CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the disappearance and suspected death of KL
Hearing dates:	29 to 31 August 2024
Date of findings:	30 September 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – disappearance and suspected death of KL - is KL deceased? – if so, can manner and cause of KL's death be ascertained – was hospital care of an acceptable standard - was it appropriate to discharge KL to a private hospital.
File number:	**2020/00296079**
Representation:	Coronial Advocate assisting the inquest: Christina Xanthos South Pacific Private Hospital: Jeunesse Chapman of Counsel i/b Landers & Rogers St Vincent's Hospital: Ben Bradley of Counsel i/b Hicksons Lawyers Dr P Sharma: S. Barnes of Counsel i/b Avant Law Pty Ltd. Family of KL: Matthew Minuccio of Counsel i/b Kingston Reid

Findings:	**Identity** The person who died is KL **Date of death**: KL died on or around 8 July 2020. **Place of death**: The evidence does not enable a finding to be made as to the place of KL's death. **Cause of death:** The evidence does not enable a finding to be made as to the cause of KL's death. **Manner of death:** KL's death was intentional and self-inflicted.

Non Publication Orders

The Court has made non publication orders pursuant to section 75 of the Coroner's Act 2009 [the Act], which de-identify the deceased person and his close family members.
A copy of these orders may be found on the Registry file.

Section 81(1) of the Act requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of KL.

Introduction

1. KL was last seen on 8 July 2020, walking towards the Lighthouse Reserve in Vaucluse, Sydney. An hour previously, staff at the South Pacific Private Hospital in Sydney's Northern Beaches had rung police to express concern for his welfare, after he had left the hospital that morning. Since 8 July 2020 there have been no known sightings of KL, nor any communications from him.

2. An inquest into the circumstances of KL's disappearance is mandatory pursuant to section 27(1) of the Act. This is because it is not known if he is deceased and if so, what the cause and manner of his death is.

Background

3. KL was born in 1958 and was 62 years old when he disappeared. His father was a Canadian-born academic who provided international consulting services. The family lived in many different countries as KL was growing up, eventually settling in Australia.

4. KL attained tertiary qualifications in the UK and in Australia. He met his future wife CT, and they had a son CD in 2001. Although KL and his wife eventually separated, CT remained a close and supportive person in his life. She and KL were committed to the care of their son. CT described her former husband as being very involved in CD's school life, taking pride in his sporting and musical achievements.

5. For over forty years KL had a distinguished career as a reporter, editor and foreign correspondent for the *Australian Financial Review*, the *Times on Sunday*, and *The Australian*. He authored books and at the time of his disappearance he was a senior reporter at *The Australian,* focusing on crime, corruption and politics.

6. KL's son and his former partner attended each day of the inquest. At the close of the evidence KL's son spoke lovingly and proudly of him. It was clear that he and his mother loved and honoured KL, and miss him deeply.

The issues examined at the inquest

7. The inquest examined the following issues:
   - Is KL deceased?
   - If so, can the cause, manner, date and place of his death be established?
   - What was KL's mental health condition at the time he disappeared?
   - Was the care which KL received at St Vincent's Hospital of an acceptable standard?
   - Was it clinically appropriate for St Vincent's Hospital to have discharged KL to South Pacific Private Hospital?
   - Did St Vincent's Hospital provide South Pacific Private Hospital with adequate information about KL?

- Did South Pacific Private Hospital respond appropriately when KL left on 8 July 2020?

KL's mental health history

8. In 2003 it became apparent that KL was suffering severe anxiety over his job and his finances. He was also concerned about his alcohol use. In May 2003 he was admitted to hospital after being found in an agitated state at The Gap on Sydney's coastal cliff line. He was diagnosed with major depression and anxiety, and was prescribed antidepressant medication as well as alprazolam for anxiety.

9. In the years following this incident KL consulted his General Practitioner and later on, a psychologist. He continued to be prescribed the above medications.

10. KL had planned to admit himself into a residential drug and alcohol clinic in 2020, but this became impossible due to the restrictions imposed during the COVID pandemic. His mental health worsened as a result of the isolation he suffered during this period. His career as a journalist was a very important part of his life, and at times due to the COVID restrictions he was unable to go into work. In addition his anxiety levels and poor sleep hampered his ability to complete his stories. He also missed seeing his family.

