CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Stephen James Douglas
Hearing dates:	26 August 2024 - 30 August 2024 12 February 2025 - 14 February 2025
Date of findings:	8 August 2025
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – mental health-homicide-community mental health treatment – mental health policy and practice
File number:	2019/00376134
Representation:	Ms S McGee, Counsel Assisting the Coroner, instructed by Ms B Lorence, of the Crown Solicitors Office Mr J Downing, instructed by Ms K Hinchcliff of Makinson D'Apice for Sydney Local Health District and Fiona Chisholm. Ms L McFee, instructed by Ms N Brown of Meridian Lawyers for Dr Caroline Harrison Mr B Fogarty instructed by Ms D Captain-Webb of Legal Aid NSW for the Senior Next of Kin, Ms S Douglas Mr B Docking, instructed by K Vegar for SafeWork NSW
Non-publication order	On 26 August 2024 a non-publication order was made pursuant to section 74(1) of the Coroners Act 2009 (NSW) in relation to some evidence in this inquest. A copy of this order is available on request from the Court Registry.
Findings:	Stephen James Douglas died on 28 November 2019 at 9/8 Nicholson St Balmain East.

	The cause of his death was multiple sharp force injuries which were intentionally inflicted by his client during a home visit conducted in the course of Stephen's employment as a community mental health nurse.
Recommendations:	**To the Chief Executive Officer, Sydney Local Health District:** ***Recommendation 1*** The SLHD review its Mental Health Shared Care documentation (Plan, Checklist and GP Information Sheet), with a view to: a. better defining the roles and responsibilities of the GP or medical practice and the Mental Health Service under the Mental Health Shared Care Plan, including (but not limited to) specifically: i. the frequency of periodic psychiatric review of a patient by the Mental Health Service; and ii. the frequency of periodic clinical review meetings between the GP or medical practice and the Mental Health Service; and iii. arrangements for in the event of the absence of either the allocated GP or allocated Mental Health Service staff member. b. better defining the expectations of communication between the GP or medical practice and the Mental Health Service under the Mental Health Shared Care Plan; c. encouraging GPs to contact HealthPathways to assist them in assessing and managing any deterioration in the mental health of Mental Health Shared Care Plan patients and determining who to contact in the event of deterioration; d. including information as to who at the Mental Health Service can be contacted by the GP/medical practice in the event of concern about deterioration in the patient's mental health ***Recommendation 2*** The SLHD formally implement a requirement that all SLHD Community Mental Health Service clients be scheduled for review by a psychiatrist, at a minimum within three months of the expiry of any Community Treatment Order and again within a further three months.

Recommendation 3

The SLHD consider as part of its ongoing electronic record systems changes, the creation of a flag, or other alert, identifying the due date for all Community Mental Health Service clients' periodic psychiatric reviews, which is identifiable both in the client's individual records and in summary reports used for the purpose of staff caseload review and management.

Recommendation 4

The SLHD amend its Core Team Model of Care guideline to provide:

a. the maximum care load for care coordinators is 30 clients; and

b. the trigger for a clinician and manager to review a care coordinator's care load is 25 clients.

Recommendation 5

The SLHD take steps to maintain within all Community Mental Health Service Core Teams, for all hours of operation, rostering of at least two "accredited persons" (in addition to psychiatrist capacity) able to schedule clients under the NSW Mental Health Act 2007.

Recommendation 6

The SLHD review its Acute Care Service and Core Team policies and procedures to clearly define and communicate to staff in both teams in what circumstances, and how, transfer of care of Core Team clients in need of Acute Care Service care is to occur, and to simply the process by which such a transfer takes place.

Recommendation 7

The SLHD review MH_SLHD_PCP2024_006 *Working in the Community-Community and Home Visiting* to:

a. more clearly communicate the requirements that:

   i. community or home visits to clients may not be conducted by a single staff member:

      1. for the first visit to the client's home or new home, including where the client is re-commencing with the service;

      2. where there is evidence of, or concerns about, a client's mental health deteriorating, regardless of any existing

	approval for visits to be conducted by a single staff member; 3. where there is a risk of violence, or the risk of violence is unknown; ii. all unplanned home or community visits which arise for consideration after the morning Community and Home Visit Huddle must be the subject of discussion with and approval by the Team Leader, or if the Team Leader is unavailable, an alternative senior clinician who is authorised to approve such visits. iii. where after the morning Community and Home Visit Huddle or subsequent discussion and approval, but prior to the conduct of the visit, further information is received that may alter the assessment of risk about the conduct of the visit, the decision to undertake the home visit must be the subject of further discussion and approval by the Team Leader, or if the Team Leader is unavailable an alternative senior clinician who is authorised to approve such visits. b. include cross-reference to the SLHD's Mental Health Service Policy Directive MH_SLHD_PD2023_027 *Consumers with Mental and/or Cognitive Acute Deterioration - A risk assessment and management approach* and any other internal resources on client mental state deterioration; and ensure clarity and consistency in its use of the term 'Huddle.' ***Recommendation 8*** The SLHD review the Community and Home Visit Huddle procedure to: a. require the discussion of a dynamic assessment of the safety risk to staff involved in the conduct of a home or community visit that day (whether consideration of the visit occurs at a daily Huddle meeting or otherwise); b. require the recording of a "decision" with respect to whether or not and how a home or community visit will be undertaken that day (whether that decision is made during a daily Huddle meeting or otherwise); and

	c. include a re-statement of the policy position as to when home and community visits may not be undertaken. ***Recommendation 9*** The SLHD formally implement a requirement that all Community and Home Visit Huddles must be attended by the relevant Team Leader and, [when reasonably possible], a psychiatrist. ***Recommendation 10*** The SLHD formally implement a requirement that all new Community Mental Health Service staff members must not undertake any home or community visits to clients alone in the first 3 months of employment. ***Recommendation 11*** The SLHD review its workplace health and safety policies, procedures and practices to consider whether the scope of the daily Community and Home Visit Huddle should be formally expanded to include discussion about safety issues generally for the relevant team that day, not merely safety issues concerning visits to clients in homes and elsewhere in the community. ***Recommendation 12*** The SLHD review the Core Team Model of Care with a view to including direction on handover planning for periods of staff leave. **To NSW Health** ***Recommendation 13*** NSW Health consider implementation of these recommendations in Community Mental Health Services state-wide.

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1 Introduction

1.2 This is an inquest into the death of Stephen James Douglas. At the opening of the inquest, Mr Douglas' family asked that he be referred to as *Stephen*. For this reason, throughout these findings, I will refer to him by that name.

1.3 Stephen died on the afternoon of 28 November 2019, in the course of his work as a community mental health nurse employed at the Camperdown Community Mental Health Service (**CMHS**). On that afternoon, Stephen visited a client, Peter Kemball, in his home. Unbeknownst to Stephen, Mr Kemball, who had schizophrenia, was suffering a delusion in which he thought that Stephen was a *hit man* who was coming to kill him. Soon after Stephen entered Mr Kemball's unit, Mr Kemball stabbed him multiple times. Stephen died at the scene from these wounds.

1.4 Stephen was born in England on 31 December 1956. He had five siblings and moved to Australia with his family when he was around fifteen years of age. He was particularly close to his sister, Wendy. Stephen was previously in a relationship with Dianne, with whom he had two sons, Adam and Sean. Stephen also had two daughters-in-law, Sarah and Emma, and three (now four) grandchildren. Stephen later formed a relationship with Craig. Stephen and Craig lived together in the Inner West of Sydney for over twenty years prior to Stephen's death. They enjoyed travelling overseas together and were happily approaching retirement when Stephen died.

1.5 Craig, Wendy, Adam and Sean, Sarah, Emma, and Stephen's nephew, Wendy's son, Damien, attended the inquest. From the evidence, the family statements, and the photo array shown at the close of the inquest, it was clear that Stephen was a much-loved partner, father, grandfather, sibling, and colleague. He loved music, movies, travel, and soccer. He was always smiling and had a wonderful sense of humour. Despite the years that had passed since his death, it was clear how keenly Stephen's loss continued to be felt.

1.6 In making these findings, I acknowledge the profound impact that the fact of Stephen's death, and the circumstances in which he died, has had, and will continue to have, on his immediate and extended family, friends, and colleagues. On behalf of the Coroners Court of NSW I extend to them my deepest sympathies for their loss.

2 Why was an inquest held?

2.1 Under the *Coroners Act 2009* ('the Act') a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death. A secondary function of a coroner is to make recommendations, arising from the evidence, in relation to any matter connected with the death.

2.2 Section 27 of the Act provides that an inquest is mandatory where it appears to the coroner that a person died, or might have died, as a result of a homicide (that is, an unlawful death) or where the manner and cause of the person's death have not been sufficiently disclosed. In this case, it was uncontroversial that Stephen died at the hands of Mr Kemball.

3 The inquest

3.1 The Court received seven volumes of extensive documentary evidence and heard oral evidence over eight days of the inquest from 12 witnesses including four expert witnesses. A number of further documents were tendered during the inquest.

3.2 While I am unable to refer specifically to all the available material in detail in my findings, it has been comprehensively reviewed and assessed.

3.3 A list of issues was prepared before the proceedings commenced. These issues guided the coronial investigation and shaped the conduct of the inquest. However, an inquest can tend to crystallise the areas which need attention. I intend to deal with the most important issues as they emerged during the proceedings under the broad headings below.

3.4 It is important to keep in mind, when reading these findings, that all inquests are undertaken with the benefit of hindsight and are the product of a significant investigation that has taken place as a result of a death. I am mindful of the potential effect of hindsight bias and the need to understand, where possible, the circumstances as they appeared to those who were involved in the care and

treatment of Mr Kemball and therefore the circumstances in which decisions were made on the day of Stephen's death, and in the preceding days, weeks, and months.

4 The Sydney Local Health District Mental Health Service

4.1 The Sydney Local Health District (**SLHD**) Mental Health Service (**MHS**) is a specialised clinical service, managing and providing mental health care across the Sydney and Inner Western Sydney region. Services are provided within hospital and community settings. Community based mental health services operate in the Camperdown, Canterbury, Croydon, Marrickville, and Redfern areas.

4.2 Mental health services are provided by a multidisciplinary team of mental health professionals including consultant psychiatrists, psychiatric registrars, nurses, social workers, occupational therapists, psychologists, exercise physiologists, dieticians and administrative staff. The multidisciplinary team (**MDT**) combines specialised skills and expertise and works together to provide high quality mental health care.

4.3 The CMHS is made up of teams which support a broad cohort of consumers and needs. The Community Mental Health Team (**Core Team**) is the largest team in Adult Community Mental Health. The other teams are considered specialist teams, and their function is focussed on a specific target group. One of these specialist teams is Acute Care Services (**ACS**).

4.4 The clients that the Core Team care for commonly present with chronic and complex mental health conditions. The Core Team operates during business hours, Monday to Friday, and offers coordination of care between primary and secondary care providers for both mental and physical health and wellbeing. By contrast, the ACS is dedicated primarily to assessments and interventions for people experiencing acute mental health problems, including a rapid response when indicated. The ACS operates seven days a week across morning and night shifts. At times, clients of the Core Team deteriorate and need more intensive care and a response within the remit of the ACS. As part of the MHS Models of Care, mental health consumers may require community or home visits as part of their ongoing health care needs.

4.5 From 1990, Stephen was employed by the SLHD as an Enrolled Nurse. He subsequently trained to become a Registered Nurse. In 2005, Stephen commenced employment as a Registered Nurse within the mental health field. Between 2005 and about 2016 he worked at inpatient mental health facilities at Callan Park and Concord Hospitals.

4.6 In around 2016, in the context of increased work pressure, particularly responding to duress scenarios and being one of few males on staff, Stephen took long service leave for eight months. Following this period of leave Stephen was diagnosed with osteoporosis with fracture and right shoulder supraspinatus tear and medically assessed as unable to respond to physically aggressive patients because of the risk of injury to himself. Stephen did not return to the inpatient setting and instead in July 2017 transitioned to work in a community setting, as a Mental Health Care Coordinator within the Core Team at the Camperdown CMHS located at the King George V building at the Royal Prince Alfred Hospital (**RPAH**) in Camperdown.

5 Mr Kemball's mental health history

5.1 Peter Kemball first experienced a decline in his mental health in his early 20s. In August 2002, when he was about 22, he was admitted for the first time to Rozelle Psychiatric Hospital as an involuntary patient. While in hospital, Mr Kemball was diagnosed with schizophrenia. From the time of his release from hospital, he became a client of Camperdown CMHS.

5.2 Over the following ten years or so, Mr Kemball *regularly questioned the efficacy of his medications and often altered or ceased his doses without consultation with his psychiatrist*. He had periods where he was admitted to private psychiatric hospitals for suicidal ideation and low mood, periods where he was in contact with the CMHS or private psychiatrists, and periods where he refused any mental health treatment.

5.3 By early 2012, Mr Kemball had refused all offers of voluntary treatment, preferring to manage his mental health via stress management techniques. Mr Kemball's parents, Lena and Howard Kemball, described his behaviour during this period as *bizarre and often frightening*. During an argument with his parents, Mr Kemball took a significant overdose and cut his left wrist. He was ultimately admitted to the Missenden

Psychiatric Unit. He was prescribed monthly paliperidone injections and was discharged on a Community Treatment Order (**CTO**) made by the Mental Health Review Tribunal (**MHRT**) on 10 February 2012, for a period of 6 months. This was the first time that Mr Kemball was subject to a CTO. Following this CTO, except for periods in March 2013 and June 2015 when he was admitted to hospital as an involuntary patient, Mr Kemball was the subject of consecutive CTOs up until the expiry of the last CTO on 18 June 2019.

5.4 Mr Kemball's compliance with the medication regime for management of his mental health, even when on a CTO, was variable. He would sometimes cease his oral medication and/or increase alcohol and cannabis intake resulting in an increase of symptoms and several involuntary admissions to psychiatric facilities. Mr Kemball did not like being on a CTO and complained consistently about it.

5.5 In about November 2017 as part of his work in the Core Team at the Camperdown CMHS, Stephen became Mr Kemball's allocated care coordinator. He remained so until his death two years later.

6 The expiry of Mr Kemball's CTO – 18 June 2019

6.1 In December 2018, after more than 6 years on a CTO, Mr Kemball was assessed by CMHS psychiatrist, Dr Justin Ho, as stable in his mental state. However, Mr Kemball maintained that he would not accept medication if not on a CTO. The CMHS sought that the CTO be extended, and the MHRT extended the CTO to 18 June 2019. However, Stephen provided feedback to Dr Ho that the MHRT *were not keen on granting further extensions of the CTO given Mr Kemball's history of compliance*.

6.2 On 8 May 2019, Mr Kemball was discussed at a weekly Camperdown CMHS MDT meeting. The MDT review sheet records Dr Ho, Stephen, Ms Denise Benfield (another Care Coordinator within the Core Team) and Dr Carolyn Stoney (psychiatric registrar) among those present. At this meeting, it was determined that Mr Kemball's CTO would be allowed to expire in June 2019 on the basis that he had been stable and compliant in the months prior. The ongoing plan was that Mr Kemball would continue to receive his depot injection from his General Practitioner (**GP**), Dr Caroline Harrison

(**Dr Harrison**) and see her monthly, and that he would continue as a client of the Camperdown CMHS and have regular contact with Stephen.

