CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Fiona Turnbull
Hearing dates:	21 and 22 November 2024
Date of findings:	6 March 2025
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a person from a fall from height – did mental health services respond appropriately – are there appropriate measures for information exchange between NSW Police Force and NSW Ambulance.
File number:	2021/87981
Representation:	Counsel Assisting the Inquest: C McGorey of Counsel i/b J Walshe of Department of Communities and Justice. The NSW Commission for Police: D Jordan of Counsel i/b Stephen Davis of Office of the General Counsel, NSW Police. H Reizer: E Sullivan of Counsel i/b Summer Dow of DLA Piper. J Rutherford: P Madden, Solicitor, NSW Nurses and Midwives' Association. South Eastern Sydney Local Health District: V Thomas of Counsel i/b Z Samadie, NSW Crown Solicitors Office. V Turnbull-Roberts: C O'Neill and I Hogan of Counsel i/b S White of Gadens.

Findings:	**Identity** The person who died is Fiona Turnbull **Date of death** Fiona Turnbull died on 12 October 2017 **Place of death** Fiona Turnbull died at St Vincent's Hospital, Sydney. **Cause of death** The cause of Fiona Turnbull's death was multiple injuries. **Manner of death** Fiona Turnbull died as a result of falling from a height while she was suffering a relapse of schizophrenia.
Non publication orders	Orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* [the Act] have been made in this inquest. A copy of these orders, and corresponding ones pursuant to section 65(4) of the Act, can be found on the Registry file.

1. 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.

2. These are the findings of an inquest into the death of Fiona Turnbull

Introduction

3. In the early hours of 12 October 2017, Fiona Turnbull aged 59 years died when she fell from the balcony of her third-floor apartment in Coogee, Sydney. Her injuries were not survivable, and she was pronounced deceased at St Vincent's Hospital.

4. In 1980 Ms Turnbull had been diagnosed with chronic schizophrenia, with symptoms of persecutory hallucinations. Over the following twenty years, due to the severity of her mental illness she had a number of hospital admissions, the last one being in 2002. After this she commenced treatment with clozapine medication, and her condition remained stable until 2017. Fiona was consistent in attending her medical appointments at her local Clozapine Clinic. She also regularly attended appointments with her general practitioner.

5. As will be seen, in the weeks leading up to Fiona's passing a distressing event took place which most likely destabilised her mental health, contributing to her tragic death.

The role of the Coroner

6. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of their death.

7. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Fiona Turnbull's life

8. Fiona was born on 18 May 1958 to her parents Charles and Valery Turnbull. She had a long term de facto partner, Albert 'Alby' Roberts, with whom she had two children: Stephen born on 31 August 1993, and Vanessa born on 8 October 1996. Fiona also had a son Luke from a previous relationship.

9. Alby Roberts was a First Nations man of the Bundjalung Widubul nation. Although the de facto relationship between Fiona and Alby ceased sometime prior to 2000, the couple remained close. Their daughter Vanessa Turnbull-Roberts told the court that Alby saw Fiona frequently, and helped her with shopping and with the management of her mental health.

10. Fiona was very much loved by her family. At the inquest Vanessa sang and spoke a loving tribute to her mother on behalf of herself, her brothers and the four grandchildren Fiona did not live to see. Vanessa's older brother Luke had asked her to share with the court his understanding of the struggles which his mother faced in her adult life. Vanessa also spoke of her mother's love of the ocean, of the sun and of poetry, and despite the challenges of her illness, of her caring and loving nature:

> *'She cared for others and loved making sure others were ok … Mum never carried a hatred bone in her body'.*

The post mortem report

11. After Fiona died, a post mortem examination was performed by forensic pathologist Dr Rianie Janse Van Vuuren. Dr Van Vuuren found the cause of Fiona's death to be multiple injuries. Fiona had suffered head, chest, abdominal and thoracic fractures. Toxicological analysis detected the presence of Clozapine in expected concentrations, taking into account the dosage which had been prescribed for her.

12. At the inquest the court heard evidence from two specialist psychiatrists as to why Fiona appeared to have suffered such a severe relapse of her schizophrenia in the days leading up to her death. The psychiatrists were:

- Associate Professor Kerri Eagle, consultant forensic psychiatrist and Clinical Director for community forensic mental health, in private practice 183 Macquarie Street, Sydney ("**Dr Eagle**").

- Professor Christopher Ryan, consultant forensic psychiatrist, and Director of Consultation Liaison psychiatry at St Vincent's Hospital, Sydney ("**Dr Ryan**").

13. In response, both experts said there was no evidence that Fiona had ceased or reduced her prescribed dose of clozapine, and therefore it could not be concluded that this had contributed to her deterioration.

14. They agreed further that on the information available, Fiona had a severe chronic psychotic disorder and was therefore susceptible to relapse regardless of her compliance with medication. They thought it was also very likely that Fiona had become unwell due to her natural distress at the sudden loss of Alby.

15. I accept therefore that it cannot be known for certain why Fiona suffered such a severe relapse of her symptoms in the days leading up to her tragic death, although the unexpected loss of her long time companion Alby very likely had an impact. There is no evidence that she was not complying with her medication.

16. As a further matter, while the direct cause of Fiona's death is clear there is insufficient evidence to conclude, even on the balance of probabilities, that she died as a result of an intention to take her own life. The evidence is clear that in the days leading up to her tragic death Fiona was suffering a relapse of her schizophrenic condition, with symptoms of psychosis. There is no evidence that she wished to end her life. The observations of her near neighbours that night (see **paragraphs 41-42** below) reinforce the tragic likelihood that Fiona fell from her balcony while in the grip of a psychosis.

The issues at the inquest

17. The inquest focused on events which took place in the hours leading up to Fiona's death, and the response which police and health services provided to her over that time. The issues were:

- whether on 11 October 2017 mental health services responded appropriately to reports about Fiona's mental condition which were made by Fiona's daughter Vanessa and Vanessa's friend Ms Isabel Ramirez

- whether an Acute Care Team member ought to have been dispatched to attend on Fiona on the evening of 11 October 2027

- at the time, what policies and arrangements were available within the South Eastern Sydney Local Health District for after-hours mental health services; and whether there have been changes to those policies and arrangements since then.

