CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Fiona Goodberg
Hearing dates:	6 May 2024 to 10 May 2024; 13 May 2024 to 17 May 2024
Date of Findings:	24 October 2024
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – manner of death, intentionally self-inflicted death, mental health diagnosis, mental health assessment, subacute mental health care, postpartum psychosis, obsessive compulsive disorder, delusions, coordination of care, collection of collateral information, referral to inpatient mental health unit, handover of care, involuntary detainment, *Mental Health Act*, discharge planning, adequacy of Mental Health Line, third party triage, referral to community mental health team, mental health intervention, Mother-Baby Unit, Motilium, SAFE START
File number:	2020/310753

Representation:	Mr H Chiu SC & Mr J Sukkar, Counsel Assisting, instructed by Ms A McShane & Ms C Hill (Crown Solicitor's Office) Mr M Walsh SC for Medibank Health Solutions (now Amplar Health), instructed by Barry Nilsson Lawyers Mr B Bradley for Dr J Flatt, instructed by Colin Biggers & Paisley Dr P Dwyer SC for Dr T Luu & Dr A V T Le, instructed by Moray & Agnew Ms K Burke for St John of God Burwood Hospital, instructed by HWL Ebsworth Lawyers Ms B Epstein for Ms L Patterson, instructed by McCabes Lawyers Mr T Hackett for the Goodberg family, instructed by Slater & Gordon Mr D Jordan for the New South Wales Commissioner of Police, instructed by the New South Wales Police Force Office of the General Counsel Mr M Lynch for Mr B Sneddon, instructed by Hicksons Lawyers Mr P Rooney for NSW Health, New South Wales Ambulance & Nepean Blue Mountains Local Health District Ms E Sullivan for Dr P Thiering, instructed by Unsworth Legal
Findings:	Fiona Goodberg died on 29 October 2020 at Landslide Lookout, Katoomba NSW 2780. The cause of Fiona's death was multiple blunt force injuries. These injuries were sustained after Fiona intentionally self-inflicted her own death by falling from a great height, at a time when she was suffering severe symptoms of obsessive compulsive disorder following the birth of her daughter some four months earlier.
Recommendations made pursuant to section 82, *Coroners Act 2009*	See Appendix A

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1. Introduction

1.1 At around 7:00am on 29 October 2020, Fiona Goodberg left her home in Wentworth Falls She told her husband, Benjamin (**Ben**) Kearney, that she was going to get a coffee. Fiona and Ben's nearly 4-month old daughter, Charlotte, remained at home with Ben. After leaving home, Fiona drove to Landslide Lookout, a viewpoint located off Cliff Drive in Katoomba, known for scenic views across the Blue Mountains region.

1.2 After leaving home, Fiona called Ben and thanked him for letting her go. This concerned Ben and he first attempted to call Fiona, without success, and then left home to look for Fiona. After seeing Fiona's car parked at Landslide Lookout, and searching the area but being unable to find Fiona, Ben contacted the New South Wales Police Force (**NSWPF**).

1.3 A NSWPF drone was deployed and at around 10:00am, Fiona was found at the base of the lookout, some 100 metres below the lookout viewing area. Fiona had sustained catastrophic injuries, showed no signs of life and was later pronounced life extinct at the scene.

2. Why was an inquest held?

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

2.2 The coronial investigation that followed the events of 29 October 2020 quickly identified evidence that Fiona had intentionally caused her own death. The investigation also identified that in the months between Charlotte's birth in July 2020 and October 2020, Fiona had been suffering from mental health issues. During these months, Fiona received treatment from a number of mental health care practitioners, both in the private sector and within the Nepean Blue Mountains Local Health District (**NBMLHD**). In addition, Fiona had been admitted to a private mental health facility, St John of God Hospital (**SJOG**) in Burwood and was discharged on 23 October 2020, six days before her death. Finally, the investigation also identified that NSWPF officers and paramedics from New South Wales Ambulance (**NSWA**) had attended Fiona's home on 28 October 2020 in response to concerns raised regarding Fiona's welfare. Each of these interactions with health care practitioners and emergency services raised a number of questions about the manner of, or circumstances surrounding, Fiona's death. For all of these reasons, an inquest was required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a

death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

3. Fiona's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge Fiona's life in a brief, but hopefully meaningful, way.

3.2 Fiona was born on 11 April 1984 at Katoomba Hospital to Teresa and Eddie Goodberg. Her older siblings are Kate Johnson and Alice Haynes. Alice describes Fiona as everybody's favourite from the minute she was born.

3.3 Fiona grew up in Katoomba where she had a safe and loving childhood. Fiona was very close to her parents and sisters. Fiona attended North Katoomba Public School between 1989 and 1995, and Katoomba High School between 1996 and 2002. After obtaining her HSC, Fiona began an Arts degree at Charles Sturt University in Albury in 2003. However, after one year Fiona returned to Katoomba and sought casual employment. In 2007, Fiona enrolled at the University of Wollongong to study nursing. She graduated in 2010 with distinction and was offered the opportunity to complete Honours.

3.4 In 2011, Fiona began working as a nurse in the mental health unit at Concord Hospital. She later moved to Airlie Beach and began working as an aged care and home care nurse. Fiona returned home in 2012 and began work as a registered nurse at an aged care facility in Leura. During this period, family members observed Fiona to have a good circle of friends and to be enjoying life. Fiona bought a house in Wentworth Falls and appeared settled.

3.5 Fiona was known to be into her health and fitness. She was tall, fit, strong, a natural athlete and an avid runner. At the same time, Alice describes Fiona as being goofy, uncoordinated and the first to laugh at herself.

3.6 Fiona ran the Canberra Marathon, competed in triathlon, and was a regular at her Crossfit gym. She was also a member of the Katoomba Tennis Club and enjoyed playing with her father. It is heartbreaking to know that Eddie will never play a game of tennis with Fiona again.

3.7 In 2016, Fiona began working at Nepean Drug and Alcohol Clinic and met Ben Kearney, who was working as a social worker at the clinic, and later formed a relationship.

3.8 In 2018, Fiona began working at Katoomba Drug and Alcohol Clinic so that she could be closer to home. She became a Clinical Nurse Specialist and enjoyed her time there, making good friends.

3.9 Fiona and Ben married in February 2020. On 4 July 2020, Fiona gave birth to their daughter, Charlotte. According to Kate, all of her family knew that Fiona would be a fantastic mother because she was so loving, caring and fun.

3.10 Alice describes Fiona as having a huge heart, generous to a fault, loyal and having a special way of weaving herself into everyone's hearts. Fiona was known to have a great sense of humour, a huge

smile and a loud, unique laugh. Fiona laughed and smiled often, and when she did Alice says that gorgeous dimple appeared on her cheek.

3.11 It is not difficult to understand why Alice says that people just wanted to be around Fiona and found it so easy to fall in love with her. It is easy to imagine Fiona being at the centre of those closest to her, surrounded by their love, and giving so much of her warmth and love in return.

3.12 Fiona was the best aunty to her nieces and nephews and a second mum to them. Fiona had so much unconditional love and attention to share with them. If you asked each of them who was Aunty Fiona's favourite, each of them would say they were. Fiona's ability to make each of them feel so special was one of her unique gifts and also one of the greatest things that they have had in their lives.

3.13 Alice says that Charlotte is the spitting image of her mother. It is devasting to know that Fiona will no longer physically be a part of Charlotte's life and that Charlotte will not hear her mother's laugh, feel the warmth of her embrace, know the comfort and safety of her protection, or learn from Fiona's life experiences and adventures. Although Alice says that if Fiona was still alive, you would not find a child who felt more smothered in love than Charlotte, it is hoped that she, and the other members of Fiona's family, still feel the enormous love that Fiona had for each of them.

4. Summary of relevant background[1]

Fiona's medical history prior to 2020

4.1 In 2010, Fiona formulated a plan to jump from the Landslide Lookout at Cliff Drive, Katoomba. At the time, Teresa was working with Dr Paul Thiering, consultant psychiatrist, and sought his assistance. Dr Thiering diagnosed Fiona with body dysmorphic disorder (**BDD**) and obsessive-compulsive disorder (**OCD**). Fiona was prescribed medication (including aripiprazole, escitalopram and sertraline) and managed with cognitive behavioural therapy.

4.2 In August 2015, Fiona first saw Dr Sherri Roberts, a general practitioner (**GP**) at the Riverview Medical Practice in Blaxland East.

4.3 On 15 September 2017, Fiona saw Dr Kathryn Jenner, a GP at the Katoomba Medical Practice to obtain a prescription for escitalopram. Fiona continued to see Dr Jenner between March 2018 and February 2019 for a number of issues, including work-related stress.

4.4 On 27 February 2019, Fiona saw Dr Jenner following a relationship break down with Ben. Fiona was given a mental health plan and referred to a psychologist, Rolf Reed.

4.5 On 6 November 2019, Fiona saw Dr Roberts after a positive pregnancy test. At around this time, Fiona stopped taking escitalopram due to her concerns about its effect on her unborn child. Dr Roberts was unconcerned about stopping escitalopram, and Fiona's mental health did not appear to be affected during the remainder of her pregnancy. In May 2020, Fiona commenced early maternity leave due to stress that she was experiencing at work.

Charlotte's birth

4.6 Fiona originally planned to give birth at Katoomba Hospital. However, at the suggestion of family members, including those who had a background in nursing, Fiona later decided to give birth at Nepean Hospital where her aunt worked as a long-term nurse. In the months that followed, Fiona would ruminate over this decision at length, and repeatedly. Between May and June 2020, Fiona Neale, a midwife, conducted regular home visits to assist Fiona.

4.7 On 3 July 2020, Fiona's waters broke and she was taken to Nepean Hospital. The following day, 4 July 2020, Fiona was induced at 41+3 weeks. She had a prolonged second stage of labour which required the use of forceps, and an episiotomy and epidural block. She later gave birth vaginally to Charlotte. Fiona later complained of suffering pelvic floor damage as a result of the delivery. She also suffered an infection at the episiotomy wound.

4.8 Following the birth, Charlotte was immediately separated from Fiona and transferred to the Special Care Nursery (**SCN**) at Nepean Hospital due to bradycardia, lethargy and poor feeding. Charlotte remained in the SCN for two days and was given a course of antibiotics. Fiona's separation from Charlotte made Fiona feel concerned about the birthing process and insecure about her adequacy as a mother.

[1] This has been drawn from the helpful submissions of Counsel Assisting.

4.9 On 6 July 2020, Fiona was discharged home, with Charlotte discharged the following day.

Referral to Child and Family Health

4.10 On 9 July 2020, Fiona was referred to Child and Family Health (**CFH**) Nursing Services for ongoing postnatal support. According to Teresa, during this period Fiona became more anxious and repeatedly commented that she wished that she had gone to Katoomba Hospital, as she had originally planned, instead of Nepean Hospital. As time passed, Fiona became fixated on this issue.

4.11 In July 2020, Dr Roberts prescribed domperidone to Fiona to assist with breast milk supply.

4.12 On 13 July 2020, Fiona expressed concerns to Christina Samios, a registered nurse (**RN**) from CFH that Charlotte was not gaining weight. During further consultations in July and August 2020, RN Samios observed that Fiona was erratic with her thought processes, giving rise to a concern about Fiona's ability to feed and care for Charlotte.

4.13 Also on 13 July 2020, Fiona was referred to Clinical Nurse Specialist (**CNS**) Decalie Brown for breastfeeding support.

4.14 On 22 July 2020, Fiona was referred to Michael Smith, a CFH counsellor at the Katoomba Community Health Centre. Between July and October 2020, Fiona had a number of consultations with Mr Smith.

4.15 On 13 August 2020, Mr Smith performed an initial psychosocial assessment of Fiona. He recorded that Fiona had increased anxiety since Charlotte's birth.

4.16 On 17 August 2020, Fiona consulted with Dr Roberts who perceived her to be increasingly anxious.

4.17 On 20 August 2020, Fiona was admitted to the Tresillian Family Care Centre for maternal exhaustion and to obtain support with breastfeeding. On admission, it was recorded that Fiona had anxiety associated with Charlotte's feeding difficulties. Fiona later decided to discharge from Tresillian on 24 August 2020.

4.18 On 1 September 2020, Fiona saw Dr Jenner and reported feeling extremely anxious again. Fiona sought to recommence on escitalopram but also told Dr Jenner that she was coping.

4.19 On 2 September 2020, Fiona attended the CFH Nursing Community Health Clinic with Charlotte. She reported overwhelming anxiety and intrusive thoughts, but denied thoughts of harming herself or Charlotte. The next day, Fiona saw Mr Smith and reported intrusive and worrying thoughts.

4.20 On 9 September 2020, Fiona asked Dr Jenner for a repeat of her domperidone. Dr Jenner suggested that Fiona wean off domperidone before recommencing escitalopram due to a contraindication between the two medications. However, Fiona told Dr Jenner that she had not restarted escitalopram despite the earlier prescription.

4.21 On 10 September 2020, Fiona saw Mr Smith who noted that Fiona was continually seeking reassurance from others (about 50 times a day) about Charlotte, and was not taking her escitalopram due to its contraindication with domperidone.

4.22 According to Ben, in mid-September 2020, Eddie reported that Fiona was at the Landslide Lookout. There is no evidence that this event gave Ben or Eddie any cause for concern, or that the event was raised with anyone treating Fiona at the time.

Referral to Dr Thiering

4.23 Also in around mid-September 2020, Teresa called Dr Thiering to obtain an urgent appointment for Fiona. Teresa reported that Fiona was extremely anxious, banging her head on the floor and ruminating about Charlotte's birth. Dr Thiering made an appointment for Fiona to see him on 17 September 2020.

4.24 On 15 September 2020, Fiona had a telephone consultation with Dr Jenner, who noted that Fiona was speaking rapidly and unable to stop ruminating. Dr Jenner advised Fiona again to wean off domperidone so that she could recommence escitalopram. At Fiona's request, Dr Jenner provided a referral to Dr Thiering and Jennifer Flatt, a psychologist.

4.25 On the morning of 17 September 2020, Fiona had a counselling session with Mr Smith. She reported that she was "*stuck on the loop*" about her birthing experience at Nepean Hospital, and that she believed the domperidone was making her "*mad and panicky*".

4.26 Following this appointment, Mr Smith spoke with the NBMLHD Access Mental Health Team (**Access Team**) to enquire if anything could be done for Fiona before her appointment with Dr Thiering later that day at 1:00pm. The Access Team informed Mr Smith that nothing could be done for Fiona before the appointment, and that they therefore did not intend to get involved with her.

4.27 At 3:00pm, Fiona, accompanied by Teresa, attended an appointment with Dr Thiering. Fiona was observed to be ruminating, brooding and displaying obsessional regrets regarding Charlotte's birth. Dr Thiering considered that Fiona presented with "*quasi-psychotic*" brooding consistent with OCD, but "*not a full-blown psychosis or postpartum psychosis*". Dr Thiering prescribed Fiona with olanzapine, an antipsychotic medication. He assured Fiona that olanzapine is commonly prescribed for severe OCD, and that he did not think she was psychotic.

4.28 On 19 September 2020, Fiona prepared a digital note on her phone, which was later modified on 24 September 2020. Part of the note read:

> Dearest Ben and Charlotte
> I am at a loss writing this and cannot believe I allowed this to happen but I did.
> Lottie bug you are one of a kind! … Your daddy I'm sure will teach you amazing things…
> Ben… I know you will take care of our gorgeous girl and smile at her with sparky eyes. You leave all my worldly possessions.

4.29 On 22 September 2020, Mr Smith called Dr Thiering to discuss Fiona. According to Dr Thiering, he explained that Fiona was towards the psychotic end of the OCD spectrum but not psychotic. Mr

Smith's notes record Dr Thiering as saying, "*Fiona has been showing psychotic symptoms but he believes that with the medication and regular reviews he can keep her out of hospital*".

Second consultation with Dr Thiering

4.30 At 10:00am on 24 September 2020, Fiona had an appointment with Mr Smith in which she reported having stopped domperidone. Mr Smith formed the impression that Fiona had improved since the last appointment.

4.31 At 2:00pm, Fiona (again accompanied by Teresa) had a second appointment with Dr Thiering, who formed the view that Fiona was still showing signs of brooding but was making progress. Dr Thiering subsequently wrote a letter to Dr Jenner in which he noted that Fiona had recommenced escitalopram and that olanzapine had been recently prescribed. Dr Thiering also wrote:

> At interview she was lost in preoccupied, brooding ruminations and was unable to intervene or stop these. She was highly anxious and expressed depressive thoughts. There was no evidence of suicidality or risk factors.
> However she is barely functioning in the rest of her life and is unable to do any domestic duties.
> […]
> Whilst I don't think she is actively psychotic she is at the extreme end of the OCD spectrum currently and is not functioning.
> […]
> She remains fragile currently. I am trying to keep out of hospital and I hope that with the support of a family (who have strong nursing background) we can treat her from home.

Events of mid-September 2020 to early October 2020

4.32 According to Ben, from about mid-September 2020 or early October 2020, Fiona began intermittently engaging in extreme behaviour once or twice a week. This behaviour included Fiona banging her head against the floor, writhing around in bed, punching herself in the head, and saying that she wanted to kill herself.

4.33 Fiona repeatedly said, "*We should have gone to Katoomba*". Similarly, Teresa observed that in mid-September 2020, Fiona repeatedly said, "*I wish I went to Katoomba Hospital*", and that it was impossible to stop her saying this phrase. Fiona's family describe this as process of looping where Fiona, despite being talked into a different topic, would eventually return to the same issue and obsess about it.

4.34 On 2 October 2020, Fiona prepared another digital note on her mobile phone, which was later modified on 17 October 2020. The final version was very similar to the note created on 19 September 2020.

4.35 On 6 October 2020, Teresa called Dr Thiering to tell him that Fiona had stopped taking her olanzapine. According to Teresa, she told Dr Thiering that Fiona was deteriorating and she was concerned that Ben did not agree with the diagnosis.

4.36 A screenshot of Dr Thiering's electronic file regarding Fiona contains the following entry (**6/10/2020 Note**) next to the word "*Diagnosis*":

> Body dysmorphic disorder
> Obsessional traits OCD
> 6/10/2020 post partum psychosis.

Events of 8 to 20 October 2020

4.37 On 8 October 2020, Fiona attended another appointment with Dr Thiering, this time accompanied by Ben. According to Dr Thiering, Fiona said that she wanted to stop seeing him and cease her medication. Dr Thiering explained to Fiona and Ben that Fiona's condition was serious, she required medication and she may need to go to hospital if she did not take it.

4.38 Despite Fiona's reluctance, Dr Thiering considered that at this time Fiona had improved. Dr Thiering prescribed Fiona with escitalopram and convinced her to see him again for another appointment on 21 October 2020. By the end of the consultation, Dr Thiering considered that Fiona had shown a "*begrudging acceptance of keeping on going… with medication*".

4.39 On 9 October 2020, Fiona had a telephone counselling session with Mr Smith. Fiona reported having stopped olanzapine with Dr Thiering's approval (although there is no evidence to suggest this), and Mr Smith considered Fiona to be in a better condition.

4.40 On 11 October 2020, Fiona sent Alice a text message stating, "*I want to fucking die*". On the same day, Fiona prepared a digital note on her phone which was very similar to the other note she had prepared earlier.

4.41 On 12 October 2020, Fiona had an initial telehealth appointment with Dr Flatt, who formed the view that Fiona suffered OCD expressed as obsessional regret. Dr Flatt found no evidence of delusion or psychosis, and following the appointment, wrote to Dr Jenner indicating that Fiona may benefit from daily treatment as an inpatient at an appropriate facility.

4.42 On or about 12 October 2020, Alice had a conversation with Fiona about potential admission to the Mother and Baby Unit (**MBU**) at SJOG.

4.43 By about 18 or 19 October 2020, Fiona had stopped taking both escitalopram and olanzapine.

4.44 On 19 October 2020, Fiona called Alice again and agreed to admit herself to hospital. An admission request was sent to SJOG, with a plan for a 21-day admission starting on 21 October 2020.

4.45 On 20 October 2020, Fiona had a second telehealth appointment with Dr Flatt, who noted that Fiona was talking positively about Charlotte and considering having a second child. Dr Flatt made plans with Fiona for two further sessions on 20 November 2020 and 8 December 2020.

Admission to St John of God Hospital

4.46 On 20 October 2020, Teresa asked Dr Thiering to provide an urgent referral letter so that Fiona could be voluntarily admitted to SJOG. Despite other patient commitments and limited time, Dr Thiering later handwrote a letter (**SJOG Referral Letter**) and placed it in a box for collection by Fiona's family. Dr Thiering wrote:

> Dear Doctor,
> I would like to refer Fiona and hopefully her daughter Charlotte (14 weeks old) for inpatient treatment. I previously saw Fiona in 2016 for management of O.C.D. and Body Dysmorphic Disorder. I was asked to see her urgently on 17/9/20, by her mother, after Fiona had developed a severe relapse with obsessional rumination about the birth and regret about decisions she made. She is highly anxious and has some depressive features.
>
> She had been stable on Lexapro 20mg mane from 2016 to 2019. She stopped medication when she fell pregnant. She recommenced Lexapro 20mg mane on 17/9/20. I also prescribed olanzapine 2.5mg nocte which she refused.
>
> I am hoping some respite in hospital may break a cycle which is exhausting her family and herself.

