**CORONERS COURT**

**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of BQ |
| **Hearing dates:** | 8-11 April 2024 |
| **Date of Findings:** | 29 September 2025 |
| **Place of Findings:** | Coroners Court of New South Wales, sitting at Nowra Local Court |
| **Findings of:** | Magistrate David O'Neil, Deputy State Coroner of NSW |
| **Catchwords:** | CORONIAL LAW – young Indigenous woman, mental health, involuntary detention, public guardian, observations in mental health ward, access to scarf used as a ligature, Aboriginal Liaison Officers in Western Sydney Local Health District, Covid-19 times, cultural training within the Public Guardian |
| **File number:** | 2021/00205817 |
| **Representation:** | Counsel Assisting: Ms Donna Ward SC and Ms Peita Ava Jones, instructed by Ms Sarah Najjar of the NSW Crown Solicitor's Office<br><br>Family: Ms Harriet Skinner, instructed by Ms Hannah Dreyer of the Aboriginal Legal Service (NSW/ACT)<br><br>Western Sydney Local Health District (Cumberland Hospital): Ms Teni Berberian instructed by Nathan Guenette of Norton Rose Fulbright Australia |

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| | NSW Trustee and Guardian: Mr Justin Zeeman, instructed by Mr Jevan Griffiths of the NSW Trustee and Guardian<br><br>Ms Tieu Pham (Enrolled Nurse): Ms Benish Haider of the NSW Nurses and Midwives Association |
| **Findings:** | **The identity of the deceased**<br>The person who died was BQ<br>**Date of Death**<br>BQ died on18 July 2021<br>**Place of Death**<br>BQ died at Westmead Hospital<br>**Cause of death**<br>The cause of BQ's death was hypoxic ischemic encephalopathy and aspiration pneumonia as a result of hanging<br>**Manner of Death**<br>BQ's death was self-inflicted |
| **Recommendations:** | I make the following recommendations pursuant to s 82 of the *Coroners Act 2009* (NSW)<br><br>**Recommendation 1**<br>That the Chief Executive Officer of the NSW Trustee and Guardian make arrangements to provide First Nation's cultural competency training to all NSW Trustee and Guardian staff with a priority to those working with Aboriginal and Torres Strait Islander clients (and with consideration to periodically repeating such training).<br><br>**Recommendation 2**<br>A copy of the Court's findings into the inquest into the death of BQ be referred to the New South Wales Attorney General. |
| **Non-publication orders:** | Final non-publication orders were made on 29 April 2024 prohibiting publication of the name of the deceased and any family members or relatives. A copy of those orders may be obtained from the Coroners Court Registry. |

## INTRODUCTION

1. BQ died on the 18 July 2021 as a result of hanging herself in the Paringa Ward of Cumberland Hospital, where she was an involuntary patient. BQ was only 23 years old.

2. BQ was a mother, a daughter, a sister, an aunty, a niece, a cousin and a friend. She is deeply missed and will always be remembered by her loved ones. BQ died far too young.

## THE CORONER'S ROLE

3. An inquest is a public examination of the circumstances of a death. It provides an opportunity to closely consider what led to the death. It is not the purpose of an inquest to blame or punish anyone for the death or to determine civil or criminal liability. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this there may nevertheless be factual findings which necessitate an adverse comment or criticism to be made.

4. The primary function of an inquest is to identify the circumstances in which a death occurred, and to make the formal findings required under s 81 of the *Coroners Act 2009* (NSW) (the Act); namely:

    - the person's identity;
    - the date and place of the person's death; and
    - the manner and cause of the person's death.

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

## CORONIAL INVESTIGATION

6. Prior to holding the inquest, a detailed coronial investigation was undertaken. Investigating Police compiled an initial brief of evidence, and a number of documents were obtained, including a report by a forensic pathologist as to the cause of BQ's death. The court also received statements from police, civilian and expert witnesses. The officer in charge of the investigation was Senior Constable Sam Keanan-Brown.

7. All the documents including witness statements and expert reports obtained during the coronial investigation formed part of the brief of evidence that was tendered at the commencement of the inquest. Material was also received and tendered throughout the inquest. All of that material, and the oral evidence at the inquest, has been considered in making the findings detailed below.

8. The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification of same:

    I. The family of BQ

    II. The NSW Trustee and Guardian

    III. The Western Sydney Local Health District (WSLHD) (encompassing Cumberland Hospital)

    IV. Enrolled Nurse Tieu Pham

## WITNESSES CALLED TO GIVE EVIDENCE AT THE INQUEST

9. The following witnesses gave oral evidence in the inquest:

    I. Ms Jessica Lax, social worker from the Paringa Ward;

    II. Dr Viswanathan Kota, BQ's treating doctor from that Ward;

    III. Endorsed Enrolled Nurse Tieu Pham, who was responsible for conducting observations of BQ across the afternoon and evening of 16 July 2021;

    IV. Anna Gauci, the Acting Public Guardian;

V. Dr Marshall Watson, expert psychiatrist.

## ISSUES CONSIDERED AT INQUEST

10. An issues list was circulated amongst the parties in advance of the inquest. An issues list is neither completely determinative nor limiting. That is, issues may fall away during the inquest and others may emerge and be considered, subject only to procedural fairness being observed.

    The listed issues were:

    I. The circumstances surrounding BQ's discharge from the Shellharbour Hospital on 15 April 2021, against medical advice, and the status of her NDIS funding at that time.

    II. The nature and adequacy of the treatment plan formulated for BQ during the Cumberland Hospital admission commencing 23 June 2021, in light of the information known to the treating team from time to time.

    III. BQ's access to the scarf ultimately used as a ligature.

    IV. The conduct of Level 2 observations (every 15 minutes) on BQ across the afternoon and evening of 16 July 2021.

    V. Any indications that BQ was at increased risk of suicide across the afternoon and evening of 16 July 2021.

## BACKGROUND

11. The following background draws heavily upon the opening and closing submissions of counsel assisting. The parties acknowledged both the fairness and breadth of Counsel Assisting's submissions, as do I.

12. BQ grew up in Nowra with family all around her. At the heart of the family were her parents.

13. BQ was born prematurely in 1997 and spent 4 months at Westmead Children's Hospital fighting for her life. BQ had setbacks during her life and experienced

some medical issues from being born so prematurely, which affected her for life.

14. Her dad describes BQ as a beautiful kid who was "happy go lucky" and "full of life".

15. BQ was a talented artist, an animal lover, and a night owl. She admired American rapper Eminem, enjoyed crocheting and experimenting with make-up and hairstyling. She liked swimming at the beach and walking in nature.

16. BQ was also a mother. Her son was born when she was 18. BQ did not have much contact with her son after the birth but she spoke of him often and longed for the opportunity to have a close and meaningful relationship with him.

17. BQ struggled from early adolescence, with a range of issues.

18. BQ reported traumatic events from childhood and adolescence including allegations of childhood sexual abuse.

19. The approach at inquest was not to seek to resolve these allegations. It was accepted however that the very existence of the allegations both affected BQ's relationships and couldn't be ignored by those who treated BQ.

20. Despite these challenges when BQ was well and with the people she trusted, she was a vibrant young woman but as her health and functioning deteriorated, as she became drug dependent, as she was exposed to abuse and violence, that vibrant young woman became lost. She was distant from her family and her culture to such an extent that at times in the last weeks of her life, she denied that she had parents, and she denied she was Aboriginal.

21. When BQ was about 14 years old she stayed with a friend for the weekend. When she returned home, she was very distressed and confused. Her parents say BQ wasn't ever the same after that night. She started speaking gibberish, would scream at people, stopped showering and made alarming statements such as people were "raping" her mind. Her family feared she might have been drugged and possibly sexually assaulted whilst staying with the friend. BQ herself later told hospital staff that her drink was spiked that weekend. From then on BQ's mental and physical health deteriorated.

