ending FACS involvement and making a referral to Brighter Futures, an early intervention program for

[250] FACS, Internal Serious Case Review, November 2016, p. 28.
[251] FACS, Internal Serious Case Review, November 2016, p. 28.
[252] FACS, Internal Serious Case Review, November 2016, p. 29.
[253] FACS, Internal Serious Case Review, November 2016, p. 29.
[254] FACS, Internal Serious Case Review, November 2016, p. 29.
[255] FACS, Internal Serious Case Review, November 2016, p. 29.
[256] FACS, Internal Serious Case Review, November 2016, p. 30.

families with children aged 0 – 9 years who face specific issues such as mental health issues and domestic and family violence. SP declined the offer of a Brighter Futures referral, telling the caseworker "she would prefer not to have people coming into the home and visiting" and would prefer to have the support of FACS, describing it as a "safety net" for her. However, SP also said she was "ok with closing".[257]

78. On 20 February 2015, the FACS caseworker unsuccessfully attempted to contact SP's mental health team and psychiatrist.

79. On 23 February 2015, the FACS caseworker again contacted SP's mental health team in order to speak to SP's psychiatrist. The caseworker was informed that the psychiatrist was on leave for 2 – 3 weeks. The caseworker then spoke with SP's mental health worker from St George Community Mental Health who advised that SP was progressing well and had made great progress in the last 6 months. The caseworker was provided with an update regarding SP's medications and other issues. The caseworker advised that SP's case at FACS had been closed and left her number so that the mental health team could make contact if needed. The caseworker also advised the mental health team to call the Helpline if necessary.[258]

80. On 23 February 2015, the FACS caseworker completed a risk reassessment decision report.[259]

81. On 25 February 2015, the caseworker sent a letter to SP telling her that her case had been closed.[260]

82. On 4 March 2015, the FACS caseworker completed a safety assessment decision report.[261]

83. On 11 May 2015, FACS received a report regarding concerns about AP including that SP had been staying in a women's refuge since 16 April 2015. The reporter stated that SP and AP were due to move to their new home in Miller in the next day or two and that Housing NSW was assisting SP.[262] The reporter also stated that SP had continued "somatic delusions" and currently had disturbed sleeping and eating patterns. The report

[257] FACS, Internal Serious Case Review, November 2016, p. 30; File Note Record dated 17 February 2015.
[258] File Note Record (page 373 of the Bundle of documents referred to in Maddocks' letter dated 18 November 2019).
[259] Page 365 of the Bundle of documents referred to in Maddocks' letter dated 18 November 2019.
[260] FACS, Internal Serious Case Review, November 2016, p. 30.
[261] Page 368 of the Bundle of documents referred to in Maddocks' letter dated 18 November 2019.
[262] Contact Record dated 11 May 2015.

was assessed as non-ROSH and closed without further assessment.[263] The reporter was advised by the Helpline that the reporter, as a mandatory reporter, should "document and continue relationship." This means that the reporter was to document the relevant information about their concerns and to continue to work with the family. The reporter stated that they were "ok" with this decision and that a referral would be made on SP's behalf to a family support service and that SP was already linked in with mental health services.[264]

Contact with Liverpool Community Mental Health Team

84. On 8 May 2015, SP was voluntarily admitted to the Liverpool Community Mental Health Team ("the LCMHT"). She was diagnosed with schizophrenia, with delusional thoughts. Her mental state was described as stable, with nil acute concerns.[265] No risks to AP were identified. The following interventions were planned:

> *"1) Ongoing support and monitoring of client's MS [mental state] and support in raising her daughter.*
>
> *2) Client lacks confidence and requires reassurance.*
>
> *3) Assistance with any re-settlement issues.*
>
> *4) Medical review (as required)."*[266]

85. On 19 June 2015, SP attended an appointment with LCMHT to meet her new clinical care coordinator, psychologist Sophie Schreuders. SP reported that she was unable to get out of bed in the morning and "sometimes sleeps until early afternoon".[267] An entry made by Ms Schreuders in the clinical record included the following:

> *"MSE: [SP] is a lady of normal build wearing casual clothing. Friendly, but superficial rapport. Speech normal RTV. Denied any perceptual disturbance. Believes that people around get physically sick/allergic because of her. Believes that her daughter [AP] however is 'immune' but this thought is challenging her delusion. Insight good, does not wish to come off medication out of fear of becoming 'unwell' again. In past believed a spell was put on her ('witchery') but*

[263] FACS, Internal Serious Case Review, November 2016, p. 31.
[264] Contact Record dated 11 May 2015.
[265] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 464.
[266] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 464.
[267] Mental Health Records of SP from Liverpool Hospital (SWSHS), pp. 467-468.