11. In April 2020 KL was again hospitalised due to a seizure, which was probably triggered by his decision to abruptly cease his use of alcohol and sleeping pills. When he was released from hospital CT and CD supported him with Facetime sessions, meals and whenever possible, personal visits. CT said that during this period KL had *'anxiety about job insecurity given the absences and inability to perform at work, his finances and the fact that he did not have any assets'.*

12. KL's psychologist was also worried about him. In a report to KL's General Practitioner dated 15 June 2020 she wrote:

'I have just spoken to [KL] who is not coping at all well. He said he is finding work very difficult … His anxiety is high anxiety … he denies being suicidal.'

13. KL did however express suicidal ideas to CT. In a phone call on 20 June 2020 he told her that he was *'extremely anxious … he referenced that he might just head off, take the keys, end it'.* Deeply worried, CT contacted a crisis service and KL was taken by ambulance to St Vincent's Hospital [SVH] in Darlinghurst. There he was admitted into the hospital's Psychiatric Emergency Care Centre [PECC], at first on a voluntary basis and then as an involuntary patient.

In PECC at St Vincent's Hospital [SVH]: 20 June to 30 June 2020

14. On 21 June 2020, psychiatry registrar Dr Chu found KL to have depressive symptoms including poor sleep, poor appetite, poor concentration and increasing agitation. KL reported low mood since January 2020, and increased alcohol consumption.

15. Psychiatrist Dr Jacqueline Huber carried out a detailed mental health assessment the following day. Dr Huber's impression was that KL was suffering from melancholic depression, alcohol dependence and features of narcissistic personality disorder. At the inquest she explained that patients with narcissistic features typically had very fragile self esteem. Dr Huber also considered that KL was suffering the effects of benzodiazepine dependence and withdrawal.

16. Dr Huber then spoke with CT, and learned that since February 2020 KL had been overwhelmed with anxiety about his work and finances.

17. In hospital over the following days KL continued to be highly anxious and distressed about his work situation. Dr Huber performed further reviews on 24 and 25 June 2020. By 25 June 2020 she considered that his symptoms were consistent with a depression having melancholic features. This is a type of major depressive disorder which is characterised by persistent and intense feelings of sadness and hopelessness. Dr Huber formulated a plan to change KL's antidepressant medication, and to seek a place for him at a private hospital. In the meantime he was to have short periods of unescorted leave, limited to one hour twice daily.

18. Dr Huber's next review of KL was on 29 June 2020. In her opinion his unescorted leave had gone well, and she noted that he had not expressed any suicidal thoughts since he was admitted. She now considered that she did not have the basis to detain him on an involuntary basis, and he was therefore made a voluntary patient.

19. Between the period 25 and 29 June 2020 there had been communications between SVH and South Pacific Private Hospital [SPPH], about a possible transition of KL to their facility. SPPH is a private hospital which offers voluntary in-patient treatment for mental health conditions. As it is not a locked facility, SPPH's Pre-Admission Assessment Policy states that it is unable to accommodate clients who are involuntary or who are actively suicidal (defined as '*has immediate intent to commit suicide').*

20. By 29 June 2020, KL had been approved by SPPH as suitable for admission. On that day, Dr Huber phoned SPPH with the intention of providing a verbal handover to KL's allocated psychiatrist there. Dr Huber was advised that a psychiatrist had not yet been allocated to KL. Dr Huber responded that she had already sent a referral letter, and that when the psychiatrist was allocated they could contact her for further information about KL if required.

21. The question of whether KL was suitable for transfer to SPPH will be examined later in these findings.

22. On 30 June 2020 Dr Huber convened a family meeting which was attended by KL and his former wife and son. Dr Huber discussed the plan of transitioning KL to SPPH. But KL had not slept well, was agitated, and expressed that he wanted to go home. Dr Huber explained to the family that this was not a safe option for KL, as he was still highly agitated and distressed and would need care. If this care could not be provided at home, he needed to receive it in a hospital setting.

