CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of JC
Hearing dates:	**14 – 18 July 2025**
Date of findings:	**22 January 2026**
Place of findings:	NSW State Coroners Court, Newcastle
Findings of:	**Deputy Chief Magistrate Freund, Coroner**
Catchwords:	CORONIAL LAW – deliberate self-poisoning, Care and Treatment, Calvary Mater Hospital, Newcastle. Benzodiazepine withdrawal
File number:	2021/19652
Representation:	Counsel Assisting the Coroner: Mr W de Mars instructed by Ms K Campbell, Crown Solicitor's Office Hunter New England Local Health District & Calvary Mater Newcastle & Dr Frank Reimann: Mr P Rooney instructed by K Hinchcliffe, Makinson d'Apice Lawyers Nurse Simeon Evans & Nurse T Jackson: Mr B Thompson, NSW Nurses and Midwives Association Prof N Buckley: Mr T Bowen instructed by Ms N Brown, Meridian Lawyers Dr S Sharma: Mr C Jackson instructed by Ms J Alderson, Avant Law
Non publication order:	Non-publication orders apply to the evidence in this inquest. A copy of the order made by Deputy Chief Magistrate Freund can be obtained from the Court Registry.
Findings:	The *Coroners Act* in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her

	findings as to various aspects of the death. These are the findings of an inquest into the death of
Recommendations:	1) That the coronial findings be drawn to the attention of the NSW Ministry of Health by the HNELHD in support of the case, when further advanced, for the funding and establishment of a Behavioural Assessment Unit within the Emergency Department at Calvary Mater Hospital Newcastle, in order to provide more effective care and treatment to patients presenting with episodes of deliberate self harm within the LHD. 2) That CMH and the HNELHD: a) provide training and education to clinicians involved in assessing patients presenting to the ED with Deliberate Self Poisoning (DSP) concerning the “red flag” of potential benzodiazepine addiction and withdrawal; and b) Provide training and education that encourages clinicians to seek advice from addiction medicine specialists when assessing patients presenting with benzodiazepine dependence and at high risk of withdrawal at discharge from the Emergency Department. 3) That the CMH require mental health clinicians assessing patients in the CMH Emergency Department to compete MH-OAT(A1) psychiatric assessment form, and that CMH require mental health clinicians assessing patients in the CMH general hospital wards to

	complete MH-OAT(A1) form when an admission is required to a mental health unit. 4) That the HNELHD ensures that the coronial findings in this matter are reviewed and taken into account by the Committees that next determine the appropriate "Scope of Practice" of Mental Health Nurse Practitioners who work in the CMH ED, including but not limited to: • whether it is appropriate for the MHNP to conduct assessments of patients presenting after an episode of DSP where a risk of benzodiazepine withdrawal after discharge has been identified; • requirements to use MH-OAT forms (or their equivalent) when assessing patients in the ED. 5) That CMH and the HNELHD take action to ensure that clinicians in the ED have a clear understanding of roles and responsibilities for the timely completion of discharge documentation in cases of multidisciplinary care. 6) That, as identified by the clinical heads during the inquest, the following aspects of policy be reviewed by CMH: • The Suicidal Behaviour policy in relation to who is responsible for the conduct of mental health assessments in the ED; • The Suicidal Behaviour policy in relation to the circumstances in which a patient with DSP is to be "admitted under Toxicology"; • The Deliberate Self Poisoning "Toxicology Pathway" in relation to who is to be contacted in connection with mental health

	assessment following toxicology clearance.

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of JC.

Introduction

1. JC was just 30 years old when he passed away on 20 January 2021, near Bar Beach in Newcastle.
2. He is survived and very much missed by his parents JC's father and JC's mother and his younger siblings JC's sister and JC's brother.
3. I had the benefit of evidence from JC's parents during the course of this inquest. It was abundantly clear, that JC had a close and loving relationship with them and turned to them for support and his darkest times. He was honest and upfront about his use with drugs, and they did their utmost to get him the help he needed.
4. JC was described by his parents as a "sensitive, intelligent and gentle" soul who had a deep love for animals and strong connection to the "ocean surfing and diving" which gave him a sense of "calm and "grounding". He was also "fearless and thrill-seeking by nature"[1].
5. Those who knew JC saw his kindness, his empathy and the quiet strength he carried despite his struggles, and like many people, JC lived with mental health challenges. He experienced life's highs and lows intensely.
6. JC took his own life near Bar Beach at Newcastle on 20 January 2021.
7. Prior to his death, on the morning of 20 January 2020, he had been taken to Calver Mater Hospital ("**CMH**") by ambulance after calling his parents in distress saying he could not go on anymore and that he intended to hang himself. His parents were at home on the Gold Coast. JC's father kept him talking while JC's mother called the ambulance that ultimately took him to hospital.
8. JC was discharged from CMH at approximately 11:00am on 20 January 2020.
9. The focus of this inquest was to examine the adequacy of the care and treatment JC received at CMH and the Hunter New England Local Health District ("**HNELHD**") on 20 January 2020.