22. BQ began to act in ways that were out of character for the "happy go lucky" child her family knew. BQ could be aggressive and demanding and when she was very unwell BQ would lose contact with the people around her who loved

her so dearly. Sometimes it was hard for her family to reach BQ, even when she was right there with them.

23. About two months after the weekend away, following a deterioration in BQ's behaviour, her parents took her to Shoalhaven Hospital Emergency Department. This was on 8 September 2012. According to the records made at that time, BQ was hostile, not eating and was behaving bizarrely. BQ was admitted to the adolescent mental health ward for about 2 months. This was her first contact with mental health services and she was given a provisional diagnosis of Schizophrenia and prescribed the antipsychotic medication Risperidone.

24. This was the first of BQ's many admissions to mental health wards. Most of these admissions were to Shellharbour Hospital. Many were lengthy involuntary admissions. BQ became well known to staff.

25. For the first few years BQ would return from hospital to live with her parents after discharge, but this arrangement eventually broke down.

26. BQ's mum indicated that BQ started "having voices in her head, she thought her family were reading her thoughts. BQ would lose her temper and would get very violent". BQ's mental health would decline between 3 to 4 weeks after discharge from Hospital, possibly as a result of BQ having access to illicit substances. Another challenge when BQ was at home was ensuring that she was taking her medication. When things escalated, the family would sometimes need to call the police and ambulance to have BQ taken away.

27. A recurring feature during BQ's illness was that she would accuse family members and others of sexually abusing her. These allegations aren't corroborated by evidence that was before me and as pointed out above, the issue was not sought to be determined at inquest. But the fact that the allegations were frequently made could not be ignored by the treating teams and other services trying to help BQ. For their part, BQ's family were aware of the accusations and eventually accepted that they would be raised by BQ from time to time during BQ's illness.

28. BQ became pregnant during the later part of 2015 and her son was born on 17 May 2016. The medical records show that BQ was clean from drugs during her pregnancy and did not show any psychotic symptoms immediately before or after his birth.

29. However about two weeks after the birth, BQ was re-admitted to Shellharbour Hospital because by this time she was again displaying psychotic symptoms and was agitated and paranoid.

30. Family and Community Services (FACS; now DCJ) became involved and BQ's son was removed from BQ's care. BQ's father indicated that this decision left BQ hysterical and "inconsolable".

31. In August 2016 a social worker at Shellharbour Hospital applied to the New South Wales Civil and Administrative Tribunal (NCAT) for the appointment of a guardian and financial manager for BQ.

32. The reality was that because of her poor decision making, and lack of insight and judgement, BQ was extremely vulnerable to physical, emotional, sexual and financial exploitation.

33. NCAT determined on 10 November 2016 that the Public Guardian should be appointed as BQ's guardian (initially for 12 months but extended by further orders in 2018 and 2020). Among other things, the Public Guardian was given authority to make accommodation decisions for BQ so that suitable housing could be located. Although she had been living with her parents prior to her admission and was welcome to return, BQ (by then aged 19) stated she would like to live independently.

34. Despite this stated desire, BQ again returned to live with her parents and attempts were made to manage her conditions in the community.

35. An Outpatient Management Plan was developed for BQ by a doctor at Shellharbour in July 2017 with an initial priority of ensuring BQ's adherence with a depot antipsychotic. Once that was well-established, it was hoped that other goals might become a focus for BQ such as reduced drug dependence and getting stable accommodation.

36. This plan did not work. BQ went missing from her parents' home returning briefly at a time when she threatened to kill them and was later apprehended by police and transported to Shellharbour Hospital in October 2017. On admission, BQ tested positive for amphetamines and cannabis. Another prolonged admission followed.

37. During this time in hospital there was a focus on stabilising BQ's mental state and behaviours and obtaining National Disability Insurance Scheme (NDIS) funding for her.

38. It was considered that BQ's adaptive functioning skills had deteriorated since they had been last assessed at age 17. This deterioration was thought to be due to BQ's long history of substance abuse and schizophrenia. It was recognised that on discharge BQ would require supportive accommodation "as her parents have been unable to manage her behaviour or ensure compliance with medication".

39. At this time BQ's parents were noted to be reluctant to accept her back home. This is understandable given that BQ had been aggressive and threatening when she was last with her parents.

40. In 2019, after another period of hospitalisation, BQ's NDIS support co-ordinator was able to find a placement for BQ at supported accommodation with Home Caring in South Nowra. This placement was approved by the Public Guardian.

41. Initially BQ seemed to enjoy things in her new place. Staff from Home Caring reported some positive interactions and that BQ was taking her medication.

42. However, this didn't last. Another resident arrived in July 2019. BQ and the new resident clashed and BQ began to show signs of paranoia, refused to take her medication, began running away and again using drugs. In addition, BQ assaulted the other resident and staff.

43. In December 2019, BQ couldn't find her camera and became frustrated, angry and upset. Afterwards she cut her hand severely with a large kitchen knife requiring stitches. She said at the time the cut was accidental and denied it was an act of self-harm.

44. BQ's parents were unhappy with the arrangements for BQ at this home and felt excluded from BQ's life as they were unable to spend much time with her. The time they did have with her was supervised. From their perspective, BQ was becoming estranged from them and from her grandparents and extended family and they felt locked out of trying to support BQ.

45. The placement with Home Caring ultimately failed and by May 2020, BQ was living at a refuge in Nowra called Safe Shelter Shoalhaven. BQ went missing from the refuge later that month.

46. On 28 May 2020, BQ was admitted to the Kiloh Centre at Prince of Wales Hospital in Randwick. The admission arose under s 20 of the *Mental Health Act 2007* (NSW) after BQ was reportedly threatening members of the public in Bondi. About one week later BQ was again transferred to the Mirrabrook Mental Health Unit at Shellharbour Hospital at the request of the Public Guardian.

47. This admission at Mirrabrook lasted for over 10 months. This gave doctors an extended opportunity to review BQ, to see her stabilise, clarify her diagnoses, and to implement a treatment and care plan to manage her complex issues.

48. The treating clinicians sought a number of extensions to BQ's Involuntary Patient Order from the Mental Health Review Tribunal (MHRT) primarily to allow time to develop a plan for BQ to be discharged into a safe environment with robust support.

49. Finding such a placement presented a challenge for all those involved in BQ's care. BQ was described as being "fixated" upon returning to Nowra albeit not to her family. It seems that BQ was determined to live with a man who, on the information available to those involved with BQ at the time posed a risk to BQ.

50. As a result, this option was not supported by the Public Guardian nor others in BQ's support team who believed supports in Nowra would be inadequate and that BQ's mental health would rapidly decline once she left hospital. Her treating team at Mirrabrook told the MHRT in November 2020: "If she is discharged prematurely without a robust arrangement in place it is likely that her mental state will deteriorate rapidly due to external stress, higher chance of relapse and would be a danger to community and herself".

51. Jodie Ward was BQ's main support worker during this admission, working for the organisation Valley Health Care. Part of her role was spending time with BQ whilst BQ was in hospital and assisting her with completing daily tasks to get her ready for a transition back into the community. BQ received this support as part of her NDIS package. Another part of Ms Ward's role was trying to find suitable accommodation for BQ.

52. BQ also had a NDIS support co-ordinator, Leonie MacDonald, who met with BQ in December of 2020 at Mirrabrook. Ms MacDonald considered BQ should live on her own but that she would need two carers around the clock due to her aggression and risk of absconding. This was consistent with the recommendations of BQ's treating team at Shellharbour Hospital and the State-wide Intellectual Disability Mental Health Outreach Service (SIDMHOS), which became involved in BQ's case in about September 2020.

53. Crucially, BQ did not at this point have accommodation funding as part of her NDIS plan. An application was made to try and secure that extra level of funding to provide around the clock care by at least 2 workers at a time.

54. An NDIS planning meeting was held on 25 March 2021 attended by Ms MacDonald, Amanda Smith (on behalf of the Public Guardian), Samantha Hall

(an Occupational Therapist from Shellharbour Hospital as part of the Pathways to Community Living initiative) and an NDIS Officer called Rosetta.