> *she is now 'clean' of this spell. Denies any suicidal ideation, plan or intent. Denies wanting to hurt self or others. [AP] looks well-groomed. Appropriate interaction mum-bub. [AP] is inquisitive and explores the room".*[268]

86. On 3 July 2015, Ms Schreuders received a phone call from a support worker with Domestic Violence NSW, who was involved with supporting SP. The support worker was returning Ms Schreuders' call. The support worker informed Ms Schreuders that she had become involved after SP had an argument with her father. She indicated she would slowly withdraw from assisting SP as she was now well linked with several other community services.[269]

87. On 23 July 2015, Ms Schreuders returned a call from an employee of Disability TAFE. The TAFE employee wished to confirm that SP was involved with a mental health service.[270]

88. On 28 July 2015, SP attended a scheduled appointment with Ms Schreuders. SP stated that she believed she emits a smell that can make others ill. She also believed she was receiving messages from TV and radio, telling Ms Schreuders "I thought I was a prophet". Ms Schreuders scheduled a doctor's appointment for a medication review, as SP indicated her tiredness may be medication related.[271]

89. Dr Hafiz was the psychiatrist at Liverpool Hospital with care of SP. On 14 August 2015, SP attended her first appointment with Dr Hafiz. Ms Schreuders was also in attendance. At the time of the initial assessment, SP was noted to be on Stelazine, an antipsychotic (2 mg nocte) and Cymbalta, an antidepressant (30 mg nocte). Clinical progress notes record that SP looked after AP, noting "I love her". The notes state that SP did not have concerns about her own safety or AP's safety. SP's sleeping patterns were discussed, with SP stating that she slept twelve hours at night and felt tired in the early part of the day. It was agreed that her Cymbalta would be changed to a morning dose.[272]

90. SP attended an appointment with Ms Schreuders on 14 September 2015. She reported improved sleep, following the change in her medication. She reported concerns about her neighbours and an over sensitivity to sounds.[273]

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[268] Mental Health Records of SP from Liverpool Hospital (SWSHS), pp. 467-468.
[269] Statement of Sophie Schreuders, 31 January 2018 at [20]-[21].
[270] Statement of Sophie Schreuders, 31 January 2018 at [31].
[271] Statement of Sophie Schreuders, 31 January 2018 at [33].
[272] Mental Health Records of SP from Liverpool Hospital (SWSHS), pp. 471-472.
[273] Statement of Sophie Schreuders, 31 January 2018 at [40]-[41].

91. An appointment with Dr Hafiz scheduled for 24 September 2015 was cancelled by Dr Hafiz and rescheduled to 15 October 2015. The appointment was again rescheduled at SP's request, as SP stated she had an exam that day.

92. On 29 October 2015, SP called to cancel her appointment that had been rescheduled for that day, as she had to attend TAFE. SP spoke to Ms Schreuders and said hadn't heard much from her. SP told Ms Schreuders that she had "gone back to old habits" in the sense that she was sleeping more and having difficulty getting out of bed in the morning.[274]

93. SP attended an appointment with Dr Hafiz on 11 December 2015. Dr Hafiz recorded that SP believed that she was "getting vibes from her neighbours" and that they were intimidating her. SP stated that she got annoyed when she got these feelings, and at times got distressed. Dr Hafiz increased the dose of Stelazine and maintained the dose of Cymbalta. The impression recorded was a possible relapse of psychotic symptoms, noted to require further monitoring.[275]

94. SP did not attend appointments scheduled with Dr Hafiz on 29 January 2016 and 31 March 2016.[276] On 8 April 2016, Dr Hafiz discussed SP's potential discharge from treatment with Ms Schreuders. SP was described as "not wanting to engage as she believes she is well and well-engaged with her local GP who can re-refer her if necessary and review her medications on a regular basis". Dr Hafiz felt "unable to make appropriate decision regarding discharge" as SP had failed to attend the last two doctor's reviews.[277] A plan was made to discuss SP at an upcoming multi-disciplinary team meeting on 8 April 2016.[278]