[1] Transcript 18/07/25 page 346

10. I note that an issues list was distributed to interested parties prior to the commencement of the inquest which after hearing and considering all the evidence I have consolidated into the following issues:

11. After hearing and considering all the evidence in this inquest I have formed the view that the following five broad issues require consideration:

    a. Firstly, was the care and treatment JC received in relation to his deliberate self-poisoning and the effects of any drugs he had consumed appropriate in the circumstances?

    b. Secondly, was JC's mental health adequately assessed, and should he have been discharged despite expressing self-harm and suicidal ideation?

    c. Thirdly, what was the nature of any contact that occurred with JC's parents, and should they have been consulted more extensively in relation to JC's history, and considerations relating to his potential discharge? and

    d. Finally, was there adequate planning and consultation in relation to JC's discharge?

    e. Finally, are there any recommendations I should consider and make?

12. Prior to dealing with these issues, I will set out the facts leading up to JC's death and then I will deal with the issues set out in the preceding paragraph in turn.

13. I note that in writing these findings I had the benefit of the following written submissions:

    a. Closing submissions of Counsel Assisting dated 6 August 2025;

    b. Submissions on behalf of Registered Nurse Simeon Evans dated 1 September 2025;

    c. Submissions on behalf of Professor Nicholas Buckley dated 1 September 2025;

    d. Submissions on behalf of Calvary Mater Newcastle and Hunter New England Local Health District dated 29 August 2025;

    e. Submissions on behalf of Dr Shweta Sharma, Psychiatrist dated 1 September 2025; and

    f. Counsel Assisting's brief reply to interested parties closing submissions dated 26 September 2025.

The Circumstances leading up to JC's death

14. In order to consider the issues set out in paragraph 11 of these findings It is important to consider firstly his early years, secondly his years at Newcastle and finally in the most detail, the circumstances of 20 January 2020 and the care and treatment he received at CMH prior to his discharge.

JC's EARLY YEARS

15. JC grew up on the Gold Coast with his parents, JC's father and JC's mother, and his two younger siblings, JC's sister and JC's brother. He moved to Newcastle about 2 years prior to his death.

16. The evidence of JC's parents can be summarised as follows:

    a. JC began using cannabis as a teenager, his father was of the view that it made him feel paranoid[2];

    b. JC suffered from a bit of anxiety as a child but was not officially diagnosed with any mental health condition[3];

    c. JC's mother described noticing JC's mental health deteriorating in his mid-20's[4];

    d. In about 2015, JC lived in Indonesia for 6 months and at that point JC's mother noticed a difference in him. It was around that time JC told his father that he was addicted to the prescription medication Xanax[5];

    e. As a result in about late 2016, JC's parents arranged for him to undertake detox at a hospital in Brisbane prior to attending an addiction treatment Centre called Mirikai in Burleigh Heads. JC's parents report that JC found this challenging and could not complete the rehabilitation program and had to leave after two weeks[6];

    f. Shortly after this JC's parents arranged for JC to attend a private psychiatric facility called Currumbin Clinic[7]. JC spent some time there, but it appears he had difficulty engaging with the program and was

[2] Tab 9 at [3]
[3] Ibid
[4] Tab 8 at page 2
[5] Ibid
[6] Tab 7 at [5]
[7] Tab 9 at [6]

discharged and not permitted to return after an argument with a doctor[8];

g. JC's mother gave evidence that in about 2018, JC began using Ice from time to time[9]; and

h. At about this time was taken to police to Gold Coast University Hospital. JC's father described JC as being in psychosis during this admission[10]. Upon his discharge to the family home JC was described by his parents as being depressed and angry and spent a period of approximately three weeks isolating himself in his bedroom[11].

17. About 2 years prior to his death JC decided that he needed to get out of the Gold Coast and he moved to Newcastle. He found work as a "roofer" and for the first 12 months lived in a rental share house in Merewether.

JC'S MENTAL HEALTH AND DRUG USE UPON MOVING TO NEWCASTLE

18. The evidence in relation to JC's drug use and mental health comes from a variety of sources in particular:

a. The records of CMH;[12]

b. JC's parents; and

c. His partner MP who provided a statement dated 13 December 2021[13] but did not provide oral evidence to this inquest.

19. On the morning of 7 July 2019, JC was taken to CMH by ambulance. He had been out with friends, had taken an excessive quantity of multiple drugs, and became unconscious. At CMH he was noted to have a history of "Xanax abuse" and anxiety[14]. He was discharged later that morning. There does not appear to have been a suggestion in the hospital records that he had intended to harm himself[15].