55. According to Ms MacDonald, the outcome of what she described as a "traumatic" meeting was that BQ's NDIS plan would not be revised. This meant that BQ remained without accommodation funding, including for the purposes of paying for emergency accommodation and getting BQ onto the complex needs pathway.

56. This proved to be a missed opportunity to set up something specialised for BQ's accommodation.

57. There was considerable urgency in finding a safe and supportive placement for BQ. Her treating team at Mirrabrook thought that BQ had stabilised over the course of her very long admission and that the MHRT would not continue to extend an order for involuntary admission as BQ no longer met the grounds for such an admission.

58. There was understandable concern that BQ would be discharged into homelessness without accommodation funding approval coming through from the NDIS.

59. Ms Hall, the Occupational Therapist from Shellharbour Hospital and others involved with BQ, continued to fight for BQ to receive additional funding from the NDIS even after the first application was rejected.

60. Amanda Smith, on behalf of the Public Guardian, was working with the treating team to "try and convince" BQ to stay at the hospital until the extra accommodation funding was secured. But BQ could not be persuaded and instead insisted she was going to leave the hospital to stay with her "Uncle" and "Aunt" in Nowra.

61. In the balance of these findings, I shall refer to these two people as “the uncle” and “the aunt” despite the fact that they were not related to BQ.

62. The place where the uncle and aunt lived was not a desirable place for BQ and exposed her to many risks.

63. Although Ms Smith did not support this option, she contacted the uncle and aunt who confirmed BQ could stay with them.

64. When BQ's matter was next before the MHRT on 14 April 2021, BQ's treating team provided a report to the MHRT confirming their view that BQ was not at that time mentally ill or disordered and there was no evidence of pervasive mood disturbance or psychosis.

65. As had been expected, the MHRT found that BQ no longer met the criteria to remain an involuntary patient and, against medical advice, BQ discharged herself from hospital the very next day (15 April 2021) to live with the uncle and aunt.

66. At the same time, decision making around her new NDIS plan had been escalated to the Director of the National Disability Insurance Agency but not yet approved.

67. The discharge referral from Mirrabrook confirms that by the end of this long admission, BQ's diagnosis of schizophrenia had been "rescinded" and her diagnoses were recorded as:

    I. Borderline personality disorder;

    II. Polysubstance misuse disorder;

    III. Dissociative personality disorder; and

    IV. Mild intellectual disability.

68. BQ was not prescribed any medication on discharge.

69. It is not known precisely what happened to BQ during the period she stayed with the uncle and aunt after discharge from Shellharbour Hospital, but BQ totally disengaged from her support workers from Valley Health Care and quickly relapsed into drug use and homelessness.

70. BQ's support co-ordinator tried to maintain some level of contact. She went to visit BQ on 11 May 2021 but was told BQ was asleep, and she could not come inside to see her.

71. At this time BQ’s parents had not been notified about BQ's discharge from Shellharbour Hospital. BQ’s father had however learnt BQ was out of hospital via a friend who had seen her in town.

72. After contacting Ms Smith, BQ's parents were informed that BQ had been taken to the house of the uncle and aunt when BQ left Shellharbour Hospital.

73. This news "infuriated" BQ's father who knew the uncle had a criminal history. He was afraid BQ would not be safe with the uncle and would have access to drugs. He also worried BQ was sexually vulnerable. Concerned for BQ's welfare, her parents tried to pick BQ up from the house of the uncle and aunt but BQ was never there when they went over.

74. In the meantime, on 21 April, six days after BQ was discharged from hospital her NDIS plan was extended with funding for accommodation finally approved. In addition, a unit was available for her in Campbelltown.

75. BQ's support team were aware that BQ would be resistant to moving to Campbelltown where she would feel isolated. In March 2021 they had tried to convince BQ to "give Campbelltown a try" when she was at Shellharbour Hospital and had driven her there to look around, but BQ had refused to even get out of the car to look at a unit on offer and said she would run away to Nowra if forced to live there. Nevertheless, further attempts to engage BQ were made by Ms MacDonald and Ms Ward, but BQ refused to move from the uncle and aunt's to a unit in Campbelltown.

76. The Public Guardian could have authorised police or ambulance to locate BQ and physically take BQ to Campbelltown, but this would have likely involved confrontation with, and physical restraint by, NSW Police in circumstances where BQ had done nothing illegal. The various options in relation to the Public Guardian's powers were explained during the inquest and I am well satisfied that the Public Guardian was correct in not authorising police to restrain BQ.

77. BQ went missing from the aunt and uncle's house for the final time in about mid-June 2021, only a couple of months after she was discharged from Shellharbour Hospital. According to the uncle, BQ was using ice and marijuana, was not washing and had stolen his medication. He said BQ had left his home several days before and he did not know where she was.

78. BQ next came in contact with authorities when she was arrested in Bomaderry following violent unprovoked assaults on a schoolgirl and another woman: each of them was a stranger to BQ.

79. BQ was bail refused in Nowra Local Court on 17 June 2021 and taken to the Amber Laurel Correctional Facility. On 23 June BQ was moved to Silverwater Women's Correctional Centre. Subsequently, as a result of orders of the Local

Court, she was taken to Cumberland Hospital for a health assessment. Upon assessment BQ was detained as an involuntary patient.

80. BQ entered Cumberland Hospital from Silverwater Women's Correctional Centre on 23 June 2021.

**23 June 2021 – Admission to Yaralla Ward, Cumberland Hospital**

81. On first assessment at Cumberland Hospital there were concerns that BQ was suffering from psychosis. The treating team thought it may have been drug induced or a relapse off a background of psychotic illness.

82. At this time the treating staff did not have much information about BQ's past medical history and BQ herself was quite guarded in what she told them. Some of the things BQ told them were significantly inaccurate. For example, BQ told the admitting doctor at Cumberland, Dr Kumari, that she did not have parents and that she was raised by various aunties and uncles. She reported having no past history of mental illness including mental health admissions. She refused to talk about her criminal history and shut down questions on that topic. BQ did say she had been living with her uncle and aunt but she could not tell the doctor their address or phone number.

83. From BQ's Nomination of Designated Carer form it appears BQ did not disclose that she had a guardian appointed and did not otherwise volunteer names of family who might be designated carers.

84. Yaralla Ward is a high dependency unit where intensive psychiatric care is provided to patients to manage acute crisis situations. After acute crisis is brought under control, patients are transferred to one of the admission wards.

85. After further reviews over the two days following BQ’s admission, doctors formed the impression that BQ was suffering from an acute psychotic episode of unknown cause and possible cognitive impairment.

86. It wasn't until six days after BQ's admission that Cumberland Hospital staff became aware of the diagnoses favoured by Shellharbour Hospital, after that Hospital's long involvement with BQ came to an end in April 2021. Cumberland Hospital only learnt this once they requested and received the Shellharbour Hospital discharge summary on 29 June.

87. BQ's prior admission to Shellharbour Hospital was discussed at a Cumberland Hospital Multidisciplinary Team meeting on 5 July 2021 after which the team

refined their diagnosis and formed the impression that BQ was experiencing drug induced psychosis superimposed on intellectual disability.

88. During her time on the Yaralla Ward, BQ was wanting to go home and pushing to be discharged.

89. Nowra Police told the hospital social worker they had no next of kin listed for BQ and when she was again asked about her home, BQ still could not provide an address.

90. Eventually, on 8 July, BQ provided hospital staff with the names of the aunt and uncle and a contact phone number for them. She also told staff that she did not identify as Aboriginal or Torres Strait Islander. One of the treating team, Dr Franklin, subsequently called the uncle who confirmed BQ was Aboriginal and provided details of her support worker, Ms Ward, at Valley Healthcare.

91. Later that same day, Dr Franklin contacted Ms Ward and, through her, was informed that BQ was under the care of the Public Guardian. Dr Franklin spoke with Ms Smith from the office of the Public Guardian and obtained information about BQ's traumatic background and history of drug dependence.