95. On 8 April 2016, discharge of SP from LCMHT was discussed at the multi-disciplinary team meeting. Dr Hafiz was not present at that meeting. It was decided that the matter would be discussed with Dr Hafiz. If he was agreeable, the team would proceed with discharge.[279]

96. On 8 April 2016, Ms Schreuders recorded that a home visit was to be conducted before SP was discharged.[280]

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[274] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 477.
[275] Mental Health Records of SP from Liverpool Hospital (SWSHS), pp. 478-479.
[276] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 480.
[277] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 486.
[278] Statement of Sophie Schreuders, 31 January 2018 at [55].
[279] Statement of Sophie Schreuders, 31 January 2018 at [56]-[57].
[280] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 487.

97. On 12 April 2016, a further multi-disciplinary team meeting was conducted. Dr Hafiz was not present. It was agreed that a home visit would be conducted in the week commencing 12 April 2016 to assess SP's mental state before further treatment decisions were made.[281]

98. A visit was attempted on 13 April 2016, but SP was not home.[282]

99. Ms Schreuders had no further contact with SP from that time, as she went on maternity leave. Bikash Ghimire, a social worker at LCMHT, was allocated as SP's Clinical Care Co-ordinator when he commenced employment at LCMHT on or around 16 May 2016.

100. On 29 June 2016, Mr Ghimire contacted SP by phone. SP expressed the belief that she had already been discharged from their care. SP stated that she was seeing a private psychologist and a general practitioner, and that she would attend her next review on 13 July 2016.[283] SP did attend appointments with a private psychologist, Michelle Fung, on 23 June 2016, 1 July 2016 and 8 July 2016.[284]

101. On 13 July 2016, SP did not attend her scheduled review. Progress notes record a plan to discuss discharging her due to a lack of follow-up, but that "ongoing care and risk management needs to be discussed with client and relative" prior to discharge.[285]

102. On 1 September 2016, Mr Ghimire phoned SP to remind her of her review scheduled for the next day. SP indicated that she would not attend her review scheduled with Dr Hafiz on 2 September 2016, as she had a TAFE class. SP restated her belief that she had already been discharged from the LCMHT and stated she "did not get much support from you guys".[286]

103. On 2 September 2016, Dr Hafiz called SP after she did not attend her appointment. She reiterated that she did not require a follow up from the LCMHT and that she was receiving treatment from her general practitioner and a psychologist, Michelle at My Health Medical Centre Liverpool. SP told Dr Hafiz that she had stopped taking Stelazine as she thought it was unnecessary and "it was a small dose anyway".[287] SP did not express any risk issues including thoughts of self-harm or harm to others. Dr Hafiz noted

[281] Statement of Sophie Schreuders, 31 January 2018 at [62].
[282] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 493.
[283] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 496.
[284] Progress notes, Michelle Fung, MindfulSpace Psychology and Coaching Practice.
[285] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 497.
[286] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 499.
[287] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 501.

that he would consider discharging SP following an appointment on 9 September 2016.[288]

104. On 8 September 2016, SP indicated that she would attend her appointment with Dr Hafiz the next day.[289] On 9 September 2016 SP did not attend her appointment with Dr Hafiz. In the progress notes he recorded:

> *"there is no imminent risk at this stage. In view of inability to engage her in therapeutic alliance and multiple failed attempts to establish contact with her, it is reasonable to discharge her from the case management. However, it is important to provide her and her family with all the relevant contact details. Also please advise GP to contact our service if there is a deterioration in the mental state."*[290]

Contact with General Practitioner: 2015-2016

105. From 28 July 2015 to 9 September 2016, SP was treated by Dr Don Ramjan, a general practitioner at My Health Medical Centre Liverpool. She saw him on 14 occasions during that period. On 28 July 2015, SP attended Dr Ramjan's practice with AP in relation to AP having an upper respiratory tract infection, and a prescription of 30 mg capsules of Cymbalta (an antidepressant) for herself.[291]

106. During her visit with Dr Ramjan on 11 September 2015, SP repeated her belief that she was making people sick. Dr Ramjan considered her to be delusional but not dangerous at that stage, and gave her a repeat prescription of Cymbalta.[292]