4.47 On the morning of 21 October 2020, Ben collected the SJOG Referral Letter. That morning, Fiona and Charlotte were admitted to SJOG under the care of Dr Than-Tham Luu, psychiatrist. At the time of the admission, COVID-19 restrictions were in place so no leave was allowed.

Initial assessment of Fiona

4.48 At around 11:15am, Dr Andrew Le, an advanced training registrar under Dr Luu's supervision, performed an initial assessment Fiona. Dr Le's notes record a provisional diagnosis of postnatal exacerbation of generalised anxiety disorder (adjustment disorder with anxious mood) on a background of BDD and cluster C traits in the context of perceived over intervention during and after her delivery of Charlotte. Fiona reported that she had not been taking olanzapine for the previous few days, and Dr Le reported no current indications of psychosis or suicidal ideation.

4.49 Between 8:56am and 6:55pm on 23 October 2020, Fiona sent Teresa a series of text messages containing the following content: "*I feel like killing myself*", "*If I'd just gone to Katoomba I'd be okay and loving this*", "*I literally feel like killing myself*", and "*I am really at risk here*".

4.50 At around 9:30am, Fiona told RN Tracey Borst that she was ambivalent about staying at SJOG and felt better at home.

4.51 At around 11:30am, Fiona was reviewed by Dr Le and Dr Luu. Dr Le's notes record that Fiona was struggling to adjust to the ward and wanted to stop taking olanzapine and escitalopram. Dr Le recorded a diagnosis of postnatal exacerbation of OCD with ongoing anxiety against a background of Cluster C traits. A plan was formulated to stop escitalopram, trial a one-week admission, obtain collateral information from Dr Thiering, and refer Fiona to a psychologist. Dr Luu observed that Fiona demonstrated no suicidal thoughts.

4.52 At around 5:00pm, RN Margaret Doyle was informed that Fiona had upset another patient when talking about her mental health issues. A short later, Fiona asked to speak to RN Doyle about potential discharge, and RN Doyle invited her and Ben to a meeting with her.

4.53 During this meeting, RN Doyle performed a Mental State Examination (**MSE**) and convinced Fiona to stay at SJOG until further review on Monday, 26 October 2020. Later that evening, RN Doyle recorded a detailed handwritten note (**Doyle Note**) which included the following:

> M.S.E
> - appearance - casually dressed, engaging, good rapport, agitated, wringing hands, changing position on chair frequently
> - speed - normal V, pressured, soft tone
> - mood - distressed, low
> - affect - tearful
> - thought form - racing thoughts : preoccupied perception - nil disturbances
> - thought content - ? delusional thinking of persecutory nature
> - obsessional thinking evident
> - cognition - orientated in T, P, P
> - insight + judgment - impaired
> - suicidal/ self harm/ homicidal ideation denies
> Impression - anxious, preoccupied, ruminations ++. Limited insight.

4.54 At the end of her shift at 10:00pm, RN Doyle performed a handover to the RN on night shift and passed on all relevant information from the MSE.

4.55 At around 7:00am on 23 October 2020, the nursing night shift handed over to the morning shift staff, which included RN Deidre Price and RN Mary Corcoran. RN Price remembered going through the Doyle Note but did not recall any issues being mentioned about Fiona's insight, judgment, or any delusional thoughts. RN Corcoran could not specifically remember that handover but said that was the usual practice.

4.56 By 7:30am, Fiona told RN Price she wanted to go home. RN Price tried to convince Fiona to stay, but Fiona was determined to leave.

23 October 2020 Multi-Disciplinary Team meeting

4.57 At around 10:00am, a Multi-Disciplinary Team (**MDT**) meeting involving Dr Luu, Dr Le, RN Corcoran and RN Borst, was held to discuss Dr Luu's patients, including Fiona. Dr Luu and Dr Le were told that Fiona wanted to leave the hospital, and while it was thought it would be good for her to stay longer, the plan was to discharge her if she did not seem at risk after another review. However, both Dr Le and Dr Luu said they could not remember the contents of RN Doyle's MSE being raised or drawn to their attention.

4.58 RN Corcoran said that it would have been her usual practice to have read the Doyle Note before the MDT and presented them, although she had no specific recollection of doing so. The MDT Conference report makes no reference to delusional thinking or impaired insight.

4.59 Throughout the morning, RN Price continued checking on Fiona, who was still determined to go home. Fiona's discharge risk assessment noted that she "*denies thoughts of self-harm*" and "*feels supported by her husband and family…feels connected with baby*."

4.60 At around 11:00am, Fiona called Dr Flatt and said that she had already spoken with her psychiatrist who had approved of a discharge from SJOG, although there is no evidence that this occurred. Dr Flatt told Fiona that she should try to stay a bit longer because two days was not enough to settle into the program. Dr Flatt considered that Fiona did not fit a diagnosis for postpartum psychosis as her symptoms did not show her to be out of touch with reality. Dr Flatt placed Fiona on a waitlist for a further appointment with her, although Fiona did not specifically request this.

Discharge from St John of God Hospital

4.61 At around 11:15am, Dr Le reviewed Fiona who said that she was not finding SJOG helpful. Dr Le recorded that there was no basis to detain Fiona and that her judgement appeared reasonable. Dr Le called Dr Thiering and left a voicemail message informing him of Fiona's plan to discharge.

4.62 Something that morning, RN Borst saw Fiona and observed her to be agitated and unsure whether to stay at all leave SJOG. RN Borst encouraged Fiona to continue with her decision to discharge.

4.63 Sometime before 12:00pm, RN Price received a call from Alice but declined to provide her with any information. RN Price provided Dr Le with Alice's details.

4.64 At around 12:31pm, Dr Le spoke to Ben on the phone. When asked his opinion on whether Fiona should be discharged home Ben said, "All right – this is what Fi wants". The discharge plan included follow up with Dr Thiering and a private psychologist, and referral to the Perinatal Infant Mental Health Service (**PIMHS**).

4.65 At around 3:20pm, Dr Le called Dr Luu to tell her that Fiona was in a reasonable state and there were adequate supports in place to manage outpatient care with Ben, Dr Thiering and Fiona's psychologist.

4.66 At 6:55pm, Fiona sent text messages to Teresa referring to her birthing experience at Nepean Hospital, and which included, "*Why the fuck that happened to me*", and "*I know that I would have been okay*".

4.67 At around 7:00pm, RN Doyle accompanied Fiona and Charlotte to the SJOG entrance where they were picked up by Ben.

4.68 Fiona's discharge summary recorded a diagnosis of "*postnatal exacerbation of health-related anxiety on b/g of OCD, BDD and cluster C personality vulnerabilities*". It was also noted that citalopram and olanzapine had been withheld as Fiona wanted to start a medication-free period. Finally, community follow up with Fiona's GP, private psychologist, private psychiatrist and PIMHS were all noted.

Contact with the Mental Health Line

4.69 Shortly after Fiona's discharge, RN Doyle called the NSW Mental Health Line (**MHL**), a 24/7 State-wide service run by NSW Health. In certain Local Health Districts, including NBMLHD, Medibank Health Solutions (**Medibank**) (as it was then known) is contracted by NSW Health to operate the MHL.

4.70 RN Doyle spoke to RN Kaylin Prasad, a RN employed by Medibank, seeking to refer Fiona to PIMHS. RN Doyle told RN Prasad that Fiona was not at immediate risk to herself or Charlotte, and had "*no psychotic phenomena*" but was highly anxious, preoccupied with the birthing process and refusing to take medication. RN Prasad indicated that Medibank would conduct a "*first party triage*" by calling Fiona to confirm the referral, and then send the referral to the Access Team.

4.71 On 24 October 2022, RN Jennifer Atayde from Medibank called Fiona, on behalf of the MHL, to perform a first party triage. RN Atayde informed Fiona of the need to do an initial assessment. Fiona said during the conversation, "*I don't think I really require that*". Ultimately, no referral to PIMHS was made as RN Atayde considered that she did not have Fiona's consent to do so.

Events of 25 to 27 October 2020

4.72 On 25 October 2020, Fiona called Ben to tell him that she had been at Rocket Point, a lookout in Wentworth Falls. Fiona told Ben that she had "sat at the edge" and Ben recalled that she was very sad.

4.73 On 26 October 2020, Dr Thiering called Dr Le in response to the voicemail message left at Fiona's discharge. Dr Le reportedly told Dr Thiering that Fiona had ceased her medication and Dr Thiering indicated, "*That's okay, I'll look after her*". Dr Thiering said that he expressed disappointment to Dr Le because the plan had been to provide Fiona with enough time in hospital to allow the medication to work. Dr Thiering said that he had made an appointment to see Fiona at his earliest availability which was at 9:00am on 29 October 2020.

4.74 Teresa went to see Fiona on this day and found her to be verbally aggressive to the extent that she was too scared to remain in Fiona's company.

4.75 On 27 October 2020, Fiona visited her parents. That evening she became angry, threw food at Eddie and walked across the room spraying breastmilk. Separate to this, Ben observed that Fiona engaged in strange sexual behaviour and was banging her head on the ground. At different points, Ben observed Fiona to be both sleepy and agitated.

NSW Police and NSW Ambulance attend Fiona's home

4.76 On 28 October 20220, Dr Thiering's receptionist called Ben to confirm Fiona's appointment at 9:00am the following day. Later that day, Teresa received a call from Fiona who spoke with a slurred voice and indicated that she had taken olanzapine. During the course of the day, Fiona sent Teresa multiple text messages some of which stated, "*I know I will die this time*".

4.77 Later that afternoon, Fiona called Teresa and said, "*Fuck there is people here*". Eddie overheard the conversation and went looking for Fiona. He found Fiona's car parked at Landslide Lookout. Eddie did not approach Fiona as he did not want to alarm her.

4.78 At 4:04pm, Eddie called Triple Zero and expressed his concerns for Fiona's welfare. A short time later, Fiona returned to her car and drove away.

4.79 At around 4:30pm, Sergeant Andrew Martignago attended the home of Fiona and Ben at Wentworth Falls and activated his Body Worn Video (**BWV**) upon arrival. Sergeant Martignago introduced himself and asked Fiona about being at Landslide Lookout earlier that day. Fiona replied:

> I've done it multiple times, I go and look at, I go into the lookouts when I feel stressed. So, and I'm quite stressed at the moment.

4.80 Later, Fiona spoke to someone on the phone and was recorded on the BWV footage to be saying:

> I wasn't standing near the cliff edge, I was driving around trying to get some calm that's all, just see some bush.

4.81 When asked why she was stressed, Fiona referred to her birthing process:

> I got put on Motilium which sort of sent me crazy and, I, I'm very angry with them for not just staying out of it, I would've just had her at Katoomba Hospital.

4.82 Fiona rejected Sergeant Martignago's suggestion that she may have postnatal depression and told him that she was a nurse.

4.83 Ben told Sergeant Martignago that they were seeing a psychiatrist the next day. Sergeant Martignago informed Fiona that he was required to call NSWA. The BWV was turned off after about nine minutes.

4.84 According to Sergeant Martignago, after the BWV was turned off, Fiona was heard to say on the phone, "*Why are you telling police lies, I never said any of those things*".

4.85 At around 4:52pm, NSWA paramedics Brian Sneddon and Linda Patterson arrived at the home. The paramedics were aware that Eddie was concerned about Fiona self-harming. After speaking with Ben and Fiona and speaking with the police officers at the scene, a consensus view was formed that there were no grounds to detain Fiona as an involuntary patient. The NSWA paramedics left at around 5:15pm.

4.86 After the paramedics and police officers left, Fiona called her parents and assured them that she would not self-harm.

The events of 29 October 2020

4.87 Fiona woke at around 6:00am on 29 October 2020. According to Ben, Fiona "*started with the loop again*" but otherwise seemed fine.

4.88 At around 7:00am, Fiona told Ben that she was going to go for a drive to Cliff Drive. She told Ben that she would bring back coffee, that she loved him and she kissed Charlotte goodbye.

4.89 At 7:09am, Fiona and Ben spoke briefly on the phone. Fiona said, "*I just wanted to thank you for letting me go. Everyone else thinks I'm mental, but you've…let me get out and drive*". Ben asked Fiona whether she was going to kill herself and Fiona replied, "*No, of course not…I'll be back soon*".

4.90 According to data later retrieved from Fiona's phone, she walked down 192 stairs at Landslide Lookout between 7:13am and 7:18am. The lookout is bordered in part by a small metal fence which did not encircle the entire lookout area. There was a drop of at least 100 metres from the lookout to the valley floor.

4.91 At around 7:40am, Ben became concerned that Fiona had not returned and 10 minutes later began to drive to Cliff Drive (having placed Charlotte in the back of the car). Between 7:51am and 8:01am, Ben made a number of phone calls to Fiona, all of which went unanswered.

4.92 At around 8:22am, Ben arrived at Cliff Drive and saw Fiona's car. He ran down to the lookout and called emergency services and Teresa. At around 8:30am, Teresa called Dr Thiering to tell him that Fiona was missing at the cliffs and that they were searching for her.

4.93 At around 8:34am, NSWPF officers arrived at the scene and began searching for Fiona. Her keys and phones were found on the cliff side of the metal fence.

4.94 At around 10:00am, a drone was deployed and Fiona was found at the base of the cliff. She had sustained catastrophic injuries and showed no signs of life. At around 11:00am, police abseiled down the cliff to commence the process of retrieving Fiona. At around 3:10pm, Fiona was recovered by a helicopter.

5. The post-mortem examination

5.1 Fiona was later taken to the Department of Forensic Medicine where a post-mortem examination was performed on 2 November 20202 by Dr Rebecca Irvine, forensic pathologist. The post-mortem examination identified a neck fracture, multiple rib fractures, a spinal fracture, a compound fracture of the right elbow, a fracture of the right femur and scattered superficial blunt force injuries. Pneumocephalus and bilateral haemopneumothoraces were also identified.

5.2 Toxicological analysis of post-mortem blood detected concentrations of olanzapine and diazepam and its metabolites, nordiazepam and temazepam.

5.3 In the autopsy report dated 24 November 2020, Dr Irvine concluded that the cause of Fiona's death was multiple blunt force injuries.

6. What issues did the inquest examine?

6.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) Whether the Nepean Blue Mountains Local Health District (including Child and Family Health Services) provided adequate antenatal and postnatal mental health care to Fiona during and after her admission to Nepean Hospital.

(2) The role (if any) of general practitioners Dr Kathryn Jenner and Dr Sherri Roberts in the co-ordination of other mental health treatment providers, and management of anti-depressive and anti-psychotic medication.

(3) The role (if any) of clinical psychologist, Dr Jennifer Flatt, in the co-ordination of other mental health treatment providers.

(4) Whether the private consultant psychiatrist, Dr Paul Thiering, provided adequate perinatal mental health treatment and care to Fiona after she was referred to him on 17 September 2020. This extends to co-ordination of other treatment providers (if required), management of anti-depressive and anti-psychotic medication, and co-ordination with Fiona's admission to and discharge from St John of God Hospital, Burwood.

(5) Whether the clinicians at St John of God Hospital, Burwood provided adequate perinatal mental health care treatment and care to Fiona during her 21-23 October 2020 admission. This extends to:

(a) management of her anti-depressive and anti-psychotic medication;

(b) adequacy of advice to Fiona in response to her (perhaps wavering) requests to be discharged;

(c) the decision not to schedule Fiona to detain her for further treatment; and

(d) discharge planning, including the apparent telephone referral to the Perinatal and Infant Mental Health Service.

(6) Whether Medibank Telehealth provided adequate follow-up and triaging of Fiona on referral from St John of God Hospital, Burwood after her 21-23 October 2020 admission.

(7) The role (if any) of the NSW Perinatal and Infant Mental Health Service (PIMHS) in the provision of acute and complex mental health care for patients such as Fiona, including in the co-ordination of other mental health treatment providers.

(8) The adequacy of policies and protocols of the NSW Police Force, and whether the attending police officer on 28 October 2020 adhered to them when attending on and assessing Fiona after concerns raised by her parents.

(9) The adequacy of policies and protocols of NSW Ambulance, and whether the attending paramedics on 28 October 2020 adhered to them when attending on and assessing Fiona after concerns raised by her parents.

(10) Whether Fiona postnatal medication (including any unprescribed medication) impacted on her mental health and her apparent suicide on 29 October 2020.

(11) Whether there are in place adequate systems for provision and coordination of sub-acute mental health care (including coordination) for complex patients such as Fiona; and if not, whether there is an opportunity for Nepean Blue Mountains Local Health District and/or NSW Health to step into that role.

6.2 These issues are considered in more detail below. The issues are dealt with chronologically and some issues have been dealt with together for convenience.

6.3 In order to assist with consideration of some of the above issues, an independent opinion was sought from Professor Anne Buist, perinatal psychiatrist, as part of the coronial investigation:

6.4 In addition, some of the sufficiently interested parties obtained opinions from the following experts:

(a) Professor Matthew Large, senior staff specialist psychiatrist, on behalf of SJOG; and

(b) Dr Olav Nielsen, consultant psychiatrist, on behalf of Dr Luu and Dr Le;

6.5 Each of the above experts provided one or more reports which were tendered into evidence, and also gave oral evidence in conclave, during the course of the inquest.

7. Fiona's actual diagnosis at the time of her death

7.1 Professor Buist expressed the view that Fiona was suffering from postpartum psychosis. She explained that "*this would be Major Depression with psychotic features but given the timing of her illness, some of its features and that her predominant presenting symptom was anxiety, and [Fiona] denied being depressed, postpartum psychosis is a better fit*". Professor Buist explained that this is because:

(a) there was onset within two weeks following delivery of Fiona's preoccupation with her birth experience which worsened over time;

(b) there were features of a "*relentless inability to get off topic*", and Fiona could not be convinced otherwise;

(c) Fiona's fluctuating course is not uncommon, including the ability to mask and present well;

(d) there was evidence of worsening symptoms linked to significantly poor sleep; and

(e) there was "*odd*" behaviour such as headbanging and asking to be held down which "*does not fit an anxiety disorder and gives evidence to the delusional quality of these beliefs*".

7.2 In forming an opinion that the correct diagnosis for Fiona was postpartum psychosis, Professor Buist emphasized the importance of timing and explained:

> The - the attachment of her, well, obsession, if you like, around the delivery, and the attachment to that is very typical of some of the ones we see. Not the early postpartum psychoses that have more the - the delirium-style attached, but the ones that linger on longer, if you like, as perhaps she has. I'm very mindful, and I think in my final report, of Professor Large thinking she had OCD, and also in Dr Thiering's supplementary statement that he's very clear about that. And I'd like to say that I do think this is possible. I - I'm not entirely discrediting that at all. But she is very typical of many of the women I have seen with that slightly later postpartum psychosis, the obsession related - obsessional thoughts, and - and that are really are so close to being delusional. And I think certainly Dr Thiering seems to have agreed with that, that there was, what he called, "quasi delusional". That whilst she was able to say "no" in some shape or form, that, I don't believe this; that's not really what her behaviours indicated. And the ability to cover it up is pretty typical as well. The - the statistics from point of view - well, sorry the - the - the work has looked at women who have suicided postpartum. This fits in fairly closely to that.

7.3 Professor Large considered that at the time of Fiona's admission to SJOG, she was suffering "*from at least two related mental disorders, those being body dysmorphic disorder and obsessive-compulsive disorder*", and that it is "*also more likely than not that she had a chronic depressive/anxiety disorder that might have been secondary to her other mental conditions*".

7.4 Professor Large explained that "*the diagnosis of any psychosis depends on the presence of delusions, hallucinations, and particular forms of thought disorder*". He went on to express the view that "*there were insufficient grounds to diagnose a psychosis*", and that Fiona "*did not exhibit the cognitive disorganisation that has been suggested to be a key clinical feature of post-psychosis*".

7.5 In evidence, Professor Large further explained his view as to the distinction between delusions and obsessions:

> And of course, delusions and obsessions are very similar. They're both false ideas, they're both unwanted, but the difference is the patient's attitude towards their beliefs.
>
> So an obsessional person knows their beliefs are not correct but can't really, just, manage them and whereas a, you know, person who has delusions has a very full-blown belief in their ideas, much less capacity to conceal them. So I think she fell this - symptomatically it fell below a delusion and on those grounds I don't think she had a psychotic disorder and I don't think that she had a postpartum psychotic disorder. I think she had a recurrence of an earlier severe obsessional disorder that occurred in the postpartum period.

7.6 Professor Large went on to explain that he considered Fiona's ruminations, and the way that she acted when she was stuck in this loop, "*phenomenologically it was an obsession. It was an unwanted, repetitive, anxiety provoking, highly emotionally laden idea into which she had some insight but couldn't control*". Professor Large also emphasised the similarity between obsessions and delusions, and said that whilst an obsession could transverse into a delusion, it rarely happened.

