STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Grace Rohanne Herington
Hearing dates:	**21 July 2020 – 23 July 2020**
Date of findings:	**9 September 2020**
Place of findings:	State Coroner's Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – death a result of police operations – fall from height – drug induced psychosis – mental health assessment – adequacy of care
File number:	2018/391439
Representation:	(1) Counsel Assisting Mr Jake Harris of counsel, instructed by Ms Clara Potocki of the NSW Crown Solicitor's Office (2) NSW Commissioner of Police Mr Craig Norman of the Office of General Counsel, NSW Police Force (3) Northern Sydney Local Health District and Ambulance Service of NSW Mr Patrick Rooney of counsel, instructed by Ms Kate Hinchcliffe of Makinson d'Apice Lawyers
Non-publication order:	None

Findings:	The *Coroners Act 2009* in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death or suspected death. These are the findings of an inquest into the death Grace Herington. **Identity of deceased**: The deceased person was Grace Rohanne Herington. **Date of death**: Grace died on 19 December 2018. **Place of death**: Grace died at Royal North Shore Hospital, NSW. **Cause of death**: The cause of death was multiple blunt force injuries. **Manner of death**: Grace sustained fatal injuries in a fall from height in the context of an acute psychotic episode, induced by cannabis use. There is no evidence that Grace intended to end her life. The death occurred as a result of police operations.
Recommendations:	None

Table of Contents

Introduction

1. These are the findings of an inquest into the death of Grace Herington. Grace died on 19 December 2018, at Royal North Shore Hospital, following injuries she sustained in a fall from height. In the early hours of that morning, Grace fell from the Burns Bay Road off ramp, at Hunters Hill, in the context of a mental health crisis. At the time of her fall, police officers were present and NSW Ambulance paramedics were also at the scene. Grace had also attended Royal North Shore Hospital for a mental health assessment the day prior to her death.

The nature of an inquest

2. An inquest is a public investigation into the circumstances of death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. Neither does the holding of an inquest itself suggest that any party is guilty of any wrongdoing.

3. Pursuant to s. 27 of the *Coroners Act 2009*, an inquest is required to be held in certain circumstances, including where it appears that the person has died as a result of police operations. While this provides an opportunity to closely examine the circumstances of death, including the conduct of police, the issues considered in this inquest were not limited to police conduct.

4. The primary function of an inquest is to identify the circumstances in which the death occurred. At the conclusion of an inquest, the role of a coroner, as set out in s. 81 of the *Coroners Act 2009*, is to make findings where possible as to:

    a. The identity of the deceased person;

    b. The date and place of the person's death; and

    c. The manner and cause of death.

5. A secondary purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves considering whether any lessons can be learned from the death, and whether anything should or could be done to prevent a death in similar circumstances in the future.

The facts

Background

6. Grace was 23 years old at the time of her death. She grew up in Grafton with her parents, Bruce and Janelle, and brother Kenneth. At the time of her death, she was living with her brother in a unit on Ryde Road, Hunters Hill.

7. She is described by her friends and family as a beautiful, intelligent, happy young woman. She was a loyal friend, if a little introverted and sometimes socially reserved. She had, according to her aunt, a tendency to build very small things up into big things.

8. Grace was generally healthy and well. She practiced Wing Chun martial arts, being an instructor in that discipline, and she attended the gym and kept fit. As a result, in her younger years she was against drugs and alcohol.

9. She had no significant childhood issues, although she had witnessed some traumatic events.

10. She was very clever, being the dux of her school in Year 12, and through hard work she obtained a place at Sydney University in 2015. She initially moved from Grafton to Hunters Hill, to live with a friend of the family.

11. The transition to university life appears to have not been easy for Grace, who may have felt isolated from her peers. It was after moving to university that she began to experience periods of poor mental health.

12. In October 2015, she attended a General Practitioner, Dr Beth Lavings, at the Central Coast Peninsula Medical Centre, Umina complaining of persistent headaches. Dr Lavings concluded that these were caused by tension or position and she suggested Grace return if her symptoms persisted.

2016

13. In 2016, Grace moved in briefly to another family's home, and then moved into her family's holiday house at Patonga. She commuted from Patonga to university throughout 2016. This may have increased her isolation from her

peers. She returned to Dr Lavings in May 2016, still complaining of headaches. A CT scan was performed, with nil result.

14. At the end of 2016, her family recall that she suffered a "*breakdown*". She returned to see Dr Lavings in October 2016. She was not coping well and was tearful during the consultation. She denied thoughts of self-harm and denied drug or alcohol use. She expressed anxiety about her course and had suffered a bereavement (her grandmother) in June that year. Her mother reports that Grace was also concerned about a Centrelink investigation for fraud. Dr Lavings completed a mental health plan a few days later and Grace was referred for counselling.

15. Grace commenced counselling with Vic Val and Melissa Turner at the Deepwater Practice, Woy Woy, on 20 October 2016. She reported no drug or alcohol use at that time. After three sessions, Grace cancelled further appointments.