- whether information provided by NSW police officers to Ambulance NSW on 11 October 2017 about Fiona's mental health history was adequate

18. Prior to the inquest, Counsel Assisting Mr Chris McGorey circulated an outline of background facts which were anticipated to be non-contentious. There was no dispute as to those facts by the parties to the inquest. I have therefore drawn from this document in the following description of Fiona's mental health history, and the events of 11 October 2017 which culminated in her tragic passing.

Fiona's mental health history

19. Fiona suffered chronic schizophrenia for which she took medication and had regular reviews. These were provided by members of the Acute Care Team [**ACT**] which operates as part of the Eastern Suburbs Mental Health Service [**ESMHS**]. The ESMHS is a health service which operates within Fiona's geographical area, the South Eastern Sydney Local Health District [the **Local Health District**].

20. Some of the employees of the ACT are accredited. This means that they have statutory powers under the *Mental Health Act 2007* [the **MHA 2007**] to assess a person and issue a certificate pursuant to which, the person can be taken to and detained in a declared mental health facility. It is accepted that on the night of 11 October 2017, the ACT in Fiona's area did not have on duty a team member who was accredited. It remains the case that only a relatively small proportion of the ACT team members are accredited.

21. A further service which is relevant to Fiona's case is the State Mental Health Telephone Access Line [the **SMHTAL**]. This is a 24 hour state-wide telephone service which is staffed by mental health clinicians. It offers a triage and referral service for callers who seek mental health assistance for themselves or for others.

22. As at October 2017, Fiona was taking her prescribed clozapine tablets and was attending a local Clozapine Clinic. The purpose of these attendances was to regularly review her condition and to monitor the side effects of her medication.

23. Fiona's last attendance at the Clozapine Clinic was on 9 August 2017, two months before she died. She reported to the medical registrar that her mood was fine and that she had no thoughts of self-harm. The medical registrar recorded that Fiona's schizophrenia was '*well managed'* and that her current mental state was stable. The following day, Fiona received a renewed supply of her clozapine medication.

24. On 6 October 2017 Fiona attended her general practitioner, to report that she had been experiencing headaches, light-headedness and dizziness. Her doctor referred her for a CT scan.

25. It appears that Fiona did not disclose to her doctor a tragic and very significant event which had recently taken place. This was the sudden passing on 30 September 2017 of her friend and former partner Alby Roberts. Alby's funeral was to take place on 11 October 2017.

26. 8 October 2017 was the birthday of Fiona's daughter, Vanessa Turnbull-Roberts. On that day Vanessa and two friends Isabel Ramirez and Nadia Hussain celebrated her birthday at Fiona's apartment, where Fiona lived alone. Vanessa thought her mother's behaviour that day was unusual. Among other things, Fiona suddenly told her she had cancer (there is no evidence that this was the case), but would not give her any more details. Over the following days Fiona told Vanessa that she wasn't sleeping well, was sweating, and needed to see a doctor.

The events of 11 October 2017: the morning

27. At 4.39am on 11 October 2017 Fiona made a phone call to '000' and asked to be taken to hospital. In response, a police sergeant based at Maroubra Police Station rang Fiona three minutes later, and she again said she wanted to go to hospital. She was unable or unwilling to explain why she wanted to be taken to hospital.

28. The police sergeant decided that the response should be provided by ambulance paramedics rather than police. A police officer therefore rang Ambulance NSW, and notified Fiona of this just after 5.00am.

29. In the above phone conversation, the operator at Ambulance NSW wanted to know from the police officer whether they (the police) had any *'history'* on Fiona. The response from the police officer (which was recorded) was as follows:

' … give me one second, I can have a look. No we've got other people by the same surname, one person living at that address but he's male and born in '93 so it could be her son or something. But she's not in the system'.

30. It is accepted that by this, the police officer was advising that the NSW Police Force had no known dealings or information concerning Fiona. The paramedics who attended on Fiona shortly afterwards therefore had no awareness of her diagnosis or of her lengthy mental health history.

31. It is also accepted that at that time, NSW Police did in fact have electronic records relating to their previous contacts with Fiona. These included episodes of transporting her to hospital for mental health assessments.

32. This evidence gave rise to the question why that information was not identified and conveyed to NSW Ambulance, an issue which is examined later in these findings.

The paramedics' attendance

33. An ambulance operator rang Fiona at 5.14am. Fiona told the operator that she didn't want an ambulance, she wanted the police. Again, she was unable or unwilling to tell the operator why she wanted to be taken to hospital.

34. Two paramedics attended Fiona's apartment very soon afterwards. As noted they were unaware of Fiona's mental history. They found Fiona to be agitated, and she asked them to leave. They did so at 5.37am, recording their visit as follows:

> *'[Fiona] became agitated and refused assessment, refused further questioning and asked [ambulance officers] to leave, stated 'get out of my home, you don't speak to a woman like that'; unable to further assess [Fiona], slammed door on [ambulance officers]. '*

Vanessa and Ms Ramirez's attendance

35. Alby Roberts' funeral took place at 9.00am that same morning.

36. At about 7.00am Fiona's son Stephen rang her to try to persuade her to attend the funeral. Vanessa also called in on her mother and asked her to attend with her, but Fiona did not feel able to. Vanessa noted that her mother's apartment looked unusually messy and cluttered, and that Fiona herself looked very unwell and appeared not to have slept. Vanessa told the court that her mother *'was disoriented … it definitely wasn't Mum'.*

37. Shortly afterwards, Vanessa's friend Isabel Ramirez came to Fiona's apartment and made a further attempt to persuade Fiona to attend the funeral. This also was unsuccessful. Ms Ramirez was concerned at the change she saw in Fiona's appearance and demeanour:

> *' … she looked different. She was sweaty. She was looking – it was like she could see things behind me. She was – her eyes were darting around …'*

38. After the funeral, Vanessa and Isabel returned to Fiona's apartment. They were not aware that earlier in the day, Fiona had been in contact both with police and with ambulance paramedics. Fiona let the two women into her apartment.