107. On 27 November 2015, Dr Ramjan prescribed SP her regular dose of Cymbalta as well as a contraceptive and Stelazine, an anti-psychotic medication. SP told Dr Ramjan that she had been prescribed Stelazine by Dr Hafiz.[293]

108. SP appeared to be stable to Dr Ramjan for some time. On 6 June 2016, SP complained of increasing anxiety and Dr Ramjan increased her dosage of Cymbalta to 60 mg. On 23 June 2016, SP indicated that she was feeling "a little bit better" on the increased dose.[294]

109. On 9 September 2016, SP visited Dr Ramjan without AP. She requested a drug screen from Dr Ramjan in order to regain custody of her twins. At this time, Dr Ramjan states he

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[288] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 501.
[289] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 504.
[290] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 505.
[291] Mental Health Records of SP from Liverpool Hospital (SWSHS), p. 473.
[292] Statement of Dr Don Ramjan, 19 November 2016, [17]-[19].
[293] Statement of Dr Don Ramjan, 19 November 2016, [23].
[294] Statement of Dr Don Ramjan, 19 November 2016, [29]-[30].

became aware that SP's mental health had been an issue for some time. During the consultation, SP told Dr Ramjan that she was being tested by God and that she had had a fight with her boyfriend the previous day. Dr Ramjan recommended that SP visit the hospital, but she walked out of the room.[295] In his consultation notes he records the following:

> *"Speech not coherent as previous consults. Tangential with little content. Asking if I am religious and if I believe in god, Jesus, heaven and hell. Describing a spiritual experience and that she is being tested. Her relationship broke down yesterday? Attempted to keep in room but left saying I wouldn't understand if not religious. Comet team contacted for urgent review as she has a 2 year old. Spoke to MH team at comet and faxed letter."*[296]

Events surrounding AP's death

110. SP commenced a relationship with [redacted] in around October 2015.[297] [redacted] states that a few weeks prior to AP's death he and SP believed they saw a ghost like figure at the house and that SP's face had "changed" and "looked evil".[298]

111. [redacted] states that SP told him "AP knows what's haunting us and she can see it", though he states SP was still being a good mother to AP and "nothing else really changed other than the fact that she was constantly reading the bible to her".[299]

112. [redacted] states he noticed SP's sleeping habits change. She started to wake up very early and he did not see her take any of her regular medication in the two weeks prior to AP's death.[300] Around this time, [redacted] and SP's relationship deteriorated and [redacted] left the house.[301] [redacted] states that after this time he and SP were still in regular phone contact.[302]

113. In early September 2016, SP told her friend Sophia Edwards she was paranoid about the house, that [redacted] had seen someone outside and that she and [redacted] had seen things in a mirror that made them afraid.[303] Ms Edwards states that a few days later SP said that

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[295] Statement of Dr Don Ramjan, 19 November 2016, [33]-[40].
[296] Medical Records from Myhealth Medical Centre Liverpool, Consultation Notes, 9 September 2016.
[297] Statement of [redacted], 13 September 2016, [3].
[298] Statement of [redacted], 13 September 2016, [16]-[17].
[299] Statement of [redacted], 13 September 2016, [18].
[300] Statement of [redacted], 13 September 2016, [19].
[301] Statement of [redacted], 13 September 2016, [20].
[302] Statement of [redacted], 13 September 2016, [21].
[303] Statement of Sophia Edwards, 14 September 2016, [17].

[redacted] and her had broken up.[304] SP also told Ms Edwards that she went to see a psychic and after this Ms Edwards states SP "seemed to feel better" and that she and [redacted] were going to stay together and attempt to "work out things between them".[305]

114. SP's father (with whom she was in regular contact),[306] stated that he last saw SP and AP on 6 September after he stayed the night at their house in [redacted].[307]

115. At around 3.00 pm on 7 September 2016, SP phoned SP's father and said her boyfriend [redacted] had broken up with her.[308]

116. On the evening of 8 September 2016, [redacted] and SP picked up AP from child care and went to SP's house.[309] SP "started talking about god again" and told [redacted] "there are messages there on the TV".[310] [redacted] "got angry and left".[311] He states "AP seemed happy and normal".[312]

117. At 8.53 pm on 8 September 2016, SP phoned SP's father and further discussed the break up with [redacted].[313] SP's father states AP sounded happy in the background.[314]