23. Concerned that KL would refuse transfer to a private hospital, Dr Huber reinstated his schedule of involuntary detention and arranged for him to be

transferred to the Caritas centre, which is SVH's inpatient mental health unit. Caritas is able to take patients for longer admissions, and Dr Huber considered that it provided a more sympathetic environment than the PECC was able to do. KL was transferred to the Caritas unit that day, and remained there for a further seven days.

24. Meanwhile the plan for an eventual transition to SPPH remained on foot. Over the next few days Ms Eloise Dunne, who is a member of SPPH's intake team, had phone discussions with KL and with SVH's nursing staff about KL's proposed transition there. According to clinical notes, KL told Ms Dunne that he was keen to come to SPPH. However, SVH nursing staff told Ms Dunne that KL continued to be anxious and ambivalent about the idea of admission to SPPH.

25. It appears that Ms Dunne did not pass this information on to SPPH's clinical team. As will be seen, the Clinical Director of SPPH, Dr Ashwini Padhi, considered this omission to be a *'missed opportunity for the clinical team at SPP … to obtain more information about [KL's] condition and to reassess his suitability for admission to SPP'.*

In Caritas, 30 June to 7 July 2020

26. On 1 July 2020 KL was reviewed by Dr Nicholas Babidge, accompanied by trainee psychiatrist Dr Stephanie Smith. At that time Dr Babidge was the Clinical Director of Mental Health Services at SVH. He was KL's treating psychiatrist during his stay at Caritas.

27. Dr Smith wrote notes of the review. These recorded that KL was anxious and agitated, and expressed that he wanted to be transferred to a private psychiatric facility. Dr Babidge declined to do so, explaining to KL that he was not yet well enough. The notes recorded his clinical impression as *'?melancholic depression'*. Dr Babidge's treatment plan was to continue titrating upward KL's dosage of the new antidepressant; to add Seroquel for night time sleep; and to maintain KL as an involuntary patient for the time being. KL was to be

encouraged to join in group activities, and Dr Smith was directed to call CT for collateral information.

28. Dr Smith rang CT the following day, and they discussed KL's extreme anxiety over his financial and professional situation. CT told Dr Smith that KL had always been prone to rapid changes between low and elevated moods. She informed Dr Smith that she and CD would support KL when he was able to have leave.

29. There was another family meeting on Friday 3 July 2020. Dr Babidge saw some improvement in KL's mood, although he noted this fluctuated with periods of anxiety and agitation. It was recorded that KL denied having suicidal thoughts. Dr Babidge increased KL's dosage of antidepressant, aiming to continue this until he reached a therapeutic dose of 150mg. Dr Babidge also determined that KL could have escorted leave with his family over the weekend. He was to be reviewed on Monday, with a view to a transfer to SPPH on Tuesday.

30. KL was granted day release on Saturday 4 July 2020, and had lunch with his son CD. CD reported that his father was anxious that he would not be able to leave hospital, with KL claiming there was '*some sort of plot to keep him inside the ward'*. On KL's return to the hospital, staff noted that he was '*fidgeting … anxious and restless'.*

31. The next day however KL seemed calmer, and CD took him to Watson's Bay for lunch. In his statement, CD said that on the way there KL said to him: *'Do you think I should top it off?'* It does not appear that staff at SVH were aware that KL had said this to his son.

32. Dr Smith reviewed KL on Monday 6 July 2020. According to the clinical notes, she found him to be restless after a poor night's sleep with nightmares. He was feeling very anxious, and was again ambivalent about going to SPPH. He again denied any thoughts of self harm or suicide.

33. Later that morning Dr Smith had a discussion with KL and his son CD about the planned transfer to SPPH. Although KL continued to express anxiety about this plan CD was supportive, and encouraged his father to call SPPH to discuss his queries. Dr Smith then spoke with Dr Babidge, updating him on the morning's meetings and obtaining his approval of the plan for KL to be transferred to SPPH the following day.

34. The next morning KL was discharged from Caritas, and his son drove him to SPPH. KL had contacted his workplace and advised that he would be back there in three weeks' time. According to CD, his father:

' … was as normal as I had seen him in about 6 months. He said he was feeling really good and optimistic about the future, extremely talkative and excited to get back to work'.