39. Vanessa and Ms Ramirez were alarmed by Fiona's appearance and behaviour. Fiona questioned them closely about the funeral, asking if certain long-deceased people were there, and if there were '*men in black and men in blue'* there. She was highly agitated, switching quickly between moods, and it seemed to Vanessa as though *'she had two different personalities*'.

40. Eventually Fiona told Vanesa that she should go, and closed the front door on her. This was distressing to Vanessa, as she normally had a very caring and affectionate relationship with her mother.

The events on 11 October 2017: the night

41. Between 6.00 and 7.00pm that night a nearby neighbour Ms Natalie Eastwood heard yelling and *'rambling'* coming from Fiona's apartment which, she said, continued for several hours. Another neighbour saw Fiona throwing things from her third floor balcony onto the ground and shouting '*you fucking dog'*. Ms Eastwood also observed and heard this from 11.00pm onward.

42. At about 12.45am, Ms Eastwood saw something large go over Fiona's balcony. Stephen Dupas, another neighbour, heard something unusual and went outside to investigate. He found Fiona lying on the ground below her balcony. Both he and Ms Eastman called emergency services, and commenced CPR. Fiona was taken by ambulance to St Vincent's Hospital. She was pronounced deceased at 2.27am.

43. Inside Fiona's apartment, police found numerous clothes and belongings stacked about. There were also prescription medications. There was nothing in the nature of a suicide note. A chair had been placed against the balcony wall, above the spot where Fiona's body was found.

44. I will now return to the events which took place earlier that evening, and the attempts made by Vanessa and Ms Ramirez to get help for Fiona.

The phone call with Ms Reizer

45. After their visit to Fiona on the afternoon of 11 October 2021, Vanessa and Ms Ramirez knew they needed to get medical help for her. Over the next few hours they remained in the area outside Fiona's apartment complex. Vanessa explained:

> *'I just knew in my – I knew in my heart I couldn't leave. Something was going to happen.'*

46. Throughout that afternoon Ms Ramirez made phone calls to Beyond Blue and to various counselling services associated with the University of NSW. She was eventually referred to the SMHTAL service (see **paragraph 21 above**) and at 5.44pm she spoke with Ms Heidi Reizer.

47. Ms Reizer is a registered psychologist and an experienced clinician. That evening she was performing shift duties with the SMHTAL. The call between herself and the two women was lengthy, lasting almost an hour.

48. During the call Ms Reizer accessed Fiona's electronic records held with the SESLHD, and ascertained that she was receiving treatment at the local Clozapine Clinic and that she had a history of mental health treatment.

49. According to Ms Reizer, the two women told her that Fiona had not expressed any suicidal ideation. In her electronic progress note Ms Reizer entered the words '*Nil expressions of suicide or self-harm'*. But in her statement Vanessa said that she recalled saying to Ms Reizer that she was *'really worried'* that '*something was going to happen'* to her mother.

50. It can be accepted that Ms Reizer likely did ask questions relevant to self harm although, as noted by Counsel Assisting in his submissions, her questions may not have been asked expressly that way. At the inquest Ms Reizer said that regardless of whether Fiona had expressed thoughts of suicide or self harm, she herself had thought that Fiona was at high risk, whether from suicide or more likely, Ms Reizer thought, from misadventure due to her disordered and psychotic state.

51. In her statements and evidence, Ms Reizer said she told Vanessa that in her opinion Fiona needed immediate assistance, and that they should call '000' for an ambulance to attend. She said that she advised them further, that it would be a matter for the '000' operator whether there was a potential risk to the safety of the attending paramedics, in which case the police would probably be required to attend as well.

52. At the inquest Ms Reizer said that she had explained to Vanessa and Ms Ramirez how the mental health system worked. According to Ms Reizer, she had told them that if an ACT team which did not include an accredited member made a home visit, and assessed that the person needed to be admitted immediately to hospital for assessment, and the person was unwilling to go with them, then the team would need to contact a service which had the necessary powers under the MHA 2007. This generally meant an ambulance, and might involve a decision by ambulance services that the police must also attend.

53. Ms Reizer said that both women expressed strong concerns about the possibility of police attending Fiona's apartment, fearing that their presence would be highly distressing for Fiona due to her past interactions with them. Therefore, she said, the two women *'declined'* her recommendation that an ambulance attend.

54. At the end of the phone call, Ms Reizer told the women that she would refer Fiona's case to the ACT team based at Prince of Wales Hospital for follow up.

The phone call with Ms Reizer: evidence of Vanessa and Ms Ramirez

55. Vanessa and Ms Ramirez disputed aspects of Ms Reizer's account of their conversation.

56. Principally, although Vanessa and Ms Ramirez agreed that they told Ms Reizer they did not want police to come to Fiona's apartment, they denied having declined the option of ambulance paramedics attending her.

57. In her statement and evidence, Vanessa also denied that Ms Reizer had recommended to them that an ambulance be called that night for *immediate* assessment of Fiona. According to Vanessa, Ms Reizer had said only '*that she couldn't send an ambulance without the police'.*

58. At the inquest Counsel Assisting questioned Vanessa further about this:

> *Q By your answer, do you mean earlier that you felt that if you didn't support the police going, then there wasn't any other option? Is that what you mean?*
>
> *A Correct.*
>
> And later:
>
> *Q If I can just put it this way, you may not have a memory, but do you say it's not possible that there was a discussion about the possibility of an ambulance attending as well? Are you certain there was no discussion about that?*
>
> *A Yeah.*
>
> *Q Is it possible, given the difficulties you were having that day, that that might have been mentioned by her and it's not something that you can recall now?*
>
> *A She had said police had to come.*

59. For her part, Ms Ramirez insisted that Ms Reizer had not told them that the police *'may well come'.* Rather, Ms Reizer had said*: 'An ambulance can come but it's police who have got to go in*'.

60. Like Vanessa, Ms Ramirez also denied that in the phone call with Ms Reizer, any other options were presented to them:

> *'Everything in that call was geared towards us having to accept that if we didn't accept the police going, then the best we could get was a visit the next day from the community mental health team'.*

61. In her evidence Ms Reizer also told the court that she at no stage intended to convey to Vanessa and Ms Ramirez that the decision fell to them as to whether '000' should be called. There is some significance to this, as both Vanessa and Ms Ramirez said in their statements and oral evidence that they had been left with the impression that it was up to them to decide what action, if any, should be taken to assist Fiona that night.