6.3 On 13 May 2019, Mr Kemball was again reviewed by Dr Ho. Stephen was unable to attend this review. As at this date, Mr Kemball's treatment included Abilify 400mg monthly by intramuscular injection, administered by Dr Harrison, and 50mg Seroquel daily orally at night. Mr Kemball indicated that he would accept the injection from his GP even if not on a CTO. Dr Ho assessed that Mr Kemball presented with *negative symptoms as before but no acute risk and positive symptoms in remission*. Dr Ho noted that Mr Kemball *did not express any overt delusions and denied any thoughts to hurt self or others.*

6.4 The documented plan set out in Dr Ho's electronic progress note was as follows:

1. *As per previous plan discussed with Stephen and Dr Harrison to let the CTO run its course, then for Mr Kemball to continue to get his depo via his GP*
2. *GP can refer back to contact the CMHS, the community mental health service, if deterioration or if Peter starts refusing to accept his depo.*

6.5 Dr Ho's notes included an assessment of risks of suicide, self-harm, violence, vulnerability or harm from others and risk to children. He rated each of these as low. The decision to let the CTO lapse occurred in the context of apparent indications from the MHRT that further extensions may not be granted in the absence of an adverse change in circumstances given Mr Kemball had been compliant with his medication for some time and had been on a CTO for nearly seven years.

6.6 The review by Dr Ho on 13 May 2019 was the last time that Mr Kemball was reviewed by a psychiatrist prior to Stephen's death on 28 November 2019. On 18 June 2019, Mr Kemball's CTO expired.

6.7 There was no evidence in the inquest that would lead to criticism of the decision to let Mr Kemball's CTO lapse in June 2019.

7 Mr Kemball's mental state following the expiry of his CTO in June 2019

July – August 2019

7.1 Throughout July and August 2019, Mr Kemball was seen on a number of occasions by Dr Harrison at her surgery at Rozelle Total Health and received his monthly depot injections as planned. Dr Harrison had no concerns regarding Mr Kemball's presentation, though reported that he was often isolated and at times was paranoid of other people.

7.2 Stephen spoke to Mr Kemball by phone on 15 August 2019 and he expressed his desire to be discharged from the CMHS. During a subsequent home visit on 23 August 2019, Mr Kemball's mental state was stable, and Stephen noted a plan to contact Mr Kemball's mother and Dr Harrison for their view of his discharge from CMHS if he remained stable.

7.3 On 16 August 2019, whilst in the waiting area at Dr Harrison's surgery, Mr Kemball reacted to an older female who had asked for his assistance with her phone, by pushing her away with his foot. The female was not injured but was a little shocked. When spoken to by staff, Mr Kemball became agitated and was talking aggressively. Dr Harrison did not witness the incident but spoke to Mr Kemball that day and explained to him that his behaviour was unreasonable. She described Mr Kemball as defensive and noted that he had reluctantly apologised to the female involved and was *very brusque in his response*.

7.4 Due to this incident Dr Harrison sent a letter to Mr Kemball, dated 4 October 2019, where she requested that he only have his appointments at 2pm on a Friday and wait on the veranda at the front of the surgery before his appointment instead of in the waiting room. Dr Harrison did this to keep Mr Kemball separate from other patients and to avoid another incident occurring. The letter noted that in Mr Kemball's *many years of attending the practice there has never been a similar incident*.

September – October 2019

7.5 In late September and early October 2019, whilst Mr Kemball had still maintained his contact with Dr Harrison, she assessed that his turning 40 years old and reflecting on his life compared to the lives of others was a destabilising factor.

7.6 On 10 October 2019, Mr Kemball's fortieth birthday, he went to lunch with his parents, who observed him to be reluctant to meet and generally withdrawn. On the same day he attended Dr Harrison's practice for his monthly depot injection, but walked out after waiting 20 minutes, stating he was going to see another GP. Up until this point, he had been attending his weekly appointment with Dr Harrison.

7.7 The same day, Dr Harrison sent Mr Kemball a letter, wishing him a happy birthday and asking him to book an appointment to have his Abilify injection. In the letter, Dr Harrison expressed that she was *very concerned* and that Mr Kemball's parents were *very worried* about him. Dr Harrison worded the letter in this manner as she was concerned about Mr Kemball's compliance and that he had not turned up to the appointment for his injection.

7.8 Dr Harrison states that Mr Kemball's parents had not in fact told her they were worried about their son but noted that they were *very powerful* in assisting Mr Kemball to reengage with treatment. Dr Harrison described her therapeutic relationship with Mr Kemball at that time as *very wobbly* and she was conscious of the impact on both Mr Kemball and his parents of having to restart again with another GP and the impact on the continuity of Mr Kemball's care.

7.9 During a phone call sometime shortly after 10 October 2019, Dr Harrison recommended to Mr Kemball that he increase his oral Seroquel 50mg dose from one to two times a day, taking a double dose at night. Dr Harrison states that Mr Kemball *had always been very happy with Seroquel and happily taken it* and her instructions to increase the dose were *to kind of top him up as it were* noting the delayed depot injection. Dr Harrison says Mr Kemball agreed to this increase and to attend the clinic the following week to receive his injection, however, he did not attend the clinic as agreed.

7.10 While not documented, Dr Harrison states she is *very confident* she would have tried to contact Stephen by calling his mobile to let him know Mr Kemball had not received his depot injection as planned on 10 October 2019 but later became aware that Stephen was on leave until 18 October 2019.

7.11 On 22 October 2019, Howard Kemball called Stephen to report his concerns for his son and that he was behind in his depot medication. Stephen then called Dr Harrison who informed him of Mr Kemball's depressed state at his birthday milestone and the circumstances of his missed depot injection on 10 October 2019. Stephen called Lena Kemball who told him she believed that Mr Kemball had not seen another GP for his depot medication.

7.12 Later that day, Stephen and a fellow Core Team care coordinator, Ms Beverly Davies, attended Mr Kemball's home to conduct a home visit, however there was no response to their door knocking, and Mr Kemball did not respond to telephone calls or messages indicating his lack of response may lead to ACS involvement or another CTO. Stephen left a letter at Mr Kemball's front door reminding him to attend his GP as soon as possible.

7.13 On 23 October 2019, Stephen telephoned Lena Kemball to follow up and she told him that she had received a text message from her son stating he would book an appointment with his GP for the following day to receive his Abilify injection. Stephen recorded a plan to monitor Mr Kemball's mood and behaviour.

7.14 That day, an MDT meeting was held at the CMHS at which Mr Kemball was discussed. The MDT review sheet records Dr Ho, Stephen, Ms Benfield, Dr Stoney and Ms Chisholm among those present. It was noted that Mr Kemball was *?deteriorating, had to wait at GP surgery*.

7.15 On 24 October 2019, Mr Kemball attended the appointment with Dr Harrison and received his Abilify injection, which by that time was two weeks overdue. Mr Kemball raised with Dr Harrison his desire to change to an oral medication and she discussed with him the possibility of aiming for a last injection in January/February if he remained stable. In her evidence, however, she stated that this was to *jolly him along and give him a bit of a carrot* and that she thought it was *very unlikely at that point* that he would make that transition.

7.16 After the consultation with Mr Kemball, Dr Harrison called Stephen and let him know that Mr Kemball's Abilify injection had been administered, and that he would come in again in four weeks to receive his next injection. Dr Harrison states that she and

Stephen had discussed Mr Kemball's management after he had come off the CTO and that their collective view was that they'd both *wait and see* how he went.

7.17 On 29 October 2019, Stephen made multiple calls to Mr Kemball and sent text messages to him, with no response. Stephen contacted Lena Kemball, who advised that Mr Kemball had a new phone number which he did not want Stephen to have. Stephen obtained the number from Dr Harrison and contacted Mr Kemball.

7.18 Mr Kemball responded by text message stating he was fine and up to date with his depot medication. He requested that Stephen bring a CMHS service discharge form for him to sign when they next met. Stephen responded *will have to let you know Peter when we can catch up, very busy at the moment. Anyway nice to hear all is well, thanks for texting*. Stephen recorded a plan to monitor Mr Kemball's mood and behaviour.

7.19 On 29 October 2019 a Rozelle Total Health reception note for Dr Harrison recorded that Mr Kemball called and asked her to call him back that day.

November 2019

7.20 From on or about 30 October 2019 to on or about 24 November 2019 Dr Harrison took leave and was not at Rozelle Total Health. She had no specific recollection of notifying Stephen of this leave, however her standard practice was to specifically phone him and let him know when she went on a period of leave. There is no record in Dr Harrison's notes that she notified Stephen of her leave on this occasion, although she states it is not something she would have necessarily written in her notes.

7.21 On 1 November 2019, Stephen reviewed the CMHS Home Visit Safety Checklist in relation to Mr Kemball, which remained unchanged from the previous assessments completed by him and by Mr Snodgrass when Stephen had been on leave, except for the summary of visit risk which stated: *Peter has been stable in his mental state for over 12 months, he visits his GP on a weekly basis for catch up which Peter enjoys, his GP also give's Peter his depot every 4 weeks. CTO was not re-applied for. When unmedicated Peter can become avoidant, depressed, paranoid, delusional and suicidal*. This is the last record made about Mr Kemball in his clinical records.

7.22 Stephen was on a period of leave in November 2019.

7.23 Dr Harrison returned from leave on or about 24 November 2019 and on her return to work, noticed that Mr Kemball had not booked an appointment for his next Abilify injection. Dr Harrison contacted Mr Kemball's mother, Lena Kemball, to follow up. Following this, Mr Kemball booked an appointment for 26 November 2019.

7.24 It was Lena Kemball's birthday on 25 November 2019. On that day, she and Mr Kemball met at a café near his home. Lena Kemball noticed that Mr Kemball became fixated on a male inside the café. She believed that Mr Kemball had started to *forget* about his injection. She observed he was very polite to the chemist, but after, when walking down the street she described him as actively avoiding people.

7.25 On 26 and 27 November 2019, Mr Kemball appeared *unstable* and had been calling and messaging his parents frequently, reporting paranoid thoughts about people on the street and next door. He was becoming more reclusive and was talking *so much gibberish…that just didn't make sense or wasn't true*. Around a month prior to this, Mr Kemball had begun to ask his mother who she was and expressed the belief that she was Julie Bishop and that his father, Howard Kemball, was Malcolm Turnbull.

7.26 On 26 November 2019, Mr Kemball attended an appointment with Dr Harrison in the company of his father. This was intended to be a quick appointment to ensure Mr Kemball received his Abilify injection, and Dr Harrison did not make a detailed assessment of him, with a longer appointment planned for 28 November 2019.

7.27 Dr Harrison administered the Abilify injection to Mr Kemball, however, he did not receive 0.5ml or 0.6ml of the 2ml depot injection, which was left in the vial after Dr Harrison drew it up. Dr Harrison only realised that Mr Kemball had not received the full dose after he had left, and she contacted him to encourage him to return to receive the remainder of the dose, however, he declined and hung up on her.

7.28 On the morning of 27 November 2019, Mr Kemball's mother sent a text message to Dr Harrison, who was not working that day, indicating that Mr Kemball appeared happier, had asked her out for a coffee, and that he was waiting for the confirmation text for his appointment the following day. Later that day Mr Kemball had separate phone conversations with his parents where he again called his mother Julie Bishop

and his father Malcolm Turnbull. Mr Kemball made these phone calls using an Android phone placed on speakerphone. He used his iPhone to record the calls.

7.29 During one such call Mr Kemball referred to Dr Harrison as Carrie Fisher. He repeatedly expressed concerns about being sent to hospital. He told his mother that he had an appointment with Dr Harrison the following day, but also that he had spoken with Dr Harrison who said he could return in December instead.

7.30 Mr Kemball's parents sent messages later that day to Dr Harrison stating they thought their son was unstable and she responded by text message that she would speak with Mr Kemball and Stephen the following day. Mr Kemball was due to attend an appointment with Dr Harrison at 2pm on 28 November 2019.

8 The events of 28 November 2019

8.1 When Dr Harrison arrived at work on 28 November 2019, she observed that Mr Kemball had cancelled his 2pm appointment, however noted that there was still a 12:45pm appointment available that day.

8.2 At about 8.30am, Dr Harrison called Mr Kemball, asking him why he had cancelled his appointment. Dr Harrison stated that Mr Kemball seemed *upbeat* and told her he had an appointment with her on 27 December 2019. She said she wanted to see him earlier than that and more regularly and said there was an available appointment at 12.45pm that day when she could see him. Mr Kemball said, *see you on the 27 December*. Following this call, Dr Harrison called Howard Kemball and asked him if he could get Mr Kemball to see her at 12:45pm that day.

8.3 The first phone call between Dr Harrison and Stephen occurred around 8:45am that morning. During this call, Dr Harrison told Stephen about Howard and Lena Kemball's concerns for their son and that there had been an underdose of Abilify given to him on 26 November 2019. Dr Harrison recalled that Stephen *felt he would probably visit Peter the next day, so that Peter did not feel he was getting too much intervention* and that he would try and arrange for Lena Kemball to be there at the same time. Stephen indicated he would call Mr Kemball, and it was arranged that Dr Harrison would ring Stephen back after the 12:45pm appointment.

8.4 Around 8:30am, Stephen spoke with the then Nurse Unit Manager (**NUM**) of the Core Team, Fiona Chisholm. Ms Chisholm's recollection is that Stephen told her he had received a call from Mr Kemball's GP (Dr Harrison) at 5pm the night before and that Mr Kemball had been *given a smaller dose [of Abilify] than was prescribed and she'd given him some oral medication…for any shortfall*. Stephen told Ms Chisholm that his plan was to go to Mr Kemball's home to ensure he had enough medication for the upcoming weekend and Ms Chisholm suggested that he speak with Dr Carolyn Stoney, the trainee psychiatry registrar, as she could give him a prescription for additional medication that he could take with him. Stephen agreed with this plan. Ms Chisholm did not recall Stephen mentioning any reports of Mr Kemball's behaviour or any contact from his family.

8.5 This was the only conversation Stephen had with Ms Chisholm that day. Around lunchtime, she saw Stephen making his way to a free staff barbeque that was taking place at RPAH. Ms Chisholm did not attend the BBQ and was out of the office at a meeting in the afternoon, returning to Camperdown around 3.45pm.

8.6 Between 9:00am and 10:00am that morning, Stephen exchanged text messages with Mr Kemball's mother Lena, indicating he had spoken to Dr Harrison and that she thought Mr Kemball *might be unwell* and enquiring about arrangements for an appointment with a psychiatrist at CMHS *before Christmas*. Lena Kemball replied that Mr Kemball *was ok but not great* and that his *thoughts were scattered and his sense of trust very low*. She indicated that Mr Kemball's father would be in contact regarding an appointment and there was a short text message exchange between Howard Kemball and Stephen about scheduling an appointment.

8.7 Linda Muir, another clinical care coordinator in the Core Team, and a psychologist, was planning to conduct a home visit to one of her clients at 3pm that afternoon and during the morning, asked Stephen to come out with her to the visit in case she needed help. The ACS had concerns about Ms Muir's client and the client required medication. Stephen agreed to attend with her.

8.8 Also, at some point that morning, Stephen spoke with another colleague, clinical care coordinator, Vivienne Upton, who was helping him complete a depot injection for an intoxicated client at the centre. He told her he had been receiving calls regarding Mr

Kemball. Ms Upton told Stephen to complete a *current assessment form* and have the ACS visit Mr Kemball that day (28 November 2019).