SVH's discharge documents

35. Staff at Caritas prepared a Discharge Summary for KL's transfer to SPPH. This recorded that KL was suffering melancholic depression with a past medical history of depression and anxiety. The Discharge Summary noted a hospital admission in 2003 resulting from a plan to jump from The Gap; and ongoing low mood regarding his work and finances, worsened by overuse of alcohol and prescription medication. It also noted that K's antidepressant medication had been changed, but that he had '*remained intermittently anxious'*. He had managed escorted leave with his family *'without issues'*.

36. Dr Huber had also provided staff at SPPH with a referral letter. This noted that KL's admission at SVH was for treatment of a melancholic depression, after presenting with low mood and suicidality, in the context of medication overuse and alcohol dependence. His agitation was noted to be persisting.

The evening of 7 July 2020

37. On arrival at SPPH that evening, KL received a physical assessment by GP Dr Poonam Sharma, who recorded that KL had '*no current desire to self-harm or suicidal ideation … previous condition includes suffering low mood and suicidality'*.

38. Dr Sharma arranged for KL to have a psychiatric assessment the next day with Dr Brendan O'Sullivan, who was to be his treating psychiatrist.

39. That evening KL also had a suicide risk assessment, administered by Registered Nurse Cassandra Crawford. KL denied any current thoughts of suicide or of having a definitive plan, but said that he been having intermittent thoughts of it.

40. RN Crawford assessed KL's risk for suicide as '*high'*, and she informed Dr Sharma of this. In response Dr Sharma documented a treatment plan of observation, psychiatric review the following day, and twice daily risk assessments to monitor any changes in KL's suicidal thoughts.

41. KL awoke the next day in an agitated state, with nursing staff recording that he was anxious and wringing his hands. He received his morning dose of olanzapine. In addition he had two separate risk assessments.

42. The first assessment was conducted by Registered Nurse Nicola Christie. At about 9.00am she was informed that KL wanted to leave the hospital. KL told RN Christie that he had not been experiencing any immediate thoughts of suicide. He said: '*I just don't think this place is for me and I just want to go home'.*

43. RN Christie encouraged KL to remain at SPPH and to stay with its program. She also told him that she did not want him to leave without a GP and a psychiatrist review. She escalated his care to hourly observations, and then rang Dr O'Sullivan to request that KL be assessed as soon as he arrived that day.

44. KL had told RN Christie that he would agree to a GP assessment, so Dr Sharma met with him while waiting for Dr O'Sullivan to arrive. Dr Sharma recorded that KL was not expressing any thoughts of self harm or suicide, but was nevertheless highly agitated and anxious.

45. At about 10.25am KL told staff at SPPH that he was going for a walk. He took his mobile phone and wallet with him, but not his laptop. Afterwards those who knew KL commented that this was very unusual, as he rarely left home without it.

46. Staff at SPPH were concerned, and rang CT to tell her that KL had left the hospital. CT immediately contacted her son, who then had the following text exchange with his father:

CD: *'Are you ok?*

KL: *Yes, I am ok.*

CD: *Where are you?*

KL: *Going for a walk'.*

47. Then at 11.10am CD messaged his father: *'Are you going back to the hospital?'* But he received no response.

48. Soon afterwards, SPPH staff rang police to report concern about KL's departure. At 11.35am a police record was broadcast, calling for assistance in looking out for KL who was described as a person with '*depression and suicidal thoughts'.*

49. At 6.00pm that evening CT and CD attended Rose Bay Police Station to report KL as a missing person.

50. The coronial investigation established that at 11.20am that day, KL had called for a taxi to collect him from a point about 900 metres from SPPH. However the taxi did not arrive. KL was collected by another taxi at 11.55am from a nearby location. KL asked the driver to take him to Manly, then changed his mind and asked to be taken to Vaucluse.

51. According to the statement of the taxi driver, at about 12.44pm he dropped KL off outside an address on Old South Head Road, Vaucluse. The driver saw KL

walk across the road to the grassed area of Lighthouse Reserve. This is the last known sighting of KL.

The search for KL

52. A full police search commenced the next day. On 9 July 2020 police were able to confirm that the last known location of KL's mobile phone was at 12.59pm on 8 July 2020, in the Lighthouse Reserve area of Vaucluse. With this information, police commenced land, air and sea searches over the surrounding areas. Land searches were made of the cliff line and the areas below. According to the Officer in Charge of the investigation, there is a drop of between 80 to 120 metres from the cliffs of Lighthouse Reserve directly into the ocean. Sea checks were also made, covering the waters around the North Head and Eastern Suburbs areas. These searches found no trace of KL.