16. During this episode, Grace sought and was given special consideration from the university for her poor exam results.

2017

17. In 2017, Grace's parents took out a lease for a unit at Ryde Road, Hunters Hill, and Grace moved in. The year followed a similar pattern to the previous, where Grace's mental health began to deteriorate towards the end of the year, possibly due to academic stress. She also had difficulties with a flatmate, who was disruptive and whom she eventually had to evict.

18. In November 2017, she completed a second mental health plan with Dr Jonathan Pham, and he also referred her for counselling, although there is no record of Grace having taken up this referral. Grace did have one counselling session with a counsellor at the university on 2 November 2017. She denied thoughts of self-harm and reported no drug or alcohol use. She again sought special consideration for her studies.

19. According to a friend, Rachel Hubble, at the end of 2017 Grace also started experimenting with cannabis and LSD. This was not known to her family at the time.

2018

20. In 2018, Grace's brother Kenneth transferred to Sydney University to study medicine and he moved into the Hunters Hill unit.

21. In about March 2018, Grace met an Iranian man called Sadra Boutorabi on Tinder. They commenced a casual relationship a few weeks later. Grace's friends believe she wanted more than a casual relationship with Sadra. According to Grace's friends, Grace also began to smoke cannabis more frequently after meeting Sadra.

22. Grace continued to struggle with her anxiety and her studies. She attended a GP, Dr Monaghan at Lane Cove, on 27 August 2018, who completed a university certificate about Grace's capacity to study. Dr Monaghan stated that Grace was "*very severely affected*" by ongoing headaches, fatigue and a consequent inability to study. Dr Monaghan also prescribed melatonin for sleep.

The alleged sexual assault

23. Two days later, on 29 August 2018, Grace reportedly suffered a sexual assault. She had gone to Sadra's home and spent time with his male flatmate. They smoked cannabis and watched Netflix. Grace later reported that the flatmate tried to kiss her and also put his hand up her top, which she resisted. When he persisted, she got up and left.

24. Grace called her friend, Hope Landsberry, in distress shortly after this happened. She called another friend, Ms Hubble, a few days later telling her that the man had tried to have sex with her and had also digitally penetrated her. Ms Hubble advised her to go to police.

25. Grace attended Dr Monaghan again on 31 August 2018. There is no record that she mentioned the sexual assault to Dr Monaghan. She returned again on 24 September 2018 for a further prescription of melatonin. Grace felt improved better energy and concentration.

26. On 1 November 2018, Grace reported the sexual assault to Constable Marsden-Jones at Chatswood Police Station. Grace did not want the man to be charged, although she did want there to be a formal record.

27. Although she had not reported the sexual assault to police before this, it appears Grace continued to be preoccupied about it; she mentioned it at the time of her attendance at hospital on 18 December 2018, and also when paramedics attended the home on 19 December 2018.

28. Grace also referred to the sexual assault when making an application for special consideration for her studies. The university determined that the period whole from 29 April to 20 November 2018 would be looked at favourably, and she was to be referred for assistance as a "student at academic risk".

29. Despite these challenging circumstances, in the final semester Grace enrolled in four units of study in an effort to complete her degree. According to Kenneth, her family advised her not to do this, in particular given how she had struggled with stress in previous years.

Taha Boutorabi

30. On 20 November 2018, Sadra went on a trip to Iran, where he remained until after Grace's death. He remained in frequent contact with Grace, mainly via Facebook messenger.

31. Following this, Grace began to spend some more time with Sadra's brother, Taha. Taha suffered from depression. Messages between Grace and Sadra show that they were concerned about Taha's mental health, and that Grace was supporting him, and in fact booked him an appointment with Ms Turner, the psychologist she had seen in Woy Woy, on 19 December 2018.

Grace's exam results

32. On 12 December 2018, Grace was at Patonga with her parents when she received her exam results. They were very poor, attaining 20% and 30% in two of the subjects. She had an argument with her parents about her results. Her parents then left for a road trip, leaving Grace in charge of their dog, Basil.

33. A couple of days later, she contacted her brother, telling him she wanted to speak to him in person about her results. When she arrived back in Sydney, he found her to be erratic and thinking rapidly, although he was not too concerned about her at that stage.

Weekend of 15 and 16 December 2018

34. On Saturday 15 December 2018, Grace went to Taha's home and they smoked cannabis. She stayed the night sleeping in his bed while he slept on the couch. She returned home the next day.

35. Grace sent Sadra messages at 12.53am on Sunday 16 December, as follows:

I think I'm hallucinating …

Weed. I coughed so much

It was really a lot

Weird day …

I took melatonin (prolonged release) about an hr before the weed.

36. Activity on Grace's computer shows that later that morning she also did internet searches for "*Can weed make you hallucinate"* and "*combining cannabis with prolonged release melatonin*".

37. Later on Sunday, Grace met up with her parents at a park in Wahroonga to return Basil to them. There was another argument, about the care of the dog. Following this, Grace drove off without saying anything further.

Monday 17 December 2018

38. Grace's father texted her the next morning, saying "*I apologize for last night and regret calling you a dill over such a trivial matter*", to which she replied, "*Thanks Dad :) xx".*

39. During the day, her brother and a friend were watching cricket on the television. Kenneth recalled that Grace sat with them and looked "*spaced out*."