8.9 Stephen spoke to psychiatric registrar, Dr Carolyn Stoney, mid-to-late morning while she was in her office. He stood at the door and told her about Mr Kemball, that he was one of his patients, had chronic schizophrenia and lived alone. He told Dr Stoney that Mr Kemball's mother had called and wanted ACS to go out to him. Stephen told her that Mr Kemball was hearing voices and that he had received an underdose of his last depot injection from his GP.

8.10 Dr Stoney asked Stephen some questions about Mr Kemball and although she could not recall specific details of the conversation, did not recall anything Stephen told her that caused her to be alarmed. Dr Stoney's impression was that it sounded like Mr Kemball was either relapsing or having an exacerbation of his underlying mental illness and that he needed to be seen.

8.11 Dr Stoney spoke with Stephen about the available options. Firstly, that someone from the Core Team could go out with him, noting that if he needed someone to schedule Mr Kemball, Dr Stoney was available to assist but not until later in the day. Secondly, that Stephen could ask someone from ACS to go out with him, noting that that could often be *very, very useful* as he knew Mr Kemball well. Or thirdly, *if push comes to shove* and Stephen was unable to complete an assessment by the end of the day, the patient could be handed over to ACS.

8.12 Dr Stoney did not recall Stephen telling her he had spoken with Ms Chisholm, nor that Ms Chisholm had told him to speak with her. Dr Stoney observed that Stephen did not appear overly worried about the prospect of a home visit to Mr Kemball and when he left her office, her impression was that he had not yet decided what to do about having Mr Kemball assessed and he was going to *go away and think about it* and talk to someone else on either the Core Team or ACS.

Mr Kemball visits his parents

8.13 At about 12pm, Mr Kemball attended his parents' home. During a discussion with his mother, Mr Kemball became upset, and he hit her on the head with a cushion three

times. He also shook a neighbour (an elderly woman) who came to his parents' front door and yelled at a workman across the road.

8.14 Between 12pm and 1pm, there were further text messages exchanged between Howard Kemball and Stephen to arrange an appointment for Mr Kemball, with Howard Kemball expressing his concerns to Stephen that his son seemed *very unstable at the moment*. An appointment with a psychiatrist was scheduled for Mr Kemball on 6 December 2019 at CMHS with Howard Kemball responding, *Ok. Diarised. However unsure he can wait that long*.

8.15 Stephen had briefly returned to Ms Upton's office at some point talking about receiving a call from a client's family requesting he book a psychiatrist appointment for the client (Mr Kemball) as soon as possible.

Mr Kemball's consultation with Dr Harrison

8.16 Between 12.35pm and 1.40pm, Mr Kemball attended the appointment with Dr Harrison, accompanied by his father, Howard Kemball. Dr Harrison found Mr Kemball to be erratic and assessed that he was *demonstrating signs of psychosis*. Dr Harrison described Mr Kemball as *kind of shutting down,* that *he was quite difficult to assess because he just didn't want to be there,* and that he was exhibiting a lack of engagement as well as *a definite lack of insight*.

8.17 Dr Harrison formed the view that Mr Kemball would likely need a hospital admission. When she told Mr Kemball that this may be the case if he became increasingly unwell, Mr Kemball responded by accusing Dr Harrison of *threatening him*, asked if she was a doctor, and whether she *had injected him with adrenaline earlier [that] week*. Dr Harrison then suggested to Mr Kemball the option of the ACS visiting him to reduce the chance of hospital admission to which he agreed, and she increased his Seroquel medication to 100mg at night. Dr Harrison remained concerned that Mr Kemball's lack of engagement would impact on his willingness to accept treatment and that he would likely require involuntary treatment or hospitalisation. Dr Harrison had observed Mr Kemball during previous periods of deterioration and noted that on this occasion he was not exhibiting the same engagement or insight that would suggest to her that he may willingly accept treatment.

8.18 At about 12.25pm Mr Kemball's father, Howard Kemball, telephoned Stephen, but he did not answer. Stephen replied by text message at 12:25pm, stating *Can I call you soon Howard? Busy at the moment*. Howard Kemball replied at 12:31pm telling Stephen he was with Dr Harrison, and they had agreed Mr Kemball needed the ACS. Dr Harrison asked Mr Kemball's father to wait outside for the second half of the consultation. Upon completion of the consultation, Mr Kemball walked out very abruptly, leaving his father behind.

8.19 After Howard Kemball left, Dr Harrison inadvertently called Mr Kemball, having intended to call Stephen. She pretended she had been calling him to make sure that he got home okay and confirmed with him that the ACS would be attending later that afternoon. Mr Kemball said, *I'll be waiting for the Acute Care Team*.

8.20 Dr Harrison then called Stephen to provide him with an update and to formulate a plan for Mr Kemball. She told Stephen that based on Mr Kemball's presentation that morning he may need a hospital admission and had shown an increase in psychotic behaviour. Dr Harrison and Stephen lamented that there was no longer a CTO in place for Mr Kemball and agreed it was very unlikely Mr Kemball would be able to swap to an oral antipsychotic in the new year.

8.21 Dr Harrison discussed with Stephen that after an admission, Mr Kemball would likely no longer wish to have a therapeutic relationship with either of them, and she suggested that the ACS team attend to assess him. Stephen agreed that Dr Harrison would contact the ACS Team.

8.22 Dr Harrison phoned the ACS and spoke to an intake officer. Once she provided Mr Kemball's name, the officer redirected her call to Stephen, noting that Mr Kemball was his patient. The phone call with Stephen after the transfer from ACS was short. Dr Harrison could hear another client in the background with Stephen, and he told her he would contact the ACS himself, stating *look, you'll just go around in circles, I'll speak to them*.

8.23 In involving the ACS Dr Harrison states that she wanted to *keep…Stephen out of the equation* in that she was concerned about maintaining the therapeutic relationship established between him and Mr Kemball. Dr Harrison states it was not her intention

for Stephen to visit Mr Kemball and the *thought did not enter [her] head* that he would go to Mr Kemball's home. It was Dr Harrison's intention that the ACS assess Mr Kemball that day.

Preparations to visit Mr Kemball

8.24 Stephen's partner Craig McGrath had attended his office about 12.30pm and observed he was writing a report. Stephen and Mr McGrath then attended the free staff BBQ at RPAH together and Stephen stayed for about 45 minutes.

8.25 At about 2.20pm, Stephen spoke with Ms Muir and told her he would no longer be able to accompany her to see her client as he had to go and see a client of his own. Stephen then told Ms Muir he would go with her and then attend Mr Kemball's home first, followed by Ms Muir's client's home.

8.26 Around this time, Stephen passed by Ms Upton's office again and told her he was going to visit Mr Kemball, and she asked him to take a student with him. Stephen responded that he could not because Mr Kemball *might kick off*.

8.27 Stephen told Ms Upton about his conversation with Dr Stoney and that she had told him to attend with the ACS. He also told Ms Upton he had spoken to Mr Kemball about the need for the ACS to attend and Mr Kemball had responded *Yes, come over, but I don't want a team of people coming over, I want you to come and see me alone*. Ms Upton said Stephen did an impression of a sinister voice when he said, *come and see me alone*, and then laughed.

8.28 Ms Upton was very uncomfortable with what Stephen had said to her and told him he should not conduct the home visit with Ms Muir and that Mr Kemball sounded *really unwell* and that it was not safe to conduct the visit. Ms Upton had spent a significant period of her career working in a forensic setting and had a *bad feeling* about the things Stephen was telling her about Mr Kemball's condition.

8.29 Ms Upton suggested to Stephen that he ask someone from ACS to go with him however having then realised that they were in a meeting at that time, she suggested to Stephen that he speak to another team member, Denise Benfield, who was at that time on intake and ask her to attend with him as she had the ability to schedule Mr Kemball.

8.30 Ms Upton said to Stephen *You can't go inside his house mate, you gotta stay outside the door with someone else* and *You mustn't mate, he sounds really unwell*. Stephen replied, *No I won't go inside* and *I won't, but he's only a weak man, doesn't leave the house much, a bit of a loner*. Ms Upton responded *Yeah but that doesn't mean anything. Go and speak to Denise*. Stephen replied, *Yeah ok I will thanks bye*.

8.31 Stephen did not then speak with Ms Benfield. A short time later Ms Upton asked Ms Benfield whether Stephen had spoken with her, and she said he had not, as she had been busy with a client. As she said this the phone rang and it was reception asking for someone to come downstairs to do an injection for one of Stephen's clients (he now being out with Ms Muir).

9 The circumstances of Stephen's death

9.1 At 2.29pm Mr Kemball spoke to his father by phone and told him that Stephen was going to visit him and that he had told him to come on his own. Mr Kemball said, *This case manager Stevie Douglas, who is my hit man and I'm his job, right?* and then said, *I'll call you after I kill him*. Howard Kemball did not hear or properly register these words.

9.2 At approximately 2.45pm, Stephen and Ms Muir exited the Camperdown CMHS and made their way to Mr Kemball's residence in Balmain East. During the car trip, Stephen told Ms Muir that a doctor and Mr Kemball's parents had phoned to report their concerns about Mr Kemball's mental state, and that Stephen had decided he had better go out and see him.

9.3 Ms Muir did not *know very much about [Mr Kemball] at all as he was not one of her clients*, but she had met him on two previous occasions and believed his diagnosis was schizophrenia. She understood that originally Stephen had planned to see Mr Kemball on his own.

9.4 While driving to Mr Kemball's unit, Mr Kemball phoned Stephen, and he answered the call on speaker phone. Mr Kemball asked Stephen to *bring the discharge form*, and Stephen responded, *Mate we can't just do that yet*. Stephen said to Mr Kemball that Dr Harrison was concerned about him. He asked if he had been taking any drugs,

sleeping well, and taking any extra Seroquel. Mr Kemball indicated he had not been taking drugs, had been sleeping well, and had not been taking extra Seroquel. He said Dr Harrison had injected him with 500ml of adrenaline and he had received more that day.

9.5 Stephen and Mr Kemball discussed the planned visit and Stephen asked, *Are you going to meet me in the park?*, to which Mr Kemball replied, *No you're coming to my house*. Mr Kemball asked how far away he was, Stephen replied *won't be long, we don't know*. Mr Kemball responded *We? I thought you said you were coming alone?*, which Stephen said was a reference to himself and Mr Kemball. Stephen ended the call saying, *see you in 20 minutes*.

9.6 Following the phone call, Stephen said to Ms Muir that Mr Kemball *sounded a bit elevated*. Stephen did not appear scared to Ms Muir. They discussed that Mr Kemball had a history of using *a bit of pot*, but no methylamphetamine. Stephen expressed concern that Mr Kemball may need a hospital admission due to a relapse of symptoms and he and Ms Muir discussed how Stephen would proceed with making an assessment. He told her that he didn't feel unsafe with Mr Kemball and that Dr Harrison had concerns about a referral to ACS jeopardising her relationship with Mr Kemball.

9.7 Stephen and Ms Muir agreed that in the event that Stephen entered the property and assessed that Mr Kemball needed to be hospitalised, they would return to the office immediately and refer the matter to the ACS who could schedule Mr Kemball, and/or call the police. Stephen and Ms Muir specifically discussed whether he would go alone, or with her. Stephen indicated he wanted to go by himself because he had told Mr Kemball he was coming by himself. They agreed that if Stephen had not returned within 20 minutes by 3.30pm then Mr Muir would go and knock on the door. She unfortunately wrote down the incorrect unit number.

9.8 Around 3.10pm, Stephen left the work car and entered Mr Kemball's unit in Balmain East. He used the Work Safe Guardian (**WSG**) application on his phone to commence a 75-minute timer within that application.

9.9 At 3.13pm Mr Kemball commenced a video recording on his phone and had placed the phone on a coffee table pointing up at the ceiling. The recording on Mr Kemball's phone captured the interaction between Stephen and Mr Kemball that followed. Stephen entered the unit and said, *What's going on Peter?* and as he apparently went to sit down, he was stopped by Mr Kemball, who directed him, in an elevated voice, to sit on another chair. Around 15 seconds later, Stephen said *I've left my keys in my car. Sorry mate. I'll just run and get them.*

9.10 Mr Kemball then commenced attacking Stephen with a kitchen knife, fatally stabbing him in an attack lasting around 7 minutes.

9.11 Around 3.30pm, Ms Muir exited the work car and went in search of Stephen, ultimately attending Mr Kemball's unit at 3.32pm, knocking several times and calling out for 'Peter' or 'Steve' over several minutes. When there was no response, Ms Muir contacted Stephen's work mobile phone. There was no answer.

9.12 Between 3.35pm and 3.41pm, Mr Kemball had two phone conversations with his father, Howard Kemball, who became aware that his son had stabbed Stephen. Howard Kemball called '000' and at 3.44pm, an urgent job was broadcast for police to attend Mr Kemball's residence. Howard Kemball also made his way there by car.

9.13 Ms Muir had a phone conversation with Mr Kemball around 3.47pm and he told her that Stephen had died.

9.14 By 3.55pm, police had arrived at Mr Kemball's residence along with his father. Mr Kemball did not open the door to them but did when his father spoke to him through the door. Mr Kemball was arrested by police. He told them he had consumed cannabis and beer that day.

9.15 Police located Stephen underneath a black futon couch in Mr Kemball's loungeroom. He was not moving, was cold to the touch and there were no signs of life. He had sustained visible injuries. A large kitchen knife with blood on it was in the kitchen sink.

9.16 Immediately following his arrest, Mr Kemball was conveyed to RPAH and treated for a bleeding laceration to his leg, during which a blood sample was taken at approximately 5:30pm. This blood sample was analysed by NSW Health Forensic and Analytical Science Service which found aripiprazole 0.44mg/L, cannabis and

metabolites and quetiapine 0.11mg. No alcohol was detected. Following surgery for his leg injury, Mr Kemball was placed into custody.

9.17 Mr Kemball was described as disordered and psychotic in his interactions with police at the scene, and with hospital and custody or medical staff in the following days and weeks.

Autopsy

9.18 On 2 December 2019, an autopsy (involving an external and internal examination and toxicology) was conducted by forensic pathologist Dr Elsie Burger. A report was furnished on 31 July 2020 which identified Stephen's cause of death as multiple sharp force injuries.

Criminal Proceedings

9.19 Mr Kemball was charged with Stephen's murder. On 4 November 2020, following a judge alone trial, Mr Kemball was found not guilty of Stephen's murder on the grounds of mental illness. Mr Kemball was ordered to be detained in a correctional facility or at such place as may be determined by the MHRT until released by due process of law. He was detained at the Metropolitan Remand and Reception Centre and Long Bay Correctional Complex for care and treatment while awaiting transfer. On 18 May 2022, Mr Kemball was transferred to The Forensic Hospital.

10 The Incident of 10 September 2018

10.1 Stephen's death was not the first incident of significant work-related violence to affect the Core Team of the Camperdown CMHS.