Ms Reizer's phone call with Mr Rutherford

62. As noted, after this phone call Ms Reizer rang the ACT team based at Prince of Wales Hospital [**POWH**]. It was by then about 7.00pm. Ms Reizer spoke

with registered nurse Julian Rutherford, then she made an electronic progress note as follows:

> *'PC to POW ACT at 18:58 hrs. Referral made to Julian for client and daughter. Agreed to PC daughter tonight'.*

63. At the inquest, there was no dispute that Ms Reizer's referral of Fiona's case to the POWH ACT team was a reasonable course of action. This team is the one which operates within Fiona's geographical area.

64. On the night of 11 October 2017 Mr Rutherford was responsible, among other duties, for taking calls about known patients of the ACT. He regarded the outcome of his conversation with Ms Reizer as a referral of Fiona to his service. Like Ms Reizer, he was unaware of Fiona's earlier contact that morning with police and ambulance officers.

65. In his progress note and in his first statement to police, Mr Rutherford summarised his understanding of the information he had received from Ms Reizer that night. This was:

- that Fiona was an Aboriginal woman (this is erroneous) who '*wasn't very well'*
- she had been diagnosed with schizophrenia, was a client of the Clozapine clinic, and was on medication
- she was exhibiting psychotic symptoms and was probably experiencing a relapse of her schizophrenic condition
- Fiona's daughter Vanessa wanted her mother assessed but was concerned that if an ambulance attended, police would also attend
- according to Vanessa and Ms Ramirez, Fiona was not suicidal.

66. Ms Reizer gave evidence that in the above phone call, she had told Mr Rutherford that in her opinion Fiona needed to have a mental health assessment that night.

67. In his evidence, Mr Rutherford said he could not recall the specifics of this phone call. However, he thought it unlikely that Ms Reizer had conveyed to him an opinion that Fiona needed to have an assessment that night. He said that had she done so, he would have recorded this opinion on her part, and would have asked her what contingencies might be considered, if he was unable to arrange a team member to visit Fiona that night.

68. It may be accepted, based on the contents of her first and second statement, that this in fact had been Ms Reizer's view. At the inquest, Counsel Assisting asked her:

'Is it possible looking back, that you might not have said to Mr Rutherford 'It's my view that Fiona needs to be seen tonight'?

Ms Reizer replied:

'No, I specifically remember being very concerned about Ms Turnbull and what my formulation and plan were'.

69. It is therefore very likely that Ms Reizer did hold the view that Fiona needed to have a mental health assessment that night.

70. However, as Ms Reizer acknowledged, she did not document in her progress note or in her first statement, that she considered Fiona needed a mental health assessment that night. Nor in either of those documents did she record that she had communicated this opinion to Mr Rutherford.

71. The weight of the evidence, outlined above, indicates that Ms Reizer did not communicate to Mr Rutherford that in her opinion Fiona needed to be seen that night. As submitted by Counsel Assisting, it is very possible that Ms Reizer's recollection on this point has been affected by the passage of time.

72. However, the overall impact of this finding is not in my view very significant. Since Fiona's case was being referred to the POWH ACT, it became the responsibility of this team to determine if Fiona needed to receive a mental health assessment and if so, when this should take place.

Mr Rutherford's phone call with the two women

73. After speaking with Ms Reizer, it appears that Mr Rutherford attempted to call Vanessa and Ms Ramirez but the call did not connect. He then called again at 8.16pm and spoke with them. It is accepted that most of this conversation was had with Ms Ramirez, with her phone on speaker so that Vanessa could hear.

74. Mr Rutherford said that in this call, he advised Vanessa and Ms Ramirez that he could ask one of his on-road teams if they could prioritise a home visit to Fiona that night. He said that he explained to them that the only available team members were not accredited to use the MHA 2007, if that should prove necessary. In that event, the team would have to call for the assistance of an ambulance crew and possibly the police, if Fiona was unwilling to go to hospital with them on a voluntary basis.

75. By way of background, Mr Rutherford told the court that on the night of 11 October 2021 he had thought it unlikely that an ACT team would have been able to see Fiona in any case. This was due to their heavy workload that night, and the fact that their shifts all ended at 10.30pm (no ACT teams are rostered over the period 10.30m until morning). This normally required the on road ACT teams to return to their base by around 9.00pm, in order to write up their case notes.

76. Mr Rutherford said that he would have had to ask his teams out on the road if they could prioritise this visit. He confirmed that none of the available teams included any members who were accredited under the MHA 2007.

77. In his statement and oral evidence, Mr Rutherford said that he recalled discussing with Vanessa and Ms Ramirez the option of a home visit by the ACT team, or a call to '000' to request that an ambulance attend. Mr Rutherford told the court that Vanessa and Ms Ramirez '*declined'* both a home visit and a '000' call, due to the risk that police might need to be called in as well:

> *– 'and it was a clear 'no', because I said I couldn't guarantee that the police wouldn't turn up …'*

78. Mr Rutherford then said:

> *' … and we, all three of us, came to the conclusion, with my lead, that a visit in the morning was the best course of action at that time'.*

79. According to Mr Rutherford, Vanessa and Ms Ramirez were both *'on board'* with this plan.

80. But in their statements and their oral evidence both Vanessa and Ms Ramirez were adamant that they had not declined a home visit or an ambulance attending that night. They had only wished to avoid the attendance of police.

81. Vanessa told the court that she had no recollection of Mr Rutherford telling her that a member of the ACT team might be able to assess her mother that night, even a member who was not accredited. Had he done so, she insisted that she would have accepted. Mr Rutherford had stated only that he would send a team tomorrow.

82. Vanessa said that she had accepted this plan only because she was under the impression that this was '*the only option offered'*.

83. For her part Ms Ramirez also denied that Mr Rutherford had offered to ask if an ACT team might be able to attend Fiona that night. Her evidence was that Mr Rutherford gave them no option that did not involve police attendance.