40. At about 5pm that day, Grace sent another message to Sadra saying it was a "*weird day I feel spacey*". She felt tired and said she should take some melatonin, and then appears to have slept.

41. At about 7pm on Monday evening, Grace messaged Taha to the effect that one of her brother's friends was in the house and she didn't feel safe. Taha offered for her to come to his house again. When she attended, she seemed to be paranoid and not making much sense, concerned about a backpack left at her home and beer bottles lying around. Grace remained at Taha's home that night and they kept talking for several hours. Sadra was also worried about Grace due to their previous messages, and he contacted Taha about this.

42. At 1.02am on Tuesday, 18 December 2018, Grace messaged her brother, asking him to text her his location. He replied that he was home in bed.

The attendance at Royal North Shore Hospital

Tuesday, 18 December 2018

43. On the Tuesday morning, Grace appeared to Taha to be well. She went home, then went to buy coffee and returned to Taha's about 10am. Taha then went to work, leaving Grace at his home. However, she messaged him at 1.38pm, saying that she was a bit confused. He was in a meeting at the time.

44. At around this time, Grace made a series of bizarre calls to her parents. She told her mother she was in Iran, she was stuck in a lift, and also that she had "*stopped 9/11, but I didn't kill* [a named person]". Her parents, alarmed, went to Woy Woy Police Station to report this and then called Kenneth. Police issued a "concern for welfare" CAD message for the Chatswood area. That message refers to Grace saying she was "*responsible for 9/11 and that she should kill more Israelis"*.

45. Grace also tried to contact Sadra, asking for help. She spoke with him and sent him a number of messages, saying she was in "*stuck in a bad loop of thoughts and hallucinations*". She appeared to have forgotten he was in Iran. Grace was trying to find Taha's office and seemed disorientated. She also said she had smoked cannabis but had not taken any other drugs. Sadra

suggested she speak to her brother. He was concerned Grace had schizophrenia, and he contacted Taha about this.

46. Taha messaged Grace, asking where she was, and she sent an address of in Railway Street, Chatswood. Grace also sent Taha a video message of herself turning slowly round, saying "*this is where I am*". Taha phoned her and she said she was at a branch of NAB.

47. Meanwhile, Kenneth had been contacted by Grace's parents and he also called Grace. At about 3pm both he and Taha located Grace at a NAB branch at Chatswood train station.

Chatswood train station

48. When located, Grace appeared "*spaced out*" and was behaving erratically, talking about her food being bad. Kenneth made a call to 000.

49. Senior Constable Albert Yang and Constable Nicola Feltham responded to that call. Part of the police interaction with Grace is captured on Body Worn Video. Grace appeared alert but subdued in the footage, although at times she became less alert, resting her head on Taha's shoulder. Police asked her about the information her mother had reported regarding 9/11; she denied saying it.

50. Police considered exercising power to convey Grace to hospital under s. 22 of the *Mental Health Act 2007*. However, as Grace had not made any threats, the officers agreed that using that power was "*a bit extreme*". They decided to wait for the ambulance and leave Grace in the care of paramedics.

51. Paramedics Byron Urbina and Ethan Hoare then attended and spoke with Grace. According to them, Grace was at first agitated and appeared to be having an anxiety attack. Grace told the paramedics that she had been hallucinating, seeing spots in front of her eyes. She was vague about the hallucinations. She denied thoughts of self-harm or harming others. She said she had spoken to her family and suggested this may have caused her to feel the way she did.

52. The information that Grace told her mother, that she should have stopped 9/11, was not recorded anywhere in the ambulance records, and nor was it recalled by either paramedic in statements provided to this inquest. It appears likely that they were unaware of this information.

53. Grace agreed to go with paramedics voluntarily to Royal North Shore Hospital (RNSH). As a result, police decided they were no longer required. Taha travelled with Grace in the ambulance.

54. On the way to hospital, Grace became agitated and fell off the stretcher. However, she settled down.

Grace arrives at hospital

55. Grace arrived at hospital at about 4.24pm. Paramedic Hoare gave an oral handover to the triage nurse, Adrienne Ling. The paramedics had not yet completed their own paperwork, and so the ambulance records were not made available to the nurse.

56. Nurse Ling recorded that Grace had been unwell over the last few days with anxiety and depression, had a previous mental health history of anxiety, depression and an adjustment disorder, and that Grace denied plans of self-harm. Nurse Ling observed Grace to be upset but not behaving erratically at that time. She allocated Grace to Australasian Triage Scale 4 (ATS4), which requires an assessment within 60 minutes. That allocation to ATS4 also had the result that Grace was suitable to be assessed in the Fast Track area of the hospital.

57. At about 4.30pm, Grace's parents and Kenneth attended the hospital. Bruce did not go into the hospital, but stayed outside. Although Kenneth and his mother wanted to see Grace, she declined to see them. She had also provided Taha's details as her next of kin, and not her family's details, although after Kenneth and his mother raised concern about this, Grace provided her aunt Judith's details as a second emergency contact.