10.2 On 10 September 2018 a peer support worker who worked within the Core Team was stabbed in the neck by a Core Team consumer, at a café near the Camperdown CMHS office. The peer support worker sustained serious injuries and was admitted to hospital for 5-6 days. This incident was described as a *huge near miss* by Denise Benfield, a Care Coordinator who was working in the Core Team, both at this time and at the time of Stephen's death. It was clear from the material related to this incident that was tendered in the inquest, that had bystanders not intervened to prevent

further injury to the peer support worker, or if the café in which the attack took place not been so close to the Emergency Department at RPAH, the outcome for the peer support worker may have been considerably worse, if not fatal.

10.3 The September 2018 incident bore significant similarities to the incident that later resulted in Stephen's death. It occurred when the peer support worker met with the consumer in circumstances where:

a) the consumer had chronic schizophrenia which was mostly non-responsive to treatment;

b) the consumer had been a long-term client of the service (since 2012);

c) the consumer was well known to the peer support worker, who had seen the consumer on 14 occasions in both the clinic and the community;

d) in the weeks prior the consumer had demonstrated changes in behaviour that were noted and which suggested that she was deteriorating, and which SafeWork NSW subsequently assessed should have triggered a reassessment of the client's risk profile;

e) the meeting was pre-arranged; and

f) the consumer had no known recorded history of aggression.

10.4 As a result of the investigation conducted by SafeWork NSW into this incident, on 9 October 2018 SafeWork NSW issued an improvement notice 7-342209 which included the following:

- *Review and as necessary revise control measure to prevent or control consumer violence when there are clinical warning signs or changes in the consumers behaviour/condition that may put workers at risk of injury*.
- *You must document and maintain the procedure that is to be used to review control measures to prevent or control consumer violence*.
- *You must provide information, training and instruction to ensure all clinicians/workers are aware of the procedure requiring a review of control*

measures to prevent or control consumer violence when there are clinical warning signs or changes in the consumers behaviour/condition.

10.5 Prior to this incident, the SLHD had developed a policy compliance procedure (**PCP**) titled *'Working in the Community – Home Visiting'* (SLHD_PCP2018_007) dated 28 March 2018 which outlined the responsibilities of all SLHD staff and managers when visiting consumers in the community. This procedure provided that all possible risks must be identified, assessed and controlled prior to the first visit using a Home Visit Risk Assessment Checklist or other risk assessment forms (as required). The home visit risk assessment was required to be checked every visit and updated if necessary. All risk assessments and associated control measures were required to be endorsed by the manager in consultation with the workers undertaking the task.

10.6 It appears that in response to the Improvement Notice, among other actions, the SLHD reviewed existing procedures and published *'Working in the Community – Home Visiting'* (MH_SLHD_PCP2018_003) dated 27 November 2018. These procedures were written to assist with operationalising the SLHD PCP in a way that was specific to the MHS.

10.7 The mental health PCP included an additional four areas related to the implementation of the SLHD PCP: Home Visit Safety Checklist (**HVSCL**), staff movement sheets, Work Safe Guardian (**WSG**), and Peer Support Workers. In relation to the HVSCL the mental health PCP provided:

- that although District Policy refers to the Home Visits Risk Assessment Forms, in Mental Health it is referred to as Home Visit Safety Checklist (HVSCL);
- the HVSCL will be completed three monthly or more frequently when there is any relevant clinical or risk changes (the SLHD PCP required only annual risk assessments); and
- a home visit should not occur unless a HVSCL has been completed within the last three months.

10.8 The Safe Work inspector conducted a follow up visit on 14 December 2018 and confirmed the actions taken to mitigate the risk. On 17 December 2018, the Improvement Notice was deemed as complied with by SafeWork NSW.

10.9 At the time of the September 2018 incident, it appears that there was very little in place in terms of the practice of the Core Team of the Camperdown CMHS to assess risk to, and protect the safety of, mental health workers working in the community. The development and implementation of MH_SLHD_PCP2018_003 was a positive step towards acknowledging and attempting to address the risk of violence faced by community-based workers working with consumers with mental illness. However, with the benefit of hindsight, it is clear that the mental health PCP that was produced in response to this investigation, failed to engage adequately with what appears to have been the key issue in both this incident, and later in the incident resulting in Stephen's death, that is, the dynamic nature of the risk of violence to community based workers in circumstances where there is evidence of a deterioration in a consumer's mental health.

11 The risk posed by Mr Kemball

11.1 During the coronial investigation into the circumstances of Stephen's death, expert evidence was obtained from Associate Professor Danny Sullivan, a consultant forensic and adult psychiatrist based in Victoria, Dr Michael Davis, a consultant forensic clinical psychologist, also based in Victoria, and Professor Matthew Large, senior staff specialist psychiatrist at The Prince of Wales Hospital. These three experts provided detailed reports regarding the care and treatment of Mr Kemball and gave oral evidence at the Inquest.

11.2 Regarding the risk posed by Mr Kemball, in his report, Associate Professor Sullivan concludes that the decision not to seek a further CTO was always going to carry a markedly elevated risk of relapse, however he also says it could not have been straightforwardly foreseen that relapse would have been associated with significant homicidal violence. He says it would have been more likely that treating staff considered risks in Mr Kemball's case to have included risk of self-harm, deteriorated mental state or distress, but not an obvious risk of violence. The consideration of the risks and benefits of ceasing compulsory treatment he says would not likely include a risk of violence to others when this was not a historical element of Mr Kemball's presentation.

11.3 I pause to make a number of observations in relation to Mr Kemball's risk profile for violence as at that time based on his history. These observations arise from the available evidence concerning his interactions with medical practitioners across the very lengthy period of his mental health treatment between 2002 to 2019 as well as his life in the community generally.

11.4 Firstly, for the most part he had little to no insight into his condition. He regularly self-ceased his prescribed medication, wanted to be off all medication and at times appears to have increased his alcohol and cannabis usage without disclosing this to his treating practitioners. He also consistently reported he did not like being on a CTO and wanted to be discharged from the CMHS.

11.5 Secondly, even when on medication, he presented with a low level of psychotic symptoms, namely hallucinations, delusions, and disordered thinking and behaviour. His schizophrenia was chronic and treatment resistant.

11.6 Thirdly, again for the most part, Mr Kemball nevertheless remained engaged in mental health care and treatment, was compliant with his medication or promptly returned to medication compliance. In this regard, Mr Kemball received significant support from his parents. They regularly attended appointments with him, maintained lines of communication with his treating practitioners and sought intervention and assistance whenever his condition deteriorated.

11.7 Fourthly, prior to 28 November 2019, there was no recorded history of Mr Kemball having engaged in interpersonal violence towards any person with or without weapons. He had never been charged with a criminal offence, and it is clear from the available New South Wales Police Force event entries that he did not engage in any antisocial behaviour that concerned members of the public and which would have brought him to the attention of police.

11.8 The extent of his documented history of behaviour that might be categorised as aggressive is outlined below.

11.9 In August 2002 when he was first treated involuntarily, he presented as agitated, posturing and threatening and required sedation and seclusion;

11.10 In early 2017 while acutely psychotic in the context of a medication delay, he variously threw a neighbour's guitar over the fence, destroyed his phone, threw a pot plant which he thought was sending messages and reported to Dr Harrison moments when he was angry and would like to calm down. He also expressed a desire to engage in therapy to manage his anger.

11.11 In early 2018 Mr Kemball reported experiencing vivid aggressive dreams though he denied any intent and no violent behaviour manifested. In August 2019 he reacted to an older female patient in Dr Harrison's GP practice, as referred to above, when she asked for his assistance with her phone. He acted by pushing her away with his foot and then pushing her in the abdomen. When spoken to by staff, he became agitated at being told off and spoke aggressively, though he did not display any violent behaviour.

11.12 Mr Kemball otherwise at times physically touched Dr Harrison in a non-sexual but nevertheless inappropriate way. However, she has said that Mr Kemball had never been violent towards her, and she never had any concerns for her safety when with him. Mr Kemball is also recorded as having made sexually inappropriate comments to a female care coordinator on one occasion which is understood resulted in a home visit rule that females were not to visit him alone, although no threats of violence were involved. In terms of physical harm, the only history Mr Kemball had was of harm to himself and to objects or potentially other property.

11.13 I also note the report in October 2018 by Mr Kemball's parents to police, Dr Harrison and to Stephen that Mr Kemball was suspected of having thrown a beer bottle through his parents' lounge room in the early hours one morning.

11.14 Both Associate Professor Sullivan and Dr Davis administered the HCR-20 risk assessment instrument retrospectively to assess Mr Kemball's risk of interpersonal violence as of November 2019. The opinion of Associate Professor Sullivan is that Mr Kemball did not have any appreciable past history of violence. Dr Davis concludes that Mr Kemball had never engaged in any overtly violent or otherwise antisocial behaviour.

12 The care provided to Mr Kemball by Dr Caroline Harrison

12.1 From early 2015 Dr Harrison became Mr Kemball's GP at Rozelle Total Health. Dr Harrison had been working as a GP since 2004, having completed a Bachelor of Medicine in the United Kingdom in 1999. Dr Harrison had been employed as a GP at Rozelle Total Health as an independent contractor since January 2013. Mr Kemball was one of only five schizoaffective patients Dr Harrison had looked after in the course of her career and the only client she had had who had been subject to a CTO, although she had had other clients who were engaged with the CMHS.

12.2 According to Mr Kemball's parents, Mr Kemball came to trust Dr Harrison. This was evidenced in his maintenance of regular, mostly weekly, engagement with her over a period of nearly five years. After Stephen became Mr Kemball's allocated care coordinator in November 2017, Dr Harrison worked with him and with Mr Kemball's parents, to monitor and address Mr Kemball's mental health concerns. In Dr Harrison's view, she, Stephen, Mr Kemball's parents, and Mr Kemball himself had a good working relationship for a very lengthy period.

12.3 Dr Harrison described Mr Kemball as *chronically psychotic*, explaining that *he always had a low level of hallucinations, delusions [and] disordered thinking and behaviour*. Mr Kemball was no doubt a challenging patient in many respects, yet it was clear from Dr Harrison's evidence that she approached her treatment of him in a way that was both diligent and compassionate. Mr Kemball's weekly attendance on Dr Harrison provided him with some respite from his social isolation, however it also had the added benefit of allowing Dr Harrison to regularly monitor fluctuations in Mr Kemball's mental state, information that she could share with Stephen and Mr Kemball's parents. Since she commenced treating Mr Kemball around March 2015, Dr Harrison recorded 280 consultations with him up until the time of Stephen's death, including over 40 in 2019 prior to 28 November.

12.4 After Mr Kemball's CTO lapsed in June 2019, his attendance on Dr Harrison for his monthly depot injections was entirely voluntary. Despite this, at least initially, he continued to see her weekly. For Dr Harrison's part, there appears to have been little change to the approach she took in relation to Mr Kemball's care. She was, for example, proactive in contacting Mr Kemball's parents when she returned to work

from leave on 25 November 2019 to discover that Mr Kemball had not made an appointment for his next depot injection. When, on 26 November 2019 she failed to administer the full dose of Abilify to Mr Kemball, she immediately contacted both Mr Kemball and his parents to ensure he returned to see her to receive the remainder of the dose. On 28 November when it became clear to Dr Harrison and to Mr Kemball's parents that Mr Kemball was experiencing a decline in his mental health, she contacted both Stephen and the ACS.

12.5 Some potential shortcomings in Dr Harrison's treatment of Mr Kemball were explored by counsel appearing for Stephen's family. For example, counsel explored with Dr Harrison her failure to refer Mr Kemball to drug and alcohol specific counselling or to anger management counselling. It was clear, however, that Dr Harrison had referred Mr Kemball to a psychologist at Rozelle Total Health, Patricia Durning. In the referral letter to Ms Durning, dated 3 July 2017, Dr Harrison specifically mentions Mr Kemball's use of cannabis and alcohol, its effect on his mental health, and the fact that *it brings out the disagreeable, aggressive side of his personality*. Dr Harrison's evidence was that she believed that Mr Kemball had seen Ms Durning for a period, although she was unsure how long. Dr Harrison's view was that even if she had referred Mr Kemball to specific drug and alcohol or anger management counselling, he would not have gone. In her words *Peter was quite resistant to any referrals*. Associate Professor Sullivan also believed that such a referral would likely have been of little value. He referred to what he described as *therapeutic pessimism* where a general practitioner tells a person repeatedly that their substance use may lead to adverse outcomes for their mental health or for offending behaviour, to no effect, and ultimately decides that it is best simply to maintain a therapeutic relationship with their patient.

12.6 Counsel for Stephen's family explored the impact of the delay in the Abilify dose when Mr Kemball left Dr Harrison's practice on 10 October 2019 before receiving his dose, and the underdosing on 26 November 2019. Dr Harrison's evidence was that when Mr Kemball had first started his monthly depot injections of Abilify, she had noticed a dip in its efficacy in the week or so prior to the next dose. In her oral evidence she clarified that this had only occurred during a period of approximately

three months when Mr Kemball had first been prescribed Abilify in mid-2018 after which the decline in efficacy during the fourth week no longer occurred. Associate Professor Sullivan's evidence was that there was no clinical adverse impact resulting from this.

12.7 In a report obtained by Dr Harrison's legal representatives, Dr Martine Wales, a registered specialist medical practitioner in general practice, considered all of Dr Harrison's clinical notes. In her opinion, Dr Harrison's treatment of Mr Kemball was appropriate and of a standard above that expected of peer general practitioners. Associate Professor Sullivan echoed this view. He felt that Dr Harrison was committed, thoughtful, and adept at interpreting mental state. She worked through a combination of assertive general practice and use of her personal link with Mr Kemball to entice him into ongoing treatment.

12.8 In my view, the evidence did not establish any inadequacies in the management and treatment of Mr Kemball by Dr Harrison following the expiration of the CTO in June 2019, or indeed, prior to this date. In my view, Dr Harrison provided an exceptional service over several years to a patient who presented with complex mental health issues.

13 The care provided by the Camperdown CMHS after Mr Kemball's CTO expired

13.1 Unlike many people living with mental illness, Mr Kemball was well supported in his community. His parents clearly had a very close and loving relationship with him and were actively engaged in ensuring his wellbeing and supporting his need for treatment. They were in regular contact with both Stephen and Dr Harrison and worked together with them to monitor and manage Mr Kemball's mental illness.

13.2 During the period between 2012 and May 2019, when Mr Kemball was subject to successive CTOs, he was regularly reviewed by a psychiatrist in the Camperdown CMHS Core team. The available reports prepared for the CTO reviews before the MHRT indicated that from at least 2016 until May 2019 Mr Kemball was reviewed by a psychiatrist every three months. From December 2017 the treatment plans ordered

by the MHRT specifically required Mr Kemball to attend upon Dr Harrison fortnightly in addition to the three-monthly reviews with a psychiatrist and monthly contact with Stephen. On most occasions during the period that he was Mr Kemball's care coordinator, Stephen attended the psychiatrist reviews. At times, Dr Harrison was also directly involved in discussions with psychiatrist, Dr Ho, who had been reviewing Mr Kemball since about June 2017. Dr Harrison also had direct contact with Stephen usually every month or so, although they never met in person.

13.3 On 18 June 2019 Mr Kemball's CTO expired. The review by Dr Ho on 13 May 2019 was the last time that Mr Kemball was reviewed by a psychiatrist prior to Stephen's death on 28 November 2019.