84. In their reply submissions, both Counsel Assisting and the Local Health District provided nuanced comment on this question. Both submitted there was an available inference that Mr Rutherford did not expressly convey to the two women that an ACT team might be able to visit and would make its own decision about whether police needed to be called.

85. As noted by Counsel Assisting, it is clear that Mr Rutherford had assessed there was little chance of being able to secure a home visit by an ACT team that night. It is possible that he conveyed this to the two women in such terms that they received the impression that this was not an available option at all.

86. In similar vein, the reply submissions on behalf of the Local Health District noted Mr Rutherford's evidence that he told the women that a home visit that night would bring the risk of police involvement. These submissions likewise proposed that Ms Ramirez may well have understood from this that Mr Rutherford was not able to offer any option that did not involve police attendance.

87. In my view the evidence does not exclude the possibility that Mr Rutherford did mention to the two women that an ACT team might be able to visit that night. It is clear however that he wished to be transparent with them and to emphasise (and did in fact emphasise) that this option caried the strong likelihood that police would have to attend. I note further Mr Rutherford's concession that he did not discuss the home visit option in any depth (most likely because he did not expect that a team would be available in any case).

88. In these circumstances, it is very feasible that Vanessa and Ms Ramirez were left with the impression that there was no possibility of securing a mental health assessment of Fiona that night which would not involve the attendance of police.

89. I find that in all probability, it was within this context that Vanessa acquiesced in the plan for Fiona to receive a home visit from an accredited ACT member the following morning.

90. I now turn to examine the appropriateness of Mr Rutherford's plan that the mental health assessment of Fiona be delayed until the following morning.

Mr Rutherford's decision-making

91. It was accepted by Mr Rutherford that notwithstanding the views of Fiona's family, the onus that night was upon him, as the mental health professional, to determine if Fiona required immediate hospital care.

92. At the inquest Mr Rutherford was questioned closely about his decision to defer any assessment of Fiona until the following day.

93. As noted in Counsel Assisting's closing submissions, the options available to Mr Rutherford that night were to:

- request an ACT team to attend Fiona if possible.
- request that an ambulance come to Fiona's apartment, with the attendant risk that if Fiona was agitated, NSW Ambulance would almost very likely request that police attend as well
- request the Psychiatric Registrar on duty at POWH to conduct a home visit.

94. It was accepted by all parties that the third of these options was not feasible. The Registrar on night shift at POWH was most unlikely to have any capacity to make a home visit, as she or he was responsible overnight for the entire

hospital, including any requests for psychiatric assessments made by the hospital's Emergency Department.

The options of requesting an attendance by an ACT team or an ambulance

95. As noted, Mr Rutherford thought it unlikely that an ACT team would be able to visit Fiona that night due to their heavy workload.

96. Nevertheless, Mr Rutherford said that on the night, he had given careful thought to this option. He explained that he had thought it very likely, on the information he had about Fiona's condition, that if an ACT team had been able to attend and assess Fiona, the team would conclude that she needed an immediate hospital assessment. If Fiona was not willing to accompany the team to hospital, then since the members were not accredited under the MHA 2007 they would have had to request that an ambulance attend, so that paramedics could exercise those powers.

97. Mr Rutherford thought that in that event, it was very likely that NSW Ambulance would have requested that police attend as well.

98. Mr Rutherford had also given thought to the option of calling '000' for an ambulance to attend Fiona's apartment. However he considered the same result to be very likely: namely that NSW Ambulance would require that police attend with them.

The decision to wait until the following morning

99. Mr Rutherford told the court that taking the above into account, he and the two women had come to the conclusion that it would be best to defer any mental health assessment of Fiona until the following morning. An accredited ACT team member would then be available to exercise statutory powers to get Fiona to hospital.

100. It was clear from Mr Rutherford's evidence that he placed very significant weight on the expressed desire of Vanessa and Ms Ramirez to avoid police becoming involved. Mr Rutherford told the court:

> *' .. when I mentioned that the police might become involved, it was off the cards for Vanessa and [Isabel] because they were so terrified of the police arriving.'*

101. He had come to the view, he said, that sending an accredited person the next day offered a reduced risk of police attending, than did the option of sending a non accredited team that night:

> *'It was the option that would perhaps have had the least risk of the police becoming involved'.*
>
> *'So I thought my plan to go with an accredited person the next day was reasonable given the family's concerns and wishes.'*

102. Mr Rutherford was asked if it was not the case that he also needed to take into account Fiona's clinical need for a mental health assessment. He replied:

> *'As the mental health professional, yes … But I have to take into account former trauma and doing no harm and risk … and once the police are involved, it often becomes a little bit – it can be quite dramatic, and traumatic. So my thinking was around that more …'*

103. Mr Rutherford agreed that notwithstanding his views, if an ACT team had been able to attend Fiona that night it would have been up to them, and not himself, to assess Fiona's response and determine whether police needed to be involved.

104. That being the case, Counsel Assisting wanted to know why Mr Rutherford had decided not to request a team to attend, given that the visiting team would have been in a better position to assess Fiona's condition and the potential need for an ambulance and police:

> Q *' … why can't the decision as to whether to call the ambulance, the risks of trauma to Fiona, fall to that team? Why does that have to be something that you build into your decision here?'*

105. Mr Rutherford maintained the view that his decision had struck the right balance between the two competing risks: namely, the emotional risk to Fiona of a home visit that night with, in his view, a high likelihood of police attendance, as against the risk that she may come to harm overnight if he deferred the mental health assessment until the following day.

106. There is no doubt that the decision which Mr Rutherford had to make that night was a very challenging one. At the inquest Mr Rutherford expressed his regret at the tragic outcome:

> *'I thought it would wait until the morning, which I am obviously very sad about what happened overnight because I didn't foresee that at all. '*

Were the responses of Ms Reizer and Mr Rutherford reasonable in all the circumstances?

107. On this question, those assisting the inquest arranged an expert conclave which took place on 14 November 2024, involving psychiatrists Dr Kerri Eagle and Dr Christopher Ryan. Following their conclave the two experts produced for the court's use a report identifying the matters on which they agreed and disagreed, and their reasons. The Joint Expert Report was tendered into evidence at the inquest.