58. Kenneth and his mother remained in the waiting room and they did not see Grace or the staff who were dealing with Grace. Significantly, that again meant

that information that they knew about Grace, including the statements she made about 9/11, was not communicated to staff who were assessing Grace.

59. At about 6.15pm Grace's parents and Kenneth left the hospital and later returned to the Hunters Hill unit.

60. At some point over course of the evening, Grace was assessed by Mental Health Clinical Nurse Consultant Justin Newton. It was the only substantial assessment Grace received at the hospital.

61. Among other things, Grace told Nurse Newton she had received treatment for her mental health via a GP care plan. She told him about the sexual assault and said that she had family difficulties. She also said that she had used cannabis 3 days prior. She said she had experienced hallucinations. She denied feelings of self-harm or harm to others. During the assessment, Grace was at times distracted, and was speaking in a child-like manner, changing her accent, and she referred to unusual visual perceptions, such as the fact that Nurse Newton's glasses had vivid tint or colouring.

62. Grace also old Nurse Newton she had an appointment with her psychologist the next day and that she intended to visit her GP about her sleep. As noted, a psychologist appointment had been arranged on 19 December, but this was for Taha, not Grace.

63. Nurse Newton spoke with Taha, who told him that he understood Grace was failing classes at University, and also noted that Grace's behaviour had changed recently, in particular after smoking cannabis. Nurse Newton did not speak with Grace's family.

64. Nurse Newton concluded that Grace did not display any overt risk and, as a result, she did not require admission. He considered it possible that Grace's presentation was drug-induced, and complicated by the sexual assault. He also considered the possibility that she was mildly psychotic, with disorganised thinking and atypical visual phenomena.

65. He told Grace that she would always be able to return to the Emergency Department if she felt necessary if she had concerns. Grace requested a pregnancy and STD test, and Nurse Newton made arrangements for her to see

a female doctor about this. Grace then returned to the Fast Track area, and Nurse Newton told her he was going to discuss her case with the psychiatrist.

66. Nurse Newton then spoke with Dr Zoltan Zsadanyi, the on-call psychiatrist, for about 15 minutes. The nurse relayed a summary of the assessment, including the fact that Grace had an appointment with a psychologist and denied suicidal ideation. They discussed the fact that Grace had reported seeing bright colours, and possible causes for this. Overall, the psychiatrist did not consider that the reported symptoms supported a psychotic or affective disorder. He suggested a review by a medical officer but otherwise agreed Grace was appropriate for discharge.

Grace leaves hospital

67. It appears that Grace was seen briefly by a doctor, Dr Bowell, who organised the pregnancy test, which was negative.

68. However, about 7.45pm, and prior to Grace being seen by Nurse Newton regarding discharge, Grace and Taha left the hospital. Taha returned shortly afterwards to retrieve a mobile phone and then left again.

69. Once Nurse Newton discovered that Grace had left, he tried to contact her by phone. He then spoke again with Dr Zsadanyi. In light of the fact that Grace was a voluntary patient, did not display suicidality, wasn't aggressive or overly agitated, and had indicated she would see her psychologist the next day, it was determined that no further efforts would be made to speak with her. No contact was made with Taha or with Grace's aunt either at any stage, whose contact details were recorded by the hospital.

The circumstances of Grace's death

Events at Hunters Hill

70. Grace and Taha returned to the Hunters Hill unit, where her parents and Kenneth were. Her behaviour continued to be unusual. She told Taha she wanted to go out with him on the town and started dressing up. She told her mother she was going to go with Taha to his grandma's "*Golden Persian palace*". She had her passport with her, tucked it into her skirt. She went

outside and started making a video call. When her father, Bruce, took her phone from her she pushed him away.

71. Grace then said to her father words to the effect "*there is not much to live for in this world there are a lot of bad things that happen*." He challenged her on this, saying that there was everything to live for.

72. Eventually, Grace agreed she would stay home, provided her parents left. They did so, leaving Grace and Kenneth at the home and giving Taha a lift back to his unit, before returning to Patonga.

73. After her parents and Taha left, Grace's odd behaviour continued. For example, Kenneth went outside to phone a friend and debrief, and when he returned Grace was on the sofa in her underwear.

74. At 10.28pm, Grace sent an image of Hanging Rock to Taha and two friends from her Wing Chun class. The meaning of that message is unknown.

75. At 10.50pm, Grace sent a message to Taha "*I'm so glad you're in my life Taha / I love you"* and he replied "*I love you too grace / But we really need professional help / I don't want to lose you / But you are disconnecting from reality".*

76. Kenneth and Grace then spent some time talking, during which Grace put on an Arabic accent. She also told him, for the first time, about the sexual assault from August. At some stage they both went to bed.

77. At about 2.30am, Grace came into Kenneth's room saying "*Taha, are you there?"*

78. At about 3.30am, Kenneth awoke and found Grace sitting on the floor with books and her diaries around her. She told him she was going to Taha's home. At this point, Kenneth called 000. He told the operator that he believed Grace was hallucinating and that she had already been at hospital the day prior. In the course of the call, when asked about weapons he said that there were knives in the kitchen. An ambulance was dispatched.