13.4 The care coordination and clinical planning policies that applied to all SLHD CMHS clinicians at the time mandated completion of a clinical review process every 13 weeks, but this did not expressly mandate face to face psychiatrist review of a client as part of this. The Model of Care for the SLHD CMHS Core Team in place at the time did not mandate any minimum timeframe for periodic psychiatric reviews of clients under the care of the Core Team, although for clients on a CTO, such review period would have been contained in the treatment plan approved by the MHRT. The only record of a plan for Mr Kemball's management by the CMHS after his CTO lapsed was contained in the electronic progress note of 13 May 2019 created by Dr Ho. Neither Dr Harrison nor Stephen was present at that particular review appointment.

13.5 The evidence was that it was not unusual for clients of the Core Team who were not on a CTO and were not coming to the attention of the team in any adverse sense, to not be seen by a psychiatrist. There was in place at the time a proforma GP Mental Health Shared Care Plan and Mental Health Shared Care Plan Checklist documents, cast on the basis that GPs had key responsibility for physical health care and the CMHS was responsible for ongoing mental health care. In any event, no such plan was ever prepared in respect of Mr Kemball in the time Dr Harrison was his GP.

13.6 The SLHD CMHS Core Team *current* Model of Care guideline document (from August 2020) provides that it is a '*Standard Care Procedure*' that *all* clients of the Core Team be subject to six-*monthly* psychiatric and medication review as *the minimum expectation* although *ideally* review should be more frequent. However, Associate

Professor Sullivan's consideration of the management of Mr Kemball in the period immediately after the lapsing of the CTO, together with consideration of the SLHD's current model of care policies, give rise to a proposed recommendation about improvement to the SLHD's framework for care of clients coming off CTOs.

13.7 In the context of clients with chronic (especially treatment resistant) psychotic illnesses who are discharged from CTOs, for whom the risk of deterioration and relapse is *very likely,* Associate Professor Sullivan suggested that scheduling psychiatric review (albeit depending on the client's voluntary attendance) at ideally three month intervals would provide a chance to compare a person's mental state over time to identify deterioration even where the client is compliant with medication. He explained this would provide greater opportunity to change the trajectory of management, and noted that periodic review by a *psychiatrist* rather than just a case manager is warranted because case managers:

> *…sadly become accustomed to dealing with people who are non-compliant, insightless, and substance-using, …and really just waiting for the moment when, when they appear so unwell that they need to be detained compulsorily*.

13.8 Associate Professor Sullivan's opinions in this regard focussed on clients with *a diagnosis of a chronic and severe mental illness which is considered likely to relapse*. Dr Stoney, who was the trainee psychiatrist in Stephen's team at the time of his death, similarly considered that a client was coming off a CTO with a long history of having been subject to CTOs, then psychiatric review within three months of the CTO ending should take place.

13.9 Understandably, the SLHD does not appear to identify the diagnoses of clients of its community mental health service specifically by reference to a risk of relapse, or treatment resistance. However, collated information about the cohort of clients of the Core Team does indicate the serious and chronic nature of the mental illnesses in relation to which such teams provide care to clients. For example, in March 2019:

- between 50-60% of all SLHD Core Team consumers had a primary diagnosis of schizophrenia;

- 30% of all SLHD Core Team consumers had a *length of stay* of longer than 5 years; and
- 21.6% of all SLHD Core Team consumers were subject to involuntary treatment.

13.10 Counsel for the SLHD submitted in relation to this issue that even if a psychiatric review of Mr Kemball had occurred between the review by Dr Ho on 13 May 2019 and Stephen's death, *there is no basis to find that they would have led to any change in Mr Kemball's treatment, rather the likelihood is that he would've been seen and assessed and they would've continued the management within the core team without recourse to either admission or a community treatment order being sought again*.

13.11 We cannot know what might have happened had a psychiatric review occurred. However, I do not suggest that had a psychiatric review of Mr Kemball occurred, it would have resulted in Mr Kemball being scheduled under the Mental Health Act or in an application for a further CTO. It might, for example, have resulted in a change to Mr Kemball's medication, the involvement of ACS, closer monitoring by the CMHS, or no action at all.

13.12 The suggestion that regular psychiatric reviews be scheduled for consumers coming of a CTO is intended to address the practice that appears to have existed at the time of not scheduling *any* psychiatric review of consumers who were not subject to CTOs unless it was clinically indicated. The purpose of more regularly reviews is to identify changes over time that may suggest deterioration, so that further decline can perhaps be avoided by changes to treatment. It is an approach that is *proactive* rather than *reactive*.

13.13 There was evidence that suggested that Mr Kemball's mental health was beginning to decline from at least 10 October 2019 when he left Dr Harrison's practice before receiving his Abilify injection. This is the event in relation to which at the MDT meeting that took place on 23 October, Stephen records *?deteriorating*. As counsel for the SLHD pointed out, on the morning of 28 November 2019 Stephen was trying to organise for Mr Kemball to be reviewed by a psychiatrist. But this was more than 6 months after Mr Kemball had last been seen by a psychiatrist, 6 weeks after the incident of 10 October 2019, and in the context of a discussion Stephen had with Dr

Harrison that morning in which she outlined the concerns that both she and Mr Kemball's parents had that Mr Kemball was becoming *unstable*. At this point, it appears that the earliest psychiatric appointment that Stephen could organise was for 9:00 am on 6 December 2019, in relation to which Howard Kemball advises *Ok. Diarised. However unsure he can wait that long.*

13.14 In relation to a cohort of consumers where the risk of deterioration and relapse is *very likely*, there is good reason to schedule more frequent psychiatric review, at least for the first six months of discharge from a CTO mandated treatment plan. On the whole of the available evidence, it is desirable that for the initial six-month period following the cessation of a CTO, consumers of the SLHD CMHS Core Team be the subject of scheduled (albeit voluntary) psychiatric review every three months, rather than six months.

13.15 It is also desirable, for the purposes of monitoring compliance with the applicable psychiatry review care standards for *all* CMHS clients, that the SLHD's electronic record system provide for a flag or alert to identify at an individual patient record level, and SLHD level, when a consumer is due for psychiatric review and when that review has taken place. The evidence was that such a system is already in place for notifying clinicians every three months of the need to update and review the CSCL. It is understood that the SLHD, as part of NSW Health, is in the process of developing and moving to a new medical records system, which may provide a further opportunity to include such alerts.

14 The absence of a mental health shared care plan

14.1 Although there was no documented shared care plan in place between Dr Harrison and the SLHD, Associate Professor Sullivan indicated that Dr Harrison did all that would have been expected of her had such a documented plan existed.

14.2 The period after the CTO lapsed in June 2019 was the first time that Dr Harrison had cared for Mr Kemball without at least the guidance provided by the MHRT plan underpinning the CTO. The lapse of the CTO represented a shift in management of Mr Kemball's mental health, but it appears that little guidance was given to Dr Harrison as to how this shift was to be managed and what her relationship would be with

Stephen and the CMHS, given Mr Kemball remained a client of the CMHS. Dr Harrison's evidence was that she understood that because Mr Kemball remained a client of the Camperdown CMHS, he would continue to be seen both by Stephen and subject to review by a psychiatrist. In fact, as already outlined, there was no policy in place at the time that mandated psychiatric review of consumers under the care of the Core Team, whether subject to a CTO or not. Dr Harrison also was unclear about who, if anyone, to contact about Mr Kemball's medication non-compliance in circumstances where Stephen was on leave. It was also uncertain who would be responsible for administering Mr Kemball's depot medication or monitoring his medication regime in circumstances where Dr Harrison herself went on leave.

14.3 Associate Professor Sullivan's consideration of Mr Kemball's management and treatment as between Dr Harrison and the CMHS following the expiration of the CTO, together with consideration of the SLHD's current Mental Health Shared Care documentation, support a proposed recommendation about improvement to the SLHD's GP mental health shared care framework. Associate Professor Sullivan's evidence included:

- concerns about ensuring management of clients by *the service* rather than *the individual* GP or staff member within the CMHS;
- concerns that the arrangement between Dr Harrison and the SLHD *did not straightforwardly allocate responsibilities;* and
- concerns about ensuring a written arrangement between a GP and community mental health service *at least sets out perhaps more explicitly what the threshold is for escalation*.

14.4 As a means of addressing these concerns, Associate Professor Sullivan suggested it would have been preferable in Mr Kemball's case to have a formal mental health shared care arrangement between the medical practice and the SLHD, to formally enable other GPs to cover care when Dr Harrison was on leave, and *provide for a schedule of regular review by the [SLHD Community Mental Health Service] which was not driven only by deterioration of his mental state* and additionally that *[SLHD*

Community Mental Health Service] review could then be expedited in the event that Mr Kemball's mental state or behaviour deteriorated.

14.5 Professor Large similarly considered that *for a patient…with [Mr Kemball's] level of severity and duration of illness and disability, a GP would want to know that they could get assistance from…a specialist mental health service*, referring to psychiatric review.

14.6 The evidence in the inquest did not suggest that some problem in the Mental Health Shared Care documentation had any causal relationship to Stephen's death. However, the evidence of Dr McDonald was that a review of the Mental Health Shared Care Plan documentation to more explicitly describe the role of a GP who is taking an active role in managing a patient's mental health condition would be desirable. This could provide further clarity to any GP that is engaged in the shared care of a patient of the CMHS.

15 The operation of the Camperdown CMHS

Core Team caseloads

15.1 In November 2019 the Camperdown Core Team consisted of approximately 11 full time and 3 part time employees. They had some 300 clients allocated between them. Some of the team were nurses of varying seniority and experience, including one with the ability to schedule clients, and one supervising nurse unit manager. Others in the team were psychologists, social workers, or occupational therapists. There was, it is understood, one part time consultant psychiatrist and one full time trainee psychiatrist which was a rotation role every six months, and there may have been an additional psychiatrist at some capacity. The team had several unfilled vacancies at the time.

15.2 While the monthly case load of Stephen and his experienced nursing colleagues was generally between 30 – 42 clients in the months prior to his death, the equivalent case load of some other non-psychiatry staff in the team was between 15 and 20. This reflects a significant disparity in experience and capacity among staff in the team, with the more experienced clinicians carrying a significantly higher case load. There was evidence that the more experienced staff in the team, like Stephen, also provided informal supervision and mentoring to the more junior members of staff. Further, it is understood that

retention of junior staff was particularly challenging. Additionally, care coordinators who were nurses, like Stephen, would routinely undertake other duties in addition to managing their own clients. This included administering depot injections to clients of other care coordinators who were not qualified to administer injections. Of the 29 clients in Stephen's practice at 28 November 2019, only three of these, of which Mr Kemball was one, received their injection via a GP. Additionally, Stephen was the only male in the Core Team which resulted in his being allocated some of the more difficult clients including males who could not safely or appropriately be case managed by female staff. Mr Kemball was one such client. Twenty five of the 29 clients in Stephen's practice at 28 November 2019 had a diagnosis of a schizophrenia disorder.

15.3 Unchallenged evidence was received from multiple staff members about the extremely high caseloads (more than 30-35 clients), many with very complex needs, that care coordinators in the Camperdown Core Team were managing at the time of Stephen's death. Also unchallenged was the evidence received from multiple staff members about the adverse impacts of such high caseloads on the ability of care coordinators to deliver appropriate care to their clients (being reduced to a *firefighting* type of approach to their work), as well as on the care coordinators' own health and wellbeing. It was also clear that the very high caseloads carried by each practitioner meant that there was very limited capacity for Core Team members to take on the caseloads of colleagues during periods when they were on leave.

15.4 At the time of Stephen's death, the SLHD CMHS Core Team Model of Care guideline document provided that:

- *…full time care coordinators should care coordinate a maximum of **35** consumers*; and
- *a manager and clinician should review a clinician's capacity to manage when numbers are high (eg over **35** is a flag for review)*.

The current Core Team Model of Care guideline document provides that:

*The current maximum care for care coordinators is **35** consumers. Once a care coordinator's care load reaches **30**, this acts as a trigger for the clinician and manager to review the care load and determine actions to reduce the care coordinator's load*.

The only policy level change that has been made since Stephen's death on this issue then is the trigger point for review of a care coordinator's case load, having been reduced from 35 clients to 30 clients, as opposed to any reduction in the case load itself.

15.5 Mr Leelawittayanon, who served as the Team Leader of the Camperdown Core Team following Stephen's death and succeeded in making various changes that served to bring down the case loads of care coordinators, gave thoughtful evidence of his views of appropriate caseloads and review thresholds. His evidence was to the effect that:

- the ideal case load is *at or slightly below 25*, noting that 30 *would tip you over*, with some clients to *receive less optimal care* as a result;
- a case load of 30 is a *red light*, a *stop* for him personally at least (as a very experienced mental health clinician), as well as from his experience having managed many practitioners of varying experience;
- a case load of 30 for *some of the clinicians [at the Camperdown team] would be an absolute struggle. They would suffer in their own health and the consumer with what they've got*.

15.6 Having regard to Mr Leelawittayanon's extensive experience in community mental health service delivery, and management of the delivery of such services, significant weight can and should be attributed to his assessment of the ideal and *red light* or *stop* case load levels.

15.7 Evidence was also received about the difficulty that the Core Team and ACS faced in terms of case load management, effectively being unable to *dictate* or *moderate* the incoming caseload of the team, compared with some of the other teams in the CMHS. In this regard, Mr Leelawittayanon described that a significant part of the work he did to achieve positive changes in individual caseload levels was to be *more robust when referrals came in*, by using the MDT meeting to actively identify whether the Core Team was the appropriate service or whether there was a better available alternative, *as opposed to doing a corridor acceptance of a referral*. This did not involve the application of any policy level changes, but rather his proactive management.

15.8 The SLHD did not support any reduction in the maximum case load of Core Team practitioners. This was primarily because of the perceived impact that any reduction in maximum caseloads would have on the capacity of the Core Team to respond to the need

for mental health services. It was submitted that the Core Team (and the ACS) have limited capacity to moderate case load and must respond to community need within the resourcing constraints that the teams have. The CMHS must provide services to new and existing patients who require such services, no matter the SLHD's resources at any given time. It was submitted that there are real consequences for the client cohort of the CMHS teams, such as the Core Team, but also the community at large, if the clients who seek the help of CMHS Teams are either not accepted on referral or wait long periods to be seen.

15.9 It is readily apparent that the volume of allocated client caseloads together with other duties expected of staff, gave rise to a workload that was extremely and unreasonably high, particularly for more experienced staff like Stephen. This necessarily had adverse effects on the ability of core team members to carry out their functions, on their stress levels, and on their workplace culture. Noting the concerns expressed by Ms Benfield about caseloads *creep[ing] up* in Mr Leelawittayanon's absence from the Core Team (there having been an average of 22 clients for each practitioner with 30 clients at most at the time of his departure around July 2024), and the central significance of resourcing limitations, and having regard to the whole of the evidence, it is desirable that the Core Team care load maximum and trigger review points be formally reduced. Setting those points in line with Mr Leelawittayanon's evidence reflects the caseload levels which the SLHD should be aiming to maintain and may provide support for management in their advocacy for more funding to meet staffing levels that correspond to such appropriate case load levels.