[8] Ibid
[9] Tab 7 at [9]
[10] Tab 9 at [7]
[11] Tab 7 at [11]
[12] Tab 36
[13] Tab 11
[14] Tab 36 at page 45
[15] Tab 36 pp 32 - 46

20. In March 2020, JC commenced a relationship with MP. JC and MP lived together in what JC's father describes as a "unit type residence on top of a garage" in Newcastle[16]. Several months into their relationship MP describes JC going into a "drug induced psychosis". She describes him believing that she and her parents were aliens[17].

21. In the early hours of 24 October 2020, JC went to CMH with MP. He was triaged in the Emergency Department ("**ED**") with the following presenting problem[18]:

> "*Male aged 29 years, 11 months presents with Mental Health Disorder, Behavioural Disturbance, patient having hallucination and increased suicidal thoughts for last few weeks. Patient requesting mental health assessment*"[19].

22. JC was reviewed by the Psychiatric Emergency Care Centre ("**PECC**") Mental Health Team who noted the following:

> "*Vol presentation, accompanied by partner….hearing voices telling him to kill himself. They vary, telling to than to not kill himself. Also, derogatory voices present as well. This has not happened to him before and has been happening for the past 2 weeks. He ceased heavy usage of benzo's just beforehand.*
> *His benzo addiction (Diaz 10-20mg daily, and alprazolam up to 20mg daily) has been an issue for 11 years. He has had brief episodes of sobriety but cannot give an account of any period of more than 2 weeks duration.*
> *He is obtaining his drugs from the internet and off the streets ever since the website was shut down. He has suffered extreme sleep deprivation over the past few days leading him to obtaining and using some more street alpraz over last 48 hours.*
> *He is pre contemplative putting up roadblock after roadblock to obtaining any help. He has steered the conversation towards getting more Diazepam. He states that it is the only medication that works for his anxiety. He does give a good list of symptoms indicative of anxiety, but it may also be withdrawal symptoms. Not wanting admission. Nil risk issues present*".[20]

23. The records indicate that JC was discharged at 6:14am into the care of MP and was prescribed quetiapine 25mg tablets to assist with sleep. He was also referred to the acute care team for follow up.

24. Three days later, on 27 October 2020, JC returned to CMH. He was triaged in the Emergency Department, and it was again noted that he presented with suicidal ideation, was expressing suicidal thoughts and requested a mental health review. He was initially admitted to the PECC and later in the day was

[16] Tab 9 at [9]
[17] Tab 11 at [10]
[18] Tab 37 p1 - 28
[19] Tab 38 page 19
[20] Ibid at page 2

admitted to the mental health ward on a voluntary basis. His mental health assessment recorded that:

"*[l]ast Thursday he took an alprazolam overdose with suicidal intent*."[21]

25. A drug and alcohol history was taken, which indicated that:

"*symptoms have occurred in the presence of benzodiazepine abuse, cocaine use, Ritalin and nitorous oxide (nangs). Note [JC] has a long history of polysubstance use*."[22]

26. I note that the following day when seen on a psychiatric ward round, the reason for admission was recorded as auditory hallucinations and anxiety[23]. He reported that he had experienced command hallucinations involving aliens that felt very real. He was also noted to be in "benzodiazepine withdrawal"[24].

27. JC spent 5 days in CMH.

28. His parents came down from the Gold Coast, and his father took him on escorted leave on two evenings.

29. On the second evening he returned to the hospital demanding to be discharged and was upset with his parents for not having brought cigarettes for him. It seems that he was persuaded to remain at CMH for a further two nights and he was ultimately discharged on 2 November 2020. The discharge documentation referred to:

"a DSP of alpraz recently (approx. 20 tabs)"[25].

30. His discharge plan included:

- "*Discharge home with support from his partner;*
- *Continue olanzapine that he had been given in hospital, to be weaned as per GP;*
- *To follow up with a GP within 7 days, for monitoring of olanzapine and to create a Mental Health Care Plan, to involve counselling with a psychologist for mood regulation, drug and alcohol issues and anxiety;*
- *To attend the McAuley Centre, for a 2 week drug and alcohol course to commence the following Monday*"[26].

[21] Tab 38 page 30
[22] Ibid at page 30
[23] Ibid at page 45
[24] Ibid
[25] Tab 38 page 24
[26] Tab 38 page 25

31. There is no evidence to indicate that JC attended the 2 week drug and alcohol program he had been booked into.

32. On 3 November 2020, JC attended on a GP who provided him with a Mental Health Care Plan. He was referred to Dr Michael Walton, psychologist.

33. On 17 December 2020, JC saw Dr Walton.

34. It was the evidence of Dr Walton[27] that JC reported that he was:

> *"experiencing clinically depressed mood, anxiety and stress. He was using various recreational drugs, struggling to sleep and hearing voices. He was confident in not attempting suicide and resisting the described voices. [JC] was not agitated in his presentation, although his affect appeared blunt as he slumped into the clinic chair*"[28].

35. Dr Walton's notes of his session with JC of 17 December 2020[29], record the following:

    a. he had been having ongoing delusions and that he had recently swallowed a bottle of Xanax before going surfing at 1.30am[30]; and

    b. he had no motivation for work and had been living off his savings and had spent $12,000 on drug use over the past month. He said that he was down to his last $2000 and that he had taken two Valium per day over the last 5 years[31].