53. The last transaction on KL's only debit card was in relation to his hire of the taxi on 8 July 2020. There were no transactions after that point. Subsequent financial searches revealed that KL was in significant debt at the time he disappeared.

54. Other lines of enquiry included checks for overseas travel, transactions on KL's OPAL card, Health Fund activity, and alerts placed with police services in other States and Territories. None of these have uncovered any trace of KL.

55. I now turn to the issues examined at the inquest.

Is KL deceased?

56. The evidence at inquest is sufficient to establish, on the balance of probabilities, that KL is deceased. The physical search uncovered no trace of him; neither have other *'signs of life'* searches carried out by police.

57. Perhaps most compellingly, KL's former wife CT and his son CD have not received any communications from him. The final communications were the text exchanges described above.

58. Without doubt KL loved his son and his former wife, and it is inconceivable that he would not have sought contact with them in the past four years unless he was unable to do so.

Can the time, place, cause and manner of KL's death be established?

59. Unfortunately the evidence is not sufficient to provide answers to all these questions.

60. It may be accepted that KL died on or soon after 8 July 2020. As for the place of his death, although the last known sighting of him was in the Vaucluse area it cannot be known if his death took place there.

61. It cannot be known for certain that KL's death was the result of a decision to take his ow life. But his low state of mind, and his long struggle with a major depressive illness (including with suicidal features) strongly suggest that this was the case. I find on the balance of probabilities that the manner of KL's death was suicide.

62. Unfortunately however, since KL's body has never been found the cause of his tragic death cannot be known.

63. I therefore find that KL died on or soon after 8 July 2020, and that his death was the result of an intentional self inflicted act. The evidence is not sufficient to enable findings as to the place and cause of his death.

64. I now turn to the other issues examined at the inquest.

What was KL's mental health condition at the time of his death?

65. On this question the Court was assisted with expert evidence from forensic psychiatrist Dr Kerri Eagle. Dr Eagle has extensive experience caring for patients with severe mental health problems both in the community and in custodial settings.

66. Dr Eagle was asked to provide her opinion on a number if questions, including what mental health condition or conditions KL was suffering around the time of his death.

67. Dr Eagle cautioned that she had never met KL, and that her psychiatric assessment was therefore a retrospective one based on documentary sources.

68. Based on her documentary review, Dr Eagle concluded that KL met the criteria for '*a major depressive disorder, severe depressive episode with melancholic features'*. She noted that while in SVH his symptoms appeared to improve with the newly prescribed medication, but that his mood '*continued to fluctuate in the context of perceived stressors'*. The perceived stressors included financial difficulties, poor work performance, isolation due to COVID restrictions, and excessive alcohol consumption.

69. Dr Eagle also considered that KL had a severe alcohol use disorder. This condition *'likely exacerbated an underlying mood disorder'.* His alcohol consumption had impaired his work and his relationships, despite his attempts to control it.

70. In her evidence at the inquest Dr Eagle stated that while he was in SVH KL appeared to have experienced a '*partial response'* to his treatment, but that he was still suffering the depressive episode at the time he was transferred to SPPH.

71. There was no disagreement with Dr Eagle's expert opinion as to the mental health conditions with which KL was struggling at the time of his death. I accept her opinion on this point.

Was the care which KL received at SVH of an acceptable standard?

72. Dr Eagle was asked her opinion as to the adequacy of the care and treatment provided to KL within SVH's PECC and Caritas units.

73. Regarding the medication prescribed to KL, Dr Eagle considered this to be appropriate. The type of medication and the dosage prescribed were standard, and she agreed that it generally took at least one to two weeks before it took effect.

74. In KL's case, Dr Eagle thought it reasonable to assume that by 3 July 2020 his medication was contributing to an improvement in his mental condition. Reportedly, although his mood continued to fluctuate, he was getting better sleep and was having some periods of a more positive mood.

75. Regarding the other aspects of care provided to KL at SVH, Dr Eagle considered these were of an acceptable and appropriate standard. KL's mental state was regularly monitored and reviewed, he had access to his family, and he was permitted to have leave.