**10 July 2021 – Transfer from Yaralla Ward to Paringa Ward**

92. BQ was "stepped down" from the Yaralla Ward and admitted to the Paringa Ward on 10 July, just over two weeks into her admission at Cumberland.

93. Each patient on Paringa Ward is assigned to a Consultant Psychiatrist who is assisted by a treating doctor. Dr Kota, a Senior Career Medical Officer, was BQ's treating doctor. He saw BQ most frequently on the ward and would speak with her Consultant Psychiatrist, Dr Narayanan, from time to time.

94. During her time at Paringa, BQ consistently asked the doctors to discharge her, telling Dr Kota she felt "claustrophobic”. She contacted police asking for them to get her out of the hospital because she was not mentally ill and she made multiple distressing calls to Ms Ward and the Valley Health Service pleading for them to pick her up from hospital. Ms Ward tried to reassure BQ over the phone but, because of covid restrictions, could not go to visit her in person.

95. BQ continued to deny that she was Aboriginal during this admission.

96. BQ's behaviour continued to be quite disturbed on the ward. A progress note made on 14 July records that whilst BQ was using the ward phone she became

agitated and smashed the phone on the floor. She started banging on a window. Attempts to verbally counsel her were unsuccessful and emergency assistance was called. BQ was given a sedative and antipsychotic medication to manage her agitation "with minimal effect".

97. The next day, 15 July 2021, BQ's admission was considered by the MHRT. BQ was agitated, repeatedly interrupting the proceedings and insisting that she wanted to be discharged. She denied having a mental illness. BQ told the MHRT that she wanted to return to her "boyfriend" in Wollongong to look after her two children with him. Her behaviour was apparently so disruptive that she was asked to leave the hearing. The MHRT ordered an extension of BQ's involuntary inpatient treatment for four weeks. The order was due to expire on 12 August 2021.

**Events on 16 and 17 July 2021 – Paringa Ward**

98. During her admission to Cumberland Hospital, BQ was observed by nursing staff at different frequencies over different points in time.

99. Clinicians in a mental health setting are expected to observe and engage with patients as a means of assessing their physical, mental and social condition. The NSW Health Policy Directive "Engagement and Observation on Mental Health Inpatient Units" advises that:

> *"Observations through engagement are for safety, protection from harm and maintenance of wellbeing. It provides an opportunity to develop rapport and contribute to ongoing assessment and recovery. The purpose of observation is to provide optimum care, to escalate and manage deterioration in a timely way and to ensure safety of the environment in which the care is being provided. Observation is indelibly linked with clinical assessment. Observation informs ongoing decisions about care and must be a continuous feature of the care of people in mental health inpatient units."*

100. The observation levels range from Level 5 to Level 1, from least restrictive to most restrictive, based on the current needs of the patient. When BQ was transferred from Yaralla Ward to Paringa Ward she was on Level 3 observations requiring "random and regular checks" of her location and activity at least every 30 minutes.

101. On the morning of 16 July 2021, BQ was seen by Dr Kota. Dr Kota talked to BQ about an incident the day before where a patient had lit some curtains on fire on the Paringa Ward. Staff seemed to think BQ was responsible. BQ repeatedly

denied starting the fire and when told she would have to pay for the curtains she replied she "had no one". She reportedly became angry when the topic was pressed further, got up and left the room briskly.

102. Later that day, another patient came forward and confessed to starting the fire.

103. During the same assessment, Dr Kota noted that BQ wanted to go to Wollongong and that she said people in the Hospital tease her. She complained that a female patient "punched her twice" to get the phone from BQ. Dr Kota recorded in the progress notes that "no psychotic symptoms could be elicited" but that BQ was "angry" and "frustrated" at being in hospital and "wants to know if she can be discharged".

104. After a discussion with BQ's Consultant Psychiatrist, Dr Narayanan, Dr Kota increased BQ's observation levels from Level 3 to Level 2, requiring random and regular observations at least every 15 minutes rather than every half hour.

105. This level of observation is considered to be "significantly restrictive to mitigate risks for consumers who are assessed as being at a high level of concern." In BQ's case, the perceived risk underscoring the increase to her observation level was that she might abscond. It was not related to any specific concerns regarding her risk of suicidality or self-harm.

106. Endorsed Enrolled Nurse (EN) Pham commenced her shift on the Paringa Ward at 2:30pm on 16 July 2021. Amongst her other responsibilities on the ward, EN Pham was responsible for conducting the Level 2, 15-minute observations of BQ.

107. EN Pham's first entry in BQ's progress notes at 3:57pm records BQ was pacing around the ward restlessly and appeared "suspicious" in the courtyard looking at bushes. BQ denied thoughts of suicide or self-harm.

108. One patient later told police that BQ was on the phone for much of the day and that he heard her say "I feel like committing suicide" and "I want to commit suicide".

109. This patient believed BQ called four different numbers as he observed her knocking on the window to the nurses' station four times asking for help to reset the handset. He describes that at one point, BQ was "screaming out for help to get out of the ward".

110. That BQ was using the phone frequently that day was confirmed in the clinical notes and EN Pham's evidence. Ms Ward from Valley Health Care indicated that BQ, who had been calling her "non-stop" for about 4 to 5 days, made a final call to her late in the afternoon of 16 July but she did not pick up.

111. BQ's father believes that some calls placed to his mother late that day might have been BQ, but nobody could be heard on the line.

112. Another patient later reported to police seeing BQ between 3:00pm and 4:00pm, carrying a 1 litre milk bottle that she thought had watered down milk in it. That patient is said to have seen BQ scoop dirt from the courtyard garden and pour it into the bottle, shaking the bottle to mix the dirt with the liquid.

113. At 6:00pm, EN Pham asked BQ to have a shower as she was wearing multiple layers of clothing, including a scarf, and had not showered for a couple of days. BQ complied and returned to her room.

114. About 2 hours later (7:50pm) police attended the Paringa Ward to speak with BQ. EN Pham explained that the police attended after BQ called them earlier in the afternoon to complain about another patient not liking her and bullying her. BQ told the police that she was punched in the arm by another patient and kicked in the stomach by a nurse at about midday because the nurse thought BQ was going to assault him.

115. Police experienced difficulties in getting an account from BQ who repeatedly asked the police if she could be discharged. BQ also became agitated at times and was yelling and screaming on occasions.

116. After the police left, BQ was observed in her room by EN Pham and at some point EN Pham gave BQ some lollies. EN Pham’s evidence was that BQ did not appear distressed in the evening and was not behaving out of character.

117. At about 9.10pm, EN Pham was conducting checks on all her patients. She states that she could not see BQ in the sitting room so she walked around looking for her and knocked on the toilet door. BQ shouted out that she was inside. EN Pham asked BQ whether she was okay, to which BQ replied "yeah". Upon hearing this, EN Pham returned to the nurse’s station.

118. The evidence of EN Pham was that approximately 5-10 minutes after she last checked on BQ, she was in the lounge area when she heard an extremely loud scream and saw a female patient running down the hallway.

119. That patient later told police that she had opened the door to the female bathroom and BQ fell to the floor outside the bathroom.

120. Registered Nurse (RN) Vincent Belleza also heard the female patient scream and ran from the nurses' station towards the end of the corridor. To his left he could see BQ lying on the bathroom floor unconscious and unresponsive. RN Belleza noticed the scarf around BQ's neck and immediately untied it.

121. RN Kandel had also run from the nurses' station towards the female dorms. He saw BQ lying on the floor outside the bathroom lying face up and immediately called a Code Blue, indicating a medical emergency.

122. EN Pham ran to where the female patient had come from, following the other nurses, and into the female bathroom. She saw BQ lying on the floor with her scarf around her neck. She was not moving. EN Pham could not tell if she was breathing.

123. CPR was commenced and paramedics arrived at BQ's side at 9:43pm.

124. Ambulance Officer (AO) Simon Zappelli recalls that when paramedics arrived there were 10 to 12 medical personnel on scene but there did not appear to be a clearly identified leader. He indicated it took "some time to find the right person" who could confirm the last time BQ had been observed on the ward. That staff member reported to AO Zappelli that BQ had been unaccounted for, for a period of up to 30 minutes. It's not clear where this information came from or who that staff member was.