108. In addition, both psychiatrist experts gave oral evidence in conclave at the inquest. It may fairly be said that each adhered to the opinions they had expressed in their November conclave.

The psychiatrists' evidence: Ms Reizer

109. Regarding the response of Ms Reizer, both experts opined that it was appropriate for her to have considered that Fiona needed an immediate mental health assessment that night. In their opinion this conclusion was strongly indicated, given Ms Reizer's awareness that Fiona had a diagnosis of schizophrenia, was being medicated with clozapine, and that according to Vanessa and Ms Ramirez, her mental health had severely deteriorated.

110. However Dr Ryan was also of the view that it would not have been *unreasonable* for Ms Reizer to have concluded that the assessment could have waited until the following morning. This decision, he said, depended on the weight which Ms Reizer placed on the various pieces of information in her possession. As I have noted, the evidence indicates that Ms Reizer did in fact consider that an immediate assessment was required.

111. As has been seen, Ms Reizer did not herself arrange for an assessment of Fiona that night. Instead she made contact with the ACT for the area within which Fiona lived. Dr Eagle and Dr Ryan were agreed that this was a reasonable course of action.

The psychiatrists' evidence: Mr Rutherford

112. Was it reasonable for Mr Rutherford to have decided to defer Fiona's assessment, by requesting that an accredited member assess her on the morning of 12 October 2017?

113. Both experts agreed that from a clinical perspective, the information which Mr Rutherford had reasonably indicated that Fiona required an '*immediate assessment'.*

114. Again however, Dr Ryan qualified his opinion by adding that it would not have been *unreasonable* for Mr Rutherford to decide that the assessment could take place the following day. This, he said, depended on the weight Mr Rutherford placed on the various pieces of information that he had come to know.

115. As has been seen, in reaching his decision Mr Rutherford placed significant weight on the concern held by Vanessa and Ms Ramirez that Fiona would be emotionally harmed if police were required to attend that night.

116. In light of this, at the inquest the two experts were asked what weight a clinician should appropriately give to this consideration.

117. Dr Eagle and Dr Ryan agreed that the weight to be given to such matters was informed by experience and clinical judgement, and that it was entirely appropriate for Mr Rutherford to consider the potential risks to Fiona involved in a police attendance.

118. However, their opinions diverged as to whether it was reasonable for him to have concluded that this risk outweighed the risk of delaying Fiona's mental health assessment.

119. In the Joint Expert Report Dr Eagle's opinion was noted as follows:

> *' … the weight to be given to [the views of family] should also take into account the clinical needs of the patient, the urgency of the required assessment, the potential understanding or lack of that the family member may have of the clinical needs and risks to the patient, the other potential options available to manage the risk of perceived harm and the other potential options available to assess the patient.'*

120. Taking these matters into account, Dr Eagle was clear in her opinion that Fiona needed to be assessed that night, as she was probably acutely unwell:

> *' .. I think the clinical need of the patient at the time would have strongly suggested, in my view, she needed an assessment that evening …'*

121. Dr Eagle stated further that assumptions about whether a police response might be required, and the potential harms to the patient as a result, needed to be carefully weighed against those clinical needs:

> *' … on the basis that the clinical needs of the patient must be prioritised whilst acknowledging a need for the least restrictive care'.*

122. Dr Eagle acknowledged that using a police response is '*a particularly restrictive option'.* Nevertheless it was '*really vexed'* to suggest that sending an ambulance and police to such a scene is '*inherently risky',* when:

> '… *[the police] are part of our emergency response processes at the moment and generally, their interactions with mental health consumers are beneficial in ensuring people and supporting mental health teams in accessing care'.*

123. She added that to assume that the situation will be worsened by the presence of police *' … is problematic when it results in a barrier to accessing appropriate mental health assessment'*.

124. Dr Eagle was thus of the opinion that it was unreasonable for Mr Rutherford to have deferred the mental health assessment of Fiona, in the absence of any other plan to manage or mitigate her risk overnight. In her opinion, if Mr Rutherford had formed the view that Fiona required an immediate assessment, there was a clinical obligation to attempt to ensure that it took place that night, whether by an unaccredited ACT member or through ambulance and/or police services.

125. Dr Ryan did not agree. Mr Rutherford, he said, had to weigh all the information available to him, including the harm to Fiona by caused by the possible involvement of police. He concurred with Mr Rutherford that if a non

accredited team member had attended and assessed Fiona that night, this would have made it '*much more likely*' that police would be called in to transport Fiona to hospital, with the risk of emotional harm to Fiona.

126. Dr Ryan explained this position in answer to the following questions from Counsel Assisting:

> Q *If you have the option of someone going around there and sighting [Fiona], laying eyes on her, and then revisiting the issue of whether ambulance or paramedics need to be called, why would it be reasonable not to request that to occur if you had the capacity?*
>
> A *… Because once we head down that track, I think it's quite likely that the police are going to be involved. And if we just wait, I think it's less likely that that's going to happen. Of course that will mean there will be this time overnight whether there'll be material risk as well. So that's got to be factored in ... the range of reasonableness probably is between 'Call an ambulance now. It doesn't really matter what the family is saying. Just call an ambulance now', to 'Okay we can get people out daylight hours tomorrow with an accredited person'. That's reasonable too.*
> ….
>
> Q *So just to understand your opinion, if there were non accredited persons, assuming they could have gone around and done this preliminary assessment on the night, why wouldn't you avail yourself of that option if you were Mr Rutherford or you had the capacity to ask that to occur?*
>
> *A Well … the reason that you might not do that is because you might think 'If I send the non accredited persons around, it's more likely that this will get the police in, and the police' – we've got data that the police is a very bad idea in this circumstance, and we might think it was more likely, to avoid that, if we went the following morning.*

127. Dr Ryan was thus of the view that it was not unreasonable for Mr Rutherford to have concluded that the risk to Fiona of a police attendance that night outweighed the risk of deferring her assessment to the following day.

Conclusion

128. There was thus a difference of opinion between the two psychiatrist experts on the question whether Mr Rutherford ought to have concluded that the risk of harm to Fiona from a possible police attendance that night outweighed the risk to her of delaying her mental health assessment until the following morning.