Transfers from the Core Team to the ACS

15.10 Early in the afternoon of 28 November 2019 Dr Harrison tried to contact the ACS in relation to Mr Kemball. In her evidence, she describes being transferred back to Stephen by the ACS intake officer upon that officer learning that she was calling in relation to Mr Kemball. Stephen then suggested to Dr Harrison that he speak to the ACS because Dr Harrison would end up *going around in circles*. It is understood that in practice, the expectation of staff in the Core Team at this time was that during business hours, they first attempt to deal themselves with a client in need of acute care, for example, by seeking the assistance of a psychiatrist or a nurse within the team who could schedule patients under the mental health legislation. If the Core

Team was unable to resolve the matter, then the matter would be taken by the ACS, though sometimes there was no capacity for this until after hours. The evidence was that a referral to the ACS by the Core Team required completion of complex paperwork that could take several hours to complete. Further evidence was to the effect that there could be *push back* from the ACS in relation to referrals from the Core Team, because both teams were so overworked, leading to *a difficult balance* between the Core Team and the ACS.

15.11 During Mr McDonald's evidence, he responds in the affirmative when it is suggested to him by counsel for the SLHD that the Acute Care Team Model of Care document (November 2021) provides in what circumstances and how transfer between the Core Team and the ACS is to occur. However, the Model of Care document is prefaced by a statement that *the model of care is a broad overview and is unable to provide details on all key policies and procedures for the Acute Care Service*. There is in fact very little in this document that explains how, and in what circumstances, clients can be transferred from the Core Team to the ACS. The document provides only that *care planning and clinical decisions regarding transfers of care or discharge from ACS should be discussed within the multi-disciplinary team and in accordance with the policies, procedures of the SLHD MHS……All transfers to the ACS should have an ISBAR verbal handover and assessment document*.

15.12 Ultimately there was little evidence as to when, or what was required, to refer a Core Team client to the ACS, only that the paperwork was complex and that in Stephen's mind, the attempt by Dr Harrison to refer Mr Kemball to the ACS was likely to result in her *going around in circles*. The evidence suggests some streamlining and clarity around the policy and procedure for referrals is required.

16 The Work Safe Guardian App

16.1 The WSG application was fully implemented across the CMHS following the incident on 10 September 2018 involving the Camperdown CMHS Peer Support Worker, referred to in Part 10.

16.2 WSG is a smart phone application, installed on a staff member's phone, which enables them to set a welfare timer when conducting a community home visit. WSG

identifies the GPS location of the staff member and if the timer activates after the set time and is not deactivated, will escalate a response to enable a check to be made on the staff member's welfare.

16.3 The evidence at inquest regarding the efficacy of WSG was mixed. Ms Upton, a Care Coordinator working with Stephen said that the WSG was not particularly effective, and she didn't think it was of use. Ms Upton noted the number of buttons that staff had to press to raise an alarm and the related slow response time. She was unaware of any instances prior to November 2019 when staff had sought to raise an alarm. In practice, Ms Upton said she would always set her timer for an hour. She said that she found the WSG unfamiliar, although noted that her opinion on WSG was based on her understanding of how it operated. Although Ms Upton had received training in the WSG, her evidence was that she still found it *clunky*.

16.4 Ms Benfield also gave evidence that although staff were required to use the WSG when conducting home visits, in her view it had *huge limitations*. She also noted that an escalation by WSG would go to the staff member's manager and was therefore dependant on the manager being available to receive the call.

16.5 On 28 November 2019, Stephen used WSG and set a 75-minute timer within the application. The timer functioned as intended and at the expiry of the timer, a call was escalated to Ms Chisholm, who by that stage was already on her way to Stephen's location. Sadly, by this time, Stephen had already died. Notably, Ms Chisholm gave evidence that Stephen had always used the WSG App properly.

16.6 It is submitted on behalf of Stephen's family that the WSG App *had and still has functional limitations and, was of little to no utility in protecting Stephen from serious injury and death once he was inside Mr Kemball's unit on 28 November 2019 alone and, despite evidence of upgrades since, if another worker were in the same situation it would be of little to no utility in protecting them from serious injury and death if they were attacked by the consumer and/or others in the home*. It is impossible to argue with this assessment.

16.7 The WSG Administrative and Operational Procedures, introduced after Stephen's death, note that the App is *designed to improve staff safety when in community*

settings and allow clinicians to identify their location on a smartphone app that is monitored via a security call centre, with its primary purpose to alert a mental health manager/team leader that an alarm has been triggered and initiate an appropriate organisational response.

16.8 There was evidence of limitations to the effectiveness of the WSG App, including its inability to directly contact NSW Police, as compared to contacting the individual themselves or their manager. Another limitation raised was its reliance on the users' telephones being connected to the application.

16.9 In addition to this, Dr McDonald recognised that the use of a duress alarm in a community setting is *very different* to other settings, such as within an inpatient unit, where a duress alarm may result in a more expeditious response from nearby staff. Dr McDonald outlined that the WSG App has now been rolled out district wide, and forms part of staff orientation, including requiring completion of a training package before staff are issued with a phone and pendant device.

16.10 While the WSG App has evolved since Stephen's death, Dr McDonald explained that its current functionality does not allow a user to *hit a button to directly connect to police* due to restrictions on such duress or alert systems. He also advised that as part of the roll out of the updated WSG App, staff received a new phone equipped with a *press button alert function* consisting of the wearable pendant enabling staff to raise an alarm when they are unable to use the phone to directly contact emergency services. This pendant links to the phone by Bluetooth.

16.11 The evidence of Dr McDonald was such that it was part of the required licencing for companies involved in the monitoring of duress alarms, such as WSG, for any alert to go through a third party before being escalated to police.

17 Safety Huddles

Before Stephen's death

17.1 On 8 January 2015 NSW Health published policy directive PD2015_001 *Preventing and Managing Violence in the NSW Health Workplace–A Zero Tolerance Approach*. This document includes the following statement:

NSW Health staff working in the community face a particular set of risks associated with being present in premises not under the direct control of a Health organisation and away from the immediate support of other staff. Work Health and Safety legislation equally applies to staff working in the community and all reasonable actions must be taken to prevent such staff from being exposed to violence.

17.2 The policy directive outlines the steps involved with risk management to assist staff in identifying, assessing, and eliminating or controlling, risks associated with violence. It identifies the circumstances when risk assessments should occur, including when new information about workplace violence risks becomes available, and mandates that risk assessments relating to violence should be documented. It further provides that NSW Health organisations must have in place procedures which must be communicated to staff and must cover, among other issues *conducting violence risk assessment prior to each visit and implementing appropriate management measures*.

17.3 On 14 May 2018, NSW Health published a further policy directive PD2018_013 *Work Health and Safety: Better Practice Procedures*. The purpose of this policy directive and its attached *Better Practice Procedures* was to support NSW Health Agencies to implement an effective work health and safety management system consistent with the NSW Work Health and Safety (**WHS**) legislation and provide information to clarify the duties and responsibilities of officers and managers/supervisors in contributing to a safe and healthy work environment.

17.4 Section 4.5.5 of this document deals with the delivery of services in the community and makes clear that even though an agency may not have full control over the working environment in the community, it is still responsible for ensuring a safe system of work and for controlling risks as far as practicable. The section that follows, 4.5.6, deals with *Safety Huddles* which are described as *brief meetings that provide an opportunity for staff to discuss significant safety and quality issues for both staff and patients with managers in order to identify hazards, assess risk and implement controls to eliminate/minimise risk to their safety in the workplace*. The word *workplace* is not defined in this document, although in PD2015_001 *Preventing and Managing Violence in the NSW Health Workplace–A Zero Tolerance Approach, workplace* it is defined to mean *a place where work is carried out and includes…domestic premises during home visits*.

17.5 In my view, it is clear from this policy directive that the intention of NSW Health was that Safety Huddles be implemented across all of NSW Health *([e]ach Agency must ensure that Safety Huddles are held*), although the document anticipates that the requirement that Safety Huddles take place may be implemented differently in *clinical areas* as opposed to *Services/Corporate/Administration,* although they *must include the same items*. The application of the Safety Huddles policy to both clinical and non-clinical settings, is reflected in section 1.3 of the policy directive, which distinguishes between *Safety Huddles* and *Safety Huddles (in a clinical setting)*. As I read this policy directive, it is not intended that Safety Huddles only be implemented in clinical settings, but that in relation to Safety Huddles that take place in a clinical settings there are additional requirements to Safety Huddles that take place in non-clinical settings (for example, that they must be multidisciplinary and that they must be held at work commencement and shift handover).

17.6 The Departmental requirement that Safety Huddles be held appears to have been first implemented at the SLHD level by SLHD_PD2017_012 *Safety Huddles* (11 May 2017) which mandated that Safety Huddles be implemented throughout SLHD facilities and services. Section 9.7 of this document provides that in relation to various *services* (within which Community Mental Health is specifically included), the General Manager/Director of Nursing will ensure that *this policy is contextualised to each service in terms of Safety Huddle frequency and determine the process to achieve the core principles of the policy*.

17.7 The requirement that Safety Huddles be held in the context of home and community visits was not reflected in *Working in the Community–Home Visiting* MH_SLHD_PCP2018_003 (27 November 2018), the procedural document that was developed in response to the Safe Work NSW investigation into the September 2018 stabbing of the peer support worker. The evidence suggested that the reason for this was that within MHS the SLHD policy directive *Safety Huddles* was not interpreted as being applicable to home and community visits due to an understanding that home or community visits did not fall within the ambit of a *clinical area* or a *clinical setting*. Dr McDonald's evidence was that because the requirement that Safety Huddles be held was interpreted as relating to clinical areas only, it was implemented in such a way

that the focus was on risks that related to work that was conducted within buildings operated by the SLHD, such that the Safety Huddles that were conducted in November 2019 were limited to physical facilities under the control of NSW Health, and didn't take in home visits. However, this evidence seemed to be at odds with other parts of Dr McDonald's evidence which was to the effect that both the ACS and Mobile Assertive Treatment teams were conducting *twice daily handovers where tasks are assigned, and risks are discussed, and plans are made in the presence of a nursing unit manager, team leader or a staff member in charge of the shift*.

17.8 It was submitted by counsel appearing for the SLHD that PD2018_013 *Work Health and Safety: Better Practice Procedures* did not require that Safety Huddles be held in relation to home and community visits. For the reasons I have already given, I do not accept this submission. I accept that hindsight bias may play some part in my interpretation of this policy directive, but to my mind it clearly required the implementation of Safety Huddles as a means of eliminating or minimising the risk to all SLHD staff in their workplace, wherever that workplace happened to be.

After Stephen's death

17.9 On 29 November 2019 in response to Stephen's death, SafeWork NSW issued an Improvement Notice under section 191 of the Work Health and Safety Act 2011 (NSW). The Improvement notice required SLHD to review and revise as necessary control measures regarding mitigating the risk of violence and aggression towards workers, so far as reasonably practicable, during home visits to mental health patients.

17.10 Consultations with relevant staff were held in January 2020 and March 2020. In response to the Improvement Notice, the SLHD MHS assessed their policies and practice relating to home and community visiting and prepared a document entitled *Home and Community Visiting–Risk Assessment* which was published in April 2020. As part of the review document the SLHD stated:

> *The MHS has a comprehensive system in place to manage violence and aggression toward workers during home and community visits to mental*

health consumers. This is encompassed by policies and procedures at the NSW Health, SLHD and MHS levels.

One of the relevant policies and procedures at the SLHD level is identified as *Safety Huddles* SLHD_PD2017_012 (11 May 2017). This was the policy directive that had been identified as having no application to home and community visits.

17.11 Whilst Dr McDonald was not in the role of the Director of the MHS at the time of this review, he agreed that from the specific reference to *Safety Huddles* SLHD PD2017_012 as being a *relevant policy and procedure* under Part 7 of the assessment, entitled *Current controls*, the inference could be drawn that there was an acknowledgment by the SLHD that as at April 2020, the conduct of community home visits attracted the application of that policy.

17.12 The review also noted that Home Visit Safety Huddles were implemented from December 2019 and stated that there would be a further review of the Home Visit Safety Huddles to ensure their consistent implementation as a routine daily meeting and also to consider:

- introduction of 'emergency' Safety Huddles to respond to urgent referrals that arise after a routine Safety Huddle meeting;
- formalisation of a mental health escalation process where there is uncertainty or disagreement regarding the plan to contact a consumer in the community; and
- updates to existing procedures to document any changes implemented.

17.13 The current version of the *NSW Health Security Manual–Protecting People and Property* (**PPP 2022**) mandates a risk assessment process, during which any issues that are identified are discussed between workers and their supervisors or senior colleagues prior to conducting a home visit. Clauses 16.1 and 16.2.1 of PPP 2022 now specifically refer to a Safety Huddle as one way discussing strategies to control risk before a community visit is conducted. It is understood that in all Local Health Districts it is now a requirement that Safety Huddles, or an equivalent process but with a different name, take place in respect of decisions about the conduct of home and community visits to consumers or patients. Additionally, the Ministry of Health

undertook an audit of 30 facilities across all Local Health Districts in 2024 which confirmed that all facilities were holding Safety Huddles or equivalent processes.

17.14 It is understood that NSW Health policy directive PD2018_013 *Work Health and Safety: Better Practice Procedures* are also now under review, with an updated version to be released in 2025.

17.15 SLHD_PCP2018_007 *Working in the Community-Home Visiting* was reviewed on 31 May 2023 and republished as SLHD_PCP2023_017 *Community Home Visiting Policy Compliance Procedure*. The new PCP included a new section mandating the completion of regular home or community visiting Safety Huddles and *arrangements for safety discussions during the day if a visit is arranged post the Safety Huddle*.

17.16 The SLHD reviewed MH_SLHD_PCP2018_003 after Stephen's death and published MH_SLHD_PCP2020_003 *Working in the Community-Community and Home Visiting* on 28 August 2020. This policy introduced additional measures relevant to home and community visits:

- the Mental Health Community Safety Checklist (CSCL) replaced the Home Visit Safety Checklist (HVSCL) from 2 June 2020;
- all planned home visits for new consumers and consumers who have deteriorating mental health are with two staff;
- all community mental health teams are required to implement the Home Visit Safety Huddle procedures which includes a review of the safety of all planned home visits, escalation strategies if there is a dispute, and arrangements for safety discussions during the day if a home visit is arranged post the Safety Huddle.

17.17 This policy compliance procedure has since been reviewed and replaced by MH_SLHD_PCP2024_006 *Working in the Community-Community and Home Visiting* (16 August 2024). In relation to community and home visiting, the Introduction to this PCP provides:

> *As an additional minimal safety standard, this Mental Health PCP provides additional safety measures including:*

> *That all planned home visits for new consumers and consumers who have deteriorating mental health are with two (2) staff. Community visits to new consumers and consumers with deteriorating mental health will also be subject to the standardised processes including the home visit huddle and determination that a community/home visit is safe in the first place and based on the most recent risk assessment.*

This is a direct copy of the same section from the previous iteration of this policy. However, within the part of the 2024 mental health PCP that deals with Risk Management, there is no mention of the requirement that visits to consumers with deteriorating mental health must be with two staff.

17.18 The 2020 version of the Mental Health PCP included as Appendix 4 considerable detail as to the Home Visit Huddle Meeting Procedure, particularly, the process to be followed in the event of the need for a home/community visit arising after the morning huddle had occurred. However, in the 2024 version of the Mental Health PCP, this appendix has been removed and the information in relation to Home Visit Huddles has been reduced to a single short paragraph, taken directly from the corresponding paragraph in the SLHD PCP. In addition, in the body of the Mental Health PCP, the term *Safety Huddles* is used instead of the terminology used by Mental Health, *Home Visit Huddle*.