Was it clinically appropriate for SVP to have discharged KL to SPPH?

76. At the inquest the Court heard evidence from different sources as to whether it was clinically appropriate for KL to have been referred to SPPH.

77. After KL's tragic death, Dr Brendan O'Sullivan provided a statement in which he expressed criticism of the decision to transfer KL to SPPH. It will be remembered that Dr O'Sullivan was the psychiatrist assigned to KL's care at SPPH, although due to KL's sudden departure Dr O'Sullivan never met him.

78. Similar criticisms were expressed in a statement of psychiatrist Dr Ashwini Padhi, who was the then and current Clinical Director of SPPH.

79. Like Dr O'Sullivan, Dr Padhi did not meet KL. However from his review of the records, he opined that KL was not a suitable candidate for SPPH at the time when Dr Huber referred him there. Dr Padhi asserted that the information which SVH had provided about KL did not '*reflect the fluctuations of [KL's] mental state, the severe changeability of his mood, and made no mention of any ongoing suicidality or cognitive instability'.*

80. In his statement and evidence Dr Padhi added the following criticisms:
    - that SVH had not undertaken a trial period to ascertain if KL's mental state was stable enough for him to be made a voluntary patient
    - that KL had not been using his new medication venlafaxine for long enough to derive therapeutic benefit from it
    - that KL probably lacked '*the capacity to engage in a deeper level therapeutic program in the context of his variation of mood, fluctuant mental state, recent switch to a new medication, severe psychosocial distractors (work/finance) and his ambivalence to transition to a private facility'.*

Dr Babidge's response

81. In his statement and oral evidence, Dr Babidge disagreed with these claims. He pointed to the fact that while he was in Caritas, KL had been tried with periods of unescorted and escorted leave and these had been successful. As for his medication, by the time of his transfer KL was tolerating the new antidepressant well, although he had yet to derive full therapeutic benefit from it.

82. As for the degree of KL's mental stability, Dr Babidge said this in his statement:

83. '[KL] was observed to improve clinically, with signs of improved mood and diminished agitation. No thoughts of suicide or self harm were noted by the treating team at the Caritas unit. [KL] was cooperative and assessed as retaining mental capacity to make decisions for himself about his ongoing treatment before his transfer to SPPH.'

84. In his oral evidence Dr Babidge acknowledged that KL's mental state during his admission at Caritas had fluctuated, but said that the trajectory was one of improvement. Dr Babidge based this assessment on the circumstances that KL's family leave had been successful, he had engaged with his treating team and taken his medications, and he had said he was agreeable to being under supervision at SPPH. In addition he was no longer suffering the effects of acute alcohol withdrawal.

85. Dr Babidge made a further important point. He and Dr Smith had personally reviewed KL a number of times while he was a patient within Caritas. In Dr Babidge's opinion, by 7 July 2020 his improvement was such that there was no longer a basis for him to be involuntarily detained under the *Mental Health Act 2007*. KL had agreed to continue with psychiatric treatment on a voluntary basis, and therefore referral to a voluntary program was consistent with the principle of *'least restrictive model of care'*.

86. Dr Babidge made the further point that a private hospital is able to provide a calmer and more therapeutic environment than that of a public hospital, which is frequently noisy and has a high proportion of patients suffering schizophrenic illnesses. In addition, private hospitals could offer group programs led by psychologists, a service which was not as freely available in a public facility.

Dr Eagle's evidence on this issue

87. Dr Eagle was asked if it was clinically appropriate to have transferred KL to SPPH on 7 July 2020. In her report and evidence she enumerated the matters to consider.

88. The fundamental factor, she said, was the principle of least restrictive treatment. Consistent with this, a patient should not be kept in an acute psychiatric unit any longer than was necessary. Dr Eagle agreed with Dr Babidge that SVH was a more restrictive environment, and it was a reasonable goal to step KL down to a more therapeutic one like SPPH.

89. A second critical factor was whether it was safe for KL to be stepped down to a voluntary hospital setting. In Dr Eagle's opinion, by 7 July 2020 KL's risk for suicide had abated. Given this improvement, it was not unreasonable for him to be transferred to voluntary treatment. Furthermore, KL had expressed that he did not want to remain in an acute care ward. Dr Eagle thought that in these circumstances, if KL wished to go to a private hospital the decision to transfer him was a reasonable one.