125. BQ was then taken to Westmead Hospital.

**BQ's death on 18 July 2021 – Intensive Care Unit, Westmead Hospital**

126. During the initial assessment at Westmead, BQ suffered a cardiac arrest that necessitated further CPR. Once stabilised, examinations were performed, and an assessment made that BQ had suffered a non-survivable hypoxic brain injury. Subsequent testing confirmed that BQ was clinically brain dead.

127. BQ's parents had not been notified about BQ being arrested at Bomaderry, entering prison or being transferred to Cumberland Hospital. They were contacted once she was admitted to Westmead.

128. BQ's father says he contacted Westmead Hospital on 17 July only after police attended his home to advise BQ was there, in a critical condition, after attempting to hang herself.

129. Later that day, BQ's father received a phone call from Westmead Hospital. The medical records indicate this call was from a social worker who told BQ's father that BQ was brain dead and nothing else could be done to save her.

130. Treatment was withdrawn the following day and BQ's death was declared at 12:21pm on 18 July 2021.

## DETERMINATION OF ISSUES

### Issue 1: The circumstances surrounding BQ's discharge from the Shellharbour Hospital on 15 April 2021, against medical advice, and the status of her NDIS funding at that time.

131. As set out in detail above, as a MHRT hearing approached for BQ in April 2021, treating clinicians were of the view BQ was no longer at risk of harm to herself or others and as such could not lawfully be kept as an involuntary patient. Whilst that remained a decision for the MHRT, the information to be provided by the treating clinicians meant the MHRT was highly likely to revoke the existing order which had been keeping BQ in hospital.

132. At the same time an application for funding for BQ's housing needs was with the NDIS but not yet favourably determined and BQ did not want to return to live with her parents. BQ was determined to live in Nowra with the people she described as her uncle and aunt. She did not want to return to living with her immediate family.

133. In the end the authorities and support services could do no more than they did. Once the MHRT decided on 14 April that BQ could no longer remain an involuntary patient, BQ could no longer be lawfully kept where she was against her wishes. BQ did not accept the medical advice to remain in hospital until the application for further financial assistance was determined.

134. In those circumstances, BQ was taken to the home of her aunt and uncle. No one involved with BQ thought this was a good situation, but I am satisfied no more could have been done.

135. I am satisfied that it would not have been appropriate to use coercive powers to place BQ somewhere else.

136. As Ms Gauci said in her evidence, the suggestion that someone could keep BQ in a specified place, when BQ did not wish to be in that place was illusory. In practice, the Public Guardian could not authorise someone to basically keep BQ locked up.

137. Based on the evidence no good came of BQ being place with her uncle and aunt however the situation could not be avoided in the circumstances which existed at the time.

138. An issue intimately connected to listed issues 1 and 2 was the lack of information relayed to the family from the time of BQ leaving Shellharbour Hospital to the time of her death. There was a significant amount of evidence at inquest as to whether BQ's parents should have been provided information relating to BQ. I shall deal with this issue separately below.

**Issue 2: The nature and adequacy of the treatment plan formulated for BQ during the Cumberland Hospital admission commencing 23 June 2021, in light of the information known to the treating team from time to time.**

139. When BQ arrived at Cumberland Hospital, the clinicians knew very little about her. She had come from the custody of Corrective Services NSW (CSNSW), but even CSNSW knew relatively little because BQ had only been in custody for a matter of days.

140. Initially, Cumberland were dependent upon BQ for details of her history and her family. As set out above, BQ said many things that were not true. For example, that she lived with her uncle and aunt, that she did not have parents, that she had two children and a boyfriend in Blacktown and that she was not Aboriginal.

141. Cumberland Hospital would have been assisted by early access to better records about BQ's history, particularly the most recent discharge summary from Shellharbour Hospital.

142. Six days after BQ arrived in Cumberland Hospital the discharge summary from Shellharbour was available to Cumberland Hospital staff. Whilst the discharge summary did give a history of what the diagnostic dilemma was, it didn't highlight what worked and what didn't work.

143. Dr Watson opined that given the complexity of BQ's conditions it would have been advantageous if the clinicians at Cumberland Hospital had the Shellharbour Hospital information available to them earlier so they could look at what treatment approaches were useful in the sense of medication. I accept that opinion.

144. As further suggested by Dr Watson, a case conference between Cumberland and Shellharbour hospitals would likely have been beneficial. Dr Kota said that such conferences can happen, but sometimes staff move on or can't remember the patient. However, as Dr Watson made clear, BQ's admission at Shellharbour was a long-term admission in a hospital that had seen her multiple times over the years. In my view, the team at Cumberland Hospital should have made enquiries of Shellharbour Hospital to assess if any clinicians who had been involved in BQ's care were available to participate in a joint consultation between treating teams.

145. The treatment plan for BQ was not adequately documented in the records at Cumberland at any stage. The records do not disclose what was offered to BQ by way of a treatment plan, beyond references to medication. One can't discern from the records if the change in medication introduced on the Yaralla Ward was thought to have been effective.

146. Accurate record keeping is a fundamental aspect of good health care, however, it can't be said that the poor record keeping had any negative impact on the level of care provided to BQ.

147. Overall BQ's medications were attended to and the clinicians provided ongoing dedicated attention to BQ. In closing submissions, Counsel Assisting noted that:

> "*[N]otwithstanding the deficiencies within the records, treatment was actually being offered to [BQ], even if it was not specifically recorded in individual assessments. She was commenced on new medication and she was referred to the psychologist on the Paringa ward. This may have been the start of some talk therapy if rapport had been gradually developed.*"

148. Whilst Dr Watson accepted that the treatment plan was satisfactory given the information known to the treating team, he also was of the view that a cultural care plan might have assisted BQ during her admission at Cumberland which he considers was seemingly a "stressful and disempowering" experience for her. He also said that in the absence of her usual supports, a peer support worker may have also assisted BQ; someone who could "meaningfully engage"

with BQ "at a different level" to the treating team and "would not necessarily be seen as someone she perceived as obstructing her discharge".

149. This is an area in which contact with the Aboriginal Liaison Officer (ALO) would likely have made a difference for BQ. As Dr Watson indicated, the way in which people spoke to BQ was important. Dr Watson explained as follows "this is about recognising the primary importance of trying to make sure that Aboriginal people can talk to other Aboriginal people when seeking help from our hospitals". It was most unfortunate that because of the pandemic, the ALO was not on the floor in the Hospital.

**Issue 3: BQ's access to the scarf ultimately used as a ligature.**

150. As BQ used her scarf as a ligature the issue arises as to whether she should have had access to the scarf.

151. The family submitted that from their perspective, it is unfortunate that BQ was allowed to have a scarf in her possession for a large portion of the day on 16 July 2021. Whilst accepting there needs to be a balance between safety and maintaining a person's autonomy and dignity by having access to their own clothes, a scarf may not be considered to be a necessary clothing item. In light of Dr Watson's evidence of there being signs of BQ's increased irritability in the hours leading up to her death and his evidence in relation to the fluctuation of her moods, the family further submitted that there may have been cause for Cumberland Hospital staff to remove the scarf from BQ at some stage on 16 July 2021.

152. Counsel assisting submitted that wearing her regular clothes was one of the last small shreds of autonomy and dignity left to BQ. Asking BQ to hand over the scarf or other clothing or forcibly trying to remove it from her would likely have been interpreted as further punitive and unduly harsh behaviour and might itself have increased the risk to BQ.