7.7 Professor Large expressed the view that Fiona's diagnosis is "*very complicated*" and that "*she may have had some of the sort of underlying biological components of a psychotic depression*" but that "*symptomatically it fell below a delusion and on those grounds I don't think she had a psychotic disorder and I don't think that she had a postpartum psychotic disorder*". Instead, Professor Large considered that Fiona had a "*recurrence of an earlier severe obsessional disorder that occurred in the postpartum period*". However, Professor Large went on to express this view:

> I mean, I have to say that I think the, you know, severe - severe obsessions are almost always treated with antipsychotics as well. So in some ways, there's a little bit of hair-splitting around the diagnosis because I think everybody who saw Fiona thought that she should have a combination of antidepressants and antipsychotics or anti-obsessional antidepressants and antipsychotics. The problem was getting her to take them and what framework could be used to do that.

7.8 Dr Nielssen expressed the view that Fiona did not have a psychotic illness, noting that the clinicians at SJOG did not elicit any features of psychosis, perceptual disturbances, clearly delusional interpretations of events, other delusional beliefs, or any disorder of communication or the capacity for logical thinking. Dr Nielssen elaborated upon this opinion in evidence:

> Well again, with the benefit of a lot more information that was available to any of the individuals along the way, I would say the diagnosis I would probably choose would have been agitated depression, but bearing in mind that a severe form of depression is itself, or any depression really, but the more severe, the more out of touch with reality, is a kind of psychosis.
>
> Because you're viewing yourself and the world and your prospects and, you know, how much people want you and all these sort of things as being much worse than they really are. And in that sense, it's a loss of touch of reality but without the kind of bizarre or obviously false beliefs to other people. And so in terms of what information, what symptoms had been elicited and recorded, I

> didn't see any grounds to say that you had a psychotic illness on the other than depression itself being a kind of psychosis.

7.9 Professor Buist acknowledged in her evidence that, technically, a person's beliefs have to be delusional or psychotic before a diagnosis of postpartum psychosis can be made. She also acknowledged that "*Professor Large is probably more expert at this, the definitions of obsessions*" and that she has not treated "*a huge number of OCD*". She did, however, note that "*a lot of obsessional thinking occurs in the postpartum depression, in the agitated depression*". Professor Buist then went on to express this view:

> And what I, in this case, I think, I still feel went over the edge, but I think it's really hard to tell. It's that really fine line and like Professor Large said, is we're going to treat it with an anti-psychotic ideally anyway.
>
> So it is very much a hair-splitting thing.

7.10 Of the clinicians that assessed Fiona:

(a) Dr Flatt considered that Fiona had "*good insight*" into her own condition, and that Fiona was calm and interacted with Dr Flatt "*as kind of fellow mental health professionals in a way*";

(b) Dr Thiering considered that Fiona accepted that she had obsessional traits and had "*partial insight*" into her condition, and "*had insight into the degree that she was unwell*" (with a difference of opinion as to how unwell she was), and could be reasoned with in the course of his treatment in September and October 2020;

(c) Dr Luu gave evidence that when she challenged Fiona, she was able to "*concede another possibility*" leading Dr Luu to conclude that Fiona was able to demonstrate some, but not full, insight into her condition.

7.11 Therefore, although there was evidence that Fiona's insight was impaired and she did not appreciate the severity of her illness, the evidence established a consensus among her treating practitioners that she was able to demonstrate some reasoning. For example, Dr Thiering said that he was able to talk Fiona down from her "*repetitive loop of rumination*", although it would inevitably return. It should be noted that apart from the reference to "*delusional thinking*" in the Doyle Note, no other clinician who treated Fiona between July and October 2020 referred to her exhibiting delusional behaviour.

7.12 All three of the experts agreed that the fact that three separate diagnoses were expressed is indicative of the complexity of Fiona's case. This is best summarised by Professor Large (with agreement from Professor Buist) in giving this evidence:

> I thought it was a very, very complicated case that could be looked at from lots of different - looked at equally validly from lots of different perspectives actually.

7.13 It was submitted on behalf of the Goodberg family and Ben (**the Family**) that Professor Buist's over 35 years of specialised experience in perinatal psychiatry should be preferred to that of Professor Large and Dr Nielssen who are "*experienced forensic psychiatrists but are not specialists in perinatal psychiatry*". Professor Buist's experience is not in issue and there is no doubt as she is very well-qualified on the issue of postpartum psychosis. However, as noted above, even she acknowledged that on the question of Fiona's actual diagnosis "*it's really hard to tell*", that it is a "*fine line*" and "*very much a hair splitting thing*".

7.14 It should be noted that counsel for the Family submitted that If SJOG had taken certain further steps "*they may have reached a diagnosis of postpartum psychosis or, at least, that [Fiona] was very unwell*". On one view, this submission appears to express some uncertainty about the ability of the clinicians who treated Fiona to arrive at a diagnosis of postpartum psychosis, even if all the management steps that it is submitted should have been taken, were in fact taken. This in turn perhaps illustrates both the difficulty in concluding that Fiona was suffering from postpartum psychosis at the time of her death, and the absence of sufficient evidence to reach such a conclusion.

7.15 In her report of 12 April 2024, Professor Buist observed:

> Professor Large believes Ms Goodberg had OCD; this is certainly possible, but combined with the odd behavior, postpartum timing, as well as my own experience and literature of postpartum psychosis presenting with obsessional thoughts/delusions often around the baby or health, then this has to be an alternative and likely diagnosis also.

7.16 It appears that Professor Buist acknowledged, consistent with her evidence about "*hair-splitting*", that both OCD and postpartum psychosis are equally likely diagnoses. Indeed, in evidence all three experts agreed that Dr Thiering was correct, following his first consultation with Fiona, that she was at the extreme end of the OCD spectrum. Dr Luu and Dr Le similarly diagnosed Fiona with postnatal exacerbation of OCD with ongoing anxiety on a background of cluster C traits and ruminations.

7.17 Professor Large noted that on her presentation to SJOG, Fiona's "*most overwhelming symptom was repeatedly described in terms like obsessional regret*". Professor Large went on to explain:

> An obsession is an unwanted and intrusive idea, not necessarily totally false, but distressing or even disabling. [Fiona]'s idea that she should have birthed at Katoomba Hospital rather than Nepean Hospital had the qualities of an obsession in that it was unwanted, intrusive, and repetitive and was only partly believed by [Fiona]. [Fiona] also seems to have had some compulsive behaviour, most notably seeking reassurance from others. The presence of obsessions and compulsion is consistent with a DSM V Obsessive-Compulsive Disorder – noting that DSM V allows the diagnosis of OCD with varying degrees of insight. [Fiona] had some insight. At admission and discharge from St John of God, the most fitting diagnosis was a relapse of OCD.

7.18 **Conclusions:** The expert evidence established that in order to arrive at a diagnosis of postpartum psychosis delusional behaviour is required. This is similar, but distinct, from an obsession. Whilst both are unwanted, false ideas, a delusion is more consistent with a person having "very full-blown belief in their ideas" with much less capacity to conceal them.

7.19 Apart from the reference in the Doyle Note to Fiona having "*delusional thinking*", no other clinician who treated or assessed Fiona observed her behaviour to have a delusional quality to it. Indeed, Professor Buist acknowledged in evidence that Fiona's obsessional thoughts were "*so close to being delusional*".

7.20 The fact that three experienced psychiatrists reached three separate diagnoses for Fiona emphasises not only the complexities associated with Fiona's case, but also that each perspective is equally valid. Further, it is clear that any difference between an eventual diagnosis may come down to what the experts described as "*hair splitting*".

7.21 Ultimately, apart from the Doyle Note, the available evidence does not persuasively establish that Fiona exhibited delusional behaviour in the months before her death. Therefore, it cannot be reliably concluded that Fiona's behaviour was consistent with a diagnosis of postpartum psychosis.

7.22 Instead, the evidence regarding Fiona's behaviour is consistent with descriptions of it being obsessive, and with a looping quality to it. Whilst Professor Buist favoured a diagnosis of postpartum psychosis, in evidence she acknowledged that a diagnosis of OCD was also likely. In addition, the expert evidence established that Dr Thiering was correct in describing Fiona at the extreme end of the OCD spectrum. Therefore, it is most likely that in the weeks before her death, Fiona was suffering from severe postnatal exacerbation of OCD. It is also most likely that the distressing nature of this condition contributed to Fiona's decision to cause her own death.

8. The adequacy of the antenatal and postnatal mental health care provided by Nepean Blue Mountains Local Health District

Referral to SAFE START

8.1 In her report of 24 July 2023, Professor Buist noted that she could find no evidence that Fiona "*was ever screened for perinatal depression antenatally or postnatally in accordance with [S]tate and [F]ederal policy*". Professor Buist went on to conclude:

> Since the Federal and State governments accepted [Beyond Blue]'s recommendations to screen for perinatal mental illness fifteen years ago, there has been accepted best practice of managing emotional care in pregnancy and postpartum, not just the physical care. Though [Fiona] had clear risk mental health factors these were largely missed or not paid adequate attention to and there appears to have been no antenatal plan which should have included discussion about medication (whether to stop/when to restart/risks with breastfeeding) and a probably earlier appointment with a psychiatrist (possibly a perinatal one rather than Dr Thiering). This plan would have involved the GP (one only hopefully) and minimized the lack of postnatal coordination and excess number of people involved.

8.2 SAFE START is a NSW Health initiative which aims to assess women at the antenatal stage for mental health vulnerabilities. If a patient is considered at risk they are referred to a CFH Service following discharge to facilitate support with their parenting. It was submitted on behalf of the Family that Fiona met the criteria for SAFE START but was not referred.

8.3 CNS Brown, a child and family health lactation consultant and midwife from the CFH team within NBMLHD, gave evidence that Fiona "*would have been offered if she wanted to be part of the [SAFE START] program*".

8.4 Although Fiona was not screened at the antenatal stage, she was referred to CFH for ongoing postnatal support on 9 July 2020, about three days after she was discharged from Nepean Hospital. CNS Brown explained that this was a "*normal process*" and that "*if anyone has a baby they would come through Child and Family Health*".

8.5 CNS Brown was asked in evidence whether it made any difference that Fiona was not screened at the antenatal stage. CNS Brown agreed that Fiona possibly would have received some early extra counselling and that she possibly would have been on the CFS "*radar*" earlier. CNS Brown gave evidence that she was unsure whether this would have made any practical difference for Fiona but said that "*it would have been ideally [sic] to have had her on the [SAFE START program]*". When asked to elaborate, CNS Brown gave evidence that "*there could have been another referral to the [PIMHS]*", and that if could "*quite possibly*" have better prepared Fiona for the anxiety that might arise from being a first-time parent. However, CNS Brown but could not express any view about whether it would have potentially better prepared Fiona for the physical trauma of a forceps delivery.

8.6 It was submitted on behalf of the Family that consideration should be given to a recommendation being made to NBMLHD to "*review training and consider reviewing or identifying multiple opportunities for clinicians to refer to PIMHS*".

8.7 **Conclusions:** The evidence establishes that having regard to her mental health history, Fiona would have been offered a referral to SAFE START if she had been screened antenatally and sought such a referral. Whilst CNS Brown gave evidence that such a referral would have been ideal, the balance of the evidence does not establish whether such a referral would have made any practical difference for Fiona. This is particularly so given that Fiona was in fact referred to CFH for ongoing postnatal support on 9 July 2020, three days after she was discharged from hospital. Therefore, whilst the absence of a referral may be described as a missed opportunity, the evidence establishes that early additional counselling for Fiona was only a possibility.

8.8 In addition, the evidence does not establish whether the absence of a SAFE START referral was a result of any systemic deficiency within NBMLHD. Indeed, as is discussed further below, the evidence establishes that established referral pathways to SAFE START already exist. Therefore, it is neither necessary or desirable to make the recommendation that is sought by counsel for the Family.

Provision of domperidone to Fiona

8.9 It was submitted on behalf of the Family that Fiona was commenced on domperidone on 11 July 2020, according to a clinical note from RN Fiona Neale. It was also submitted that "*the provision of a script without a medical review was unsafe*" and that "*there was no assessment of risk of drug interaction with Fiona's other prescribed medications*".

8.10 Professor Buist opined that Fiona's intermittent compliance with her medication and the taking of domperidone could have worsened Fiona's mood and agitation, and "*likely contributed to the fluctuating course of [her] illness which deteriorated*". Professor Buist concluded:

> I would not have advised her taking [domperidone] because of the interaction with Lexapro. Given her past history and risk factors the Lexapro should have been prioritized; this appears to have been the directive of the health professionals other than the midwife who suggested the use of [domperidone] in the first place and Dr Roberts.

8.11 **Conclusions:** Having regard to the opinion expressed by Professor Buist, it is evident that following the commencement of domperidone other clinicians involved in Fiona's care recognised that escitalopram should be prioritised. This establishes that there was assessment of the risk of contraindications with Fiona's prescribed medications. There is therefore no evidentiary basis to make the findings that counsel for the Family submitted ought to be made with respect to the provision of domperidone for Fiona.

Referral to Access Team

8.12 On 17 September 2020, Mr Smith contacted the Access Team regarding the following concerns arising from his recent consultation with Fiona:

(a) she felt things had gotten worse since their last consultation;

(b) she felt "mad" and "panicky" from taking domperidone;

(c) she needed help looking after Charlotte; and

(d) she was in mental health crisis due to sleep deprivation.

8.13 Mr Smith states that the Access Team "*indicated that they did not feel they needed to be involved in [Fiona's] management at that stage*". Mr Smith accordingly made the following entry in Fiona's clinical records:

> 1230hrs
> Consultation with Access MHT, Katoomba CHG.
> Clinician outlined concerns following recent telephone contact with Fiona.
> Discussed plan - Fiona seeing Dr Thiering (Psychiatrist) at 1300hrs today and the clinician will contact Fiona tomorrow at 11 00hrs.
> Contact Dr Thiering for update and recommendations.
> No involvement of Access MHT at this time.

8.14 Mr Smith gave evidence that his understanding of the rationale for the decision of the Access Team was not that they considered Fiona was not severe enough for their attention, but that she already had an appointment with a psychiatrist known to her that day.

8.15 It was submitted on behalf of the Family that "*whatever the criteria for Access the pathways for referral must be reviewed so vulnerable patients are not refused because they have a specialist*", that "*the involvement of Access could have been life-saving for Fiona*", and that "*there should be a recommendation to NBMLHD regarding training for referrals to Access or nothing will change*".

8.16 It should be noted that there was only a very short window of time between the end of Fiona's appointment with Mr Smith at 11:00am on 17 September 2020, and her scheduled appointment with Dr Thiering at 1:00pm later that same day. In evidence, Mr Smith explained his reasoning for contacting the Access Team and their response during the following exchange:

> Q. But you were sufficiently concerned that you wanted to speak to someone, even just to bridge that time?
> A. Well, I think sufficiently wanting reassurance more than them to actually necessarily do anything. I wanted to clarify that would they do anything that would be better for Fiona than what was already arranged. And reassurance for myself that there was nothing else more that I needed to do or could do.
>
> Q. And what was the response from the team?
> A. Well, the response I had was that we – that they wouldn't be able to get to Fiona or to do anything faster than that.

8.17 **Conclusions:** Given the evidence of Mr Smith, it could not be said that there was a missed opportunity for Fiona to be referred to the Access Team within a period of about two hours between the end of her appointment with Mr Smith, and the start of her scheduled appointment with Dr Thiering. The evidence established that the Access Team were practically incapable of seeing Fiona any earlier.

8.18 Further, there is no evidence that any deficiency in training contributed to Fiona's non-referral to the Access Team. Instead, it is evident that decision-making on this issue did not relate to appropriateness or need, but rather whether there was sufficient time for intervention or escalation of care. In addition, this issue was not explored, or sought to be explored, with any witness during the inquest, including by counsel for the Family. Accordingly, it is neither necessary nor desirable to make the recommendation advanced by counsel for the Family.

Mother-Baby Units (or Parent-Baby Units)

8.19 Professor Buist expressed the view that the recommended treatment for postpartum psychosis is inpatient care. As at October 2020, there were no public MBUs in NSW. Since 2020, two State-wide public MBUs have opened at Royal Prince Alfred Hospital and Westmead Hospital, with 12 month capacity figures at 76% and 81% (as at May 2024). SJOG is the only private hospital with a MBU. Dr Flynn stated that there are currently no proposals for building or introducing additional MBUs in NSW and the "*focus remains on optimising the operations and capacity management of the existing facilities*".

8.20 Dr Flynn also stated that the wait lists and admission timeframes for public MBUs "*vary due to factors such as bed availability and geographic catchment areas*", and that "*each unit conducts regular intake meetings to manage referrals efficiently, ensuring that priority patients receive timely admissions*".

8.21 Dr Thiering gave evidence that (as at May 2024) he was unaware of any MBUs in the Blue Mountains area, with the closest being at Westmead. He gave evidence that this is a problem in day-to-day practice when treating patients with babies, and that if there were appropriate MBUs, "*you'd be much more liable to refer*". In addition, Dr Thiering noted that there would be "*a lower threshold for sending people into hospital if you knew you had a functional and good system like that*".

8.22 In evidence, Dr Flynn agreed that it was reasonable to ask whether two units within metropolitan Sydney provided for access to people in regional areas. Dr Flynn explained that as subspecialist units, they "*require a critical mass of subspecialists*", but that there are "*networked services that provide access for everybody in New South Wales to those subspecialty services*". In addition, Dr Flynn acknowledged that "*demographic variables definitely come into it*" and that "*if district X outside of Sydney demonstrated a need that was simply not being met by these units, that would be very important information for planning*".

8.23 Counsel Assisting submitted that a recommendation ought to be made that NSW Health consider the capacity of public-run MBUs to meet the needs of new mothers with severe mental health issues requiring admission with their babies. Counsel for NSW Health submitted that it "*will continue to consider its operations and, for present purposes, focus on optimising the operations and capacity management of the two already existing public-run MBU facilities*" and that, accordingly, such a recommendation is not necessary or desirable.

8.24 **Conclusions:** The evidence establishes that the two existing public MBUs (as at May 2024) were not at capacity, which may in turn suggest that the metropolitan location of both MBUs is sufficient to service persons in both metropolitan and regional locations. However, the inquest did not receive evidence that this is indeed the case, and it is noted that an inquest is not the forum for issues of service capacity and increases in service feasibility to be explored. The evidence that the inquest did receive is, firstly, that where new mothers with significant mental health issues require inpatient treatment, that this treatment is best provided in a MBU; and, secondly, that, at least in the Blue Mountains area, there likely would be a lower threshold for referral to inpatient treatment if such facilities were readily available. Having regard to these matters, it is desirable to make the following recommendation.

8.25 **Recommendation:** I recommend that the Deputy Secretary, Health System Strategy and Patient Experience, NSW Health give consideration to whether the current capacity of Mother/Parent-Baby Units in NSW is sufficient to meet the needs of prospective inpatients from both metropolitan and regional areas.

9. The coordination and management role of general practitioners

9.1 Dr Jenner assumed that Fiona was seeing another GP because she had not given Fiona a mental health plan even though she was seeing a psychologist. Dr Roberts gave evidence that she was aware that Fiona was mainly seeing her for nutritional medicine. Dr Roberts was also aware Fiona was seeing a psychiatrist and psychologist, that she had been to Tresillian, and that "*all that was being handled by other professionals*". Dr Roberts considered her role "*in the end was just the postnatal check and organising the vaccinations for Charlotte*".

9.2 Dr Roberts said that there were no "*routine steps*" for a GP to take in order to coordinate a patient's care with another GP, if the patient began showing signs of mental health deterioration. Dr Jenner explained that whilst "*regular connection*" between the GPs can assist coordination, there are no "*routine steps*" to take.

9.3 Dr Roberts went on to explain her more recent experience working as a GP in the Blue Mountains area and the extent to which she had engagement with her colleagues:

> We used to have good contact with colleagues, and then with government changes of divisions, and we've actually become quite alone again as individual practitioners.

9.4 When asked about primary health networks in the Blue Mountains area, Dr Roberts said:

> They are supposed to connect with us, but I don't think they do very much. We had divisions of general practice before and there was a lot of incentive for us to get together as practitioners, to plan projects for our area, knowing the needs of our area. We got to know each other, and as soon as that was changed and the primary health networks came up, that we just all never have any contact with each other.

9.5 Dr Jenner gave evidence that after she referred Fiona to Dr Thiering, this constituted a handover of care and that Dr Jenner "*would then wait to hear back*". Dr Jenner explained that she received a letter from Dr Thiering which provided reassurance that he had seen Fiona. Dr Jenner also gave evidence that she expected that Dr Thiering would manage Fiona's medication, until such time as Fiona had "*recovered and [Dr Thiering] referred her back to me - handed care back*".

9.6 **Conclusions:** The evidence established that the GPs involved in Fiona's care did not have a clear and full understanding of treatment that was being provided to her by other health care practitioners. The available evidence suggests that prior to 2020, there likely was greater contact and connections between GPs in the Blue Mountains region.

9.7 However, as at October 2020, and now, the evidence suggests that such contact and connections have diminished with no clear or established pathway for practitioners to coordinate a patient's care. In addition, the evidence suggests that a view is taken that once a patient is referred to a specialist practitioner, that referral constitutes a handover of care, with no coordination responsibility left with the general practitioner. This general issue of fragmentation of care as it related to Fiona is discussed further below.