90. Dr Eagle acknowledged that the decision whether to transition KL to a private hospital was not an easy one. She commented that:

91.' … it is difficult to know with certainty when a patient is able to be safely and effectively cared for in a less restrictive setting.'

92. However, '*transition to a less restrictive environment is part of the recovery process'.* KL had been in an acute hospital setting for over two weeks; there had been some improvement in his symptoms; and he had expressed the wish to leave SVH. Overall, Dr Eagle considered that the decision to transition him to SPP was an appropriate one.

93. Dr Eagle was then asked about the opinion expressed by Dr Padhi, that at the time of his transfer to SPP KL did not have the capacity to engage in '*a deeper level therapeutic program'.*

94. Dr Eagle responded that fluctuation in mental states was common in the context of depressive episodes, as was ambivalence about engaging in treatment programs. She was unable to say whether KL had this capacity.

95. However in her opinion, if a facility's program required a certain level of capacity to engage, then it was incumbent on that facility to assess whether a prospective patient had this capacity. In his evidence Dr Babidge expressed the similar view that there was an obligation on a receiving private psychiatric facility to determine if the patient to be transferred was suitable for their program, and was able to meaningfully engage with it.

Conclusion

96. Sadly this Court conducts numerous inquests, where a person has taken their life within days or even hours of discharge from an involuntary admission. It is clear that for psychiatric treating teams, the question whether to step a patient down to a less restrictive status is one of the most difficult decisions they face.

97. In my view the evidence establishes that KL's treating teams at PECC and Caritas gave careful consideration to this question. Within both units KL received regular and careful psychiatric reviews. On two occasions a proposed transfer to SPPH was postponed due to concerns on the part of his treating team that his mental condition was not stable enough to permit him to be a voluntary patient.

98. I also acknowledge that the ultimate decision to change KL's status to that of a voluntary patient was made by treating psychiatrists who had the benefit of actually observing and speaking with him, and therefore may be presumed to have been in a more informed position to make this decision than those who had not.

99. Significant weight is to be given to Dr Eagle's opinion that overall, the decision to transition KL to voluntary status '*appeared appropriate in the circumstances'*. Dr Eagle is highly experienced within this field. Her report and evidence demonstrated that she had carefully reviewed the material and had given balanced and careful consideration to this question.

100. I find that the assessment of KL's treating team on 7 July 2020 that there was not a sufficient clinical basis to maintain him as an involuntary patient was appropriate.

101. Further, bearing in mind Dr Eagle's evidence that '*transition to a less restrictive environment is part of the recovery process',* and the informed support which KL's family gave to the proposed transition, I find that it was reasonable for KL's treating team at SVH to transfer him for ongoing care to SPPH.

Did SVH provide SPPH with adequate information about KL on his transfer?

102. In Dr Padhi's opinion, the referral information provided by SVP did not '*reflect the fluctuations of [KL's] mental state, the severe changeability of his mood, and made no mention of any ongoing suicidality or cognitive instability'.*

According to Dr Padhi, this reduced the capacity of those at SPPH to make an accurate assessment of his suitability to be accepted there.

103. In his evidence Dr Babidge conceded that KL's ambivalence about going to SPPH could have been made clearer in the Discharge Summary prepared by SVH staff. He agreed that if this had been the case, it may have prompted SPPH staff to highlight to KL the benefits of remaining with their program, and to remind him that he had been transferred there on the understanding that he was willing to do so.

104. In her evidence Dr Eagle emphasised the benefits in such cases of there being a verbal clinical handover of care between the two facilities ' … *in ensuring a smooth transition of care'*.

105. I have noted above, Dr Huber's unsuccessful attempt to provide such a handover. In his statement Dr Padhi conceded that Dr Huber's offer '*was a missed opportunity by SPP, for SPP to obtain more information about [KL's] condition. In hindsight, Dr Huber's invitation for a SPP psychiatrist to receive a verbal handover from her should have been communicated to the Clinical Director or Director of Nursing prior to [KL's] admission.'*

106. Similarly, Dr Padhi regretted that SPPH staff had not passed on to the SPPH clinical team the information provided by SVP's nursing team, regarding KL's anxiety and ambivalence about the proposed transfer.