153. In written answers to questions put to him, Dr Watson indicated that BQ:

> *"[B]eing able to access regular clothing, including a scarf is that it was a basic human right that she could do so. If there were no concerns assessed by staff, there would have been no reason for these items to have not been available."*

154. As Dr Watson pointed out in oral evidence, it's not just what patients are wearing. It's also about access to ligature points. It could've been anything that could've been used, absolutely any part of any item of clothing. And, whilst BQ was "*detained under the Mental Health Act you still want to respect patients'*

*autonomy … and try to address things in the least restrictive practice, just [in] the spirit of the act.*"

155. Staff needed to minimise opportunities for self-harm but could never completely eliminate them.

156. I am satisfied that BQ's circumstances were not identified to be so serious that she should have been deprived of the comfort of regular clothes.

157. The issues surrounding assessment of risk for BQ shall shortly be discussed as part of Issue 5.

**Issue 4: The conduct of Level 2 observations (every 15 minutes) on BQ across the afternoon and evening of 16 July 2021.**

158. The reason for the increase in observation level was neither well documented nor well communicated.

159. EN Pham thought the level was increased because BQ might light a fire, although EN Pham was also aware that BQ might go AWOL. As set out above, Dr Kota and the consultant thought BQ was a flight risk. Dr Watson ultimately did not place any weight on the fact that the EN Pham was not aware of the precise reasoning behind the increase in frequency. It is relevant to emphasise that the change in observation level was not implemented as a result of an identified increased risk of self-harm or suicide.

160. In her observations of BQ, EN Pham adopted the practice that was common amongst the nurses on the ward in that no attempt was made to record the actual time BQ was seen. The entries recorded observations on the hour, quarter past, half past, and quarter to the hour. None of those times are reliable as to when BQ was actually seen by staff. Additionally, again consistent with the approach of other nurses, the notes as to the interaction with BQ were most often very short, in that they were contained within one line. I shall comment further on this later, in the context of a recommendation raised by BQ's family.

161. EN Pham indicated in oral evidence that she would come back and write up observations after the fact based upon the notes she made on a piece of paper that she carried with her during her shift. Nurse Pham further indicated in her oral evidence that the piece of paper she used to record observations across the afternoon and evening of 16 July 2021 was not retained.

162. EN Pham had not mentioned the note to police when she spoke to them or to lawyers for the Western Sydney Local Health District when she spoke to them.

163. Counsel Assisting fairly submitted that whilst the note would have been an important document to have as part of the investigation into BQ's death, the statements from ambulance officers make clear, EN Pham was not the only staff member who was extremely distressed and may not have been able to think clearly once BQ was found.

164. The statements of the ambulance officers record a sense of disruption and disorganisation amongst staff on the ward and that paramedics had to direct staff on what to do.

165. An issue arose within the evidence regarding EN Pham's observations of BQ as to whether there had been a period of up to 30 minutes during which BQ was unaccounted for. The issue arose from the evidence of AO Zappelli, who indicated when he attended the scene:

> "*One of the staff members was able to confirm that the patient had been unaccounted for for a period of up to 30 minutes. I remember this person was looking at a clipboard when they passed on this information*".

166. EN Pham was adamant that she was conducting her observations as required, that is every 15 minutes. I am satisfied it is more likely than not the information relayed to AO Zappelli was from the observation chart relating to BQ. Whilst EN Pham should have retained any notes she made on the piece of paper about which she gave evidence, I accept that the extremely distressing circumstances may have impacted on EN Pham's actions that evening in not retaining that piece of paper. As EN Pham did not make contemporaneous entries, the apparent 30 minute gap may have been the result of delay in an entry being made rather than an absence of an observation being made. Consequently, I am unable to conclude that BQ was unaccounted for for a period greater than 15 minutes.

**Issue 5: Any indications that BQ was at increased risk of suicide across the afternoon and evening of 16 July 2021.**

167. Counsel Assisting submitted that Dr Watson's evidence was that "suicide or self-harm is very difficult to predict precisely and risk assessment is difficult".

168. Counsel Assisting further submitted that Dr Watson's evidence was that:

> "*BQ was at an increased risk on 16 July 2021 and his reasons for that were, noting her increased irritability, distress at being in hospital, impulsivity, not following instructions, having conflict with people on the ward, contacting police, calling external agencies, and also walking out of the Mental Health Review Tribunal the day before*".

169. Counsel Assisting submitted that it was Dr Watson's view that "a more comprehensive risk assessment should have been done".

170. Dr Watson developed these comments with regards to risk assessments as follows:

> "*… it should not be just limited to one person. It really should be done between a couple of people and if there are changes in risk then that needs to be either escalated within management, in line management, or then escalated to the doctors that certainly discuss the patient on a regular basis.*"

171. And he also said:

> "*… the risk assessment is based on a few different factors. There's subjective, what people report, so [BQ] had currently stated that she didn't – she wasn't going to harm herself … the other part of risk assessment is the objective, so it's what people observed.*"

172. I stress here that the report by a patient that they had overheard BQ saying she would self-harm was not reported to police (by that patient) until after BQ was found in the bathroom. Dr Watson went on to say that:

> "*we can't predict risk, we can't predict suicide and we can't predict violence but there are certain things that we can look for that would raise levels of suspicion that someone is becoming more destabilised or more distressed*".

173. And Dr Watson gave evidence that there were things in the preceding 24 hours, "*levels of irritability which were present, impulsivity, not following instructions, easily making some threats or negative attitudes and so forth.*"

174. Dr Kota had recognised an increased level of risk and had discussed the issue with the consultant psychiatrist before increasing the number of observations, or put another way, shortening the period between observations. Nevertheless,

I accept Dr Watson's view that there was a missed opportunity for an even more fulsome assessment of risk to BQ on 16 July 2021.

## PROVISION OF INFORMATION TO BQ'S FAMILY

175. The provision of information to BQ's family was not listed as an issue prior to inquest. However, as not infrequently occurs, as the inquest progressed, it became an issue of significant interest and substantial evidence.

176. Both Ms Gauci and Dr Watson gave extensive evidence on this issue. The issue had been raised with Dr Watson in questions he was asked to address in his written report.

177. Dr Watson's overall evidence revealed the complexity of the situation. In his report, Dr Watson indicated that as BQ was under the care of the guardian, it was not unreasonable that her parents were not contacted by the clinical staff at Cumberland. But, Dr Watson continued, it is not clear why, as a matter of courtesy, they were not informed that the guardian was aware of BQ's circumstances, that is, imprisonment, and hospital admission. Doctor Watson went on to point out that whilst BQ's parents may not have been directly involved in her care, nevertheless as parents, they understandably had a keen interest in her welfare. Doctor Watson developed these views in his oral evidence.

178. In that evidence, Dr Watson initially stated, "*If [BQ] doesn't consent you couldn't do anything about it ... to go beyond that would be … the culturally wrong thing to do.*" However, this evidence must be taken in the context of his overall evidence. Doctor Watson later said:

> "*… where it gets a little bit difficult is about what the optics are culturally here, is that for a family, an Indigenous family not to know where their person … their family member is would be very, very disheartening and very, very distressing for them.*"

179. And later, Dr Watson set out:

> "*… the way to approach such a situation is, yes, it's the guardian, it's the support workers liaising and everyone liaising to try and identify family members the legacy of colonisation and legislation … is in a sense around Indigenous people being done to, and I don't want to go on too*

*much about it but I think we've got to be very mindful about whilst the … legislation is there to protect the Guardian order is there to sort of protect [BQ's] interests, that culturally where do the family's sort of views come into this as well as their needs as well? I think that's an important consideration. That may not get resolved here but I think it's certainly something to be considering around being open and transparent to the best of the people providing care's ability … but also respecting [BQ's] wishes at the same time.*"

180. Later in his evidence, whilst agreeing that BQ's family would be able to provide information, Dr Watson continued:

> "*… it's the [manner] in which the information, that sort of contacting conversation with the family is had, if the Guardian is the person looking after [BQ], that should initially be the central point of contact … We know that she's Indigenous. Can we get an idea of the family's situation because we think that it would be really useful for the family to be involved and know … because the family could actually also be support members for her at the same time, you know? It is a sense of cultural connection. It is … having family around. All of those are cultural protective factors.*"

181. Dr Watson emphasised that when talking about contacting family, this is not limited to thinking about contacting parents. Culturally, families are much wider than that. It could be, for example, "*contacting aunties, uncles, it could be cousins*". He emphasised that considering Aboriginal kinship structure, it would depend on who BQ felt comfortable with and that she would need to be asked about that.