Attendance of paramedics

79. At 3.37am, Paramedics Evan Steinle-Davis and Jessica Rose attended. They found Grace pacing around the unit, talking to her brother. Paramedic Steinle-Davis attempted to develop rapport with Grace. She declined to comply with his assessment or even have her temperature taken. Kenneth told the paramedics that Grace may have smoked cannabis. He also told them that she had been at RNSH the day prior with similar behaviour.

80. Grace then went into her bedroom and left the unit through the window. The paramedics and Kenneth followed her outside, to see her walking away to the south along Ryde Road. Kenneth gave the paramedics his details and asked to be recorded as Grace's next of kin, in the event she was taken back to hospital.

81. The paramedics requested police assistance at 3.45am. Police categorised this request as a "concern for welfare", initially with a priority 3 non-urgent rating.

82. The paramedics got into the ambulance and followed behind Grace at a distance, initially without warning lights. Grace continued walking towards Gladesville Road. There is CCTV footage which shows her throwing her arms around and apparently speaking as she walked.

83. Grace was then seen to lie down on the ground and flail her arms and legs around, yelling and screaming. A local resident, Michael Fardoulis, also heard someone screaming around this time, saying "*leave me alone*".

84. Paramedic Steinle-Davis asked for an upgraded police response. This request was made at 3.46am. Police dispatchers gave the incident a priority 2 and made an all resources broadcast. Several police units responded. The first of these was Ryde 16, comprising Senior Constable Timothy Shields and Constable Harriet Fordyce (who was at that time a Probationary Constable).

85. Paramedic Steinle-Davis attempted to approach Grace on foot but was unable to engage her. He returned to the ambulance to draw up a syringe of droperidol, in order to sedate her. While he was doing this, Grace began running off towards the off ramp from Burns Bay Road. The ambulance followed her and broadcast her location.

Arrival at Burns Bay Road

86. Burns Bay Road is a dual carriageway running approximately north / south. At the relevant point it is intersected by Church Street which passes over it as a bridge. There are two on-ramps and two off-ramps running between Church Street and Burns Bay Road. Grace's death occurred at the northbound off ramp, which has three lanes.

87. The ambulance drove onto Burns Bay Road via the southbound on-ramp, did a U-turn across Burns Bay Road and then proceeded up the northbound off-ramp towards Grace.

Attendance of police

88. At about 3.54am, Senior Constable Shields and Constable Fordyce arrived at the scene. The roof bar lights of their vehicle were illuminated. They approached towards the ambulance, driving the wrong way down the off-ramp.

89. About halfway down the off-ramp, they saw Grace lying down in some bushes at the side of the road. Senior Constable Shields stopped the vehicle, and Grace immediately got up and started to run back up the off-ramp. Senior Constable Shields shouted "*stop*" and ran after her. Grace was said to be running in an erratic way and she started to scream.

90. Grace then suddenly diverted to her right and ran towards the edge of the off-ramp. She climbed over guard rail, lay down along a low cyclone fence and then tipped over the edge.

91. Senior Constable Shields arrived and attempted to grab at Grace, taking hold of her leg. Grace's body continued to fall over the ledge, until she was hanging from her leg. According to Senior Constable Shields, Grace then began to swing her body. He was unable to continue holding her, and she fell headfirst towards the road below, landing on her side. The fall was approximately 10 metres.

92. The paramedics drove down the ramp and provided assistance immediately. Police broadcast a message for further assistance, although a number of

officers were already arriving at that point. Grace was transferred to RNSH for treatment, arriving at 4.27am.

93. Grace underwent surgery for a laceration to her liver and significant internal injuries, including a large amount of free fluid in her abdomen. Despite the efforts of medical staff, her injuries were deemed non-survivable. A decision was made to palliate her. She was pronounced deceased at about noon the same day, 19 December 2018.

94. An autopsy was conducted on 21 December 2018, which recorded the cause of death to be "*multiple blunt force injuries*". Toxicology recorded ketamine (administered during treatment) and Lamotrigine; it is unclear when the latter drug was administered. No illicit drugs or alcohol were detected; antemortem urinalysis taken at RNSH on 19 December 2018 was also negative for illicit drugs.

Issues for the inquest

95. The following issues were raised in the inquest:

(1) The nature of Grace's mental health condition at the time of her death.

(2) Whether the care and treatment provided to Grace during her attendance at Royal North Shore Hospital at about 4.24pm on 18 December 2018 was adequate and appropriate in the circumstances including:

(a) Whether it was appropriate to allocate Grace to Australian Triage Scale 4;

(b) Whether it was appropriate to assess Grace within the Emergency Department Fast Track area;

(c) The adequacy of the mental health assessment, including the extent to which information from Grace's family might have affected that assessment; and

(d) The adequacy of action taken when it was discovered that Grace had left the hospital.

(3) Whether the care and treatment provided to Grace by paramedics who attended her home at about 3.37am on 19 December 2018 was adequate and appropriate in the circumstances?

(4) The action taken by the police officers who responded to the CAD incident broadcast at about 3:46am on 19 December 2018 to attend Grace's home 2018.

(5) Are any recommendations necessary or desirable arising from any matter connected with Grace's death?