129. Counsel Assisting has submitted that on this question I would prefer the opinion of Dr Eagle. In his submission, the alternative approach involved a flawed process of decision-making, in that:

- had a clinician been able to attend Fiona that night, the clinician would have been in a better position than Mr Rutherford to assess Fiona's situation, and any need for police attendance; and

- it could not be known what course of action the attending clinician might have decided upon, and what Fiona's reaction might have been.

130. There was, as Counsel Assisting stated in reply submissions, *'nothing to be lost'* from an ACT team attending that night if they had capacity to do so.

131. After careful consideration, I have reached the view that Mr Rutherford ought to have requested that an ACT team attend Fiona that night, had one been available.

132. There was no dispute between Dr Eagle and Dr Ryan that Fiona was most likely acutely unwell, at elevated risk of harm, and in need of a mental assessment as soon as this could be arranged. It is difficult not to accept the position expressed by Dr Eagle that when faced with such decisions ' … *the primary consideration is the clinical need and urgency of the assessment'.* .

133. Furthermore, Mr Rutherford's risk assessment pre-empted the more informed one which could have been made that night by an attending team, had one been available to assist. An attending clinician would have been in a better position than he to assess Fiona's clinical need for an immediate assessment, to consider how this might be achieved, and to gauge how she might have reacted.

134. For these reasons I have concluded that the appropriate decision would have been to request that an ACT team attend Fiona that night, or an ambulance if such a team was not available.

135. Having said that, I accept the submission of Counsel Assisting that it would not be right to be critical of Mr Rutherford for the approach he took. The decision he faced that night was a very difficult one, and any judgement of it has the benefit of hindsight.

136. It was also very clear that Mr Rutherford is a caring and experienced clinician, and gave careful thought to the question of how best to help Fiona and her family that night. His ultimate view was sincerely held – namely that the risk of harm to her from a possible police presence outweighed the risk to her in delaying the assessment until the following day.

137. I also accept the reply submission of Counsel Assisting, that Mr Rutherford's decision was probably not material to the tragic outcome that night. It appears most unlikely that an ACT team would have been available to assist Fiona that night, if asked to do so.

Whether information provided by NSW police officers to Ambulance NSW on 11 October 2017 about Fiona's mental health history was adequate

138. It was not disputed that on 11 October 2017, NSW Police had electronic records about Fiona. These records contained information about Fiona's condition of schizophrenia and her interactions with police. They highlighted her lengthy mental health history dating back to 1980, which involved involuntary hospital admissions for psychiatric treatment.

139. There was in October 2017, and continues to be, a Memorandum of Understanding between NSW Police Force and NSW Ambulance that concerns responding to a Mental Health emergency. Amongst other things this deals with the exchange of information between officers of each agency about a person suspected to be suffering a mental health episode.

140. As of 11 October 2017, the "*NSW Health, Ambulance Service of NSW, NSW Police Force, Memorandum of Understanding – Mental health Emergency Response, July 2007"* operated (**2007 MOU**). This was later superseded by the '*NSW Health, NSW Police Force, Memorandum of Understanding 2018"* (**2018 MOU**).

141. The 2007 MOU at [2.1]-[2.2] stated as regards its purpose:

> *2.1 To ensure persons with a known or suspected mental illness or mental disorder, or who exhibit behaviours of community concern, are identified, assessed, receive care, and where necessary, transported to an appropriate health facility or other place in a manner consistent with the persons' clinical needs.*
>
> *2.2 To ensure NSW Health, NSW Police Force and carers, work together in a collaborative manner with coordinated processes that address the safety of the individual, the staff involved, and the community.*

142. The 2007 MOU at [7.2] stated as regards exchange of information:

> *"7.2 Privacy and Information Exchange It is recognised that all parties to this MOU are required to comply with the following laws, policies and protocols in respect of any collection, use or disclosure of personal information or personal health information:*
>
> - *The Privacy and Personal Information Protection Act 1998 (NSW) as it regulates "personal information" and any Direction, Code of Practice or Regulation made there under;*
> - *The Health records and Information Privacy Act 2002 (NSW) as it regulates "health information" and any Direction, Code of Practice, Guideline or Regulation made there under;*
> - *Any internal policies, protocols or policy directives issued by the respective parties in relation to privacy or information*

management and exchange by that party or a related agency.

In relation to any personal information or health information collected, used and disclosed for the purposes of this MOU, the parties particularly note that information on collected in the course of providing a health service will only be released or disclosed:

- *for the purpose of providing necessary health services; or*
- *for a purpose directly related to the provision of the health service, including disclosures necessary to ensure that appropriate measures are taken to address the patient's physical and mental health care needs and safety issues in the course of any transportation by any of the parties; or*
- *as authorised by the Mental Health Act 1990 (NSW), in particular information which can be provided to Police at admission or which can be provided in order to apprehend a patient who has left the hospital without leave or which is necessary to disclose to comply with the terms of the Mental Health Act 1990 (NSW); or*
- *as necessary to lessen or prevent a serious and imminent threat to the life, health or safety of any person, or a serious threat to public health or public safety; or*
- *to law enforcement agencies (such as NSW Police Force) to enable them to exercise their law enforcement functions but only where there are reasonable grounds to believe that an offence may have been, or may be, committed."*

143. It is reasonable to conclude that the information within police records about Fiona's condition of schizophrenia and her interactions with police in a mental health context, had it been known to the police officers who responded to Fiona's call on the morning of 11 October 2017, would have been relevant information for the paramedics who were attended on Fiona later that morning.

144. If nothing else the fact that Fiona was known to police in the context of mental health disturbances, including her being taken to hospital for mental health assessment, would have been relevant to the paramedics' assessment of Fiona. It may have informed their assessment of what had led Fiona to call police that morning to request she be taken to hospital given her denial of an injury or the absence of an explanation from her as to why she needed to go to hospital. As one of the attending paramedics stated in his statement, having information about the "*job, history of the caller/ patient*" can assist and inform his approach.