36. JC had a further appointment with Dr Walton arranged for early February 2021.

37. After visiting JC in hospital in late October 2020 JC's parents maintained close contact with JC. JC's mother recounted how they had provided assistance to JC so that he could see a psychologist and that JC had reported to her that for the first time he had had a positive experience talking with the psychologist and that he was keen to see him again[32]. On 16 January, just four days prior to his death, in a text to his mother, JC had indicated that he was due to see the psychologist again on 20 January 2021.

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[27] Tab 39
[28] Tab 39 at [10]
[29] Tab 40 pages 5-12
[30] Tab 40 at page 5
[31] Ibid at page 9
[32] Transcript 14/07/25 page 43.5-25

EVENTS IMMEDIATELY PRIOR TO AND INCLUDING 20 JANUARY 2021

38. It was the evidence of MP, that:
    a. on 19 January 2021, she told JC that she "wanted some space apart" and to "see how that would go"[33];
    b. JC took some bedding and a couple of t-shirts from their house with him[34];
    c. JC attempted to call MP multiple times after they broke up, however, she did not speak to him[35].
39. At around 8:21pm, JC contacted Friend A, a friend who he sometimes worked with, and told him that he and MP had broken up and asked Friend A to cover for him on site the next day. JC also indicated that he would stay with another friend, Friend B known as "Friend B", that night[36].
40. At around 9:00pm, JC contacted his father saying he had had enough of life. JC's mother texted MP and asked what was wrong, however, MP replied that JC said he would end his life if she said anything. JC subsequently indicated to his father that he would spend the night at Friend B's place.
41. At 5:54am on the morning of 20 January 2021, JC called his father. JC told his father that he could not go on anymore and was going to hang himself. He also said that he was at Bar Beach carpark. JC's father kept talking with him over a lengthy period of time while JC's mother called 000[37].
42. An ambulance arrived at Bar Beach carpark at 6:40am and the paramedics located JC.
43. The evidence of Paramedic Juliet Stark can be summarised as follows[38]:
    a. She was also a registered nurse of 27 years[39]
    b. JC was in the front seat of his 4WD vehicle;
    c. When she arrived on scene JC was still on the phone to his father, on speakerphone[40];

[33] Tab 11 at [13]
[34] Ibid
[35] Ibid at [14]
[36] Tab 12 page 2
[37] Tab 9 at [16]
[38] Tab 14; Transcript 14/07/25 page 46.15-24
[39] Ibid at [3]
[40] Ibid at [4]

d. JC told her that he had taken some medication overnight and that morning. He also said that he had taken some MDMA at 6:00am and also a small amount of alcohol[41];

e. JC appeared to be drowsy and had slurred speech; however, he was cognitively OK and aware of his surroundings[42];

f. JC told her that he had taken the tablets with the intent to harm and kill himself;

g. She told JC that because of the amount of medication and because he had said that he wanted to kill himself, she would have to take him to CMH for a Mental Health Assessment[43];

h. She examined empty pill packaging in JC's car and considered that JC had taken as many as 37 5mg tablets of Etizolam and 10 1mg tablets[44];

i. She regarded this as a substantial quantity and notified the hospital of JC's deliberate self-poisoning, and the quantity of drug involved prior to their arrival at the hospital;

j. She provided a thorough handover to doctors and nursing staff and says that those staff were made well aware that JC had deliberately poisoned himself with the intent of harming himself[45].

44. The paramedic who attended with Juliet Stark, Ms Sacha McLaughlin, also provided a statement in which she describes JC as being in a really flat mood[46].

45. The evidence of JC's father, who was on the phone with JC when the paramedics arrived and while they were attending to him and what he did thereafter, was as follows:

a. That when the paramedics arrived on scene JC denied that he was JC, saying his name was Jonathan however, in his amended statement, it was JC's father's evidence that when the paramedics arrived JC indicated that his name was "Jarrod"[47];

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[41] Ibid at [5]
[42] Ibid at [6]
[43] Ibid
[44] Ibid at [8]
[45] Ibid at [10]
[46] Tab 15 at [6]
[47] Tab 9 at [16]; Tab 10 at p. 3

b. the officer established that it was JC and that he was on the phone to his father[48];

c. shortly thereafter he received a phone call from police who advised that:
"[*JC] had been taken to the Hospital and they searched his care and found anxiety pills and [JC] had admitted to taking MDMA*"[49]

d. He then called CMH and:

"spoke to mental Health Admin and I told him my son [JC] is coming in by Ambulance and I would like to speak with the Doctor on Duty because my son would tell him what they want to hear, they said that I could not speak to the doctor at that moment but would inform them and get a doctor to call me back"[50]

e. explained that his son was "coming in by ambulance" and asking to speak to the Doctor on duty. He says he was told that a Doctor, would call him back.