10. The role of Dr Flatt in care coordination

10.1 Dr Flatt gave evidence that where a patient may be seeing her and also a psychiatrist , there was not a "*typical way*" in which she and the psychiatrist would work together to treat a patient. Dr Flatt explained that whilst the psychiatrist might be managing a patient's medication, and she would be providing treatment, she "*wouldn't necessarily have much contact with [this psychiatrist] at all*".

10.2 Dr Flatt described understanding of a patient's treatment in this way:

> [T]he GP would be the person in the middle, the psychiatrist would report to the GP and I would report to the GP, they're the kind of centre of the wheel and I am on the end of one spoke.

10.3 Dr Flatt agreed that where a patient is seeing both a psychologist and a psychiatrist, they may not be necessarily seen by a GP regularly. This in turn could mean a lack of coordination between the different treatment providers.

10.4 Dr Flatt agreed that it would be better and "*much more effective*" for there to be coordination amongst different treatment providers for a patient like Fiona who was considered to have required intensive inpatient treatment but was not so unwell that she could be involuntarily detained.

10.5 Dr Flatt explained that if a patient wanted their care to be separated amongst different treatment providers then coordination would be possible. However, for a patient who does not actively want such separate care, there was similarly no way to coordinate their care. Dr Flatt summarised the challenge in this way:

> I don't know how - I can't imagine how that could work. Like, if I don't know that she's seeing someone at some other place, how am I going to - how am I going to talk to them or how am I going to ask for consent to talk to them, if I don't even know that she's seeing them?

10.6 **Conclusions:** Dr Flatt's evidence reinforces the notion that where a patient, like Fiona, is receiving treatment from different general and specialist practitioners, coordination of care becomes a challenging exercise. The challenge becomes even greater when health care practitioners are unaware of what other treatment is being provided to a patient, which can frustrate attempts to obtain a patient's necessary consent so that care coordination can be attempted.

11. The adequacy of perinatal mental health treatment and care provided by Dr Thiering

11.1 On 17 September 2020, Dr Thiering had a 30 minute appointment with Fiona. He said that at multiple times during the session Fiona demonstrated brooding: she went from being reasonable(but slightly agitated) to a repetitive loop of rumination and being agitated ("*rocking a bit*") while doing so. Dr Thiering said that he saw these ruminations as "*obsessive-compulsive phenomena*", and an exacerbation and severe deterioration of her pre-existing condition.

11.2 Dr Thiering explained that he considered Fiona to be at the extreme end of the OCD spectrum, requiring a low dose antipsychotic (such as olanzapine 2.5mg) to "*take the agitation away*". Dr Thiering considered the possibility that Fiona's preoccupation with the hospitalization and birth might be delusional but found no signs of delusion because it was based on reality. Instead, he considered it to be an over-preoccupation or "*over-valued idea*" about events that had actually occurred.

11.3 Dr Thiering said that if Fiona's focus on events that actually occurred was unreasonable, irrational or obsessive then it was "*sort of getting over the boundary of OCD, heading towards psychosis*" but was "*not in itself sufficient*". He considered that there needed to be a "*bizarre, irrational belief, not based on reality*" for there to be clear evidence of delusion but acknowledged that an obsession may be so out of proportion that it crosses into delusion.

11.4 Ultimately, Dr Thiering described there being "*shades of grey*" between the extreme end of OCD and the point at which it crosses into delusion and psychosis. Dr Thiering described Fiona in these shades of grey, which he described as "*quasi-psychotic brooding*".

Dr Thiering's diagnosis of Fiona

11.5 Central to the issue of whether Dr Thiering diagnosed Fiona with postpartum psychosis is the 6/10/2020 Note. Dr Thiering gave evidence that it was his usual practice to put possible diagnoses in the diagnosis box and that it was his normal practice to use a question mark to reflect this. However, Dr Thiering acknowledged that the 6/10/2020 Note did not have a question mark or make any reference to a differential or possible diagnosis. Notwithstanding, Dr Thiering gave evidence that the reference to postpartum psychosis "*was there as a possibility not as a clear established diagnosis*". Dr Thiering went on to explain that what he was "*really thinking at the time was what [he] said about severe end spectrum OCD with the possibility of postpartum psychosis*".

11.6 In a letter to the Coroner's Court dated 15 June 2021 (**15 June 2021 Letter**), Dr Thiering said:

> The second presentation was in a state of anxiety and disorganisation after the birth of her child as can be seen by her consultation notes below. My view was that she had an early postpartum psychosis with obsessional features given her previous propensity for this. She essentially was lost in the state of sessional regret regarding going to appear in hospital for the birth and blamed the Hospital for the complications that occurred after this. These thoughts were not of a delusional intensity, in that one good reason with these regrets, however she had quite significant obsessional ruminations.

11.7 In a statement dated 16 April 2024, Dr Thiering sought to explain the 15 June 2021 Letter and the 6/10/2020 Note. He said:

> On reflection, what I intended to convey was my concern that Fiona was at risk of *developing* or was showing some *signs of early* post-partum psychosis, but that I had not made a diagnosis of post-partum psychosis [original emphasis].

11.8 In evidence, Dr Thiering acknowledged that he did not qualify the reference to postpartum psychosis as a differential diagnosis, and that he made no mention of any other diagnosis, although he said that he referred to the OCD after birth. Dr Thiering gave evidence that the apparent diagnosis of postpartum psychosis "*might have been a bit strong*" and that he was "*talking about [his] consideration of it*", even though no mention of any consideration was raised in the 15 June 2021 Letter. Dr Thiering concluded by giving evidence that what he had stated in the letter was not clear in his mind in October 2020 and that he "*hadn't clearly come to that diagnosis*". However, Dr Thiering ultimately conceded that, with all the thinking and reflection that he has done since 2020, it is possible he may be mistaken about his mindset in October 2020.

11.9 When asked a number of leading questions by his own counsel, Dr Thiering gave evidence that the 15 June 2021 Letter represented a response that was sought to be given at the earliest available opportunity, within five days, over a weekend, without the benefit of legal representation, and without his letter of 24 September 2020 to Dr Jenner. In that letter, Dr Thiering relevantly wrote:

> In addition to recommencing her escitalopram which had previously been very effective but had been ceased during pregnancy, I have added Olanzapine 2.5mg nocte as I am concerned about her thought processes. Whilst I don't think she is actively psychotic she is at the extreme end of the OCD spectrum currently and is not functioning.

11.10 However, it should be remembered that this letter preceded Dr Thiering's discussion with Teresa on 6 October 2020, his 6/10/2020 Note, and his assessment of Fiona of 8 October 2020.

11.11 In evidence, Dr Thiering was asked a number of leading questions by his own counsel during the following exchange:

> Q. And you've been taken to this by counsel assisting but I'm referring to the box that says diagnosis and there's a reference on 6 October 2020 postpartum psychosis.
> A. Yeah.
>
> Q. Do you see there there's a full stop?
> A. Yes.
>
> Q. Is it possible that that could have been a question mark?
> A. It is possible, yes, that's what I was actually - it was in my mind a query. It should have been a question mark.
>
> Q. But can I ask you this question, we know that by 24 September, you had prepared the letter that set out your most considered analysis and diagnosis of Fiona's case. On 6 October, you hadn't seen Fiona again. Is that the position?
> A. That's right, yes.
>
> Q. The only new information you could have had was from the conversation with Teresa?

A. With Teresa, that's right.

Q. Is it possible that in the context of that conversation with Teresa, because she had indicated to you that Fiona had stopped her medication, you needed to remind yourself about the potential for the condition to further develop into a postpartum psychosis?
A. Yes.

Q. Is that a possibility?
A. That's a possibility, yes. I mean, yeah, it was there as my fallback position or the - not fallback position, the possibility, yes, I had to remind myself this could occur.

Q. That it could develop along the spectrum from OCD at the severe end into a postpartum psychosis.
A. Yes.

Q. Is that the position?
A. Yes.

Q. Is it correct to say that it's not your practise to make a diagnosis of a patient based on information conveyed by her mother without seeing her?

A. Yes.

Q. In fact, that would be inappropriate to do that?
A. Yeah, I wouldn't make a diagnosis, I might have a thought, but not a diagnosis, that's right, you see the patient, of course.

11.12 Earlier in his evidence, when Counsel Assisting canvassed the same topic with Dr Thiering, he did not volunteer that the full stop was intended to be a question mark or that he needed to remind himself that Fiona's condition could develop into postpartum psychosis. Dr Thiering also made no mention of these matters in his 2024 statement. Ultimately, Dr Thiering's evidence was that he did not make a formal diagnosis of postpartum psychosis and that "*the picture*" was that it was "*contemplated as a differential diagnosis that could develop if things got worse*".

11.13 It was submitted on behalf of Dr Thiering that his "*private clinical notes were not adequate*" and the 6/10/2020 Note "*should be construed in this context*". However, Dr Thiering gave evidence that although his notes were relatively brief he "*wrote the critical things [he] had to remember*". Dr Thiering agreed that the notes were kept so he could remember the key information from each consultation. Therefore, whilst the evidence establishes that the notes were inadequate for lack of detail, there is no evidence that they were inadequate for lack of accuracy.

11.14 **Conclusions:** The two most contemporaneous documents regarding Dr Thiering's diagnosis of Fiona are the 6/10/20 Note and the 15 June 2021 Letter. Both documents record an apparent diagnosis of postpartum psychosis by Dr Thiering. Both documents do not qualify the diagnosis as a possible or differential diagnosis. Both documents also do not indicate expressly that Dr Thiering was only giving consideration to postpartum psychosis as a possible diagnosis.

11.15 The 15 June 2021 Letter may have been written without legal representation and without all of Dr Thiering's records. However, it can be inferred that Dr Thiering well understood that he was being asked to provide the Coroner's Court with an accurate and precise account of his management and treatment of Fiona, including her diagnosis.

11.16 It was only in April 2024, some 3½ years after Fiona's death, that Dr Thiering for the first time put in issue that the reference to postpartum psychosis in the 6/10/2020 Note and 15 June 2021 Letter was only a possible diagnosis. Similarly, it was only during the inquest, a month after Dr Thiering's 2024 statement, that he said for the first time that the full stop after the words "*postpartum psychosis*" was intended to be a question mark, thereby reflecting it as only a possibility. This evidence was led from Dr Thiering. It was not mentioned in his 2024 statement, and not volunteered when asked Dr Thiering was asked questions by Counsel Assisting. Overall, Dr Thiering's evidence on this issue was unconvincing.

11.17 Having regard to all of these matters, there is sufficient evidence to be comfortably satisfied that on or about 6 October 2020, Dr Thiering diagnosed Fiona with postpartum psychosis. Indeed, Dr Thiering conceded in evidence that with all the thinking and reflection that he has done since Fiona's death, it is possible that he is mistaken about his mindset as asserted in his 2024 statement and in the evidence he gave during the inquest. At the very least, Dr Thiering recognised that Fiona's condition was significantly worse than when he had previously treated her for OCD many years before, and that she was at risk of deteriorating into postpartum psychosis.

11.18 It should be remembered that this is a separate issue from the question of what Fiona's actual diagnosis was at the time of her death, which has already been dealt with above.

The period between 8 October 2020 to 21 October 2020

11.19 Dr Thiering gave evidence that by the end of his 8 October 2020 appointment with Fiona, he was not confident that she would continue taking her medication and that she would not return for the subsequent appointment. This raised the possibility that Fiona could become actively psychotic, especially given Dr Thiering's opinion that Fiona was in the "*shades of grey*".

11.20 Despite this, Dr Thiering did not send any update to Dr Jenner. He explained that decision would be based on whether Fiona actually attended her next scheduled session with him. If she did not, then Dr Thiering considered that to be the time to send an update to Dr Jenner or contact the Access Team.

11.21 Dr Thiering acknowledged that it "*might have been a good idea*" to alert Dr Jenner because it was possible Fiona may go off her medication and not return, and because the situation had changed from the last report he sent to Dr Jenner which was positive about the direction the treatment was going.

11.22 Dr Thiering considered that Mr Smith only needed to be updated if Fiona did not attend the next scheduled session. However, he acknowledged that, with hindsight, it would been ideal to let Mr Smith know that Fiona had changed her views about medication because he might be able to assist in persuading her to continue with it.

11.23 Dr Thiering also gave evidence that he did not think that Ben "*quite understood how unwell [Fiona] was*" because he was "*very unemotional about the whole situation*" and perhaps did not perceive the intensity of the situation. Dr Thiering agreed that if Fiona subsequently deteriorated, someone

would have to be monitoring for any deterioration, and would need to know how to contact the Access Team to seek assistance. However, Dr Thiering gave evidence that he could not recall discussing with Fiona, Ben or Teresa how to contact the Access Team, or specifically checking whether they knew about the MHL. Dr Thiering explained that "*it would be reasonable for [him] to expect that they'd know how to contact the Access Team*".

11.24 The expert conclave was asked whether a psychiatrist in Dr Thiering's position during this period ought to have done more moving forward to safety plan for Fiona. Professor Large gave this evidence:

> [Y]ou think that there's a course of action that is clearly needed, and you yourself are not able to follow through with that, then the obvious thing would be to enlist the support of other people to some extent. So that could be a private hospital, or it could be a whole range of things, but to get someone else involved […]

11.25 Professor Large went on to explain that these steps might involve "*referral to a community mental health team, referral to a private hospital*" and "*maybe further contact with the GP*" within a period of "*a few days*". Dr Nielssen and Professor Buist both agreed with the views expressed by Professor Large, with Dr Nielssen noting that additional assistance could be sought from an acute care team, and Professor Buist noting that Mr Smith could also have been notified.

11.26 Notwithstanding the above, each expert agreed that as at 8 October 2020 there were insufficient grounds for Fiona to be involuntarily detained.

11.27 **Conclusions:** Given Dr Thiering's uncertainty as at 8 October 2020 about whether Fiona would continue her medication and/or return to see him for their next scheduled appointment, additional steps could have been taken by Dr Thiering as a measure of safety planning for Fiona. Dr Thiering acknowledged that such steps might have been a good idea. The expert evidence established that such steps – including contact with previous treatment providers and referrals to a private hospital or community mental health team – should have been taken within a few days.

11.28 Although no such steps were taken, the evidence establishes that between 8 and 21 October 2020 there were insufficient grounds for Fiona to be involuntarily detained.

Referral letter to SJOG

11.29 Dr Thiering described the circumstances in which he wrote the SJOG Referral Letter:

> I was told that Fiona and Ben were on the way to the hospital, or going to hospital. We finally persuaded her to go to hospital. I was between two patients. They needed a letter for referral for the hospital to take them. I wrote it in haste between patients with Bernadette, my receptionist standing over me while I wrote it.

11.30 Notwithstanding, Dr Thiering agreed that he made no mention of Fiona being at the extreme end of the OCD spectrum, and said that it was important information that probably should have been in the letter. Dr Thiering also agreed that he made no reference to postpartum psychosis as a

differential or possible diagnosis, but said that if he had raised it, he would have said that he did not think Fiona had postpartum psychosis but that it was a possibility. Dr Thiering also acknowledged that there was an opportunity to send a further letter providing more detail to SJOG later in the day and that he "*had it on the backburner to do but not on the acute*". Dr Thiering agreed that he could have faxed the information to SJOG directly or could have called to provide a verbal handover. However, he said that his expectation when generally dealing with private hospitals is that he would have received a call "*at a later time to discuss the case*".

11.31 Dr Le gave evidence that if the SJOG Referral Letter had referred to Fiona being at the extreme end of the OCD spectrum and that she was not currently functioning, it would:

(a) be taken very seriously;

(b) have made him query whether Fiona (at the time of the 22 October 2022 consultation) was more unwell than she presented;

(c) cause him to enquire deeper about her function; and

(d) potentially have led to a call to Dr Thiering to discuss his formulation.

11.32 Dr Le gave evidence that any reference to postpartum psychosis in the referral letter would be "*definitely significant*" as it is "*quite a serious diagnosis*" as it can "*impair thinking, judgment, rationality*". Dr Le explained that "*what we worry about is, you know, patient safety, safety to the baby*".

11.33 Dr Luu gave evidence that if the SJOG Referral Letter had mentioned Fiona being at the extreme end of the OCD spectrum and/or a possible or differential diagnosis of postpartum psychosis, this would result in exploring this incongruence in more detail with Fiona and "*as a matter of urgency, actually requesting that we speak with Dr Thiering*". Dr Luu also gave evidence that this additional information, and the Doyle Note, would have made her quite concerned for Fiona's safety.

11.34 When asked whether this combined information would have made it possible for Fiona to be involuntarily detained on 23 October 2022, Dr Luu said:

> I think it would depend ultimately on Ben, because he was the person that was going to be the nominated person who actually had all the information. So he knows of Dr Thiering's involvement; he knows what has been treated; he knows her mental state, and I also assume if there's any sort of concern that her family had that it would be expressed with Ben as well.
>
> So if Ben is saying I'm not concerned I can manage this, and we're talking always about a least restrictive option and if there appears to be compliance to all those things with the numbers provided with the access to an emergency department at any time which they both knew as mental health trained - or involved in nursing, at least.

11.35 Dr Luu said that it was a "*fair assumption*" that both Fiona and Ben knew how to contact an emergency department and went on to say:

> Then I don't think that there - and she has, you know, made those follow-up phone calls and appointments - then I don't think that we would have been able to hold her under the Mental Health Act.

11.36 Professor Buist, Dr Nielssen and Professor Large all agreed that Dr Thiering should have included in the SJOG Referral Letter his formulation of Fiona being at the extreme end of the OCD spectrum and not functioning, and the possibility of a provisional or differential diagnosis of postpartum psychosis. Professor Buist gave evidence that "*in the ideal world*" this information "*needed to be communicated*", whilst acknowledging that there may have been some complication because Fiona was going to collect the letter, and may have read it, which might affect Dr Thiering's therapeutic relationship with her.

11.37 Professor Large was asked about the significance of the extra information not being included in the SJOG Referral Letter, and whether it would have affected Fiona's management at SJOG. He said that the clinicians' assessment of Fiona would have been "*the overwhelming, overriding piece of information*" that they used, but that the additional information "*might have*" placed them in a better position to at least suspect that the picture Fiona was presenting to them in their assessment was not quite the full picture. Overall, Professor Large explained that the significance is "*[p]robably not as much as you would think".* Professor Large also opined that Dr Luu and Dr Le "*would have considered both of those two factors irrespective of their inclusion in the letter*".

11.38 Dr Nielssen explained that it is "*very much a cross-sectional assessment*" depending on the patient's presentation. In other words, the information can be put to the patient and "*they would, if they chose to, convince you otherwise*".

11.39 Professor Buist said that she largely agreed with the opinions expressed by Professor Large and Dr Nielssen but said that the information that might have been a most helpful was that Fiona "*really had a period of time of not being well and not really managing with any input that had been so far given*".

11.40 Counsel for Dr Thiering sought to highlight that towards the end of his evidence, and when asked a question about what Dr Thiering might have done after speaking to Dr Le on 26 or 27 October 2022, Professor Large said:

> And actually, I might add I hadn't seen the transcript of the referral before, I'd just seen the handwritten note. I don't remember seeing it, But I think it was a very, sort of – there more [sic] in that letter of referral than there often would be.
>
> Actually, I thought it was a perfectly adequate letter of referral with all the important information in it, just to backtrack to that point.

11.41 **Conclusions:** The evidence established that Dr Thiering made no mention in the SJOG Referral Letter of postpartum psychosis (whether as a possible, differential or concluded diagnosis), or to the fact that Fiona was at the extreme end of the OCD spectrum and not currently functioning. The evidence also established that Dr Thiering had opportunities to communicate this information after the SJOG Referral Letter was sent but did not seize these opportunities.

11.42 The expert evidence was somewhat equivocal about the significance of these omissions. Initially, the experts agreed that the information ought to have been included, with some qualification about this being done in an "ideal world" and that it carried a risk of damaging Dr Thiering's therapeutic relationship with Fiona if she read the information. In addition, the expert evidence also established that the clinicians at SJOG would likely have given independent consideration to these matters, and relied predominantly upon their own assessment of Fiona as the patient before them.

11.43 However, the actual evidence from both Dr Luu and Dr Le is that if the information had been included in the SJOG Referral Letter it would have been treated very seriously, may have resulted in deeper enquiry into how Fiona was presenting and functioning, and may have resulted in additional steps in her management such as speaking with Dr Thiering. The omissions from the SJOG Referral Letter therefore represented a potential missed opportunity for any of these steps to be taken.

Enquiries between 26 October and 29 October

11.44 As noted above, Dr Thiering gave evidence that when he saw Fiona on 8 October 2022, he considered that she needed medication to treat what he considered to be a presentation at the extreme end of the OCD spectrum. If Fiona did not take such medication then she needed to be in hospital.

11.45 On 26 or 27 October 2022, Dr Thiering spoke with Dr Le and said that Dr Le did not say anything about whether Fiona would be having medication, or had a prescription, from that point forward. When asked whether he was concerned whether Fiona had gotten worse, Dr Thiering explained:

> There was no description of her getting worse or being suicidal or anything like that. The description was just, like, she was the same. I was concerned in my own mind about what was going to happen from here. Yes.