118. According to Daniella Palumbo, Centre Manager of Community Kids Child Care (which AP had attended since July 2016),[315] AP's last attendance was on 9 September 2016.[316] Ms Palumbo states that "AP's behaviour was as it had been on every other occasion".[317] Lead educator at the Centre, Akhtar Safiyyah, stated that around 3.40 pm she saw AP crying on the play equipment by herself but that she would not say what was wrong.[318]

119. On 9 September 2016, a classmate of SP at Granville TAFE, [redacted], states that SP appeared "stressed" and "tired" in class.[319] [redacted] states SP asked him

[304] Statement of Sophia Edwards, 14 September 2016, [18].
[305] Statement of Sophia Edwards, 14 September 2016, [18].
[306] Statement of [redacted] 13 September 2016, [11].
[307] Statement of [redacted] 13 September 2016, [12].
[308] Statement of [redacted] 13 September 2016, [13].
[309] Statement of [redacted] 13 September 2016, [24].
[310] Statement of [redacted], 13 September 2016, [24].
[311] Statement of [redacted], 13 September 2016, [26].
[312] Statement of [redacted] 13 September 2016, [27].
[313] Statement of [redacted] 13 September 2016, [14].
[314] Statement of [redacted] 13 September 2016, [14].
[315] Statement of [redacted] o, 14 September 2016, [12].
[316] Statement of Daniella Palumbo, 14 September 2016, [16].
[317] Statement of Daniella Palumbo, 14 September 2016, [16].
[318] Statement of Akhtar Safiyyah, 15 September 2016, [5].
[319] Statement of [redacted], 27 September 2016, [6].

"Do you believe in a differentworld?" and he responded that she should "just focus on the study".[320]

120. On 9 September 2016, SP attended an appointment with Dr Ramjan. The details of this visit are outlinedabove.

121. At around 4 pm on Friday 9 September 2016, SP attended Ms Edwards' house without AP and spoke about her visit to Dr Ramjan, stating she had argued with him because he had not answered her questions about whether he was religious.[321]

122. She also told Ms Edwards that she had an appointment with a psychologist scheduled at Liverpool Hospital that day but that she did not attend because "she thought that if she told them what was going on at the moment, that they would put her in the mental institution".[322] Around 4.30 pm, [redacted] also attended Ms Edwards' house for a time before he and SP departed together.[323]

123. At about 7.30 pm on 9 September 2016, Ms Edwards phoned SP who talked about being scared in the house and about [redacted] reading the bible.[324] Around 9.15 pm SP phoned Ms Edwards and said that [redacted] was evil and the devil.[325]

124. At around 7.30 am on 10 September 2016, SP's father states SP phoned him and told him she was having trouble sleeping.[326]

125. On the morning of Saturday 10 September 2016, SP phoned Ms Edwards to ask if Ms Edwards' daughter could attend SP's house to help her remove the demon that she believed was causing the supernatural events she perceived.[327] Ms Edwards declined[328]

126. At around 5.00 pm on Saturday 10 September 2016, SP attended Ms Edwards' house and spoke about receiving messages from the television, having a spiritual connection with all children, needing to get baptised and about AP being evil and having an old soul

[320] Statement of [redacted], 27 September 2016, [7].
[321] Statement of Sophia Edwards, 14 September 2016, [19].
[322] Statement of Sophia Edwards, 14 September 2016, [19].
[323] Statement of Sophia Edwards, 14 September 2016, [20].
[324] Statement of Sophia Edwards, 14 September 2016, [21].
[325] Statement of Sophia Edwards, 14 September 2016, [22].
[326] Statement [redacted] 13 September 2016, [15].
[327] Statement of 14 September 2016, [23].
[328] Statement of Sophia Edwards, 14 September 2016, [24].

that needed to be removed.[329] She said she had experienced a spiritual awakening, that heaven was the real world and that something big was going to happen.[330]

127. Ms Edwards states that SP was "in a strange mood" and that she had "never seen her like that before".[331] Ms Edwards states her "behaviour was very bizarre and she started walking around like she was seeing things that weren't there".[332]

128. SP spoke about fasting and sacrificing and Ms Edwards states that she "had a feeling that [SP] wasn't allowing AP to eat".[333] She noted that AP vomited on the floor, and there was no food in her vomit. She saw SP take a biscuit away from AP. At around 7 pm, SP left Ms Edwards' house with AP.[334]

129. At about 10.30 pm on 10 September 2016 Mr Mediarito drove to SP's house and states that "the house was very bright" and "the front window curtains were fully open".[335] SP was sitting in the lounge room with the bible in her hand and Mr Mediarito could not see AP.[336] He spoke to SP through the window. They argued and SP told him to go away.[337]

130. Sometime in the evening of 10 September 2016 or the morning of 11 September 2016, SP drowned AP in the bath at 35 Merino Street, Miller. AP's death was not immediately detected.