182. Dr Watson's evidence shows the complexity of the situation.

183. As Counsel Assisting pointed out in her submissions, while s 4 of the *Guardianship Act 1987* (NSW) emphasises the importance of preserving family and family relationships, if a person under guardianship was adamant they did not want someone involved, the Public Guardian, as Ms Gauci said in her evidence, would try to abide by those views as much as possible and maintain privacy.

184. Ms Gauci acknowledged that personal relationships between family members can fluctuate over time and said that the Public Guardian tries to monitor fluctuations in relationships to the extent that it might influence how information is shared. She also emphasised that support workers would typically be expected to gather information about family relationships and the views of the

person under guardianship as to how their private information should be shared.

185. Ms Gauci also appropriately conceded that in BQ's case, it would have been preferable for the Public Guardian to clarify if BQ's parents had been contacted by the support coordinator or hospital and to ask for that to occur if it hadn't.

186. Other relevant matters, or another relevant matter to emerge from the evidence, was that, as a consequence of COVID, the WSLHD's ALO was not physically on the ward. If an ALO had been on the ward, the aim would have been to connect with BQ and gradually learn about her background and family with the hope that BQ might identify family members she was happy to have contacted.

187. The broad circumstances in which this issue is to be considered were:

I. an unwell young Indigenous woman who was detained against her will off country, completely isolated from family and friends.

II. BQ was under the care of the Public Guardian and was wrongly indicating she was not Aboriginal and had no parents. It was known after contact with Shellharbour at the latest, that BQ was indeed Aboriginal and did indeed have parents.

III. No one thought the situation would end as it did. As those involved considered whether to contact family, their contemplation was BQ would be well treated and ultimately would be dealt with in Court and at some stage returned to the community.

IV. BQ had previously been an involuntary patient, most recently for a very long time, and had not only survived that period, but at the end of it was well.

V. Not long prior to the hospitalisation, the Public Guardian, although not initially telling BQ's parents of her discharge from Shellharbour, had, when contact was made, not only advised the parents of BQ's discharge, but also that she was taken to the house of the aunt and uncle.

VI. It was also on the mind of clinicians that if the family, having been contacted and advised of BQ's situation, intervened in a way which upset BQ, then the therapeutic relationship between BQ and her

clinicians, social workers, and potentially the ALO may have been compromised.

188. All these were factors impacting on those who made the decision not to contact the family.

189. The evidence on the issue leads me to the conclusion that it would have been appropriate for the Public Guardian or a nominee on the Public Guardian's behalf to let BQ's parents know that BQ had been deprived of her liberty, firstly following arrest and secondly as an involuntary patient.

190. In my view, that should have happened.

191. It then should have been explained to the parents that BQ didn't want her parents to know of her situation and in the circumstances, the parents be asked to not make any effort to contact BQ at that stage as interference or contact could possibly impact upon the therapeutic relationship.

192. The parents could have been further told that clinicians, social workers and the ALO (if she was able to talk with BQ given she was off the ward during covid) would continue engaging with BQ and ask her to identify family members who could be contacted, advised of BQ's situation and asked to provide information. It could have been further indicated to the parents that they would be advised if BQ was to change her mind about them being informed of her situation and the parents also could have been reassured that they would be advised if BQ was to be discharged or her circumstances otherwise changed.

193. I find the Public Guardian's acceptance in evidence that the family should have been contacted was an appropriate concession. I am well satisfied that at the end of the day, the parents should have been advised of BQ's position after arrest and after she became an involuntary patient. I am confident they would have dealt with the passing on of the information in an appropriate way.

## RECOMMENDATIONS

194. Following the completion of the oral evidence and oral submissions, arrangements were put in place for further written submissions, including submissions in relation to recommendations. Some of that material has now been marked exhibit 3, 4 and 5. In relation to the NSW Trustee and Guardian, within which organisation the Public Guardian sits, Counsel Assisting had

raised in oral submissions the need for cultural competency training to be more frequent than once in every six years.

195. The evidence before me was that as at April 2024, of 4,180 clients of the Public Guardian, 179 identified as Indigenous and yet there was only one person within the staff who identified as Indigenous. As Counsel Assisting pointed out:

> *"Clearly there is a need for cultural competency training to be conducted more frequently than once in six years. Ms Gauci accepted this. In the intervening period, new staff are potentially exercising functions on behalf of the Public Guardian and making significant life changing decisions for Aboriginal clients without having undergone any cultural competency training.*"

196. No objection was taken to the recommendation. Following written exchanges counsel assisting's recommendations are:

1) That the Chief Executive Officer of the NSW Trustee and Guardian make arrangements to provide First Nation's cultural competency training to all NSW Trustee and Guardian staff with a priority to those working with Aboriginal and Torres Strait Islander clients (and with consideration to periodically repeating such training).

2) A copy of the Court's findings into the inquest into the death of BQ be referred to the NSW Attorney-General.

197. Recommendation 2 acknowledges the public information available about the position of the State budget and is included to ensure the responsible Minister is informed of the need for the recommended training to take place and to be repeated as frequently as possible.

198. In relation to WSLHD, as agreed at the end of oral submissions, a series of questions were forwarded from the assisting team to the representations for the LHD. The questions addressed training of clinical staff in relation to: (a) risk assessment including suicide risk, self-harm risk, and risk of absconding; (b) documentation of assessment and management plans; (c) observation of patients.

199. In addition, further questions addressed the issues of: (a) auditing of mental health observation charts; (b) whether CCTV is used to conduct observation of patients; (c) the need for Aboriginal Liaison Officers; (d) employee access to NSW Health and LHD policies and the proposed single digital patient record.

200. In response, WSLHD provided extensive material related to training in the areas of violence prevention and management (VPM), personal safety training, DETECT (Detecting Deterioration, Evaluation, Treatment, Escalation and Communicating in Teams) and COPSETI (Clinical Care of People who may be Suicidal, Education and Training Initiative). This training came under the banner of Risk Assessment and Documentation of Management Plans and is incorporated in a range of education programs.

201. It was noted that all staff, including medical staff, undertake the VPM and DETECT training and that all new staff undertake a Mental Health Service orientation program.

202. In relation to Mental Health Observation Charts, all nursing staff were provided with a face-to-face presentation on the engagement and observation in mental health inpatient policy provided by clinical nurse educators and nurse educators. At the time of the face-to-face staff orientation all staff are provided information regarding the location of policy documents and how they can be accessed.

203. Four issues were identified in relation to the observation charts and the training thereto:

I. The entries were not made contemporaneously.

II. The entries did not reflect the actual time the observations were made.

III. The notes alongside the time entry were limited to one line only and consequently were sometimes inappropriately short.

IV. In BQ's case there was no evidence the entries were ever checked by the nurse in charge or alternatively the NUM, Nurse Unit Manager.

204. The non-contemporaneity of the entries was a systemic issue, as was the failure to reflect the actual time of the observation. The evidence did not allow a conclusion to be drawn as to the full extent of nurses not using more than one line to record notes or as to the full extent of the lack of checking by senior nurses. Somewhat surprisingly, in circumstances where none of the charts relating to observations of BQ were signed off by a NUM or nurse in charge, no investigation was conducted into why that was the case.

205. However, the training in relation to observations referred to above specifically covered the deficiencies observed in BQ's case and the LHD provided written

evidence of the ongoing requirement for regular audits, random checks and reviews where appropriate. The checks are required to include a check as to whether the actual time of observation is being recorded.

206. In relation to CCTV, WSLHD confirmed that there is no capacity for nursing staff to view live CCTV on the ward. CCTV is not an appropriate means of clinical observation. The policy requires that observations include engagement with the consumer as well as visual observation.