107. Thus, senior clinicians at both SVH and SPPH have acknowledged that there were shortfalls in their sharing of clinical information about KL.

108. I note further the opinions of Dr Babidge and Dr Eagle, that a receiving facility needs to be proactive in determining whether a proposed patient is suitable for its program, and to seek relevant information as to the patient's mental state and capacity to engage.

109. Dr Padhi advised the court of changes which have since been made to SPPH's Pre-Admission procedures, which are outlined below. These appear to reflect recognition of the need for SPPH, in the case of more complex patients, to undertake appropriate enquiries about their suitability for their hospital's programs.

Changes to SPPH's Pre-Admission procedures

110. Following these events, SPPH reviewed and reformed its Pre-Admission Policy. As a result, before accepting a patient into its program SPPH now requires that:

- if the patient has had an ICU or psychiatric unit admission in the previous 6 months, a discharge summary must immediately be sought for SPPH staff to review; and
- if the patient seeks admission to SPPH from a public hospital, there must be a doctor to doctor handover prior to acceptance of the patient.

111. In addition, prior to acceptance prospective patients with complex mental health conditions must be reviewed by SPPH's Director of Nursing, Medical Superintendent, or the Senior Psychiatrist. This measure is intended to ensure a more expert assessment of the patient's suitability for admission to SPPH.

Conclusion

112. I have found that the decision to transfer KL to SPPH for ongoing treatment was not inappropriate. Further, although there were acknowledged deficiencies in the information which SPPH held regarding KL's mental state at the time of his transfer, there is no evidence that these deficiencies of themselves contributed to the tragic outcome.

113. I note in addition, the introduction of improvements to SPPH's processes in assessing patient suitability for its program.

Did SPPH respond appropriately when KL left the hospital on 8 July 2020?

114. Counsel for SPPH submitted that KL received professional and caring support from SPPH's medical and nursing staff during his brief admission there. The evidence supports this submission, and I make this finding.

115. In addition there was no submission, nor any basis for such a submission, that staff at SPPH did not respond appropriately when KL left the hospital on the morning of 8 July 2020. It is clear that there was no lawful basis under the *Mental Health Act 2007* for anyone at SPPH to prevent KL from leaving their hospital. Nevertheless appropriate efforts were made to persuade him to remain. When KL made it known that he wanted to go, RN Christie spoke with him and encouraged him to stay. She carried out a risk assessment, and tried to ensure he would receive a psychiatric review as soon as possible. She also arranged for GP Dr Sharma to speak with KL.

116. After KL's departure SPPH staff appropriately notified KL's family of his departure so that they could attempt to contact him. SPPH staff also notified police.

The question of recommendations

117. The evidence did not identify any areas where recommendations would be necessary or desirable in the interests of public health and safety.

Conclusion

118. It is unfortunate that, through the fault of no persons, it has not been possible to provide KL's family with the answers they need about the cause and place of his death.

119. I express to KL's family my sincere sympathy for his loss. KL was an eminent and dedicated journalist, whose long career and extensive body of work was widely respected. KL and his family were justly proud of his long and distinguished career.

120. But above all, KL was a father and a husband. KL's son and former partner cared very deeply for him, and would never have wished for him to pass alone and in such distressing circumstances. I hope it is of some comfort to them that the health staff at both SVH and SPPH provided him with professional and caring support, and tried to relieve his mental anguish in his last days.

121. I thank Coronial Advocate Christina Xanthos for her excellent work in the preparation and conduct of this inquest. I thank also the legal representatives of the interested parties in the inquest, and the Officer in Charge, Detective Senior Constable Kylie Morris.

.**Findings required by s81(1) of the Act**

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

Identity

The person who died is KL

Date of death:

KL died on or around 8 July 2020.

Place of death:

The evidence does not enable a finding to be made as to the place of KL's death.

Cause of death:

The evidence does not enable a finding to be made as to the cause of KL's death.

Manner of death:

KL's death was intentional and self inflicted.

I close this inquest.

Magistrate E Ryan

Deputy State Coroner, Lidcombe

30 September 2024