17.19 The effect of these differences between the 2020 Mental Health PCP and the 2024 version of the same document, is to diminish the importance of Safety Huddles/Home Visit Huddles within the suite of measures to be used by mental health staff to assess and minimise risk, particularly dynamic risk, in the context of home or community visits. The evidence of Dr McDonald was that all staff were aware of the requirements as outlined in the introduction to the PCP in relation to two staff visits in the event of client mental health deterioration, however, he conceded that there may be some benefit in standardising the use of the terms Safety Huddle and Home Visit Huddle. In my view, the most recent version of the mental health PCP, particularly as it relates to Safety Huddles, requires more substantial review.

17.20 At the close of the inquest, counsel for Stephen's family submitted that the absence of processes such as Safety Huddles within the practice of the Core Team at the time

of Stephen's death meant that dynamic risk assessment for home visits relied too heavily on the individual clinician: their discretion, their experience or lack thereof, and their knowledge of the consumer. This, it was submitted, exacerbated the risk of treating clinician myopia and potentially, a clinician's assessment and judgment of the risk posed by a particular consumer. Although the changes that have been made to MHS policy and procedure after Stephen's death, acknowledge and, for the most part, address these concerns, there remains a need for greater clarity in relation to some aspects of SLHD policies and procedures for risk management as they apply to home and community visits.

18 The need for recommendations

18.1 Counsel Assisting put forward several draft recommendations arising from the evidence. These recommendations were circulated to all parties and were the subject of written submissions. Counsel Assisting produced a detailed written response to the submissions made by Stephen's family, the SLHD and SafeWork NSW in relation to the recommendations. I have relied heavily on this document in the paragraphs below, at times directly adopting the comments made by Counsel Assisting. I have, however, reviewed the draft recommendations carefully and the comments made by each party in relation to them. In all respects the conclusions I reach as to the necessity for a particular recommendation, and its wording, is my own.

18.2 The draft recommendations were in these terms:

GP Shared Care

1. The SLHD review its Mental Health Shared Care Plan document to:

(a) articulate the division of mental health care and treatment responsibilities between a GP or medical practice and the SLHD CMHS, and timeframes for fulfilment of those responsibilities, including:

(i) administering of medication;

(ii) periodic psychiatric review;

(b) require the sharing of regular updating information between the GP or medical practice and the SLHD CMHS (and the kind of information that should be shared, including mental state deterioration or signs of deterioration and ongoing dynamic risk assessment);

(c) provide for the circumstances in which, and mechanism by which, the following should occur:

(i) the immediate or urgent escalation of mental health care and treatment to the SLHD CMHS, or

(ii) re-allocation of any allocated mental health care and treatment responsibilities from the GP or medical practice to the SLHD CMHS;

(d) provide for arrangements in the event of the absence of either the allocated GP or allocated SLHD staff member;

(e) provide for scheduled periodic clinical review meetings between the GP or medical practice and SLHD.

18.3 This draft recommendation was supported by Stephen's family with the addition of a requirement that *the Mental Health Share Care Plan and Checklist be signed by the GP and SLHD with copies uploaded to the EMR by the SLHD*.

18.4 The SLHD was generally supportive of the proposed recommendation, subject to revising its terms to avoid an overly prescriptive approach to shared care arrangements, and potential impairments to clinical judgments. The SLHD suggested an alternative formulation intended to reflect the scope of most of the information sought to be captured by the original proposed recommendation, and the incorporation of explicit reference to the HealthPathways resource, which appears to be a useful resource to GPs in understanding and developing skills to assess mental health deterioration.

18.5 While the inclusion of the record maintenance requirements do not appear necessary on the available evidence, the SLHD's alternative formulation is supported, subject to retaining inclusion also of provision of information about arrangements in the event of the absence of either the allocated GP or allocated SLHD staff member, and the

scheduling of periodic psychiatric reviews for the client and clinical review meetings between the GP or medical practice and SLHD.

Care of clients following expiry of Community Treatment Orders

2. The SLHD formally implement a requirement that all SLHD Community Mental Health Service clients be scheduled for review by a psychiatrist, at a minimum within three months of the expiry of any Community Treatment Order and again within a further three months.

18.6 This draft recommendation was supported in full by Stephen's family.

18.7 In its response to this recommendation, the SLHD emphasised the scarcity of psychiatrists within community mental health and *was concerned to set minimum expectations for psychiatric review at a realistic and achievable level*. For this reason, the SLHD maintained that the current minimum expectation of 6 monthly psychiatric review under the Core Team Model of Care remained appropriate.

18.8 In my view, recommendation 2 should be retained in its original format. The introduction of a requirement for more regular psychiatric review applies only to a specific group of clients, namely those who have been discharged from the oversight provided by a CTO. The rationale for such review is not merely that it provides an extra layer of scrutiny and would thus help to minimise the effect of *treating clinician myopia*, but more significantly, that this group of clients includes persons for whom the risk of deterioration and relapse following the cessation of a CTO is *very likely* according to Associate Professor Sullivan.

3. The SLHD consider as part of its ongoing electronic record systems changes, the creation of a flag or other alert identifying the due date for all Community Mental Health service clients' periodic psychiatric reviews, which is identifiable both in the client's individual records and in summary reports used for the purpose of staff caseload review and management.

18.9 This draft recommendation was supported in full by Stephen's family.

18.10 The SLHD supports an alternative formulation of proposed recommendation 2 concerning the creation of a flag or alert to identify due dates for periodic psychiatric

review based on the process currently underway reviewing the Single Digital patient Record.

18.11 The SLHD's proposed alternative formulation is not supported. Whilst evidence that Dr McDonald gave as to the Single Digital Patient Record project is acknowledged, the evidence from Nurse Unit Manager, Fiona Chisholm, is that there already exists an alert that appears on each consumer's eMR every 3 months to advise care coordinators that they are required to update the CSCL. It is proposed that a similar alert be incorporated into the eMR for each consumer in relation to periodic psychiatric review, irrespective of how incorporation of such an alert is achieved, as well as ensuring that such an alert is also identifiable in summary reports used for the purpose of staff caseload review and management.

Core Team case load management

4. The SLHD amend its Core Team Model of Care guideline to provide:

(a) the maximum care load is 30 clients, and

(b) the trigger for review of a care load is 25 clients.

18.12 Stephen's family submits that the maximum care load should be 25 clients and that the trigger for review of a care load should be 20 clients. They also propose a rewording of this recommendation that provides for regular review and redistribution, if necessary, of the care load of all clinicians.

18.13 The current Core Team Model of Care guideline sets a maximum of 35 clients, with 30 clients being a trigger for the clinician and manager to review the care load and seek to reduce it. The SLHD submits that *if the proposed recommendation were made and resources were not increased beyond their current level, it would result in decisions about client care having to be made which would have adverse consequences for those clients…community mental health services would simply have to be refused to referred clients at times.*

18.14 In terms of care loads Mr Leelawittayanon indicated that the *ideal* care load for a care coordinator was at, or slightly below, 25. He further indicated that 30 clients would be a tipping point, both in terms of quality of client care and the effect on the clinician with the care load. Mr Leelawittayanon's evidence was that at the time of his initial

departure from the Camperdown Core Team around July 2024, the average care load of clinicians was *definitely under 30, probably around 22 at most*, and it would concern him if a clinician suggested (as Ms Benfield did in the course of her evidence) that they had 32 clients (being three under the current maximum care number). The additional amendments as to care load review proposed by Stephen's family is not supported by the evidence, noting that the existing Core Team Model of Care document already provides for monthly case load reviews by Team Leaders, and the determination of actions to reduce the care coordinators load, for example, *identifying clients suitable for discharge, or reallocating clients to another care coordinator*.

18.15 The proposed amendment as to care load numbers is in accordance with the evidence given by Mr Leelawittayanon and represents an effort to balance the numbers of consumers who can access the CMHS, the quality of care afforded to them, and the wellbeing and safety of clinicians.

5. The SLHD take steps to maintain within all Community Mental Health Service Core Teams, for all hours of operation, rostering of at least two 'accredited persons' (in addition to psychiatrist capacity) able to schedule clients under the NSW Mental Health Act 2007.

18.16 This draft recommendation was supported in full by Stephen's family.

18.17 The SLHD suggests an alternative recommendation, that it continue to encourage eligible staff to undertake the accredited person training and seek to increase the number of CMHS staff who are accredited persons.

18.18 The draft recommendation in its current form is preferred. The wording of the draft recommendation envisages the SLHD doing more than simply encouraging staff to undertake training, but might also encompass other measures, for example, identification of suitable staff to undertake training, payment of study fees, and provision of paid study leave. It also deals with rostering of suitably accredited staff. The alternative wording suggested by the SLHD is insufficient to address the driver of the proposed recommendation, namely the availability of sufficient scheduling capacity during all Core Team hours of operation. The proposed recommendation

does not suggest the SLHD implement a formal requirement that two accredited persons be rostered for all Core Team hours of operation, but rather that the SLHD *take steps to maintain* this position.

6. ***The SLHD review its Acute Care Service and Core Team policies and procedures to clearly define and communicate to staff in both teams in what circumstances, and how, transfer of care of Core Team clients in need of Acute Care Service care is to occur.***

18.19 This recommendation was supported by Stephen's family with the suggested addition of a requirement *that the SLHD arrange regular meetings of Core Team and Acute Care Team management, with a standing item of transfers between Core Team and Acute Care Team, for all operational hours*.

18.20 The SLHD does not support this proposed recommendation on the basis that it is unnecessary as information as to the referral process to the ACS is contained within the SLHD Acute Care Services Model of Care dated November 2021 and that there was no evidence given by members of the Core Team at the inquest that there was uncertainty as to the process for referral of patients to the ACS. This submission does not engage with the issue that the proposed recommendation seeks to address, which was to the effect that, at least in November 2019, referrals to the ACS were time consuming and that there was often *push back* when the Core Team attempted to refer clients, which meant that Core Team staff often saw clients that they believed should have been seen by the ACS.

18.21 Currently, only the ACS Model of Care document addresses the fact of referrals to it. However, the document does not detail when Core Team clients may be referred, and how. Formal written clarity specifically addressing referrals to the ACS from the Core Team may better guard against a re-emergence of the referral difficulties that were plainly in place at the time of Stephen's death. In my view, the proposed recommendation should be retained in its original format, although I intend to add a requirement that any review should also look at simplifying the referral procedure. The object of the proposed recommendation is to ensure, into the future, clarity on the part of staff in each team, about the threshold for the transfer of care, and simplicity in how such transfer can occur.

18.22 The addition proposed by the family is not supported on the basis that the evidence did not indicate any need or desirability for such meetings on a regular basis, and implementation of such a requirement may well give rise to an unwarranted adverse impact on resourcing considerations with uncertain practical benefit.

Community and Home Visiting policy and procedure

7. The SLHD review MH_SLHD_PCP2024_006 to:

(a) more clearly communicate the requirements that:

(i) community or home visits to clients may not be conducted by a single staff member:

- ***for the first visit to the client's home or new home, including where the client is re-commencing with the service;***
- ***where there is evidence of, or concerns about, a client's mental health deteriorating, regardless of any existing approval for visits to be conducted by a single staff member;***
- ***where there is a risk of violence, or the risk is unknown;***

(ii) all unplanned home or community visits which arise for consideration after the morning Community and Home Visit Huddle must be the subject of discussion with and approval by the Team Leader, or if the Team Leader is unavailable, an alternative senior clinician who is authorised to approve such visits.

(iii) where after the morning Community and Home Visit Huddle or subsequent discussion and approval, but prior to the conduct of the visit, further information is received that may alter the assessment of risk about the conduct of the visit, the decision to undertake the home visit must be the subject of further discussion and approval by the Team Leader, or if the Team Leader is unavailable, an alternative senior clinician who is authorised to approve such visits.

(b) Include cross-reference to the SLHD's Mental health Service Policy Directive MH_SLHD_PD2023_027 'Consumers with Mental and/or Cognitive Acute

Deterioration – a risk assessment and management approach' and any other internal resources on client mental state deterioration; and

(c) ensure clarity and consistency in its use of the term 'Huddle'.

18.23 This draft recommendation was supported in full by Stephen's family.

18.24 The SLHD accepts proposed recommendation 7 to the extent it provides for the review of the policy to ensure consistency in the use of the term 'huddle.' The SLHD also appears to accept the appropriateness of review on an ongoing basis of the current SLHD policy compliance procedure *Community and Home Visiting* to ensure it provides clear guidance to staff. However, the SLHD suggests that there is no need to review the policy/procedure specifically with a view to better articulating the guidance set out in proposed recommendation 7, based on the evidence of current staff indicating there is no confusion about the requirements of the policy/procedure.

18.25 I do not accept the submission made by the SLHD that there is no need to review the policy/procedure specifically with a view to better articulating the guidance set out in the proposed recommendation. For the reasons I have given in earlier in my findings, the current version of MH_SLHD_PCP2024_006 is more vague and less robust in terms of Safety Huddle Policy and Procedure than the previous version of the same PCP.

18.26 In relation to the definition of *deterioration*, contrary to the suggestion made by the SLHD, the recommendation as proposed does not suggest insertion into either the *Community and Home Visiting Policy Compliance Procedure* or *Home Visit Huddle Meeting Procedure* a definition of what constitutes *deterioration* of mental health, but rather the inclusion of cross-references to existing relevant guidance on that concept (such as that contained in MH_SLHD_PD2023_027) in circumstances where the policy of SLHD is that clinicians should not visit clients alone where there is a *deterioration* of their mental health. The object of proposed recommendation 7 is to ensure clarity into the future. Further, the effect of proposed recommendation 7 is simply to direct clearer communication or expression of home and community visiting decision-making requirements that the evidence indicated already exists within current policy and practice.

18.27 In general terms, SafeWork NSW suggests several improvements to the proposed recommendation to:

1. more explicitly articulate in policy and procedure documents the steps involved in a risk assessment;
2. include not only 'mental state deterioration' but a reference to 'new information' in recommendation 7(b)
3. objection to the use of the term 'ad hoc' huddle being used when new information in relation to a client comes to light after the formal Huddle has taken place.
4. More clearly articulate the steps involved in a risk assessment.

18.28 MH_SLHD_PCP2024_006 is a procedural document the purpose of which is to implement NSW Health and SLHD policy at the MHS level. The suggestions made by SafeWork NSW either have been, or may be, more appropriately integrated into NSW Health or SLHD policy, as opposed to the document the subject of the recommendation.

8 The SLHD review the Community and Home Visit Huddle procedure to:

(a) require the discussion of a dynamic assessment of the safety risk to staff involved in the conduct of a home or community visit that day;

(b) require the recording of a 'decision' with respect to whether or not and how a home or community visit will be undertaken that day; and

(c) include a re-statement of the policy position as to when home and community visits may not be undertaken

18.29 This draft recommendation was supported in full by Stephen's family, with the additional proposal that a checklist including, among other information, when the SLHD last communicated with the client's GP, psychologist, psychiatrist, and carer, and input or opinion from clinical staff as to any dynamic risk factors concerning the client.

18.30 The SLHD does not support this proposed recommendation. The evidence both from staff and the expert witnesses who gave evidence at the inquest does not suggest any problem with the recording of a decision in respect of community or home visit or

with an understanding as to when two clinicians need to conduct a community or home visit.