145. This information was not provided to triple zero because the police officers involved in responding to Fiona's call themselves did not identify or realise that police had records about Fiona including those about her mental health.

146. It would have been open to police to have advised the triple zero of this fact, consistent with the intent of the 2007 MOU, had that fact been realised by the police officers who responded to Fiona's call.

147. Not only wasn't that fact disclosed, when the triple zero operator asked if police had "*any history or anything on"* Fiona, the operator was told she was "*not in the system".* That statement suggested police had no record of police interactions with Fiona. As the evidence shows that was not correct.

148. While it cannot be known whether the outcome of the paramedics' visit would have been any different had they been aware of this information, there can be no doubt that it was relevant to their purpose in visiting her.

149. The evidence at the inquest did not disclose why it was that on the morning of 11 October 2017 the police officers did not realise that police had electronic records regarding past dealings with Fiona It is regrettable that they did not do so, but in the absence of clear evidence as to why this happened, it is not open to me to make adverse comment about any individual police officers involved.

150. Given the existence of the Memorandum of Understanding, which appropriately provides for the exchange of such information, there is no evidence of systemic deficiency and no basis for any recommendation in relation to this issue.

The question of Recommendations

151. Counsel Assisting proposed two Recommendations arising out of the evidence at inquest.

Recommendation 1

152. The first proposal concerned communications between ACT clinicians and concerned persons.

153. Counsel Assisting acknowledged that mental health clinicians often face a difficult task when communicating with family members and other concerned persons. The Recommendation which Counsel Assisting proposed was supported by the SESLHD.

154. In my opinion the proposal has merit and is supported by the evidence heard at the inquest.

155. I therefore make the following recommendation:

> *To the CEO, SESLHD:*
>
> *That the SESLHD review the instruction and training provided to clinicians of the Acute Care Team with regard to:*

a. *weighing the risks of possible police involvement when determining whether to request an immediate mental health assessment of a person reported to be acutely unwell; and*

b. *the manner of communicating with concerned persons to minimise the risk that they are mistakenly left with the view that responsibility for decision making about a response falls to the concerned persons.*

Recommendation 2

156. The second proposal concerned the evidence heard at inquest about the availability, both in 2017 and now, of afterhours mental health services in the area where Fiona lived.

157. A statement was provided to the inquest from Mr Mike Gatsi, who is the Service Director of ESMHS. Mr Gatsi confirmed the following, which I accept:

- that an accredited ACT team member was not available on the night of 11 October 2017
- a non-accredited team could have attended on Fiona that night to carry out a mental health assessment
- if the non-accredited team members had concluded that Fiona needed to attend hospital, they could request her to do so voluntarily. But they could not detain her for this purpose
- they could however have requested that ambulance and/or police officers attend to involuntarily transport Fiona to hospital.

158. The inquest also heard evidence from Mr Christopher Hay, General Manager for Mental Health with the Local Health District. Mr Hay told the court that within the Local Health District, ACT staffing numbers have not increased since 2017 despite the population in that area having done so.

159. In addition Mr Hay advised that accreditation programs are conducted by NSW Health twice a year. Limited spaces are available, with the Local Health District allotted two spaces per program. On occasions, he said, the Local Health District has also funded 'one off' accreditation programs in order to increase its numbers of accredited clinicians.

160. In his evidence, Mr Rutherford stated that in his opinion there needed to be more accredited members on the ACT teams. There were tangible benefits, he said, when a mental health assessment is performed by an accredited clinician, particularly where a person is assessed as needing hospital assessment but is unwilling to go. In his experience, when he is able to explain to the patient that '*they have to come to the hospital under the Mental Health Act',* they frequently agree to come with him and there is no need to call emergency services.

161. His estimate was that approximately 25% of ACT team members are accredited.

162. Notably, in their Joint Expert Report Dr Eagle and Dr Ryan concurred that there would be benefit in having ACT services staffed by accredited clinicians where possible. They agreed that the availability of an accredited person on the night of 11 October 2017 would at the least have broadened the therapeutic options available to the clinicians. Referring to information that only around 30 people per year were being trained for accreditation, they noted that:

> *' … thirty new accredited persons per year is likely insufficient to meet the reasonable needs of mental health services in New South Wales'.*

163. This evidence provided the basis for Counsel Assisting's proposed recommendation to the Chief Executive, NSW Health that:

> *'NSW Health, in consultation with Local Health Districts, consider reviewing the arrangements for the provision of accreditation training in the case of Acute Care Team clinicians with a view to [significantly] increasing the number of clinicians with accreditation'.*

164. The Local Health District did not support this proposal, submitting that the evidence at inquest was not sufficient to support it. The Local Health District's submissions noted that the NSW Ministry of Health had not been a party to the inquest, and therefore had not had the opportunity to provide information about accreditation training arrangements, and whether there was a need to increase these.

165. In reply, Counsel Assisting pointed to evidence heard at the inquest which indicated that the numbers of accredited staff were not sufficient to meet the reasonable needs of NSW mental health services. This evidence is outlined at **paragraphs 112 to 127** above.

166. Counsel Assisting submitted further that no significant issues of procedural fairness arose, since the proposed Recommendation did not amount to an adverse finding against the Ministry of Health, and did not compel the Ministry to take any particular action.

167. In my view the evidence at inquest provided a sufficient evidentiary basis for the Recommendation, and I propose to make it.

Conclusion

168. I convey to Fiona's loving family and friends my sincere sympathy for her loss. She was and is deeply loved. I hope that in time, their feelings of grief and pain will fade and that they will have a sense of peace in remembering how much she loved them.

169. I thank the outstanding assistance provided by Counsel Assisting Mr Chris McGorey, and the other Counsel and instructing solicitors who represented the interests of the parties in this inquest.

Findings required by s81(1)

170. 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

171. The person who died is Fiona Turnbull

Date of death

172. Fiona Turnbull died on 12 October 2017

Place of death

173. Fiona Turnbull died at St Vincent's Hospital, Sydney.

Cause of death

174. The cause of Fiona Turnbull's death was multiple injuries.

Manner of death

175. Fiona Turnbull died after falling from a height while she was suffering a relapse of schizophrenia.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner, Lidcombe

Date 6 March 2025