46. In her statement made on 21 January 2021[51], JC's mother recounts how both she and JC's father were relieved upon learning that an ambulance had arrived and was taking JC to CMH on the morning of 20 January, stating: "*we were both thinking they have to keep him this time because it's not voluntary*"[52].

JC'S CARE AND TREATMENT AT CMH ON 20 JANUARY 2021

47. JC arrived at CMH by ambulance at 7:14 am on 20 January 2021. He was initially triaged by a nurse and then seen at 7:30am by Dr de le Piedad. JC left the hospital at approximately 11:15 am.

48. In the approximately four hours he was in the care of CMH he was seen (or his case considered) by the following medical practitioners/ teams:

a. The senior doctor in charge of emergency department namely, Dr Arsenal de le Piedad;

b. The toxicology team comprising Professor Nicholas Buckley and Dr Frank Reimann; and

c. Mental health nurse practitioner, Simeon Evans who consulted with Dr Shweta Sharma, consultant psychiatrist.

[48] Tab 9 at [16]
[49] Tab 10 at p. 3
[50] Tab 10 at p. 4
[51] Tab 8
[52] Tab 8 at p. 5

49. I note that JC also interacted with the Nursing Unit Manager, Kim-Marie Blaydon and Nurse Jessica Hoarty.

50. Prior to considering the issues to be examined in this inquest it is important to set out the facts in relation to the care JC received, and any relevant considerations given by those in charge of his care for the decisions they made on 20 January 2021. I will deal with each of the treating teams in turn.

Emergency Department

51. Dr de le Piedad was the senior doctor in charge of the emergency department on 20 January 2021. She gave evidence on the second day of the inquest, and her evidence can be summarised as follows:

a. At approximately 7.30am, shortly after she commenced her shift, she reviewed the Ambulance records relating to JC and noted the following:

"*he had taken 37 * 5mg Etizolam tablets and 10 * 1mg Etizolam tablets*".[53]

b. She then attended on JC and obtained the following history:

"a) He had Ingested Etizolam tablets on the evening of 19 January 2021. He then slept between 1:00 AM and 4:00 AM on 20 January 2021
b) he then went for a drive
c) add 0600 hours, he took an MDMA tablet
d) he purchased the Etizolam on the Internet
f) he was talking to his father on the phone whilst he sat in his car at the bar beach car park
g) the overdose was intentional with the intent to end his life
he casually drank alcohol and took party drugs, including cocaine, LSD and MDMA and had taken ice in the past".[54]

c. She was aware at the time of her assessment that:

"[*JC] had a past medical history that included anxiety, depression and Poly substance use disorder (benzodiazepine's)*."[55]

d. She was also aware that JC had two previous suicide attempts one involving a Xanax overdose and the other hanging attempt[56].

e. She reviewed JC's physical health observations and noted that they were within normal limits[57].

[53] Tab 32 at [13]
[54] Tab 32 at [14]
[55] Ibid at [15]
[56] Ibid
[57] Ibid at [17]

f. She referred JC to both the Toxicology team and mental health team to be reviewed[58].

g. She did not recall whether or not she discussed JC's suicidality with either the toxicology or mental health teams.[59]

The Toxicology Team

52. Sometime between 9:00am and 9:30am JC was seen by two Doctors from the Toxicology Team, Professor Nicholas Buckley and Dr Frank Reimann, who both gave evidence at the inquest.

53. The evidence of Dr Reimann was inter-alia that:

a. As at 20 January 2021, he was the advanced trainee under specialist supervision at CMH in clinical pharmacology and toxicology and had held that position for approximately 2 years[60];

b. He saw JC together with Professor Buckley at about 9:00am in the emergency department[61]. They conducted an assessment of JC which took approximately 20 minutes.[62]

c. The assessment of JC would have involved:

"*an assessment of his overall cognition, as in orientation to a time, place and person, and a, a neurological examination testing vision, co-ordination, gait, balance, tremor, to get a sense of how physically affected [JC] was by the overdose*"[63].

d. He also said:

"*we had a fairly lengthy discussion with [JC] around his work and how his drug use may place him and others at risk, and I recall [JC] engaging quite well and appropriately in the discussion. He displayed insight; he had good recollection of, of the events; and we - he seemed quite forthcoming in his statements that he made to us*."[64]

e. He did not recall seeing the Toxicology Admission Form that had been completed by Dr de la Piedad[65] that contained significant information concerning JC's presentation and the history he had given earlier that morning.