207. In relation to Aboriginal Liaison Officers (ALOs), Dr Watson's report and his evidence during the inquest confirmed that more could have been done in BQ's case in relation to providing more culturally appropriate and safe care for her while she was at Cumberland Hospital. Dr Watson listed a number of ways that this could have been achieved. This included an increase of Aboriginal and Torres Strait Islander staff, whether it be ALOs, Aboriginal peer workers, or Aboriginal medical staff, who could have assisted BQ to engage with treatment.

208. The evidence of Mr Loy had been that no one monitors the number of consumers moving through Cumberland Hospital who identify as Aboriginal and Torres Strait Islander beyond the ALO tracking their own workload. This was clarified in correspondence from WSLHD wherein it was pointed out that the number of patients admitted to the Mental Health Service is monitored and an email is circulated to the Mental Health Service executive and nurse managers on a weekly basis. That email includes statistics regarding the number of patients of Aboriginal origin.

209. Decisions regarding the number of ALOs throughout the WSLHD are made at the facility level and based on patient and family use of the service and demographic data.

210. At a more general level, in relation to servicing the mental health needs of the Indigenous community, WSLHD provided its Aboriginal Health Strategic Framework which was launched in 2023. Figures included in the documentation reveal that whilst on 11 April 2024, for example, Aboriginal people comprised approximately 1.6% of the population within the WSLHD, 10% of admitted patients to the Mental Health Service were of Aboriginal origin.

211. Counsel Assisting pointed out in written submissions dated 4 June 2024 as follows:

> "25) *Sadly, it is of no surprise that Aboriginal people continue to be overrepresented in mental health services ...*

*26) Obviously more and more needs to be done, led by Aboriginal communities for Aboriginal communities.*

*27) In this regard the Aboriginal Health Strategic Framework outlines some initiatives … which does focus upon greater opportunities to consult with Aboriginal communities, increased employment opportunities for Aboriginal staff, and 'improve cultural safety across the organisation'*".

212. In relation to employee access to NSW Health policy directives and LHD specific policies, WSLHD noted by letter dated 20 May 2024 (Exhibit 5) that:

> "*There is an intranet for the whole of WSLHD, and each hospital has its own intranet home page, including Cumberland Hospital. Every NSW Health Policy Directive is available via the Policy and Procedure homepage of the WSLHD intranet or on the NSW Health website.*
>
> *There are currently 18 WSLHD Mental Health Service policies, procedures, and guidelines that are published on the WSLHD intranet."*

213. It was also clarified by WSLHD that:

> "*Staff members are not expected to access WSLHD and/or NSW Health policies, procedures or guidelines outside paid working hours. It is considered appropriate during a shift for staff to access computers during their paid working hours and review a policy directive*".

214. The written material provided by WSLHD led Counsel Assisting to submit along the lines that, "A number of recommendations would have been proposed" in relation to WSLHD "but for the information provided in the detailed written material and annexures".

215. I agree with this approach and consider it appropriate.

216. The correspondence reveals significant steps have been taken by WSLHD since 2021 to address issues highlighted by BQ's experience in Cumberland Hospital. In relation to policies and procedures, I gratefully adopt the following portion of Counsel Assisting's submissions to note:

    I. Policy documents are important as part of a framework guiding medical and nursing staff but they cannot, and are not intended to, replace clinical judgment.

II. The practices prescribed by the various policies need to be inculcated into everyday practice on the units, almost like a habit. If managers lead the team to develop habits that are in accordance with policy, there will be less need for individual staff to consult the policies.

III. The habit of everyday practice on the unit needs to be audited and assessed from time to time to check that it is still being completed as required by the policies.

217. This is particularly important, given EN Pham's evidence that her "busy life meant she had no time to read policies outside work hours". Whilst the LHD indicated staff are not expected to read policies outside work, in my observations, staff rarely have time to access policies during work hours. This increases the importance of organised training at work and the need for policies to be implemented, overseen, and as counsel assisting suggested, "inculcated into daily practice". This is an important function of senior staff.

218. BQ's family suggested six recommendations be made:

I. The single digital patient record should be introduced by NSW Health.

II. Western Sydney Local Health District implement appropriate and continuing training on ATSI culture and communication.

III. Western Sydney Local Health District create more Aboriginal Liaison Officers.

IV. The Public Guardian implement appropriate and continuing training on ATSI Culture and Communication, and the important connection between culture and families.

V. The training received by nurses within the Western Sydney LHD in relation to observations should be compulsory and ongoing.

VI. There should be consideration by the Western Sydney Local Health District to updating the level chart observation form. The behaviour column should have more depth so that more detail can be recorded in the behaviour/activity column.

219. Given the further information now available, these proposed recommendations can be dealt with in relatively short order. In relation to proposed recommendation 1, the single digital patient record, NSW Health have been

working on that program since (at least) 2023, with the current plan being for a trial to commence in March 2026 in the Hunter region, and within Justice Health. This trial will be followed by a phased rollout, finalising in 2029. The single digital patient record has been eagerly awaited by many for years. It is to be hoped that the rollout, firstly through the trial, proceeds smoothly and is in place State-wide by the proposed date in 2029 at the latest.

220. In relation to recommendations 2, 3, 5 and 6, aimed at WSLHD, it is my view that WSLHD has taken sufficient steps in the areas of:

a) Continuing training on ATSI culture and communication.

b) Staffing of ALOs.

c) Training in relation to observations by nurses.

221. In relation to recommendation 6, the mental health observation chart, I note it has been confirmed by WSLHD that the observation charts continue to be paper based. As I observe the chart, there is in fact no limit on the amount of detail that can be added under any single time entry. The fact that the charts in evidence contain only one line of writing for each time entry, is the choice of the nurse rather than any limit imposed by the document. The oral evidence was that the times were not entered in advance. If the times are to be entered at the time of the actual observation, then as many lines as are required can be used for fleshing out what is observed. Then on the following line, the next time of observation can be entered.

222. In those circumstances, I do not propose to make the recommendations sought.

223. Finally, in relation to the family's proposed recommendation 4, concerning the Public Guardian, I note that a recommendation is to be made in relation to ATSI cultural competency training for all staff within the NSW Trustee and Guardian, which ultimately deals with the family's suggestion.

## FORMAL FINDINGS – FINDINGS REQUIRED BY SECTION 81(1)

224. Based on the foregoing the formal findings are as follows:

**The identity of the deceased**: The person who died was BQ

**Date of Death:** BQ died on 18 July 2021

**Place of Death:** BQ died at Westmead Hospital NSW

**Cause of death**: The cause of BQ's death was hypoxic ischemic encephalopathy and aspiration pneumonia as a result of hanging

**Manner of death**: BQ's death was intentionally self-inflicted

## RECOMMENDATIONS

225. I make two recommendations for the reasons set out above.

### Recommendation 1

That the Chief Executive Officer of the NSW Trustee and Guardian make arrangements to provide First Nation's cultural competency training to all NSW Trustee and Guardian staff with a priority to those working with Aboriginal and Torres Strait Islander clients (and with consideration to periodically repeating such training).

### Recommendation 2

A copy of the Court's findings into the inquest into the death of BQ be referred to the New South Wales Attorney General.

## ACKNOWLEDGEMENTS AND CONCLUDING REMARKS

226. Before concluding this inquest, I would like to express my sincere and respectful condolences to BQ's family and friends for their tragic loss. I hope the inquest has, in some way, helped soothe your pain and provided some answers. I turn again to what your representative submitted. BQ was a mother, a daughter, a

sister, an auntie, a niece, a cousin, a friend. She is deeply missed and will always be remembered by her loved ones. BQ died far too young.

227. I would like to thank all those in the assisting team over the investigative and coronial stage. This inquest had very significant complexities which were managed expertly and empathetically. I am deeply grateful for your assistance.

228. I thank the lawyers for all the parties, for the helpful, considerate and respectful manner in which the inquest was conducted. In my view, it is likely most helpful for families when inquests are conducted in that manner.

229. I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

29 September 2025