11.46 Dr Thiering agreed that, as part of his original plan, the next step was involuntary admission at a public hospital:

> Well, that was on my mind for the Thursday session. Unless something had dramatically changed, my plan was that she'd have to be involuntarily treated, even though I knew that wasn't an ideal situation, that that would be - and probably the end of her treatment with me, that that was all that was left for me to do, all I could do.

11.47 Dr Thiering went on to qualify this by saying that this was not the only next step. He explained that Fiona may have been stable when he next saw her, referring to the fact that his receptionist had relayed a message from Ben who reported that Fiona was weaning Charlotte and therefore possibly starting olanzapine again.

11.48 Regardless of which of these next steps were possible, Dr Thiering acknowledged that he did not know Fiona's "*exact condition*" and that it probably would have been a good idea to call her and check in on how she was. Dr Thiering agreed that if he had, for example, called and been told that Fiona had been to a lookout by herself on Sunday without telling anyone beforehand that his response "*would have been a call to the access team and the schedule*". Dr Thiering went on to

acknowledge that if he had been told on Wednesday night that Fiona had been to the lookout for a second time then his response would have been the same. He explained:

> Well, clearly in the level at which she could be scheduled. Risk to self, recent activity, evidence of instability, not mental illness, but mental disorder and unwell. She was clearly schedulable in my view at that point. I would have scheduled her. I probably would have rung the Access team directly.

11.49 Professor Large gave evidence that what Dr Thiering did "*was quite reasonable*" and that:

> …making an appointment with the person at the first available opportunity is what you would do, without any other further information. You'd have to have a lot of different information to do anything different to that.

11.50 Professor Large also gave evidence that if in Dr Thiering's position he would not involve the Access Team and that he would not have taken steps to obtain further information regarding how Fiona was over the weekend by calling her directly. Instead, Professor Large considered it "*quite reasonable to make an appointment to see [Fiona] in the circumstances*".

11.51 On the same topic, Professor Buist gave this evidence:

> Look, I'm inclined to agree. I mean, I think he's given the appointment as fast as he could and probably a lot faster than many busy private psychiatrists could. It's within the week. He wasn't the last person to see her. I'm sure he was worried about her. He could have rung, but he could have done a lot - you know, I don't think it would have made any difference. I think it's perfectly reasonable what he did.

11.52 Finally, Dr Nielssen gave this evidence:

> *Well I might just say I agree, I think it's pretty good service to see someone so quickly and you know it reflects his concern but that he didn't consider it to be a kind of an emergency from the information in front of him.*

11.53 It was submitted on behalf of Dr Thiering that his agreement that it would have been a "*good idea*" to call Fiona before her appointment on 29 October 2020, should be noted as a "*reflection as one made after Fiona's tragic suicide*" and with reference to a journal article (by Dr Rachel Gibbons) which addresses how "*in the aftermath of a tragic suicide, clinicians may make more concessions than are ultimately warranted*".

11.54 **Conclusions:** It is not possible to reconcile the submission on the one hand that Dr Thiering was an "*honest, insightful and reflective witness*", and the submission on the other hand that he may have made more concessions than are warranted. Perhaps such reconciliation is unnecessary given Dr Thiering's own evidence that after finishing his phone call with Dr Le, the possibility of detaining Fiona was "*certainly the number one option*" for Dr Thiering, and that "*unless something had dramatically changed [his] plan was that [Fiona would] have to be involuntarily treated*". This speaks to the seriousness with which Dr Thiering regarded Fiona's condition after discharge.

11.55 That said, the expert evidence established that Dr Thiering's response in making an appointment to see Fiona as quickly as possible within a week was reasonable. Further, the expert evidence also established that even if he had followed through on the good idea to call Fiona (or taken any other steps short of involuntary detainment, which was not available), it is likely that this would have made no material difference.

12. The adequacy of perinatal mental health treatment and care provided at St John of God

12.1 Following the morning ward round review on 22 October 2020, Dr Le made an entry in Fiona's progress notes regarding the following plan:

> cease Lexapro
> trial 1-week admission
> family meeting Tuesday > 15.00
> collateral from psychiatrist Thiering
> refer 1:1 psychologist
> normal obs

12.2 Dr Le gave evidence that the collateral information sought from Dr Thiering would include the following:

> So how he saw her, what his thoughts about treatment should be, if there was any risk issues, what the treatment goals are, what he would be comfortable with in terms of taking over care once she's discharged from hospital.

12.3 Dr Luu explained the purpose of gathering this collateral information:

> The first was to actually get a more complete assessment of what had happened in - before she came into hospital. And, partly, that is because the perinatal, sort of, period is very vulnerable. So it was very important to actually - for me, to actually know what had actually led up to this admission. It was not seen to be urgent however, because there was nothing reflected in what he wrote or what I saw of Fiona to alert me to an urgency of that.

12.4 Dr Le also gave evidence that, given a one-week admission was being trialed, the timeframe for gathering this collateral information from Dr Thiering was any point "*within the week*".

12.5 Dr Luu gave evidence that her expectation was that the ordinary timeframe within which a registrar would gather such information was between a few days to up to a week. In Fiona's case, Dr Luu explained that if there was a clinical need, such information could be obtained earlier, but that unless there was some incongruence between what was contained in the referral letter and how Fiona was presenting, this would not be considered an urgent task.

12.6 Professor Large gave evidence that whilst "*[o]bviously it's better earlier*" to gather collateral information, it can take "*often a week*" to weigh up what extra information is required and to obtain consent from a patient. Dr Nielssen acknowledged that if a patient wanted to self-discharge after 48 hours, that would be a reason to expedite the process of obtaining collateral information "*but it might not be practical*".

12.7 Professor Buist agreed that "*it can certainly take a week*" to obtain collateral information from a referring clinician (due to, for example, their existing patient caseload). Professor Buist went on to explain that in a mother-baby unit, it would be rare not to speak to a mother's partner within 24 hours to obtain a full history and "*get a really clear kind of picture of what's been going on at home*".

This is because the baby also becomes the responsibility of the unit and there is a need to understand the level of any potential risk to that baby.

12.8 Professor Large, Professor Buist and Dr Nielssen all agreed that a receiving hospital would rely "*somewhat*" or "*to some extent*" on information contained in a referral letter, but also rely on information from the patient's partner.

12.9 Counsel Assisting submitted that a recommendation should be made for SJOG to consider whether its policies and procedures for obtaining collateral information from referring clinicians should impose a stricter timeframe. The submissions advanced behalf of SJOG indicate that this proposed recommendation "*is in the process of being considered*".

12.10 In addition, it was submitted on behalf of SJOG that the recommendations "*seemingly fails to consider the expert evidence, where each expert identified the difficulties that are present in obtaining collateral information within a specific timeframe*". However, it has already been acknowledged that the expert evidence established that the process can take some time, and that whilst a patient's wish for early discharge might be a reason to expedite the information gathering process, according to Dr Nielssen, "*it might not be practical*".

12.11 It was submitted on behalf of the Family that any such stricter timeframe should be narrowed to a period of 48 hours. In contrast, it was submitted on behalf of SJOG that a 48-hour timeframe is "*impracticable and unreasonable*" as it fails to take into account practical considerations involved with attempting to contact healthcare practitioners who have a variety of other commitments.

12.12 **Conclusions:** The evidence established that the gathering of collateral information is an important part of the patient assessment process. In practical terms such a task can take up to a week and the expectation in Fiona's case was that it be obtained within this timeframe. That said, there are instances, such as Fiona's expressed intention to self-discharge after 48 hours admission, where the process ought to be expedited. It is acknowledged that practical considerations may still bear upon this need for expedition.

12.13 The question of whether a 48-hour timeframe is feasible or necessary in any given case, let alone every case, was not explored during the inquest. Therefore, although the following recommendation is desirable, it cannot be stated in the terms as advanced by counsel on behalf of the Family. It is also noted, and welcomed, that the recommendation is already being given consideration by SJOG.

12.14 **Recommendation:** I recommend to the Chief Executive Officer, St John of God Burwood Hospital, that consideration be given to whether any existing policies and procedures regarding the obtaining of collateral information about an inpatient from a referring clinician should impose a stricter timeframe and if so, what clinical indications warrant the imposition of such stricter timeframes.

Consideration of the Doyle Note

12.15 RN Corcoran gave evidence that she had no specific memory of Fiona from October 2020. However, she said that in her experience, nurses in the MBU always adhered to the usual practice during handover of discussing important aspects of a patient's observations overnight to ensure that all

incoming staff are up-to-date with the patient's current presentation. RN Corcoran also gave evidence that she considered the Doyle Note to be of some significance, and that it suggested that Fiona was potentially unwell. RN Corcoran gave evidence that she expected that, in accordance with usual practice, some reference would have been made to the Doyle Note during the handover on the morning of 23 October 2020. RN Corcoran said this:

> Yes, because it would have been an MSE is part - like, taken when something changes in the presentation. So it's not, like, done as part of every, like, conversation you have. It's done when a change in presentation is observed. So that would have been passed over to the night nurse if there was concerns raised, which would - then would have been handed over again to the morning staff, because the treating team would have been coming in then to the ward.

12.16 Dr Le gave evidence that in his assessment of Fiona on 23 October 2020, apart from taking into account information gathered from Fiona directly, he also took into account "*the nursing observations, what we have observed in the units, information from her husband*" (and "*ideally, it would have included psychiatrist information*"). Later, Dr Le gave evidence that he reviewed the nursing notes for the duration of Fiona's admission to SJOG, consistent with his practice when performing these sorts of assessments.

12.17 Dr Le gave initially gave evidence that he was unaware at the time that Fiona and Ben had had a meeting with RN Doyle on the afternoon of 22 October 2020 regarding the issue of whether Fiona should be discharged. On the basis of this evidence, Dr Le was later taken to the Doyle Note and the following exchange took place with Counsel Assisting:

> Q. A little earlier, you said you weren't aware of that discussion—
> A. Yeah.
>
> Q. --at the time you did your assessment the next day.
> A. Yep.
>
> Q. Would it be fair to say that you had not read this note before your assessment?
> A. I think I would have read this note.
>
> Q. But a minute earlier, you said you weren't aware of--
> A. Well, you framed it like a meeting, so I thought what you meant was a literal sense, like, a meeting, like, a separate meeting. This to me reads like a nursing entry which is, throughout the course of their nursing care, they speak to patients and they will reassure - calm them when things are going on.
>
> Q. But the husband was also there.
> A. Okay. Yep.
>
> Q. So it was a meeting.
> A. Sure.
>
> Q. And it's a very detailed note.
> A. Yes, it is.

Q. It's not a routine discussion between the nurse and the patient, is it?
A. Sure. Yep.

Q. And there's some observations that Ms Doyle made.
A. Yep. Yep.

Q. And they are fairly detailed observations.
A. Yes.

Q. They are fairly concerning observations about Fiona.
A. Sure.

Q. So it's not an occurrence that you would have missed the next day had you read this note. Is that correct? Do you agree with me?
A. Perhaps. Perhaps.

Q. So could it be that the following day when you were doing the assessment, you had not gone in detail through the notes?
A. Maybe, yes.

12.18 Dr Le gave evidence that the reference to "*? delusional thinking of a persecutory nature* " would have been of significance at the time because the delusions would suggest psychosis. Dr Le said that if he had seen the Doyle Note, it would have been of relevance to ask RN Doyle what led her to reach that conclusion. In addition, this reference, and the reference to Fiona being "*anxious, preoccupied, ruminations ++, limited insight*" would possibly suggest at least that Fiona was more unwell than she presented.

12.19 Dr Le gave evidence that if he had seen the Doyle note, it would have prompted him to "*dig a bit deeper in the assessment the next day*". Dr Le also gave evidence that if he had confirmed the same observations made by RN Doyle, it would have affected his assessment "*but not necessarily changed the decision to schedule*". Dr Le explained:

> The - you know, it's - it's the picture, what we're seeing, you know, the patient, the patient's views, what we think might be helpful, what the husband is saying, what they think they can manage, what they want to happen, and what we think is ultimately going to be helpful. You know, so scheduling a person is a pretty big deal, especially, you know, a new mum with a young child. You're forcing separation, so the threshold to do that is actually really high. We obviously don't take that lightly, so we have to be very sure it's not just one word here or there. We take the whole picture.

12.20 Counsel Assisting submitted that the failure of Dr Le to consider the Doyle Note when deciding whether to discharge Fiona was a missed opportunity. The submissions advanced on behalf of SJOG appear to acknowledge the possibility of this missed opportunity, but it was submitted that the missed opportunity is "*contextually misapplied*" as the evidence does not establish that it would have changed the decision by Dr Luu and Dr Le to not schedule Fiona, and did not establish on its own any reason for involuntarily detainment pursuant to the *Mental Health Act*.

12.21 However, as noted above, the evidence established that the Doyle Note should have been disclosed because it may have had clinical significance in the assessment of Fiona prior to discharge. In

addition, the significance of the Doyle Note was relevant to both the question of whether Fiona could or should be detained, but also to the issue of discharge planning.

12.22 Dr Nielssen, Professor Large and Professor Buist all agreed that the Doyle Note was information that should have been before Dr Le when he conducted his assessment. Dr Nielssen gave evidence that if Dr Le had this information it "*might have*" affected his assessment in some way, although a lot of the symptoms described were known to the SJOG medical officers and Dr Le would have been assessing the person in front of him more than considering how the person was described.

12.23 Professor Large gave evidence that he would have expected Dr Le to have been on the lookout for delusion and persecutory ideas anyway, regardless of whether there was any reference to such matters in the Doyle Note. Professor Large also described the distinction between obsession and a delusion to be a "*key skill possessed by a psychiatrist who can use the Mental Health Act*", although he did not think that "*that particular piece of information would necessarily have influenced the assessment*".

12.24 Professor Buist agreed that the definition between obsession and delusion is very difficult and that it would have been in Dr Le's "*mind to assess regardless*" of whether he knew about RN Doyle's observations.

12.25 **Conclusions:** The evidence established that if RN Corcoran followed her usual practice, the Doyle Note would have been presented for discussion as part of the handover on 23 October 2020. The evidence also established that if Dr Le had followed his usual practice then he would have read the Doyle Note as part of his review of all the available information in advance of assessing Fiona. In either case, there was a missed opportunity for the significance of the Doyle Note to be appropriately considered on the morning of 23 October 2020. However, given the concessions made by Dr Le in his evidence, it is most likely that he did not go through the nursing notes, including the Doyle Note, in detail.

12.26 This then suggests that whilst the Doyle Note was disclosed by RN Corcoran in accordance with her usual practice, there is no evidence that it was considered by Dr Le or Dr Luu. Their evidence is that if consideration had been given to the Doyle Note it would have prompted interrogation regarding the basis upon which the note was written.

12.27 However, the evidence of Dr Le and the expert evidence established that even the Doyle Note had been considered it might not have affected Dr Le's assessment, and might not have resulted in Fiona being involuntarily detained. That said, consideration of the Doyle Note was also relevant to the question of discharge planning for Fiona. Overall, the absence of consideration given to the Doyle Note represented a missed opportunity to perform a thorough assessment of Fiona on 23 October 2020, although the consequence of this, if any, cannot be stated with certainty.

Did Dr Le promise to call Alice and not do so?

12.28 In her statement dated 4 January 2023, Alice said that the morning of 23 October 2020, she received multiple phone calls from Fiona who was saying that she wanted to go home. Alice said that she began pleading with Fiona to stay, telling her that she was too unwell to come home. Alice said that

she called SJOG to express her major concerns regarding Fiona and was told that she was not listed as a contact person and therefore could not be provided with any information about Fiona. Alice said that she responded by saying:

> That's fine, I completely understand. I don't need to know anything about [Fiona], I just really need to give YOU some information about her. I am really worried that she is so unwell, and she is talking about being discharged from hospital today, I have been on the phone to her and she is way too unwell to come home [original emphasis].

12.29 Alice states that she was told by the nurse she was speaking to that the psychiatrist would call her after he had seen Fiona, which was due to happen very soon. Alice also states that she later spoke to Fiona on the phone again and told her that the psychiatrist was going to call Alice after he had seen her. Alice states further that Fiona had her on speakerphone when a male psychiatrist came into the room. Finally, Alice states that Fiona asked her if she wanted to stay on the phone for the consultation, but she decided to hang up and what Fiona focus on what was being said. Alice then states:

> Before I hung up, I asked, "But the psychiatrist is going to call me, yeah?". I heard [Fiona] ask him if he would and I heard a male voice reply "yes".

12.30 Alice did not give evidence during the inquest and her account of these events was not tested.

12.31 Dr Le gave evidence that he had no recollection of Alice being on a speakerphone on 23 October 2020, and could not recall telling Alice that he would call her back after his assessment with Fiona. Later, when asked questions by his own senior counsel, Dr Le gave evidence that if Alice had been on the phone and if he had been asked to call her back, then he would have made a note of this in accordance with his usual practice.

12.32 Dr Le also gave evidence that if he had been told that a family member wanted to speak with him, he would have regarded it as significant, that in accordance with his general practice he would have returned the phone call, and there was nothing in his notes to suggest he was ever asked to return a phone call to receive any information. Dr Le also gave evidence that there is nothing preventing a family member from contacting the hospital and recording concerns for the benefit of the treating team, that this has previously occurred with other patients, that Dr Le has had regard to such information and, on occasion, spoken to family members and received that information directly.

12.33 It was submitted on behalf of Dr Le that it could not be expected that Alice's account of the day is an "*entirely accurate recollection*" given that it is "*first recorded in her statement over two years after the event*". In addition, senior counsel for Dr Le draws attention to the following note made by RN Deirdre Price:

> Contacted by sister today but due to consent and information form not indicating her details, staff were unable to discuss Fiona's wellbeing. Contact details given to Dr Yang [sic] should Fiona wish to involve Sophie [sic] in her care.

12.34 In her statement, RN Price stated that sometime before 12:00pm she received a call from Fiona's sister, who RN Price believed was named Sophie, who indicated that she wanted to discuss Fiona's

care. After reviewing the notes, RN Price advised Fiona's sister that she could discuss Fiona's care as only Ben was listed as having been given consent to disclose information. RN Price states that she advised Fiona sister that she would pass on the number to Dr Le and ask him to call her back if Fiona wanted her sister involved in care. This evidence is consistent with Alice's account, but Alices goes on to state that she spoke to Fiona on the phone a second time, as described above, and it was on that occasion that she was placed on speakerphone.

12.35 All the expert witnesses agreed that it was open for Dr Le to receive information that Alice wanted to impart about Fiona. As Professor Large explained, "*the duty of confidence is owed by the doctor to the patient and so that doesn't mean you can't listen*". He agreed that it did not prevent making use of any credible information that might be imparted by a patient's relative, regardless of whether they were the next of kin or not.

12.36 **Conclusions:** According to Dr Le, if he had been asked to call Alice so that she could impart information relevant to Fiona's treatment, he would have done so. Further, Dr Le gave evidence that he would also have documented this occurrence because of its significance. Both steps would have been in accordance with Dr Le's usual practice.

12.37 Ordinarily, the absence of a contemporaneous record would lend weight to the likelihood that the promise of a return call was made by Dr Le. However, it has already been established with respect to Dr Le's purported review of the nursing notes prior to Fiona's assessment on 23 October 2020, that Dr Le did not always follow his usual practice.

12.38 Whilst it is true that Alice made her statement more than two years after the event, and the contents of her statement were not tested in oral evidence, there is no demonstrated basis to otherwise consider that her recollection is unreliable. Indeed it might be considered that the importance of the phone call was much greater for Alice than for Dr Le, making the prospect of accurate recollection by Alice more likely.

12.39 For all of these reasons, it is most likely that Dr Le promised to call Alice back on 23 October 2020 but did not do so. This again represented another missed opportunity to gather all relevant information so that a thorough assessment of Fiona could be performed. However, it is again not possible to define the consequence of this missed opportunity with any certainty.

Decision to discharge and discharge planning

12.40 Professor Large described the decision to discharge Fiona into Ben's care as "*acceptable peer-acceptable practice, and it was what other teams in other hospitals would have allowed*". Professor Large described the situation of Fiona not taking any medication prior to her admission and not intending to take medication after discharge to be "*minor to moderately important factors*". Professor Large was of the view that Fiona was not implacably opposed to medication but that she just wanted to stop breastfeeding due to the perceived effect that the medication might have on Charlotte, which was not unreasonable. Professor Large considered that Fiona "*probably had some capacity*" to make that decision, and in any event, that fact alone would not have been enough to justify involuntary detainment.

12.41 Dr Nielssen opined that, based on the information that was available to Dr Luu and Dr Le at the time, it was reasonable for Fiona to have been discharged as she was separated from Ben, removed from the familiar surroundings and arrangements she had made to care for Charlotte at home, and unable to exercise due to COVID-19 lockdown restrictions. In addition, Dr Nielssen opined:

> Arranging an assessment under the Mental Health Act would be unusual for a person who appears superficially rational and deemed to be competent to make decisions about their own care, and who assures their doctors that they wanted to continue treatment are engaged with mental health services and who appeared to have the support of a partner and immediate family. [Fiona] was asked repeatedly about suicidal thoughts, and did not disclose those thoughts to any of the condition she spoke to, other than to report having experienced those thoughts while taking a medication that made her agitated.