[58] Ibid at [21] and [22]
[59] Tab 32 at [21], Transcript 15/07/25 page 113.40-50
[60] Tab 35 at [7]
[61] Ibid at [15]
[62] Ibid at [21]
[63] Transcript 15/07/25 page 66.25-30
[64] Ibid at page 66.30 - 35
[65] Ibid at page 71.25

f. I note that in cross examination Dr Reimann accepted that information from JC's October 2020 admission concerning psychosis brought on by benzodiazepine withdrawal would have been relevant for him to be aware of, however he could not recall the extent to which they were aware of or had access to those details.[66]

g. When asked whether there was ever cause to contact family for information about a patient Dr Reimann indicated that that might be done for the purposes of gaining medical information but that "we don't tend to go into the psychosocial history from the toxicology service."[67]

h. When asked whether his team could ask for a doctor from the Drug and Alcohol service to conduct a review notwithstanding that JC declined a referral to that service, Dr Reimann did not think this was possible in the absence of consent.[68]

54. The evidence of Professor Buckley essentially corroborated that of Dr Reimann. Of note however was that:

a. referred to there being a "second review" of JC that he and Dr Reimann conducted together at 10:50am, at which time JC was again offered a referral or consultation with the Drug and Alcohol Team and given advice concerning work and driving.[69]

b. In cross-examination he conceded that this had never occurred. It appears that his belief that it had occurred came about as a result of his incorrect understanding of the notes that had been made retrospectively by Dr Reimann about the 9:30am review.[70]

c. Professor Buckley also expressed the view that he had an expectation that someone (whether form his team or another team) would have had a further interaction with JC at the time he left the hospital, to again offer drug and alcohol referral.[71] There does not appear to be any evidence that this occurred at the time of JC's departure.

[66] Ibid at page 73.11-25
[67] Ibid at page 74.24-25
[68] Ibid at page 74.41.
[69] Tab 27 at 6.1(d)
[70] Transcript 15/07/25 page 91.20
[71] Ibid at page 91.34

The Mental Health Team review

55. JC's mental health assessment was carried out by Registered Nurse Simeon Evans.

56. RN Evans gave evidence on the third day of the inquest, and his evidence can be summarised as follows:

    a. He is a "registered mental health nurse practitioner" with experience as a mental health nurse dating back to 2006 in the UK[72].

    b. His scope of practice is to provide specialist, autonomous mental health care and assessment in the emergency department and has been employed by Hunter New England Mental Heath at CMH since February 2016[73]

    c. On 20 January 2021, he was notified of NUM Baydon of JC's presentation to the ED and requested that he carry out a one off crisis assessment[74]

    d. After being called the ED he spoke with NUM Kim-Marie Blayden who provided some details of JC's initial presentation[75].

    e. He also spoke with the Toxicologists who were still in the ED and then reviewed the records of JC's past presentations to the Hospital.[76]

    f. His discussion with the Toxicologists was "in depth" and he considered that he therefore had most of the relevant information available to him from JC's presentation that morning, rather than from the records that had been made.[77]

    g. RN Evans acknowledged having the ambulance record and triage form for the purposes of his assessment of JC. However, he could not recall whether or not he had seen the Toxicology Admission Form at the time of his review of JC. He could not offer a reason as to why it would have been inaccessible to him.[78]

    h. He carried out an assessment of JC in the Emergency Department his notes of that consultation[79] include the following:

        - *"no history of serious suicide attempts"*

[72] Tab 25 at [2]
[73] Tab 25 at [2] and [3]
[74] Ibid at [7]
[75] Transcript 16/07/25 page 161.31-36
[76] Ibid at page 161.38-48
[77] Ibid at page 162.3
[78] Ibid at pages 174.42-47 - T175.10
[79] Tab 36 pages 7-9

- *"Benzos used daily usually 5-20mg"*
- *"nil suicidal ideation prior to behaviour last night"*
- *"regrets OD – "a waste of tablets"*
- *"Nil pervasive low mood"*

i. He noted the following regarding his consultation JC as recorded in his statement dated 23 April 2021[80]:

   i. JC expressed irritation and frustration about the ongoing time he had been in the ED[81];

   ii. He had not been scheduled and was keen to leave[82];

   iii. He agreed to an assessment and was open and engaged. As a result, he had no reason to doubt the information he was being provided by JC was honest[83];

   iv. JC advised that he took the overdose to escape the distress of an argument with his partner and not part of planned behaviour and there was no clear intent to kill himself[84];

   v. "he seemed ambivalent about the outcome of taking the tablets thinking he might not wake up. He called his father after taking the overdose and was brought into the ED voluntarily"[85];

   vi. JC made good eye contact and did not present as guarded[86];

   vii. JC denied any paranoia or auditory and or visual hallucinations[87];

   viii. He asked JC if he had any ongoing suicidal ideation which he denied and he expressed regret and remorse for taking the overdose[88]; and

   ix. JC was clear that he had no plans to repeat the behaviour.[89]

[80] Tab 25
[81] Ibid at [8]
[82] Ibid
[83] Ibid
[84] Ibid at [9]
[85] Ibid
[86] Ibid at [11]
[87] Ibid at [12]
[88] Ibid at [14]
[89] Ibid at [15]

j. He discussed with JC his ongoing issues with substance abuse and noted that JC did not see his daily use of benzodiazepines as an issue other than the occasional difficulties sourcing them.

k. JC agreed prior to his discharge that if he was anxious or feeling unsafe he would return to the emergency department for assistance.

l. He discussed the case with Dr Shweta Sharma, psychiatric emergency service locum consultant who agreed that "although an unpredictable ongoing risk existed there was no imminent risk identified" in his assessment of JC.

m. As there were no grounds to detain JC under the Mental Health Act nor was there a treatable mental health condition which would necessitate a compulsory hospital admission but simply a "situational crisis" he was cleared for discharge.