Grace's mental health condition

96. The inquest had the benefit of evidence from Dr Danny Sullivan, Consultant Forensic Psychiatrist and the Executive Director of Clinical Services, Forensicare, the Victorian Institute of Forensic Mental Health. He reviewed material from the brief of evidence, provided a report and gave oral evidence by video link at the inquest.

97. Dr Sullivan gives the opinion that Grace suffered an acute psychotic episode. Concerns about Grace's mental state commenced abruptly on the weekend prior to her death, after she smoked cannabis. Her symptoms, including disorganised and confused behaviour, disorientation, disinhibition, anxiety, unspecified persecutory ideas about her family, bizarre delusional ideas and hallucinations, were inchoate features characteristic of an acute psychosis.

98. Dr Sullivan notes that it appears Grace did not disclose the full nature of her condition to anyone, minimising her symptoms and being guarded during the assessment. She did not disclose the full extent of her symptoms to either her family or medical staff.

99. The psychotic episode arose on a background of significant stress about her studies and financial concerns. Grace also appeared preoccupied with the sexual assault, and was experiencing some conflict with her family. However, Dr Sullivan considers it unlikely that stress alone induced a psychotic state.

100. Dr Sullivan also considered the fact that Grace had taken melatonin. He was not aware of cannabis and melatonin having a specific interaction, but in any

event, cannabis is known to have a capacity to induce psychosis. In his view cannabis is likely to have had a far larger contribution to the psychosis. Similarly, he did not consider the presence of Lamotrigine to be significant; it was unlikely to have been taken either deliberately by Grace or ingested as an adulterant, and it would not have contributed to her psychosis.

101. Accordingly, the most likely precipitant of the psychosis was cannabis use alone. A cannabis-induced psychotic episode is generally short-lived (from hours to days) and will settle with the passage of time after cessation of cannabis use. Symptoms may persist beyond the presence of cannabis in the body; this is consistent with the fact that no cannabis was detected in Grace's system at autopsy. Dr Sullivan also notes that Grace's reaction to cannabis on this occasion could not clearly have been predicted by her reported experiences when previously smoking cannabis.

102. Accordingly, I find that Grace suffered an acute psychotic episode that was induced by cannabis use.

Sadra and Taha Boutorabi

103. Both Sadra and Taha Boutorabi gave evidence to the inquest. Sadra stated he met Grace through Tinder and initially saw her about once a week. He denied smoking cannabis with Grace often, or giving her any cannabis, but said he had been out with her at weekends and had observed her smoke cannabis in a group setting ("*a few puffs from a joint"*). He did not know who supplied the cannabis to Grace. She was not a drinker and he was unaware of her taking any other drugs. This evidence is generally consistent with other evidence about Grace's drug use.

104. Sadra agreed he communicated with Grace quite frequently after he went to Iran. He was aware she was having some difficulties with her family, although he thought these were just "*normal family issues".* On 18 December 2018, Grace appeared paranoid and he became concerned for her. In particular, Sadra was aware that it was possible to develop mental health issues as a result of drug use. For this reason, he contacted his brother and advised that

Grace should go to hospital. He had no insight into to why Grace spoke to her mother about 9/11; this was not a topic they had spoken about.

105. Taha did not think Grace was a regular cannabis user. He could recall 3 to 5 occasions when Grace smoked cannabis, including the weekend prior to her death. On that occasion, Grace smoked part of a joint. He and Grace were supporting each other, and she spoke to him about the sexual assault. He noted that Grace seemed "*energetic*" on the Tuesday morning, which is in contrast to the way she appeared later on. He also did not have any insight into why Grace spoke to her mother about 9/11. However, he explained that the lift in his building requires a code to be used; this may explain why she told her mother she was stuck in a lift.

106. My impression of both Sadra and Taha is that they were genuinely concerned for Grace. They each took appropriate steps to get her help once they realised, she was not mentally well. I accept their account about their knowledge of Grace's cannabis use. There is no evidence that Grace was coerced into using cannabis or tricked into taking anything she did not want. The evidence supports a finding that Grace was not a regular cannabis user, but that she smoked cannabis on the weekend prior to her death. The consequences of that decision were, of course, tragic.

Treatment at Royal North Shore Hospital

107. Dr Robert Day, the Director of the Emergency Department (ED) at RNSH, gave an overview of the operation of the ED and the manner in which mental health presentations are assessed at RNSH. Dr Day explained that there is a service-level agreement between RNSH and the North Shore Ryde Mental Health Service, which provides 24-hour mental health staff at the ED, including psychiatrists. The Fast Track area is intended to allow ambulatory patients to be dealt with more quickly. This is important, as a long wait might mean that some patients choose not to wait.

Triage and allocation to Fast Track

108. Grace was assessed as ATS4, which is appropriate where a patient presents with a semi-urgent mental health problem and who is at no immediate risk to

self or others. The more serious ATS3 category is for patients who are "*acutely psychotic or thought disordered*" in "*situational crisis*" or "*agitated / withdrawn*".