12.42 Professor Buist in her first supplementary report dated 21 December 2023, considered that the clinicians at SJOG did not take into account the level of Fiona's agitation at times, the stopping of her medication and the lack of corroborative history, and Fiona's clear failure to improve without medication prior to admission. Due to this lack of information, Professor Buist considered that the SJOG clinicians "*understandably felt they could not make her involuntary but a referral to a crisis mental health team was needed*".

12.43 Professor Buist described the situation of Fiona being discharged without any intent to take her medication as being "*a bit concerning*" but accepted Professor Large's opinion that "*would have come across as quite reasonable*" regarding her concerns about the possible effects of medications on Charlotte. Professor Buist expressed greater concern about "*not having the full picture from the family at the time she was being discharged to them*", but noted that Ben was very prepared to take Fiona home and usually if there was any concern from a family it would have been raised at the time of discharge that the person was not well enough.

12.44 Dr Nielssen was asked about the adequacy of the discharge plan, and specifically whether there ought to have been some coverage for Fiona until an appointment could be made for her to see Dr Thiering. Dr Nielssen gave this evidence:

> Look, I mean, "discharged, home with husband, follow up with Dr Thiering, psychologist, and for nursing staff to refer to the perinatal service." I mean, it seems a fairly complete plan for a person who you've decided is competent to take their discharge.

12.45 Professor Large expressed agreement about the adequacy of discharge planning in this way:

> [T]he current standard for post-discharge follow-up for any patient discharged from a psychiatric hospital is that they should have some sort of follow-up within seven days. So that clearly, that, you know, kind of requirement was met.

12.46 Professor Buist also appeared to agree with these opinions and noted that the only extra measure that could have been put in place was to ensure that Ben was aware of the number for the MHL and provided with advice to call the number if he had any concerns, particularly as Fiona was being discharged close to the weekend.

12.47 **Conclusions:** The expert evidence established that it was quite reasonable for Fiona to be concerned about continuing to take her medication following discharge due to perceived concerns about its impact upon Charlotte. In any event, this factor alone would not have been enough to justify Fiona's involuntary detainment.

12.48 In addition, Fiona had provided reassurance that she intended to continue engagement and treatment with mental health care providers, and appeared to have the support of her family and Ben who, Professor Buist noted, raised no issues at discharge, at a time when a concerned family member would be expected to voice any reservations. Having regard to these matters, and the fact that discharge would allow Fiona to return to familiar surroundings at home, exercise, and care for Charlotte, there is no persuasive evidence upon which to conclude that the decision to discharge was unreasonable.

12.49 The expert evidence also established that the discharge plan for Fiona was adequate and "fairly complete", particularly given that it had been determined that Fiona was competent to be discharged. In addition, the provision of follow up in the community after discharge was within expected timeframes. One additional matter that could have been incorporated as part of the discharge plan, given that Fiona was being discharged close to the weekend, was ensuring that Ben was aware of the MHL number and given advice to call it if he had any concerns. No conclusion can be reached, of course, about whether Ben would have called the MHL if the opportunity presented.

Additional matters

12.50 Counsel for the Family submitted that wide-ranging criticism should be made of the clinicians at SJOG, and of various aspects of care provided by SJOG to Fiona generally. These criticisms were repeated in several parts of the submissions by counsel for the Family. The criticisms include, but are not limited to:

(a) the failure of nursing staff to escalate concerns about Fiona's symptoms, handover or present critical observation, and follow relevant SJOG policy;

(b) the failure of clinicians to better inform themselves of the severity of Fiona's condition;

(c) an inappropriate management and discharge plan for Fiona; and

(d) that the clinicians suggested that "*Fiona proceed with discharge [as] she was agitated, looping, was disrupting other patients and so did not fit with the program*".

12.51 As to the submission that SJOG nursing staff failed to escalate concerns regarding any deterioration of Fiona's condition, and failed to follow relevant SJOG policy, counsel for the Family did not canvass these matters with the expert conclave. In addition, counsel for the Family also did not canvass with any witness the asserted breach of any SJOG policy and indeed correctly noted in submissions that any current policy was not in force at the relevant time in 2020.

12.52 Counsel for the Family also did not explore with any witness from SJOG that nursing staff did not take Fiona's condition seriously, or that Fiona was discharged because she "did not fit with the program".

12.53 In addition, counsel for the Family submitted that the SJOG nursing staff failed to discuss the importance of weaning with Fiona so that she could recommence her medication, and that this represented "*a missed opportunity which could have been life-saving*". On this issue, Dr Luu gave the following evidence (in response to questions from counsel for the Family):

> [T]he most important thing for the child is the mother and the focus should be on her recovery from her illness and so often we talk about being able to actually wean breastfeeding in order to allow her to keep to her values of not wanting her child to be impacted in any way by the escitalopram. So we did have that discussion. But at that time with her, she was very anxious about being the best mother that she could be and that included actually breastfeeding.
>
> But we talked about that. So we're making this sort of informed decision. We present all of those options and that's my role to do that in actually being able to allow her autonomy and choice in her treatment, bearing in mind that there was a lot of mistrust of medical sort of intervention previously.

12.54 Notwithstanding, counsel for the Family did not seek to explore this issue with any of the SJOG nursing staff who gave evidence, or with the expert conclave.

12.55 Counsel for the Family also submitted that RN Tracey Borst "*should have capitalised on Fiona's query regarding if she could stay in SJOG and should have encouraged Fiona to remain in hospital*" and escalated Fiona's presentation and her query to her treating clinicians. RN Borst explained in her statement her rationale for saying to Fiona, words to the effect of, "*It sounds like you've already made a plan with the doctor to go home today, so perhaps see how that goes*". RN Borst stated that she said this because a discharge plan had already been formulated and because Fiona "*was a voluntary patient and I wanted to promote her sense of control, choice and decision-making, especially considering these have been some of the issues that she felt were compromised (and led to her current distress) following her birthing experience"*. None these matters were challenged in evidence by counsel for the Family.

12.56 Counsel for the Goodberg family submitted that a number of recommendations ought to be made to SJOG regarding provision of training to staff regarding:

(a) indications for supporting patients to wean if breastfeeding is proving a barrier to essential treatment;

(b) escalation of deterioration in a mental health patient;

(c) the conduct of risk assessments; and

(d) safe discharge planning, including handover to community treatment providers, discussion with family members, ensuring the availability of prescriptions for medication, additional planning for premature discharge, and follow up and escalation when a patient cannot be contacted.

12.57 As to matters (a) and (b), as noted already above, there is no evidentiary basis upon which these recommendations could be made.

12.58 As to matters (c) and (d), counsel for the Family did not explore these matters with any witness in evidence. In other words, there is no evidence to support the criticisms which counsel for the Family submits ought to be made regarding the care provided by clinicians at SJOG.

12.59 **Conclusions:** It can be seen from the above that either there is no evidentiary basis to support the criticisms which counsel for the Family submitted ought to be made, or the available evidence contradicts the making of any such criticisms. As to the first matter, the purported criticisms were raised for the first time in submissions and not explored in evidence during the inquest. As to the second matter, the evidence on two particular issues establishes that Dr Luu did discuss the importance of weaning (and the consequent recommencement of medication) with Fiona, and RN Borst approached Fiona's query regarding discharge in a rational and therapeutic manner.

13. The adequacy of follow-up and triaging provide by Medibank Telehealth

13.1 Following Fiona's discharge, RN Doyle was unable to refer Fiona directly to PIMHS or any other community mental health service within the NBMLHD. Instead, a referral through the MHL was required.

13.2 However, the MHL could only refer patients to the Access Team and not to PIMHS directly. Dr Janette Randall, Chief Medical Officer of Amplar Health (formerly known as Medibank), initially described the importance of the triage process in managing transfer of care:

> So our job there really is not to decide whether it's an appropriate referral or not. Our job is to assess the current symptoms, the need for that ongoing care, and particularly the urgency of that care that's required. So I don't think there was ever a question about whether the referral should go through. It was more a question of what's the urgency of the need for that referral, and that then helps the receiving mental health team to receive that referral in a way that they're used to receiving those referrals in a triaged way, and then make a decision about the next steps of care for that - for that patient.

13.3 Dr Randall acknowledged that a referring hospital may not necessarily know the referral pathway to different mental health services within a particular Local Health District, or the capacity of such services. As a result, Dr Randall said:

> So I think that the mental health line providing that single front door actually provides quite an important service in the way that it directs referrals to, you know, one place, but them then to be directed most appropriately through to those additional services within that LHD.

13.4 Dr Randall explained that that the purpose of the MHL is to deal with the influx of referrals from various sources and locations. Whilst private hospitals may prefer a more direct referral pathway, Dr Randall acknowledged from a public sector perspective "*the value of having a process to help manage those referrals that are coming in from a range of sources*".

13.5 Dr Randall went on to describe the protocol that applies to referrals:

> So the protocol is that if we receive a third party referral we are required to contact the first party and re-triage just to make sure that, you know, we've got as much information as we can. The first party may sometimes provide information that the third party was not able to provide. So we're asked to do a first party triage, confirm the urgency of response category and also confirm consent for the referral.

13.6 Cindy Foot, Director of Clinical Services at SJOG, gave evidence that the discharge process from hospital care to a mental health team often presents challenges, particularly in terms of communication and procedural inefficiencies. Despite SJOG clinicians having determined that a mental health team is the appropriate next step for a patient's care, they are still required to use the triage system which can introduce delays and miscommunication.

13.7 Ms Foote gave evidence that her understanding from the nurses at SJOG is that this process can be frustrating, especially when information is handed over through a number of clinicians. This creates the risk of information dilution and transfer of incomplete information. Ms Foote agreed that ideally direct clinician-to-clinician communication would occur between SJOG and a mental health team to reduce the risk of information loss, but acknowledged the challenges associated with such a process.

13.8 Matthew Russell, Director of Mental Health at NBMLHD, agreed with the "*one entry point*" described by Dr Randall. He gave evidence that the purpose of the triage system is to obtain clarity regarding the intent behind the referral to ensure that appropriate services are provided for the person being referred. Mr Russell agreed that the triage process provides a safeguard against the risk of services being overwhelmed with direct referrals, and ensuring that community mental health teams can focus on the work they are involved in, and "*not just spend their whole time triaging and chasing information as well*".

13.9 Dr Brendan Flynn, Executive Director of the Mental Health Branch within NSW Health, also referred to the triage system being the "*consistent front door*" of the mental health system. He drew a comparison with the system which existed prior to 2006 and the introduction of the MHL and described it as "*generally well-intentioned but often fairly fragmented attempts for people to get service with a - with a public mental health provider*". Dr Flynn explained that with no universally accepted way of triaging community mental health consumers, this resulted in inconsistencies and inefficiencies.

13.10 Dr Flynn described two benefits of the triage system:

(a) allowing "*community mental health teams to not continually be interrupted, but to get on with doing their job while someone else assesses and triages*"; and

(b) using a triage practitioner with a specific skill set employing an evidence-based tool to triage who is aware of all the treatment options available, and has the ability to provide other options.

13.11 Counsel Assisting submitted that given the divergence of opinions described above, it would be open for a recommendation to be made to NSW Health and the NBMLHD to investigate the merits of direct referral between inpatient mental health units (whether public or private) and community mental health teams without the need to go through the MHL.

13.12 Counsel for NSW Health referred to the same divergence of opinions and submitted that the making of such a recommendation "*may not be desirable*" "*when considered against the weight of the evidence heard at Inquest*". In addition, counsel for NSW Health drew attention to NSW Health's Single Front Door Program (**the Program**) which commenced phased implementation in late 2022.

13.13 The Program:

(a) is a "*key enabler that connects people with urgent, under plan care needs to be right care through one point of phone-based nurse assessment, triage, and referral*"; and

(b) "*aims to officially connect people with the care they need, close to home or virtually, safely diverging avoidable Emergency Department demand*".

13.14 It was also submitted that $39 million will be invested "*to strengthen mental health services within NSW by establishing a new Mental Health Single Front Door*" and that in 2025 it is envisaged that the Program will integrate a nationally endorsed assessment and referral decision support tool to assess and refer people based on clinical need.

13.15 **Conclusions:** The evidence established that there are both advantages and disadvantages with the existing referral pathway from inpatient mental health units to community mental health teams. The triage function performed by the MHL provides a consistent single entry point which ensures that service resources are used appropriately and referring patients are referred to the most appropriate service. However, the single entry point also creates other inefficiencies by introducing an additional referral step and the potential for information loss. The evidence at the inquest succinctly captured the contrasting viewpoints of those administering the system and those using it on the ground.

13.16 Given that the Program was not raised or canvassed in evidence, it is not possible to make any assessment of its efficacy and whether its implementation, including the envisaged enhancements in 2025, renders it unnecessary or undesirable for any recommendation to be made. Having regard to only the evidence at the inquest, it remains the case that the divergence of opinion indicates that the issue of direct referral without the need for triage through the MHL be given additional consideration, perhaps in conjunction with the features of the Program that are yet to be introduced. It is therefore desirable for the following recommendation to be made.

13.17 **Recommendation:** I recommend that the Deputy Secretary, Health System Strategy and Patient Experience, NSW Health and the Chief Executive Officer, Nepean Blue Mountains Local Health District investigate and consider the advantages and disadvantages of direct referral from public and private inpatient mental health units to community mental health teams without the need for triage through the Mental Health Line.

The triage on 24 October 2020

13.18 On 23 October 2020, RN Doyle spoke with RN Prasad who recorded information about Fiona on Medibank's document management system. On 24 October 2020, RN Atayde called Fiona to perform a first party triage, which would allow for a referral to the Access Team.

13.19 Ms Atayde gave evidence that she saw the references in RN Prasad's notes to obsessive thinking, nil insight and refusal to take escitalopram and olanzapine. RN Atayde agreed that the notes showed a person who was "*potentially quite unwell mentally*" and who could "*potentially get worse mentally*". RN Atayde also agreed that she saw references to the fact that Fiona was aware of the referral and had consented to it.

13.20 The transcript of the entire call between Fiona and RN Atayde, which took 2 minutes and 26 seconds, is set out below:

Fiona: Hello?
Jennifer: Hi, is this Fiona?
Fiona: Yes.
Jennifer: Hi, Fiona. This is Jennifer from Mental Health Line. How are you?
Fiona: I'm good, how are you?
Jennifer: I'm good, thank you. You've been referred to us by the nurse at St. John of God.
Fiona: Yes.
Jennifer: Did they tell you about the referral to the Mental Health Team?
Fiona: Yes, isn't it a antenatal – a postnatal team, or ... ?
Jennifer: It's just the Community Mental Health Team.
Fiona: Oh, just the Community Mental Health Team?
Jennifer: Yes, yes, that's right.
Fiona: Right.
Jennifer: And I just need to do an assessment with you.
Fiona: OK.
Jennifer: Is now a good time?
Fiona: It's an assessment with the Community Mental Health Team, is it?
Jennifer: So we're the Mental Health Triage Team. We need to do an initial assessment, and then we'll send that off.
Fiona: I need to do an initial assessment. Right.
Jennifer: Yes.
Fiona: I don't think I really require that.
Jennifer: OK. And do you have any services in place at the moment?
Fiona: I can see Dr. Thiering and a psychologist.
Jennifer: And Dr. Thiering is a GP or a psychiatrist?
Fiona: He's a psychiatrist.
Jennifer: OK, and your psychologist as well?
Fiona: Yes.
Jennifer: And when's your next appointment with your psychologist?
Fiona: It's not until 20 November, but I'll see Dr. Thiering before that.
Jennifer: OK, all right. And just with some risks, Fiona, we need to check that. Any risk of suicide or self-harm?
Fiona: No.
Jennifer: No. Any thoughts of harming others?
Fiona: No.
Jennifer: OK. And are you linked up with any other services aside from the psychiatrist or the psychologist?
Fiona: No.
Jennifer: No, OK. And did the nurse give you her number in case you need to call us?
Fiona: Yes.
Jennifer: OK. So we're open 24/7, Fiona. You can call us any time if you need some support.
Fiona: Mm-hmm.
Jennifer: Otherwise, you know, if you feel that you need immediate help you can call 000 or present to ED.
Fiona: Sure.
Jennifer: OK? And I'll let them know that you don't want to be referred at this point.
Fiona: OK, thanks.
Jennifer: OK. All right, thanks, Fiona. Bye now.
Fiona: OK. Bye, bye.

13.21 RN Atayde gave evidence that her interpretation of Fiona's response of, "*I don't think I really require that*", was that Fiona did not "*want a referral to the mental health team*". RN Atayde agreed that Fiona did not expressly say one way or the other whether she wanted a referral to the community mental health team. RN Atayde gave evidence that when Fiona said, "*OK thanks*", in response to, "*And I'll let them know that you don't want to be referred at this point*", this gave her comfort regarding Fiona's apparent assertion that she did not want to be referred.

13.22 RN Atayde gave evidence that she did not explore with Fiona the reason(s) why she did not want a referral and explained that this was because Fiona was "*already linked up with a psychologist and a psychiatrist*" and "*already got [sic] a treating team with her*".

13.23 In evidence, RN Atayde was asked whether she would want to know more about why Fiona had (on RN Atayde's assumption) refused a referral despite RN Prasad's notes indicating that she had previously consented to a referral, and was someone who was unwell and could get worse. RN Atayde gave evidence that, "*If she's that unwell, she will not be in the community*". RN Atayde explained that it was her practice to make an assumption of this kind. That is, if a person was so unwell they would not be in the community being apparently referred to a community mental health team. RN Atayde also gave evidence that it was not part of the protocols which she followed to make any enquiry about why Fiona did not want her case to be referred.

13.24 In her statement, Dr Randall considered that RN Atayde appropriately took into account the fact that Fiona denied being at risk of self-harm, the protective factors (including family support) in place for Fiona, that Fiona was scheduled to see her psychiatrist and psychologist, and that Fiona had a new baby to care for. Accordingly, Dr Randall opined that RN Atayde's conduct on 24 October 2020 "*was appropriate and that she performed her assessment of [Fiona] in accordance with the 2020 MHL*".

13.25 Whilst Medibank's internal policies as at October 2020 are not available (due to a change over in information technology system), Dr Randall explained that there have been two relevant changes in the current versions of the equivalent policies:

(a) changes to the *Guidance in the Professional Third Party Calls Protocol* now requires a MHL mental health professional to advise a third-party professional referrer if the referral was unsuccessful, and specifically whether contact was not made, the first party declines referral, or if it is determined that referral is not suitable; and

(b) a Category D minimum Urgency of Response (the recommended timing of any follow-up required) being allocated to anyone being discharged from hospital or an emergency department.

13.26 The Amplar *Urgency of Response Guidelines Protocol - Mental Health Triage* provides an urgency of response scale ranging from Category A (extreme urgency) to Category G (Intervention completed and nil further action/referral required). Category D is defined as low urgency, requiring contact within 48 hours.

13.27 In her report of 12 April 2024, Professor Buist opined that RN Atayde appropriately checked what supports Fiona had, that she had their number, informed her that they were available 24/7, that a

hospital emergency department and Triple Zero were also options, and asked routine risk assessment questions. Professor Buist then went on to conclude:

> However RN Atadye [sic] didn't enquire at all as to why [Fiona] didn't think she needed the referral and didn't confirm when [Fiona] was seeing her psychiatrist (and the psychologist appointment was for a month's time); these should ideally both have occurred given the referral (though deficient) did note that [Fiona] was very unwell, but most clinicians would consider the basic requirement had been covered.

13.28 It was submitted on behalf of Medibank that "*the better understanding of the conversation between [Fiona] and RN Atayde as evidenced in the transcript was that [Fiona] did not agree to a referral to the Access Team*". It was submitted that support can be found for this interpretation from the confirmation that RN Atayde sought at the end of the phone call, and from Professor Buist's interpretation of the call when she said in her supplementary report of 12 April 2024, that Fiona "*made it clear from the start that she did not think she required this referral*". Accordingly, it was submitted on behalf of Medibank that "*RN Atayde necessarily and properly respected [Fiona's] fundamental right to autonomy and her right to make decisions*".

13.29 In her evidence, RN Atayde did not refute the suggestion from Counsel Assisting that what Fiona was in fact saying was that she did not need an initial assessment. Instead, RN Atayde maintained that her interpretation of Fiona's response was that she did not want a referral to the mental health team. As noted above, RN Atayde acknowledged, correctly, that Fiona did not expressly say that she did not want a referral to the Access Team.

13.30 It was submitted on behalf of Medibank that it was appropriate for Ms Atayde to not seek to explore Fiona's apparent change of mind regarding the referral because:

(a) she was discharged appropriately;

(b) the SJOG team had assessed her as not being at "*immediate risk*";

(c) Dr Randall's evidence that it was appropriate and reasonable for RN Atayde to rely upon the SJOG assessment;

(d) RN Atayde herself confirmed this low risk during her own assessment;

(e) Fiona had community support in place; and

(f) the opinion expressed by Dr Buist that "*given the information RN Atadye [sic] had, it could not be expected she would have asked more specifically in this space*".