57. Dr Shweta Sharma was the locum consultant psychiatrist at CMH on 20 January 2021. She did not see or evaluate JC while he was in the Emergency Department of CMH. Her involvement regarding JC's care and treatment was limited to a discussion with Nurse Evans in the hospital café. Her evidence was inter-alia that:

a. She was approached by RN Evans who sought advice in relation to JC;

b. RN Evans "*provided a history including that [JC] had been brought into the Hospital's ED by ambulance following an overdose. He informed me of [JC]'s history of drug use and said there had been no clear suicidal intent leading to the overdose, no history of suicide attempts and no current suicidal ideation*"[90]; and

c. They agreed there was no grounds to detail JC under the Mental Health Act and that he should be discharge and advised to return to the emergency department if he felt he needed further help.[91]

<u>The interaction of nursing staff with JC</u>

58. The nursing unit manager at the time of JC's admission to the ED at CMH was Kim-Marie Blaydon. Her evidence can regarding her observations and interactions with JC can be summarised as follows:

[90] Tab 31 at [8]
[91] Ibid at [9]

a. She first became of JC at about 7:20am on 20 January 2021, when he was being transferred from ambulance stretcher to bed 2 of the Emergency department[92];

b. JC's physical observations were normal[93];

c. She observed JC with Professor Buckley and Dr Reimann. She then had a conversation with Professor Buckley where he said:

"*[JC] did not require admission to the Hospital from a toxicology perspective but that he required an assessment by the mental health team prior to discharge*"[94]

d. She later observed RN Evans talking with JC by his bedside;

e. At about 11:00am RN Evans advised her that:

"*he had assessed [JC] and also discussed [JC]'s assessment with his psychiatric consultant. Mr Evans advised me [JC] did not meet the requirements for an involuntary admission under the Mental Health Act and was able to be discharged from the Emergency Department. Mr Evans stated that [JC] had a psychiatric or psychological appointment that afternoon or the next day and that a friend was going to pick him up from the Hospital*"[95];

f. Following the conversation she directed RN Jessica Hoarty to return JC's personal belongings to him; and

g. At 11.20am, she signed the Adult Emergency Department Observation Chart as the Clinical Nurse Unit Manager[96].

59. Nurse Jessica Hoarty was the nurse assigned to take care of JC on 20 January 2021. Her evidence was inter-alia that:

a. JC was compliant, respectful and cooperative[97];

b. She took his observations, and they were normal[98];

c. JC's Glasgow Coma Scale ("**GCS**") score was 15 he was drowsy but rousable[99];

d. She took his personal belongings off him in accordance with hospital policy[100];

e. At 10.50 am she was told by NUM Blaydon:

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[92] Tab 34 at [12]
[93] Ibid at [13]
[94] Ibid at [15]
[95] Ibid at [17]
[96] Ibid at [21] and [22]
[97] Tab 33 at [19]
[98] Ibid at [17]
[99] Ibid at [20]
[100] Ibid at [18],

"*return [JC]'s belongings to him as he was to be discharged from the hospital."*[101]

f. At 11:00am she removed JC's cannula[102], and JC subsequently left the hospital[103].

EVENTS FOLLOWING JC'S DISCHARGE FROM CMH ON 20 JANUARY 2021

60. The evidence indicates that while JC was still at the Hospital, he made a number of phone calls. JC's phone records, in the form of a cellebrite extraction, provided some understanding of his actions and movements after leaving the Hospital, together with the evidence of his parents and his friend, Friend A.

61. JC left CMH unaccompanied.

62. The evidence of Friend A was inter-alia that:

a. He received a call from JC soon after 9:40am (likely from the hospital phone as it was a private number). JC told him he was "already getting released" and would need asked him to pick him up after he had finished his current work job.

b. Friend A expressed surprise at this, and JC told him that "they did the test and had a low reading so he was fine to go."[104]

c. At 11:02am he received a further call from JC who said:

"*he was "out" and was going to get some cigarettes from the Shell servo down the road from the Mater, and that he would wait for me there*"

d. At around 12:15pm, he picked JC up from the service station. They went for lunch, after which he dropped JC off to car at around 2:30pm.