109. Given Dr Sullivan's opinion that Grace was suffering an acute psychotic episode, it may have been more appropriate to allocate Grace to ATS3. However, it is unclear that this would have made any difference. The relevant RNSH policy only excludes higher risk ATS1 and 2 patients from the Fast Track. Dr Sullivan also considered the triage process and allocation to the Fast Track to be appropriate. I do not find any issue arises in these circumstances.

110. Dr Day also explained how the reception processes at RNSH have been improved since Grace's death, so that the ambulance record, which had not been available in Grace's case, is now kept with a patient's records and staff are advised to treat it as an important document. It is gratifying that this, and other changes, were identified and implemented by RNSH prior to the inquest having occurred.

Assessment by Nurse Newton

111. Mental Health Clinical Nurse Consultant Justin Newton gave evidence to the inquest. He has over 20 years' experience in mental health work. His role was to complete a mental health assessment and to discuss those requiring admission with the on-call psychiatrist, Dr Zsadanyi. He had performed that role regularly.

112. He spoke with Grace alone in an assessment room near the fast Track area. His assessment was substantial, taking about an hour. He used a mental health assessment template, making handwritten notes and later transferring those to the electronic record. He wanted to review the ambulance record, but it was not available; it is unlikely to have made a difference to his assessment.

113. Grace gave him a history, as set out above, including the conflict with her family and the sexual assault, which appeared to him to be a significant part of her presentation that day. His primary impression was that Grace's condition was drug-induced, although his differential impression was that she was mildly psychotic. They discussed her plan to see a psychologist the following day, and that she could return to the ED if she had concerns.

114. Grace did not give Nurse Newton permission to talk to her family, but agreed he could talk to Taha. Nurse Newton agreed that obtaining collateral information was an important part of his assessment. The fact that Grace declined to let him speak to her family did not itself cause concern, given the family conflict she had described.

115. Nurse Newton also said that, at some stage, he went into the waiting room to see if Grace's family were present, but they were not. It is unclear when this might have occurred, given Grace had asked him not to speak with them. In any event, Nurse Newton did not think he could go against Grace's wishes and never in fact spoke with her family.

116. As I have noted, a consequence of this was that Nurse Newton did not become aware of the information known to Grace's family, about some of her more bizarre delusions. Dr Sullivan agreed that this information might have demonstrated more clearly that Grace was thought disordered and psychotic. Nurse Newton said that, if he had been told the information Grace's family knew, he would have discussed it with the psychiatrist. However, his impression was that Grace engaged well in the assessment, had participated in treatment planning and appeared to be making good decisions about her health. He therefore said it was questionable whether the outcome would have been any different.

117. Overall, Dr Sullivan considered Nurse Newton's assessment to be of good quality, by an appropriately skilled and experienced mental health specialist. Grace was guarded about her symptoms and wanted to appear in control, which presented a problem for Nurse Newton's assessment. Dr Sullivan stated that, while it is important to obtain collateral information about a patient, it is a challenge for clinicians where a patient who has capacity to make decisions expresses clear wishes not to involve her family in treatment. In Grace's case, she presented voluntarily and appeared to be competent. Mental health legislation and policy supports a patient's rights to make decisions about their treatment.

118. Dr Day indicated that Northern Sydney Local Health District is in the process of preparing a policy which will provide further guidance to treating staff about this

issue, where patients refuse consent to obtain information or discuss treatment with family members. Again, it is pleasing to see that issues identified in relation to Grace's death are under active consideration. In these circumstances, it is unnecessary to make a recommendation about this issue.

119. The outcome of the assessment by Nurse Newton was that Grace was not considered to be at acute risk, and less intrusive care was available, namely discharging her home with Taha and allowing her to present to her GP and (it was believed) a psychologist the next day. Dr Sullivan does not criticise this decision, and notes that the hospital would not have had power to hold Grace there involuntarily under the *Mental Health Act 2007* in these circumstances in any event.

Steps taken after it was discovered Grace had left

120. Once Nurse Newton realised Grace had absconded, he appropriately escalated the issue to the psychiatrist. However, when he was unable to contact Grace, he did not seek to make contact with Taha or Grace's aunt, whose contact details were available. Nurse Newton said that he did not hold concerns about Grace, so he did not try to contact Taha; and also, he did not feel he had Grace's permission to contact Judith, absent there being concerns about her safety.

121. Dr Sullivan considered this decision "*understandable*" in circumstances where Grace had actually left with Taha. Ideally, contact would have been made with Grace to complete the discharge planning process, including providing Grace the contact details for the mental health helpline.

122. Of course, even if Nurse Newton had contacted Taha or Grace's aunt, it would have been discovered that Grace had returned to the Hunters Hill unit, with her family and Taha present. It is therefore unclear that making such contact would have had any impact on the events that followed.

123. Since Grace's death, RNSH has provided updated guidance to its staff in relation to patients who do not wait. This policy requires ED staff to inform mental health staff, and, where safety concerns exist, to make attempts to call

the patient's phone, contact relatives and if required to contact police. In light of that revised guidance, no recommendation is necessary.