13.31 As to this last matter, it should be noted that Profession Buist went on to express the view set out above that RN Atayde should ideally have enquired as to why Fiona did not think she needed the referral and did not confirm when Fiona was seeing her psychiatrist next.

13.32 Whilst some weight should be given to these matters, it should also be remembered that at the time of triage, Ms Atayde had access to RN Prasad's notes which recorded Fiona was preoccupied with negative thoughts, had nil insight, and was refusing her medication.

13.33 It was also submitted on behalf of Medibank that Ms Atayde had no compulsive powers to refer Fiona to the Access Team without her consent. Properly understood, the submissions of Counsel Assisting do not dispute this, and do not suggest that RN Atayde should have referred Fiona against her wishes. Rather, the submissions of Counsel Assisting are directed towards the missed opportunity for a referral that may have arisen if Ms Atayde had explored Fiona's apparent change of mind. The submissions of Counsel Assisting correctly acknowledge that even if a referral had been made and the Access Team made contact with Fiona, there may not have been sufficient concern to justify urgent intervention, including scheduling.

13.34 **Conclusions:** A fair reading of the transcript of the triage call on 24 October 2020 suggests that Fiona's answer of, "*I don't think I really require that*", was in direct response to the statement from RN Atayde which immediately preceded it, that is, "*I need to do an assessment. Right*". This is particularly so given that when the community mental health team was mentioned twice earlier in the conversation, Fiona did not indicate that she did not want a referral. As RN Atayde correctly acknowledged, Fiona did not expressly say at any stage during the conversation whether she wanted a referral to a community mental health team or not. Therefore, it is most likely that the assumption made by RN Atayde that Fiona did not want such a referral was incorrect.

13.35 It is acknowledged that Fiona's response is open to interpretation, and that Fiona did not voice any objection when RN Atayde said at the end of the conversation that the Access Team would be told that Fiona did not want a referral. However, the apparent disconnect between the content of RN Prasad's notes and what Fiona appeared, on RN Atayde's interpretation, to be saying on the phone warranted further exploration and confirmation.

13.36 This is particularly so given that RN Atayde correctly acknowledged that Fiona was potentially already quite unwell mentally, and potentially could get worse. Although Professor Buist opined that most clinicians would consider that the basic requirement had been covered, good practice and the particular features of Fiona's case would suggest that more than just the basic requirement was needed. Having regard to these matters, the conduct of the triage call on 24 October 2020 represented a missed opportunity for Fiona to be referred to the Access Team. However, even if such a referral was made, it is not possible to say whether it would have resulted in any urgent intervention, including involuntary detainment.

14. The adequacy of NSWPF policies and protocols

14.1 The NSWPF Handbook under the heading, *Alternative Options for Mental Health Intervention*, provides:

> Where concerns are held by police about a person's mental health status that has not met the criteria for the person detained and taken for assessment under Section 22 of the Mental Health Act 2007, the NSW Police Force promote the use of alternate means of intervention which could include:
>
> - Referral to a Community Mental Health Team;
> - Contacting the 'Mental Health Line' on 1800 011 511. This is a NSW Ministry of Health service that is available 24 hours a day/7 days a week. The service provides police or the person who is living with a mental illness, next of kin, carer or other involved party, immediate access to advice from a mental health professional;
> - Engaging with a member of the person's family or a primary carer to take responsibility for the welfare of the person;
> - Where possible, make an attempt to contact the person's treating clinician, or care coordinator;
> - Engaging the services of Ambulance Service of NSW, who may detain and take for assessment the person, where the ambulance officer believes on reasonable grounds that the person is mentally ill or mentally disturbed and that it would be beneficial to the person's welfare to be dealt with in accordance with Section 20 of the Mental Health Act 2007.

14.2 As to the above options, Sergeant Martignago gave evidence that:

(a) welfare checks are performed regularly, "*at least every couple of shifts*";

(b) on 28 October 2020, he did not consider a referral to a community mental health team because an ambulance had already been called, but acknowledged that such a referral was still open to him;

(c) he appeared to place reliance on a Suicide Prevention Outreach Team;

(d) he did not consider contacting the MHL for the same reason but also accepted that it was an available option, although he had never previously done so;

(e) he did not regularly attempt to contact a treating clinician because they were hard to get a hold of or unavailable, but denied that this meant that he would not bother to do so;

(f) he was unsure what a care coordinator was and believed it may have been a general practitioner; and

(g) paramedics usually had a lower threshold for detaining someone involuntarily than the NSWPF.

14.3 Sergeant Martignago also gave evidence that:

(a) he attended Fiona and Ben's house armed only with the information from the Incident Detail Report and specifically that Fiona had threatened self-harm and walked away from a cliff;

(b) he was aware that other police officers at the station were speaking to Fiona's father and was not given any more information;

(c) agreed that information about Fiona's discharge from hospital was not contained in her history on the police system, and agreed that this might be relevant but relied on the paramedics to tease this out;

(d) whilst it was open to him to contact Fiona's father, who was the source of the concern for welfare report, he did not do so;

(e) he did not seek to test, or explore further the information given by Fiona and Ben with Fiona's father;

(f) despite Fiona alleging that her father had told police lies, he did not seek to test, or explore, this with Fiona's father.

14.4 The Incident Detail Report records the following comments:

> HIS WIFE – DIDNT WANT POL TO GET INVOLVED
> […]
> DAUGHTER WHO RESIDES IN WENTWORTH FALLS NFD HAS THREATENED SELF HARM AND WALKED AWAY FROM CLIFF AND NOW IN CAR

14.5 Sergeant Martignago appropriately called for an ambulance to attend Fiona's house, and said that he told the female paramedic (presumably Ms Patterson) that Fiona was seen leaving the Landslide Lookout and had threatened self-harm. Ms Patterson gave evidence that her understanding of the job that she and Mr Sneddon were asked to attend was that "*we had to go and assess somebody for their mental health, that's about all*". Ms Patterson gave evidence that although she could not recall doing so at the time, she "*must have*" have read the information contained in the NSWA Mobile Data Terminal as it was her usual practice to do so. Ms Patterson also gave evidence that she did ask Fiona about Eddie calling, and said, "*because I think the police told us that her father had called*".

14.6 The NSWA electronic medical record notes the following case description from 28 October 2020:

> c/t female MHA o/a police on scene pt standing In lounge room holding baby o/e pt states that she does not want to commit suicide that she has too much to live for. pt states that she had a difficult, birth and not to plan so has been stressed. pt states that she has taken her medication today as prescribed plus a prn dose of 2.5mg olanzapine Which is also prescribed. pts husband stated he knows his wife goes to lookouts to. de stress and was not worried that is were [sic] she had been pt has psychiatrist appointment tomorrow. hx pt had argument with mother and went for a drive, father rang 000 concerned that pt was going to kill herself pt left in care of husband

14.7 As to education and training, Sergeant Martignago gave evidence that:

(a) he has undertaken a mental health course in 2013 and an online course since that date, but could not remember the specifics of any training;

(b) he agreed that he was subject to mandatory continuing police education training, but could not remember the specifics of it;

(c) he had never received any training that because a person says that they are not contemplating self-harm they may not be telling the truth;

(d) he had received no training about the Alternative Options for Mental Health Intervention, and had never called the MHL during the course of a welfare check; and

(e) he considered it would be helpful to receive training about such options for persons who are not scheduled.

14.8 Sergeant Martignago also gave evidence that he was never provided with any information about a conversation between the NSWPF and Eddie that Fiona had mental health issues and a past breakdown, and that she had been very anxious and rambling.

14.9 Acting Inspector Sharna Masters, the Acting Manager of the Drug, Alcohol and Mental Health Team, gave evidence that she was responsible for the oversight of the policy and training of the organisation. Acting Inspector Masters was asked whether she was aware of any training provided to police officers for when the *Alternative Options for Mental Health Intervention* might be appropriate. Acting Inspector Masters gave evidence that, "*not outside of the framework or training for section 22*". When asked what training there is within the framework regarding these alternative options, acting Inspector Masters said that she was "*not familiar with that*".

14.10 Acting Inspector Masters was also asked whether, within the limits of her knowledge, front-line police officers have a good awareness of the different treatment providers for mental health care out in the community. Acting Inspector Masters said:

> Generally? They're aware of the section 22, the Mental Health Act training surrounding that, the mandatory training framework that we provide as an organisation, and also where they can seek further information as to where to get that information.

14.11 As to how this further information might be sought, Acting Inspector Masters referred to, "*the Handbook, the Mental Health Act, MOU".*

14.12 The MOU referred to by Acting Inspector Masters is the *NSW Health – NSW Police Force Memorandum of Understanding 2018*. Under the sub-heading of Risk Assessment, when dealing with Initial Response and Attendance in the Community, it relevantly provides that:

> Incident response, timeframes and resources will be informed by the nature and degree of risk. Complex situations often require a collaborative multi-agency response. In these circumstances, staff will consider a range of factors when assessing risk. However discussions to determine the

response which best provides for the safety and wellbeing of the person and the safety of staff involved, should include consideration of the following factors:

[…]

- options for effective response and the benefits, risks and limitations of each

14.13 Acting Inspector Masters agreed that this appears to be a reference to alternative options besides involuntary detainment of a person. She also referred to a mandatory three-hour lecture (presented by a mental health clinician and one of the sergeants attached to the Drug Alcohol and Mental Health Team) as part of training for NSWPF Academy students, with a session described as incorporating "*operational and clinical components concerning mental health*". However, Acting Inspector Masters' evidence was that the content of the lecture was almost entirely devoted to critical incidents and the decision of whether or not to involuntarily detain a person. When asked how much time is devoted to alternative options that do not involve involuntary detainment, Acting Inspector Masters said, "*I can't answer that question*".

14.14 Counsel Assisting submitted that it would be open to find that the NSWPF "*mental health training regime did not adequately equip Sergeant Martignago with the skills needed to adequately assess Fiona's risk of self-harm*".

14.15 Counsel for the Commissioner of Police submitted that "*the police response led by Sergeant Martignago was 'textbook' in the sense that Sergeant Martignago gave practical effect to his training as well as observing and acting upon the guidance in the Handbook*". Counsel for the Commissioner further submitted that having regard to the apparent evidence that other health professionals who had assessed Fiona were "*unable to identify the risk of self-harm*", "*it would seem that no amount of training would have 'adequately equipped' an officer in the position of Sergeant Martignago*". As Counsel Assisting correctly submitted in reply, such a finding, if made, is not contingent upon there being evidence that such skills would have materially altered the eventual outcome.

14.16 In addition, it was submitted on behalf of the Commissioner of Police that NSWPF officers are not "*mental health experts*" and that Sergeant Martignago appropriately arranged for a mental health assessment to be performed by NSWA paramedics. As to this last matter, it was submitted that there is no basis to make any recommendation, as advanced by Counsel Assisting, regarding consideration to be given to the adequacy of training for the conduct of mental health assessments.

14.17 Counsel for the Commissioner also submitted that there ought to be a finding that "*emphasises that Sergeant Martignago's response was polite and respectful, and that he exhibited a warm and caring approach to [Fiona]*". The evidence, including the BWV, does not suggest anything to the contrary, and it should be noted that Sergeant Martignago's demeanour in interacting with Fiona on 28 October 2020 was an issue before the inquest.

14.18 **Conclusions:** The interaction between Sergeant Martignago and Fiona on 28 October 2020 is commonly known as a concern for welfare check. The evidence established that this type of interaction is performed with some degree of frequency, at least in the Police Area Command where Sergeant Martignago is based. It is not difficult to imagine that similar interactions occur with the same frequency in other metropolitan Police Area Commands.

14.19 The NSWPF Handbook, the overarching policy and procedure document, that Sergeant Martignago was required to apply in his interaction with Fiona, provides for a number of alternative options for mental health intervention. Of the five options set out in the Handbook, Sergeant Martignago only employed one. His evidence was that as at October 2020, he had never previously or regularly employed, or was unsure how to employ, any of the remaining four options. Sergeant Martignago's evidence was also that his training regarding mental health interactions was outdated, and that he had never received any specific training regarding these alternative options. His evidence was also that he had never received any training that a person contemplating self-harm may present in a manner intending to conceal such contemplation in order to prevent any intervention. In conclusion, Sergeant Martignago considered that it would be helpful to receive such training.

14.20 This absence of training is particularly relevant to the events of 28 October 2020. Had Sergeant Martignago received such training it is likely that he would have been better placed to act upon the apparent contradiction between the reason for the call from Fiona's father which resulted in Sergeant Martignago's attendance at Fiona's home and Fiona's presentation during his interactions with him. In addition, Sergeant Martignago would also have been better placed to consider all of the available alternative options for mental health intervention provided for by the Handbook.

14.21 Regrettably, Acting Inspector Masters' evidence provided little to no assistance in determining whether the NSWPF has a sufficiently robust and comprehensive training framework regarding mental health interventions. This framework is crucial for properly equipping officers, like Sergeant Martignago, to perform concern for welfare checks as part of their everyday duties. Accordingly, it is necessary to make the following recommendation.

14.22 **Recommendation:** I recommend to the New South Wales Commissioner of Police that consideration be given to whether New South Wales Police Officers have adequate training to (a) apply the provisions of the NSWPF Handbook regarding the alternative options for mental health intervention, including how such options might be employed and in what circumstances; and (b) respond appropriately to a concern for welfare report regarding a person's mental health status.

15. The adequacy of NSWA policies and protocols

15.1 In 2021, NSWA conducted an internal review of the events of 28 October 2020. Dr Thiering Evens, NSWA Associate Director of Medical Services, said in a statement that:

(a) it appears that the care and treatment provided by Ms Patterson and Mr Sneddon was "*outside of expectations*";

(b) the time spent on scene, especially with Fiona, "*did not allow for a comprehensive physical or mental health assessment of her*";

(c) in the absence of a more thorough assessment, "*there was a high risk that key and critical information was overlooked or not obtained, and therefore potential opportunities for medical interventions were missed*";

(d) the attending paramedics "*did not adequately explore Fiona's mental health history*" or the reason why NSWPF officers were in attendance, and "*did not rule out organic influence nor consider a potential drug overdose for [Fiona's] reported behaviour*";

(e) The paramedics "*did not comply with [NSWA] procedures and protocols around patient primary and secondary assessment and mental health assessment, standards with regard to documentation and they were not compliant with their obligations to produce accurate and factual patient records*".

15.2 Overall, the NSWA review concluded that the clinical assessment of Fiona "*did not meet the minimum expected standard for an assessment under NSWA protocols*". In evidence Dr Evens provided more detail about this conclusion:

> The review found that the clinical assessment that was recorded in the medical record included some elements of the mental health assessment that would be carried out using the Ambulance protocols, but that the notes did not suggest that the protocols had been used in a structured way or in their entirety. The review also found that the fact that Fiona had visited a lookout suggested that this was a means, and that that should have been considered in the course of the mental health assessment. The review noted that the time that our clinicians were with Fiona was relatively short, and although we do not prescribe an amount of time that an assessment should take, there were concerns as to whether that was enough time to properly explore--

15.3 Whilst the NSWA review did not make any comment about which specific aspects of Fiona's mental health history or to have been explored, Dr Evens expressed this view what could have been done differently:

> So, the key areas in my review is an establishment of the past history and particularly the recent past history. And then the other question is, I think, the disparity between the corroborative history that Fiona's husband was providing and the information from her father and the fact that that disparity was not noted in the assessment.

15.4 Dr Evens acknowledged that this was a "*difficult case*" and expressed "*a lot of empathy*" for clinicians who are trying to perform the assessment in circumstances where the person "*that we would regard as their primary relative is not offering the information that we know to be available*". However, Dr Evens gave evidence that it was important to note that Ben's agreement with what Fiona was saying conflicted with the information about Eddie's concerns and that, as a matter of thoroughness when evaluating a patient, there may be times "*when clinicians may recognise that a relative is inhibiting the information and take separate steps*" and to verify the information being presented.

15.5 As to the issue of his note taking, Mr Sneddon gave evidence that "*it could have been more extensive*". He otherwise maintained that the findings of the NSWA review were incorrect. Otherwise, Mr Sneddon's general evidence was that he could not recall the specifics of the conversation with Fiona. He said that he was aware that Fiona said she was seeing a psychiatrist for depression, but could not recall the details of this engagement. He did not ask who the psychiatrist was, and could not recall the details of how long and how frequently Fiona was seeing her psychiatrist. Mr Sneddon gave evidence that he could not recall asking if Fiona had a usual GP or if she was receiving treatment from anyone else other than the psychiatrist. He asked what medication is Fiona was taking and was aware that she was prescribed olanzapine, and that it was an antipsychotic but said that is "*not unusual for people with anxiety or depression to be on olanzapine*".

15.6 Overall, Mr Sneddon gave evidence that he "*found Fiona very able to reassure us that there was no cause for concern*". He described the assessment process in this way:

> However we do have to go on what's in front of us, the assessment that's in front of us, which largely comes down to how Fiona presents and the feedback that we get from Fiona and - and another family member on scene to - to confirm that information

15.7 Ms Patterson also disagreed with the conclusions reached by the NSWA review. Specifically, Ms Patterson gave evidence especially that it was her belief that she "*did ask all the appropriate questions*", and that she thought she "*spent enough time with Fiona to get those answers that I needed and I had the backup of her husband*".

15.8 Later in her evidence, Ms Patterson agreed that she did not ask Fiona who her psychiatrist was or how long she had been seeing them because it "*probably didn't come into my thinking at the time*". Ms Patterson agreed that if the patient has been seeing a psychiatrist regularly that might give an indication as to how unwell they are, what their illness might be and that this would have a bearing on an assessment for whether the person needed to be scheduled. Ms Patterson agreed that this was something that she should have "*probably*" explored with Fiona.

15.9 Ms Patterson gave evidence that she did not consider contacting the psychiatrists (and said it was not usual practice to do so), and did not ask Fiona whether she was seeing a GP or if they had been to hospital for treatment (which were also not usual questions that she asked).

15.10 The NSWA *Reference R47 9 Step History Taking Process* (**Reference R47**)(which appears to have been introduced in July 2018) is "*a systematic and logical guide to obtain a complete patient history*", with a number of headings "*used to structure and prompt your long case history taking*". The 9 steps are described as:

Introduction
Presenting Problem
History of Presenting Problem
Past History
Allergies
Medications
Family History
Social History
Systems Review

15.11 Dr Evens gave evidence that NSWA would not provide "*an exhaustive list as a checklist*" but that the expectation was that paramedics would "*seek to understand the context for [a] patient*". Dr Evens gave evidence that this would extend to exploring how long a patient had been receiving treatment from a psychiatrist, establishing the diagnosis, exploring the regularity of taking prescribed medication, and exploring any prescribed medication as part of the patient's history. Overall, Dr Evens gave evidence that he agreed with the conclusion reached by the NSWA review and that the mental health assessment described in the clinical record did not meet the standard of being thorough.

15.12 Counsel for Ms Patterson submitted that she had taken a history from Fiona and Ben in a "*nuanced and 'human' way, guided by her experience rather than the checklist approach critiqued by [NSWA]*". The evidence of Dr Evens is not in conflict with this submission. Dr Evens gave evidence that NSWA training "*includes case discussion and discussion of different approaches*" as to how a detailed mental health history might be elicited, and that the expectation of NSWA is that its clinicians "*use the most appropriate means of asking the questions that they need to ask to answer the things that are in [Reference R47], the important questions that are in there*".

15.13 Ms Patterson gave evidence that this guidance "*didn't come out till quite late*" and that she had from "*years of being on the job*" a "*standard way of operating*" and had her "*own way of asking questions*" of a patient. Ms Patterson also explained:

> You'd have a - standard sort of questions, but you wouldn't ask them in the same way to each patient, sort of thing. You'd - you - you look at each patient how - how they - what they presented like before you'd ask the questions, sort of thing.

15.14 Ms Patterson agreed that asking whether Fiona had been in a hospital might be a relevant question to ask. She gave evidence that she asked Fiona about her medications but did not explore with her whether she had been compliant for a period of time. Ms Patterson agreed that based on the information from Fiona's father that Fiona was threatening self-harm, and the picture presented by Fiona and Ben, there were two possibilities: either that Fiona's father was mistaken, or that Fiona was more unwell than she presented.

15.15 Ms Patterson gave evidence that she did not explore the second of these possibilities because the way that Fiona presented was, "*she seemed happy, she was bouncing the child up and down the lap*" and "*telling me that she had everything to live for cause of her – her child*". Ms Patterson said, that in her experience up to that time, she had not previously encountered a patient who presented well

initially but, after questioning, presented more unwell. Ms Patterson gave evidence that she did not consider that Fiona may have been presenting this way at the time.

15.16 Ms Patterson gave evidence that if she had been told that Fiona had been herself against advice, and that she had been to two different lookouts without telling her husband, this information would be taken into consideration and would cast doubt on what Fiona was saying. Ms Patterson went on to agree that if informed that Fiona had been obsessing about the birthing experience, asking to be held down, exhibiting aggression to her husband and her parents, and verbalising about ending her life, she would have involuntarily detained Fiona "*there and then*".