131. Ms Edwards states she had three missed calls from SP at around 6.40 am on 11 September 2016.[338] At around 7.30 am, SP attended Ms Edwards' house without AP.[339] SP was speaking about going to get baptised and wanted to take Ms Edwards' daughter with her but Ms Edwards refused.[340] Ms Edwards did not hear from SP again after this time.[341]

132. At around 2.30 pm on 11 September 2016, SP was involved in a car accident on the Great Western Highway near Leura. Sergeant Dallas Atkinson attended the scene of the collision and spoke to SP who was sitting on the steel barrier in the middle of the

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[329] Statement of Sophia Edwards, 14 September 2016, [25]-[26].
[330] Statement of Sophia Edwards, 14 September 2016, [26].
[331] Statement of Sophia Edwards, 14 September 2016, [26].
[332] Statement of Sophia Edwards, 14 September 2016, [27].
[333] Statement of Sophia Edwards, 14 September 2016, [28].
[334] Statement of Sophia Edwards, 14 September 2016, [29].
[335] Statement of [redacted], 13 September 2016, [29].
[336] Statement of [redacted], 13 September 2016, [29].
[337] Statement of [redacted], 13 September 2016, [29]-[30].
[338] Statement of Sophia Edwards, 14 September 2016, [30].
[339] Statement of Sophia Edwards, 14 September 2016, [31].
[340] Statement of Sophia Edwards, 14 September 2016, [31]-[32].
[341] Statement of Sophia Edwards, 14 September 2016, [33].

highway.[342] He asked her to leave the highway and she asked if he believed in God.[343] He stated she "appeared to be calm. She was not visibly upset, nor did she demonstrate any aggression".[344] Though later she resisted police and was physically carried from the scene and taken into the care of paramedcs.[345]

133. After observing her behaviour at the scene of the accident, police accompanied paramedics to Blue Mountains District Anzac Memorial Hospital and requested an assessment of her mental health under s. 22 of the *Mental Health Act.*[346]

134. Between 6.00 pm and 8.00 pm on 11 September 2016, SP phoned SP's father. He states they had "a normal conversaiton" during which SP described a visit to the doctor for AP, who had "a chest cough and a runny nose".[347] SP's father has stated that "everything seemed to be fine" and that his daughter told him AP was "okay".[348]

135. On the afternoon of 13 September 2016, the following impression was recorded of SP during review with Dr Djurovic and psychiatrist, Dr Byrne:

> *"History of diagnosis of schizophrenia in past. Currently presenting with disorganised behaviour, guarded and religious thinking and history of deterioration of mental state over past week in context of non-compliance with medicationand stressors of ending relationship',3*[49]

1 36 . A p lan w as recorded to detain her as mentally ill and continue treatment with antipsychotic medication.[350]

137. On 12 and 13 September 2016, SP made several phone calls to her friend, [redacted]. SP requested [redacted] assistance,stating"I have been admitted into the mental health ward and they are trying to keep me here … I need you to help get me out".[351] [redacted] asked where AP was, and SP said she was with her father. [redacted] called SP's father, who said he did not have AP with him.

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[342] Statement of Sergeant Dallas Atkinson, 19 September 2016, [5].
[343] Statement of Sergeant Dallas Atkinson, 19 September 2016, [6].
[344] Statement of Sergeant Dallas Atkinson, 19 September 2016, [6].
[345] Statement of Sergeant Dallas Atkinson, 19 September 2016, [7].
[346] Statement of Sergeant Dallas Atkinson, 19 September 2016, pp. 1-4.
[347] Statement of 13 September 2016, [16).
[348] Statement of 13 September 2016, [16).
[349] Medical Reco ntains Hospital, progress notes.
[350] Medical Records of Blue Mountains Hospital, progress notes.
[351] Statement of [redacted], 13 September 2016, [14).