18.31 SafeWork NSW supports the substance of this recommendation but suggests the inclusion of an express requirement to risk assess *individual circumstances* and *new information* as required by NSW Government Health Policy. These suggestions have already been addressed in relation to recommendation 7 above.

18.32 The existing wording of this proposed recommendation is supported. In my view, it is sufficient to focus the attention of those involved in the decision-making without being unduly prescriptive, or confining staff to a checklist type approach to Safety Huddle discussions.

***9*. *The SLHD formally implement a requirement that all Community and Home Visit Huddles must be attended by the relevant Team Leader and a psychiatrist*.**

18.33 The SLHD submits that although it is correct that the Policy Compliance Procedure in respect of community and home visiting does not specify who must attend the daily Safety Huddle, and likewise, the Home Visit Huddle Procedure does not prescribe who must attend, nonetheless, the evidence was clear, and the language of those documents supports the understanding, that all staff on duty on a given day are expected to attend. The evidence indicates that the Home Visit Safety Huddle Procedure has functioned well since it was introduced.

18.34 The SLHD does not support the recommendation that psychiatrists be required to attend Safety Huddles due to the already significant limitations in the availability of consultant or trainee psychiatrists. The SLHD points to the decline in the available days per week of consultant psychiatrist cover in recent times, and the fact that psychiatrists are a limited resource in community mental health and need to be utilised where the Service feels they are most appropriately used. The SLHD is cautious about recommendations being made that it cannot practically implement.

18.35 A core benefit of the Huddle procedure is that it is multi-disciplinary. Psychiatrists are an integral part of the Core Team Model of Care, with the expectation that the Team will be staffed with a psychiatrist (or psychiatrist coverage) full-time. Psychiatrists bring to the dynamic risk assessment specific and more extensive expertise in clients'

mental conditions and a nuanced assessment of deterioration as well as risk assessment more generally, compared with other staff.

18.36 The SLHD otherwise appears also to not support proposed recommendation 9 insofar as it would direct the attendance of a Team Leader, on the basis that current practice evidence indicated this is already occurring and is therefore unnecessary. For the reasons outlined above in relation to ensuring clarity and certainty about required procedures into the future, the inclusion of a requirement that the Team Leader attend remains desirable and necessary.

18.37 Stephen's family support proposed recommendation 9 subject to the addition of a requirement for the NUM to attend. On the understanding that each Team Leader is a NUM, or other appropriately senior qualified senior clinician, this addition appears unnecessary.

18.38 Support is maintained for proposed recommendation 9 in its original format subject to clarification of wording to make clear that the Team Leader and psychiatrist need only attend the Huddle if they form part of the Core Team that day.

10. The SLHD formally implement a requirement that all new Community Mental Health Service staff members must not undertake any home or community visits to clients alone in the first 3 months of employment.

18.39 The SLHD does not support this recommendation in circumstances where no expert suggested that a three-month period during which any new staff member should not conduct home visits alone was desirable or necessary and where the proposed requirement ignores the obvious difference between a new and an experienced mental health clinician in the first 3 months of employment, and may paradoxically mean that more complex cases get allocated to junior clinicians.

18.40 Dr McDonald's suggestion of a paradoxical result in the allocation of more complex cases is supposition only. The three-month compared with six-month timeframe is responsive to the tension with resourcing consideration.

18.41 Stephen's family supports the substance of the recommendation, subject to the timeframe being six months rather than three months. The family additionally suggests that it be defined that a person who has only worked in a mental health

clinical setting in the last five year is to be considered a *new Community Mental health team staff member*. The recommendation as drafted provides that 'new' is by reference to employment in the specific SLHD community mental health service such that the specific clarification proposed by the family appears unnecessary. Proposed recommendation 10 is supported in its original format.

Other

11. The SLHD review its workplace health and safety policies, procedures and practices to consider whether the scope of the daily Community and Home Visit Huddle should be formally expanded to include discussion about safety issues generally for the relevant team that day, not merely safety issues concerning visits to clients in home and elsewhere in the community.

18.42 This draft recommendation was supported in full by Stephen's family.

18.43 In circumstances where the current practice within the SLHD CMHS is to discuss more general safety issues at the home visit safety huddles, the SLHD submits that a formal recommendation in this regard is not necessary.

18.44 This is in fact a justification for the proposed recommendation, because the current Huddle procedure directs focus only on planned community and home visits. This recommendation is supported in its original form.

12. NSW Health consider implementation of these recommendations in Community Mental Health Services state-wide.

18.45 The family supports proposed recommendation 12 with the suggested addition that NSW Health consider avenues for greater information sharing between LHDs. No evidence was given in the inquest as to the existing modes by which information was shared between LHDs and what, if any deficiencies there may be in the sharing of such information. This addition to the proposed recommendation is not supported.

18.46 The SLHD submits that NSW Health is not a party of sufficient interest in relation to this matter, and as a matter of procedural fairness, a formal recommendation directed to NSW Health should not be made, and further, that a copy of the coroner's findings will be provided to NSW Health by SLHD in due course.

18.47 The making of the proposed recommendation does not involve any adverse comment against NSW Health, adverse impact on the interests of NSW Health, and asks only that NSW Health consider implementation of the recommendations state-wide. In those circumstances, the fact that NSW Health was not a sufficient interest party in the Inquest does not preclude the recommendation being made. This recommendation is supported in its original form.

Additional proposed recommendations

18.48 The family proposes that the copy of the findings and transcript be provided to SafeWork NSW for consideration as to a further investigation of the circumstances of Stephen's death. This proposed recommendation appears to be founded on the submission that the SLHD was negligent because NSW Health Policy mandated daily Safety Huddles, and these were not implemented in the Core Team until after Stephen's death. The SLHD disputes whether Safety Huddles by the Core Team were mandated.

18.49 As was submitted in closing oral submissions, the framework that existed for Home and Community Visit decision making that existed at the time of Stephen's death may plainly be described as *inadequate*. However, whether the SLHD's conduct specifically amounted to negligence in law, or whether any related breach of the work health and safety legislation occurred were not issues the subject of examination at inquest and determination of such issues is not properly part of a coroner's role. SafeWork NSW was present and represented throughout the hearing and is aware of the whole of the evidence. SafeWork NSW is undoubtedly aware of its own powers to institute a prosecution within an extended period by virtue of the coronial proceedings.

18.50 The evidence does not support the family's proposed recommendation concerning the implementation of a requirement that all clients upon the cessation of a CTO be considered for management under a formal GP shared care arrangement for 12 months to monitor non-compliance, deterioration of mental state, and whether compulsory/involuntary treatment should be recommended. The concern about adequate monitoring of clients ceasing CTOs is addressed by recommendations 2

and 3 regarding increased frequency of psychiatric review, and the creation of a flat/alert for psychiatric review due dates.

18.51 The proposed recommendation that the SLHD consider effectively only using a duress or alarm application that can simply and quickly send a duress or emergency alert directly to police along with GPS coordinates is not supported. The evidence given by Dr McDonald makes clear that there simply is no such functionality option in any available application, for reasons beyond the control of the SLHD.

18.52 The evidence would additionally not support the need for consideration of more formal clinical supervision of new staff, particularly around dynamic risk assessment in the community/home setting. Proposed recommendation 10 would, together with the existing features of the team Huddle discussions around risk, facilitate information sharing and valuable supervision of new staff in dynamic risk assessment.

18.53 As to the proposed recommendation concerning leave handover arrangements, the evidence supports the substance of this suggestion as desirable.

18.54 The ACS Model of Care and Assertive Outreach Team Model of Care documents include reference to *handover* of clients within those teams, presumably because clients of those teams are not allocated to individual clinicians but rather the Team as a whole. The Core Team Model of Care document does not include any reference to case load planning when a person is on leave and there was evidence that given the care loads of case coordinators, it was very difficult for staff to manage additional consumers while colleagues were on leave. While it may be accepted that this likely occurs in practice where a person is on pre-approved leave for a period, it is desirable that this requirement be stated in the Core Team's Model of Care. The recommendation need not be prescriptive as to the specific matters to be planned for. A new proposed recommendation to this effect is set out below.

18.55 As to the proposed recommendation that the Royal Australian College of General Practitioners and the Australia Medical Association consider avenues for further training GPs in community mental health, including but not limited to complex and chronic mental health disorders and appropriate reporting and escalation guidelines,

the evidence does not support this suggestion as necessary or desirable. The evidence did not suggest inadequacies in GP training in these areas (at the individual level of Dr Harrison, or more broadly).

19 Conclusion

19.1 All inquests are necessarily conducted with the benefit of hindsight. It is understandable for those who have lost a loved one to ask *What if?*, to speculate whether if one thing or another had or had not occurred, the person they love might still be with them. Ultimately it is impossible to know what would have happened if a Safety Huddle had been held on the morning of 28 November 2019 or if Stephen had entered Mr Kemball's house with a second person. The focus of an inquest is not to speculate about what might have happened if different decisions had been made, but to consider whether there has been some shortcoming in policy or practice, and if so, to make recommendations as to how best such failures can be remedied, in order hopefully to mitigate the possibility of another death occurring in the same way.

20 Findings required by s81(1) Coroners Act 2009

20.1 As a result of considering the documentary evidence and the oral evidence given at the inquest, I am able to make the following findings in relation to the matters listed in s 81(1) of the Act:

The identity of the deceased

The person who died was Stephen James Douglas.

Date of death

Stephen died on 28 November 2019.

Place of death

Stephen died at 9/8 Nicholson St, Balmain East

Cause of death

Multiple sharp force injuries

Manner of death

Stephen died as a result of intentional injuries inflicted by his client during a home visit conducted in the course of Stephen's employment as a community mental health nurse.

21 Recommendations pursuant to s82 Coroners Act 2009

To the Chief Executive, Sydney Local Health District:

Recommendation 1

The SLHD review its Mental Health Shared Care documentation (Plan, Checklist and GP Information Sheet), with a view to:

a. better defining the roles and responsibilities of the GP/medical practice and the Mental Health Service under the Mental Health Shared Care Plan, including (but not limited to) specifically:

   i. the frequency of periodic psychiatric review of a patient by the Mental Health Service;

   ii. the frequency of clinical review meetings between the GP/medical practice and the Mental Health Service; and

   iii. arrangements in the event of the absence of either the allocated GP or allocated Mental Health Service staff member.

b. better defining the expectations of communication between the GP or medical practice and the Mental Health Service under the Mental Health Shared Care Plan;

c. encouraging GPs to contact HealthPathways to assist them in assessing deterioration in the mental health of Mental Health Shared Care Plan patients and determining who to contact in the event of deterioration;

d. including information as to who at the Mental Health Service can be contacted by the GP/medical practice in the event of concern about deterioration in the patient's mental health.

Recommendation 2

The SLHD formally implement a requirement that all SLHD Community Mental Health Service clients be scheduled for review by a psychiatrist, at a minimum within three months of the expiry of any Community Treatment Order and again within a further three months.

Recommendation 3

The SLHD consider as part of its ongoing electronic record systems changes, the creation of a flag or other alert identifying the due date for all Community Mental Health service clients' periodic psychiatric reviews, which is identifiable both in the client's individual records and in summary reports used for the purpose of staff caseload review and management.

Recommendation 4

The SLHD amend its Core Team Model of Care guideline to provide:

a. the maximum care load for care coordinators is 30 clients; and

b. the trigger for a clinician and manager to review a care coordinator's care load is 25 clients.

Recommendation 5

The SLHD take steps to maintain within all CMHS Core Teams, for all hours of operation, rostering of at least two *accredited persons* (in addition to psychiatrist capacity) able to schedule clients under the NSW Mental Health Act 2007.

Recommendation 6

The SLHD review its Acute Care Service and Core Team policies and procedures to clearly define and communicate to staff in both teams in what circumstances, and how, transfer of care of Core Team clients in need of Acute Care Service care is to occur, and to simplify the process by which such transfer takes place.

Recommendation 7

The SLHD review MH_SLHD_PCP2024_006 *Working in the Community-Community and Home Visiting* to:

a. more clearly communicate the requirements that:

i. community or home visits to clients may not be conducted by a single staff member:

1. for the first visit to the client's home or new home, including where the client is re-commencing with the service;

2. where there is evidence of, or concerns about, a client's mental health deteriorating, regardless of any existing approval for visits to be conducted by a single staff member;

3. where there is a risk of violence, or the risk of violence is unknown;

ii. all unplanned home or community visits which arise for consideration after the morning Community and Home Visit Huddle must be the subject of discussion with and approval by the Team Leader, or if the Team Leader is unavailable, an alternative senior clinician who is authorised to approve such visits.

iii. where after the morning Community and Home Visit Huddle or subsequent discussion and approval, but prior to the conduct of the visit, further information is received that may alter the assessment of risk about the conduct of the visit, the decision to undertake the home visit must be the subject of further discussion and approval by the Team Leader, or if the Team Leader is unavailable an alternative senior clinician who is authorised to approve such visits.

b. include cross-reference to the SLHD's Mental Health Service Policy Directive MH_SLHD_PD2023_027 *Consumers with Mental and/or Cognitive Acute Deterioration - A risk assessment and management approach* and any other internal resources on client mental state deterioration; and

c. ensure clarity and consistency in its use of the term "Huddle".

Recommendation 8

The SLHD review the Community and Home Visit Huddle procedure to:

a. require the discussion of a dynamic assessment of the safety risk to staff involved in the conduct of a home or community visit that day (whether consideration of the visit occurs at a daily Huddle meeting or otherwise);

b. require the recording of a *decision* with respect to whether or not, and how, a home or community visit will be undertaken that day (whether that decision is made during a daily Huddle meeting or otherwise); and

c. include a re-statement of the policy position as to when home and community visits may not be undertaken.

Recommendation 9

The SLHD formally implement a requirement that all Community and Home Visit Huddles must be attended by the relevant Team Leader and a psychiatrist when they form part of the Core Team on any given day.

Recommendation 10

The SLHD formally implement a requirement that all new Community Mental Health Service staff members must not undertake any home or community visits to clients alone in the first 3 months of employment.

Recommendation 11

The SLHD review its workplace health and safety policies, procedures, and practices to consider whether the scope of the daily Community and Home Visit Huddle should be formally expanded to include discussion about safety issues generally for the relevant team that day, not merely safety issues concerning visits to clients in homes and elsewhere in the community.

Recommendation 12

The SLHD review the Core Team Model of Care with a view to including direction on handover planning for periods of staff leave.

To NSW Health

Recommendation 13

NSW Health consider implementation of these recommendations in Community Mental Health Services state-wide.

22 Close of Inquest

22.1 I thank Counsel Assisting, Sian McGee, and her instructing solicitors, Bronwyn Lorence and Lara Shepherd, of the Crown Solicitors Office, for all the assistance they have provided in preparing and conducting this inquest, and for the care and compassion they have shown in their dealings with Stephen's loved ones. I also thank Detective Senior Constable Christine Abela for the hard work she has done in investigating the circumstances of Stephen's death over several years.

22.2 Once again on behalf of the Coroners Court, I offer my sincere and respectful condolences to Stephen's family, friends and colleagues.

22.3 I close this inquest.

Magistrate Kasey Pearce
Deputy State Coroner
Coroner's Court of New South Wales

Date 8 August 2025