15.17 Ms Patterson also gave evidence that the last time that she had any training on conducting a mental health assessment was more than 10 years ago, and her last certificate regarding "*anything to do with mental health*" was in 2009. Dr Evens in evidence expressed belief that this was the case. Dr Evens also agreed with counsel for Mr Sneddon that prior to October 2020, there was far less focus on the training of paramedics regarding mental health assessments than there has been since October 2020.

15.18 In his statement, Dr Evens described the changes made to training since October 2020:

(a) All new paramedic staff at NSW Ambulance that have joined in the last two years (from 2023) received 15 hours of training specific to mental health in the induction and intern period. This training covers the definition and prevalence of mental illness, managing stigma and appropriate interactions with people suffering with mental illness, the Mental Health Act 2007 (NSW), the 2018 Memorandum of Understanding with NSW Police and all NSW Ambulance Protocols.

(b) All paramedics employed prior to 2021 have now completed an online package related to the current NSW Ambulance Protocols.

(c) It is intended that all NSW Ambulance Protocols will be changed to Clinical Practice Guidelines in 2023.

(d) NSWA has released an internal podcast in relation to making use of third party information and another in relation to the use of section 20 of the Mental Health Act 2007 (NSW).

(e) A mental health package has been prepared for the next mandatory continuing professional development block (which was due to start in January 2024) and will include a module on suicide and suicide risk assessment.

(f) NSW Ambulance now has a formalised clinical advice line for staff that is available 24/7 and staffed by senior clinicians (experienced paramedics and Clinical Nurse Consultants). This means that any paramedic can call the line at any time to access an on-call physician for advice in relation to any presenting scenarios.

15.19 In addition, Dr Evens also gave this evidence:

> The guideline that has been produced and which is going to be introduced from mid-June, although it does not significantly change the content of the mental health assessment, we've included one further part of the suicide screen, which is an assessment for substances ingested. And that addition aligns our assessment fully with the standard mental health assessment and suicide screen.
>
> But the new guideline contains considerably more context and advice for paramedics about elements such as corroborative history and some guidance for decision-making. And it also includes what we've described as an action card, but which is a card that provides significantly more advice about how to interpret the answers in a suicide screen.

15.20 Counsel for Mr Sneddon submitted that there was never any basis upon which the paramedics could have lawfully detained Fiona on 28 October 2020, and there were no reasonable grounds upon which they could have formed any belief that Fiona was a mentally ill or mentally disturbed person. In support of this submission, reference was made to other health professionals who had an opportunity to assess Fiona (Dr Luu, Dr Le and the nursing staff at SJOG) as well as the three experts.

15.21 As to this last issue, both counsel for Mr Sneddon and Mr Patterson relied upon the evidence given by the three experts. In evidence, each of the experts was asked whether it was open for the paramedics to form the view that Fiona should have been taken to hospital for assessment under the provisions of the *Mental Health Act*. Professor Large gave this answer:

> I don't think it was open to them to make that call and had they sought further information, an enormous amount of information, differing information, would have been needed to overcome the observations that they made, presuming they're similar to the body-worn footage. And I actually thought that the criticisms within the ambulance service were a bit overblown, actually. I mean, you know, the body-worn footage was I think very crucial piece of information just more generally but with respect to the ambulance officers I don't think there's any way they could have overcome the observations of her apparently normal mental state.

15.22 Dr Nielssen then gave this answer:

> I mean, if they were interviewing the person that was seen on the body worn camera or someone even slightly calmer, I mean, she would have run rings around them, you know, even if they did have a referral that contradicted her account of why she was at the lookout. Again, they would be interviewing a person who did not appear mentally ill and it would have been quite unreasonable for them, I think, if she presented like that.

15.23 Finally, Professor Buist gave this answer:

> I would actually completely agree in any perceived criticism of the ambulance officers in my report was not so much of them in these circumstances with what they knew, but was there a possibility of learning from this and getting - should they have got more information? I don't think, in the circumstances they were in, there was any opportunity to do that. They had the husband there. You know, I think I had one suggestion. You know, could they have spoken to him separately?
> […]

> I think they behaved - I think they - given the circumstances and what they didn't know and what they did know on how she presented, I think they behaved completely reasonably.

15.24 Counsel Assisting submitted that there was a missed opportunity on 28 October 2020. This did not relate to the issue of whether Fiona should have been detained for the purposes of being taken to hospital for compulsory mental health treatment. Rather, it is submitted, there was a missed opportunity to better explore her background and surrounding issues, and whether relevant NSWA protocols were followed.

15.25 As to this second issue, counsel for Mr Sneddon submitted that little weight should be attached to the criticisms made by the NSWA Review because it is unclear who conducted the investigation, who arrived at the criticisms, what the reasoning process was as to how the conclusions were drawn, and what facts were found as the basis for the criticisms. It was further submitted that Mr Sneddon had set out a detailed response to the criticisms made by NSWA in the context of an enquiry conducted by the Paramedicine Council of NSW.

15.26 First, it should be noted that the inquest did not seek to examine the process of the NSWA Review or the validity of its findings. Second, even accepting that Dr Evens was not the author of the NSWA Review, none of the matters raised by counsel for Mr Sneddon in submissions were explored with Dr Evens in evidence. Similarly, counsel for Mr Sneddon did not seek to explore with Mr Sneddon the substance of his response to the NSWA Review.

15.27 Counsel for the Goodberg family submitted that the likely outcome of the attendance of NSWA paramedics "*would not have been a decision for Fiona to stay at home and therefore she would have been transported for a mental health assessment with a collateral history at an acute mental health units and likely admission to an Acute Mental Health Unit or, alternatively, re-admission to SJOG*". However, this submission speculates on matters not in evidence. Further, there is no direct evidence to support a conclusion that a more thorough assessment by the attending paramedics would have resulted in a decision to involuntarily detain Fiona.

15.28 **Conclusions:** The expert evidence established that Mr Sneddon and Ms Patterson acted reasonably in their interactions with, and assessment of, Fiona on 28 October 2020. However, the reasonableness of any such interactions must be viewed in the context of the evidence given by the attending paramedics themselves.

15.29 This evidence disclosed inadequacy in note taking, and the possibility of exploring certain matters with Fiona in order to better understand her mental health history, her medication history, any acute risk of self-harm, and the disparity between the reason for the paramedics attending on the hand, and Fiona's presentation and corroborative history provided by Ben on the other. This evidence is consistent with the findings of the NSWA review that the mental health assessment described in the clinical record did not meet the NSWA standard of being thorough. Accordingly, the interactions between the attending paramedics and Fiona on 28 October 2020 represented a missed opportunity to explore such matters as part of a thorough mental health assessment.

15.30 The evidence also established that an absence of recent and relevant mental health training provided to Ms Patterson and Mr Sneddon contributed to this missed opportunity. However, given the evidence of Dr Evens regarding the changes made since October 2020 to aspects of the training and advice support provided by NSWA to its paramedics as part of their continuing professional development, it is unnecessary to make any recommendation.

16. The impact of Fiona's postnatal medication

16.1 According to Ben, Teresa gave Fiona 50mg of temazepam and 25mg or 50mg of diazepam on 25 or 26 October 2020. Ben also said that Alice gave Fiona eight 2.5mg tablets of olanzapine. According to Ben, Fiona consumed all the medication between 26 and 28 October 2020. He observed Fiona to be sleepy and engaging in unusual behaviour of a sexual nature that he had not seen before.

16.2 Teresa said in a statement that she gave Fiona two 10mg temazepam tablets and three 5mg diazepam tablets. When interviewed by police, Teresa said that she gave Fiona "*three or four of each*" temazepam and diazepam.

16.3 The expert evidence was unable to establish whether the post-mortem toxicology findings demonstrated that Fiona had consumed the quantity of medication described above in the days before her death. Each of the experts deferred to the opinion of a pharmacologist on this issue. However, Professor Large expressed surprise that the post-mortem toxicology findings demonstrated subtherapeutic levels of diazepam and nordiazepam given the amount of medication it is believed that Fiona had taken.

16.4 All of the experts were, however, in agreement as to the effect of this medication. Professor Large gave evidence that for benzodiazepines, "*the mechanism is fundamentally that it disables our natural anti-suicide defences*". Professor Large went on to note that 25mg of diazepam "*is a lot*" and "*it's hard to think that that had no impact on [Fiona]*". Professor Buist agreed that Fiona clearly had taken some benzodiazepines and that likely had "*an impact on decreasing her anxiety, and unfortunately potentially decreasing her anxiety of, of dying as well*".

16.5 Dr Nielssen summarised the impact of the medication on Fiona in this way:

> Yes, I mean, temazepam and diazepam are benzodiazepines. They're very effective for reducing anxiety. At its heart, anxiety is fear of death. And you take away fear of death, and you increase your risk of suicide. They're a dangerous drug for people who are suicidal. They work in a similar way to alcohol, but without quite the same kind of motor effects.
>
> Diazepam is very long-acting, the half-life is 48 hours, and it's accumulative because it dissolves into your tissues. So, even though the toxicology showed a lowish level, it was a significant dose, especially for a person who wasn't a habitual user of it either, who never really had much exposure to it. So, I believe it was quite a dangerous treatment. I mean, inadvertently, obviously, it was prescribed to alleviate distress, and people might not realise quite how dangerous it is.

16.6 Senior Counsel for Dr Luu and Dr Le submitted that information should be included "*advising of the dangers of the link between diazepam consumption and suicide*". As can be seen from the above summary and extract of the expert evidence, the correlation between the disinhibiting effect of benzodiazepines and the reduction of anxiety that increases the risk of suicide is not limited only to diazepam.

16.7 **Conclusions:** The evidence does not establish precisely how much medication Fiona took in the days before her death. The evidence established that the effect of the benzodiazepines taken by Fiona reduces anxiety and the fear of death, and therefore increases the risk of suicide. However, the particular effect of the medication on Fiona's thinking and behaviour cannot be measured in any meaningful way. This is particularly so given that the evidence also established that by late September 2020, Fiona had made notes in her phone consistent with a plan to intentionally cause her own death.

17. The adequacy of systems for provision and coordination of subacute mental health care

Care coordination

17.1 Between July and October 2020, Fiona was treated by several different clinicians, but it is evident that no one person was in charge of coordinating her care. Instead, she was often seen by multiple clinicians at the same time, without a clear treatment plan or even awareness by some clinicians of which other clinicians were involved in her care.

17.2 Apart from the evidence in relation to Dr Roberts, Dr Jenner and Dr Flatt already described above, there were also other examples of this fragmentation of care:

(a) Although Mr Smith spoke to Dr Thiering on 22 September 2020, he could not recall discussing how they might coordinate Fiona's treatment moving forward. As a result, Mr Smith was unaware of the severity of Fiona symptoms recorded by Dr Thiering, and was not told about Fiona's deterioration throughout October 2020.

(b) The brevity of Dr Thiering's referral letter meant that there was no awareness or discussion amongst the SJOG clinicians as to Dr Thiering's assessment that Fiona was very unwell, and his intention for her to receive treatment in hospital to break the cycle of her rumination and as a safeguard whilst she was not taking medication.

(c) Most significantly, in the days before Fiona's death when she was likely at her most unwell, there was no single clinician responsible for her care. She had been discharged from SJOG, and the referral to PIMHS did not go through. Even if it had, it would not have guaranteed an immediate assessment or admission. Similarly, Dr Thiering planned to see Fiona as soon as he could, but also could not do so immediately. The attendance of the NSWPF officers and NSWA paramedics was hampered by the absence of information about Fiona's condition and treatment history which may have led them to question Fiona's denial of risk of self-harm. It is also unclear whether Fiona's family were aware of the Access Team referral pathway.

17.3 Mr Russell gave evidence that if a person comes under the care of the community mental health team then they would have a care coordinator allocated to them. However, if the person was seeing a GP, a psychologist, a psychiatrist and a counsellor within CFH then Mr Russell gave evidence that "*the hope in that situation would be that the GP would be acting more as the care coordinator*" because "*the GP would mostly be responsible for making referrals*". Mr Russell acknowledged that a clinician may consider that coordination is transferred once a person is referred to a different treatment provider. In addition, Mr Russell also acknowledged that "*it's definitely not a clearly articulated role as it's not as clearly articulated [sic] as it is once people are within a community mental health team*".

17.4 Dr Flynn expressed caution "*about the notion of community mental health services are stepping into a generic coordination role when the principal providers are actually in private practice or outside of the New South Wales health system*". Dr Flynn also gave evidence that a potential adverse effect of a coordination role being performed by state services is that "*people who are extremely unwell and*

need the focus of New South Wales health for their care could miss out if we were expending resources on trying to coordinate the care between multiple private providers".

17.5 Dr Flynn referred to his own previous experience in private practice and expressed the view that most private practitioners "*have trained in the public sector so they know what services are there, they have a sense of the ability of what care coordination can provide, 24/7 services, and also a sense a [sic] level of acuity that can safely be managed privately versus something that might need to be escalated to that more universal higher acuity service*".

17.6 Professor Buist expressed the view that Dr Thiering or a GP would be the obvious candidates to fulfil a coordination role, but said that she did not think "*it was anyone kind of quite taking it on partly because of Fiona not taking medication and being intermittent with what she was doing*". Professor Large expressed the view that "*the level of complexity was a bit beyond the care of a private psychiatrist operating in isolation*". Dr Neilssen acknowledged that the issue was beyond his area of expertise, but agreed that it seemed like Fiona's case was too serious to be capable of being managed adequately by private psychiatrist.

17.7 It was submitted on behalf of the Family that a regulation ought to be made to NSW Health to "*consider policy to identify clinicians responsible for case managing new mothers with mental health conditions/relapses*".

17.8 Counsel for NSW Health submitted that care coordination between multiple public and private providers "*is ordinarily within the remit of a general practitioner*". In addition, it was effectively submitted that such a role does not fit within either the private or public sector, due to the absence of visibility around care from the opposite sector. It was also submitted that where care is exclusively within the public system, appointment of a care coordinator "*would already be reflective of usual practice in the ordinary course of utilising available services*".

17.9 **Conclusions:** The evidence established no clear and obvious solution for the issues relating to fragmentation of care in Fiona's case, and more generally. Whilst acknowledging that a care coordinator would be appointed if a person falls under the remit of a community mental health team, there is no consensus as to what occurs if both the private sector and public sector are involved in a person's care. That warrants further consideration and whilst it may be the case that the complexity of the problem does not allow for a ready solution, it is still desirable for the following recommendation to be made.

17.10 **Recommendation:** I recommend that the Deputy Secretary, Health System Strategy and Patient Experience, NSW Health and the Chief Executive Officer, Nepean Blue Mountains Local Health District consider whether appropriate safeguards exist, and whether sufficient guidance is provided to clinicians, to overcome the fragmentation of care that can occur when a mental health consumer is receiving treatment from different health care providers, and within both the private and public health care sectors, without having a single clinician responsible for coordinating such care.

Additional review

17.11 Counsel for the Family submitted that recommendations ought to be made to NSW Health to review antenatal screening and relevant referrals relating to maternal mental health conditions, the referral pathways to SAFE START, the referral pathways to the Access Team, and referral pathways to PIMHS.

17.12 Given that a recommendation has already been made regarding consideration of direct referrals between inpatient mental health units and community mental health teams, it is unnecessary for any recommendation to be made regarding referral pathways to the Access Team and PIMHS.

17.13 In relation to the issue of antenatal screening, referrals relating to maternal mental health conditions, and referral pathways to SAFE START, the evidence of Dr Flynn established:

(a) NSW Health has developed policies and clinical guidelines to support healthcare providers in implementing best practice perinatal mental health screening, triage and referral;

(b) SAFE START includes universal antenatal and postnatal preventive screening, and referral into care. Perinatal screening includes mental health, psychosocial and domestic violence screening. Women are offered screening at the first antenatal visit during pregnancy, and again at 6 to 8 weeks and 6 to 8 months after the birth of their baby. For women who need additional care, referral pathways to other services are integrated with maternity and child and family health services.

(c) SAFE START mental health screening includes the Edinburgh Postnatal Depression Scale and a series of psychosocial questions relating to mental health, trauma, social support and relationships. The woman's scores on these measures are reviewed and recorded by the clinician. Depending up on the interpretation of the scores and clinical observations, women may be asked to do repeat screening, be referred for a SAFE START multidisciplinary case review or for an immediate mental health assessment.

17.14 Mr Russell elaborated upon the existing referral pathways in evidence:

> So the [SAFE START] process is a really - it does screen at about 34 weeks. So the purpose of it is to screen people who are attending public antenatal services for potential levels of psychological distress or psychosocial distress. Once they've been identified as being at risk, then there's a case conference that occurs to look at what supports are in place or not in place and who would then be, or which agency would then be, allocated to be the lead agency for organising those supports and making sure that there is a coordinated package for people.
>
> That would not necessarily always sit with mental health or always sit with PIMSHs. It might sit with DCJ, it might sit with Primary Care and Community, it might sit with Drug and Alcohol. The idea is that from the screening process who - whichever is the most presenting need, is then picked up by the appropriate agency to coordinate and provide the level of support and care for a person.

17.15 Mr Russell went on to explain that the agency allocated as the lead for organising any identified supports would have responsibility for ongoing coordination. If this had hypothetically occurred in

Fiona's case, Mr Russell gave evidence that the relevant agency would be aware of who she was seeing, be aware of her discharge and might be able to step in to provide further care coordination.

17.16 It was submitted on behalf of NSW Health that "*the services that are suggested requiring 'review' are already appropriately operational with established referral pathways*" and that "*the existing referral pathways are adequate for purpose*".

17.17 **Conclusions:** The evidence did not establish any systemic deficiency with regard to antenatal screening, referrals relating to maternal mental health conditions, and referral pathways to SAFE START. Indeed, the evidence of Dr Flynn and Mr Russell instead identified that these services already have established and adequate referral pathways. Accordingly, it is unnecessary for the recommendations advanced by counsel for the Family to be made.

18. Findings

18.1 Before turning to the statutory findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Hilbert Chiu SC and Mr Josh Sukkar, Counsel Assisting, and their instructing solicitors, Ms Alexis McShane, Ms Claudia Hill and Mr Gareth Martin from the Crown Solicitor's Office. I acknowledge the tremendous assistance that they have provided throughout the coronial investigation and inquest. The Assisting Team has approached their task with dedication, and worked tirelessly to gather and present all relevant evidence in a meticulous, professional and impartial manner. I am extremely grateful for their thoroughness, and for the compassion and empathy that they have shown through this complex and difficult matter.

18.2 I also thank Detective Senior Constable Thomas Murdoch for his role in the police investigation and for compiling the initial brief of evidence.

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

Identity

The person who died was Fiona Goodberg.

Date of death

Fiona died on 29 October 2020.

Place of death

Fiona died at Landslide Lookout, Katoomba NSW 2780.

Cause of death

The cause of Fiona's death was multiple blunt force injuries.

Manner of death

These injuries were sustained after Fiona intentionally self-inflicted her own death by falling from a great height, at a time when she was suffering severe symptoms of obsessive compulsive disorder following the birth of her daughter some four months earlier.

18.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Fiona's family, and in particular her daughter, Charlotte; her husband, Ben; her parents, Teresa and Eddie; and her sisters, Alice and Kate. I extend these condolences also to Fiona's extended family, especially her nieces and nephews, her friends and other loved ones for their most tragic and devastating loss.

18.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
24 October 2024
Coroners Court of New South Wales

Appendix A

Inquest into the death of Fiona Goodberg
2020/310753

RECOMMENDATIONS MADE PURSUANT TO SECTION 82, *CORONERS ACT 2009*

To the Deputy Secretary, Health System Strategy and Patient Experience, NSW Health:

1. I recommend that consideration be given to whether the current capacity of Mother/Parent-Baby Units in NSW is sufficient to meet the needs of prospective inpatients from both metropolitan and regional areas.

To the Deputy Secretary, Health System Strategy and Patient Experience, NSW Health and the Chief Executive Officer, Nepean Blue Mountains Local Health District:

2. I recommend that there be investigation and consideration of the advantages and disadvantages of direct referral from public and private inpatient mental health units to community mental health teams without the need for triage through the Mental Health Line.

3. I recommend that consideration be given to whether appropriate safeguards exist, and whether sufficient guidance is provided to clinicians, to overcome the fragmentation of care that can occur when a mental health consumer is receiving treatment from different health care providers, and within both the private and public health care sectors, without having a single clinician responsible for coordinating such care.

To the Chief Executive Officer, St John of God Burwood Hospital:

4. I recommend that consideration be given to whether any existing policies and procedures regarding the obtaining of collateral information about an inpatient from a referring clinician should impose a stricter timeframe and if so, what clinical indications warrant the imposition of such stricter timeframes.

To the New South Wales Commissioner of Police:

5. I recommend that consideration be given to whether New South Wales Police Officers have adequate training to:

   (a) apply the provisions of the NSWPF Handbook regarding the alternative options for mental health intervention, including how such options might be employed and in what circumstances; and

   (b) respond appropriately to a concern for welfare report regarding a person's mental health status.

Magistrate Derek Lee
Deputy State Coroner
24 October 2024
Coroners Court of New South Wales