138. After being unable to ascertain AP's whereabouts, [redacted] went to SP's house at 35 Merino Street at around 11.35 am on 13 September.[352]

139. At around 12 pm [redacted] phoned the police and asked if they could come and look at the house. [redacted] subsequently found three garbage bags of AP's toys in the rubbish bin outside the house.[353] She used the bin to climb through a window. She noted the house was untidy which was out of character for SP.[354] Inside the bathroom, [redacted] saw a towel in the bath and AP's arm.[355] She informed the police AP was dead.[356] Police then attended the scene.

Arrest of SP and legal proceedings

140. On 13 September 2016, SP was arrested at Blue Mountains Hospital Mental Health Unit for the murder of AP.

141. Two interviews were conducted by police on Tuesday 13 September 2016. The first occurred at Blue Mountains Hospital at 7.30 pm.[357] In this interview SP stated that she drowned AP because "that wasn't my child. That was, something evil in her".[358] She stated "this isn't the real world. Everything's a delusion. And that's why I sped. I was speeding my car to prove the power of God, because God is power".[359]

142. Another interview was conducted by police at 9.11 pm at Katoomba Police Station.[360] In this interview SP stated that in the last couple of weeks "… some supernatural stuff was happening and I went to the psychic … because I didn't know what to do … I was a bit scared, he [redacted] was very scared".[361]

143. SP stated that she and [redacted] were arguing.[362] She stated that in the previous week she felt "like something religious was happening" and that "[I] haven't been eating, haven't been sleeping and like supernatural things were [happening] to me".[363] She stated:

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[352] Statement of [redacted], 13 September 2016, [27]-[28].
[353] Statement of [redacted], 13 September 2016, [31]-[32].
[354] Statement of [redacted], 13 September 2016, [32], [34].
[355] Statement of [redacted], 13 September 2016, [35].
[356] Statement of [redacted], 13 September 2016, [35]-[36].
[357] Transcript of video interview at Blue Mountains Hospital, dated 13 September 2016.
[358] Transcript of video interview at Blue Mountains Hospital, dated 13 September 2016, Q&A 14-19.
[359] Transcript of video interview at Blue Mountains Hospital, dated 13 September 2016, Q&A 19.
[360] ERISP Transcript of interview with SP, dated 13 September 2016.
[361] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 130.
[362] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 130.
[363] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 130.

"I'm not saying my actual child was evil maybe something happened in the last few days, like it's happened to me, something went bad in her? And I, I wanted it to get out because it wasn't my child. I would never hurt my child, I love my children, all my children. But that wasn't my child".[364]

144. SP stated that on Saturday 10 September 2016 she put AP in the bath and "put her head down".[365] She said she "wasn't trying to kill [her] actual child" but that she knew she would see her again and that she "did it to save her".[366]

145. She stated that she had drowned AP but that this was the "very first" time she had experienced thoughts to do something like that.[367] She stated that on the morning of 11 September 2016 she baptised herself in a lake near Palm Beach,[368] and drove to Westmead Children's Hospital because she has "a connection with children and … was guided there".[369]

146. SP stated her stress was "a spiritual warfare stress … you have no idea, you obviously don't know. I've seen everything, I've seen this world, I've seen … it for what it is. I've seen demons, seen demons in my own child. I've seen demons in people that I loved."[370]

147. On 25 September 2017, Dr David Greenberg completed a medico-legal forensic psychiatric report in relation to SP. He formed the opinion that she was mentally ill at the time of killing her child and had a defence of mental illness available to her. Dr Greenberg diagnosed SP with schizophrenic disorder and suffering an acute relapse at the time of AP's death.[371]

148. On 23 November 2017, SP was found not guilty of murder by reason of mental illness by Acting Justice Hidden in the Supreme Court of NSW.

Autopsy report

149. On 14 September 2016, Dr Lorraine Du Toit-Prinsloo conducted an autopsy. Dr Toit-Prinsloo recorded AP's cause of death as "in keeping with drowning".[372]

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[364] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 201.
[365] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 203.
[366] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 203.
[367] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 293-294.
[368] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 236.
[369] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 249-251.
[370] ERISP Transcript of interview with SP, dated 13 September 2016, Q&A 332.
[371] Expert Statement of Dr David Greenberg, 25 September 2017, pp. 19-21.
[372] Autopsy Report for the Coroner, 2 December 2016, p. 2.