Action taken by the paramedics

124. Paramedic Steinle-Davis gave evidence to the inquest. He impressed as a careful, thoughtful witness. He spent some time trying to develop rapport with Grace, but she did not interact with him. He wanted to assess her competency and capacity and wanted to encourage her to return to the hospital voluntarily.

125. He believed Grace had gone into her room to obtain some belongings. When he realised, she had absconded through the window, he requested routine police assistance (a "*slow response"*). At that stage, he was not concerned as neither Grace nor anyone else appeared in danger.

126. Paramedic Steinle-Davis and his colleague then followed Grace along the road. He instructed his colleague not to use the warning lights; this was part of his usual practice, as "*the last thing we want to do is spook someone who may be having a psychotic episode*." Grace then became more disorderly, flailing her arms around and at one stage lying on the ground. As a result, Paramedic Steinle-Davis upgraded the request for police to an urgent "*R1*" response. He formed the view that Grace would need to be scheduled.

127. After unsuccessfully trying to engage Grace on foot, he also believed she may need to be sedated, and he returned to the ambulance to draw up the droperidol. He explained that this would be used only as a "*last resort*", in circumstances where a patient was being scheduled. It would also only be used if police were present, as it would be physically difficult to administer.

128. Dr Sullivan was not specifically asked to consider the paramedic response. However, he considered their actions were appropriate. In his view, there was no opportunity to use coercive powers to prevent Grace from leaving the apartment. Once she did so, they escalated their response appropriately, including by contacting police and preparing sedative medication.

129. I find that the paramedics took all appropriate steps in the circumstances.

Action taken by the police

130. Constable Harriet Fordyce gave evidence to the inquest. At the time of these events, she was a probationary constable with about 8 months experience. She told the inquest she had received some training in mental health issues at the Academy. She was also aware of the Memorandum of Understanding between NSW Police Force and NSW Health ("MOU").

131. She recalled first becoming aware of the incident via a CAD message or radio broadcast. She understood that she would be responding to the incident and assisting paramedics by helping to detain Grace.

132. She confirmed that the initial CAD message made reference to Grace having access to a knife, which was of some concern to her. She did not recall a further incident broadcast to the effect that the paramedics had said Grace did not in fact have a knife. She also made further enquiries via the Mobile Data Terminal inside the police vehicle while en route, although did not recall what information she obtained.

133. When she and her colleague arrived at Burns Bay Road, she says the police vehicle's siren was deactivated but the warning lights remained on. She understood this was because Senior Constable Shields was driving the wrong way down a major road, with traffic heading in the opposite direction. The sirens were also appropriate because they were responding to an "*urgent duty*".

134. When they saw Grace, there was no time for any discussion about what they would do. Her colleague said, "*there she is*" and she saw Grace get up and start running. Constable Fordyce said she did not have time to plan a response; she left the vehicle and gave pursuit, arriving after Grace was already over the edge. Neither was there an opportunity to discuss with the paramedics what action ought to be taken.

135. To the extent that Constable Fordyce undertook a risk assessment, as the MOU suggests should be undertaken when attending mental health incidents, she described this as a "*swift process*", taking into account the risks to police and to Grace. Although she was aware of the fact that there was a drop off one

side of the off-ramp, she did not specifically address her mind to the fact that this presented a safety risk.

136. There was no opportunity to coordinate a plan with the paramedics in the circumstances, as Grace began running as soon as police discovered her location. I do not criticise the officers for giving pursuit, as Grace was running along a major road and clearly at risk from traffic, quite apart from the unforeseen risk posed by the height of the off-ramp.

137. Sadly, it appears to me likely that the arrival of police on the scene contributed to Grace's escalation in behaviour. While she had been disordered prior to that point, her immediate reaction to the police arrival was to run away and climb over the fence at the side of the off ramp. It was, however, unpredictable that she would do so. As Grace was suffering an acute psychotic episode, I do not find that she formed any intention to harm herself. Her death was therefore a tragic accident.

138. It is also apparent to me, after hearing from Constable Fordyce and reading the interview of Senior Constable Shields, that the officers did all that possibly could have been done to prevent Grace from falling.

139. Overall, I consider that the police took appropriate action in the circumstances.

Findings required by s81(1)

140. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred, and I make the following findings.

The identity of the deceased

The person who died was Grace Rohanne Herington.

Date of death

Grace died on 19 December 2018.

Place of death

Grace died at Royal North Shore Hospital, NSW.

Cause of death

The cause of death was multiple blunt force injuries.

Manner of death

Grace sustained fatal injuries in a fall from height in the context of an acute psychotic episode, induced by cannabis use. There is no evidence that Grace intended to end her life. The death occurred as a result of police operations.

Conclusion

141. Grace's parents, Bruce and Janelle, her brother Kenneth and aunt Judith, attended throughout the inquest. I was grateful for their attendance and their contributions. They asked a number of questions through Counsel Assisting and provided me with important information about Grace. I saw that the inquest was a painful and upsetting experience for them. However, I hope that, looking back, they will draw some comfort from having participated in this process.

142. Grace's death was a tragic end to a young and promising life, and I am truly sorry for their loss.

143. I now close this inquest.

T M O'Sullivan
NSW State Coroner
Lidcombe
9 September 2020