63. The evidence from JC's parents after he was discharged from CMH can be summarised as follows:

a. At about 4:30pm on 21 January 2021, JC's mother received a phone call from JC, her evidence was

"*..and was saying goodbye and that he loved us and he told me he was going to hang himself. I got angry at him and asked him why would he say that too me. [JC] said he*

[101] Ibid at [24]
[102] Ibid at [26]
[103] Ibid at [27]
[104] Tab 12 at p. 2

was tired and couldn't do this anymore. I told [JC] I needed to get rid of the visitors and I would phone him straight back"[105].

b. At 4:52 pm JC telephoned his father and said:

"*that he had had enough and was going to a better world*"[106].

He would not tell his father where he was but simply said that:

"*he was somewhere remote*".

They spoke for 23 minutes (until 5.15pm).

64. JC's father then made a number of phone calls:

a. He called RN Evans three times, on the number RN Evans had given him without success and left a message about JC's "state of mind";

b. He then rang "Mental Health Administration", saying that he needed urgent help with his son, who was going to hang himself, and was told to ring the Mental Health Line ("**MHL**");

c. He finally called the MHL who he understood subsequently rang the police.

65. There after the evidence is that:

a. At 5:46pm Ambulance services received a message from the MHL;

b. At 6:08pm, an ambulance attended Bar Beach Carpark, and located JC's vehicle, but the paramedics could not locate JC;

c. At 5:57pm, NSW Police received a Computer Assisted Dispatch ("**CAD**") message informing them of the need to attend Bar Beach carpark as JC was threatening self-harm and had been at that location that morning in similar circumstances. The first police arrived on scene at 6:21pm, the matter having been assigned "priority 3" status;

d. The relevant police COPS event records that police conducted patrols in the vicinity of King Edward Park and the cliff edge along the "Bodgie Hole" with no success. A phone triangulation was conducted which pinged in the vicinity of the coast of Bar Beach and Merewether;

e. Around 7:00pm a passer-by, Justin Trehet, was walking north of Bar Beach, with his dog. His evidence was:

"I saw a world war two-gun bunker on the side of the cliff. I had not seen the bunker before. I could see someone hanging from the outside of the bunker. I walked closer and confirmed that there was a person hanging on the outside of the bunker. I wanted

[105] Tab 8 at p. 6
[106] Tab 1 at p. 3; Tab 9 at 21

to check if there was anything I could do to help this person, so I climbed up the cliff to the bunker. ..and saw that the male was clearly deceased…

There was a white plastic bag in the bunker on the floor, I opened the plastic bag and there were 3 or 4 unopened cans of Jack Daniels and a set of keys."[107]

f. Mr Trehet returned to where the police were with the keys and advised police of the circumstances;

g. Due to the encroaching darkness and the challenging terrain and location, police decided that recovery of JC's body would take place the next morning.

66. Later that evening, JC's parents received a call from one of JC's friends informing them that a body had been located. They immediately set out in their car to drive down to Newcastle, ultimately arriving at around 6:30am in the morning on 21 January. Their statements to police were made in harrowing circumstances. Without sleep and after spending some time at Bar Beach, they provided statements to police later that morning (21 January 2021) at Newcastle police station. They later supplemented those statements with additional statements in March 2021.

Was the care and treatment JC received in relation to his deliberate self-poisoning and the effects of any drugs he had consumed appropriate in the circumstances?

67. Associate Professor Naren Gunja provided an expert report dated 29 August 2024[108] with respect to the care and treatment JC received at CMH by the toxicology team. He also gave oral evidence on the second day of the inquest.

68. He was largely uncritical of the role played by the Toxicology Team and his oral evidence helped to clarify some of the matters of concern that he had expressed in his report.

69. I note that when preparing his report dated 29 August 2024, A/Professor Gunja was under the erroneous impression that the Toxicologists had seen JC for a second in person review at 10:50am. Accordingly, he was asked whether there should have been some further direct engagement with JC by the Team prior to JC's discharge. He stated that:

[107] Tab 13 at [6]-[7]
[108] Tab 49

"Yes. As a consultant toxicologist, I want to - I would want to make sure that somebody from my team, or somebody, if working in ED, had done the adequate checks prior to discharge that he was able to walk steadily, that he was able to manage out of the hospital, that he was advised not to do these things. You would want to make sure because you have been consulted as a team. And in this case, you're the primary treating team for the primary problem which is drug overdose. So, as the primary team, you have a responsibility to ensure that the patient is safe for discharge".[109]

70. The fact that Professor Buckley was under the false impression that there had been a second review of JC demonstrates the difficulties caused where notes are not made contemporaneously.

71. Mr Bowen, Counsel for Professor Buckley submitted inter-alia that:

a. That documentary evidence cannot and is not the complete record of all interactions and discussions had in relation to the care of JC[110]

b. The absence of notes or records does not necessarily mean an absence of action or consideration[111]

c. JC was never admitted as a patient and under the care of Toxicology. He remained in the care of the emergency department.

d. JC did not consent for drug and alcohol treatment and in that circumstance the:

"*role for withdrawal treatment and, for that matter, an addiction specialist can only be engaged following consent by the patient… D & A treatment cannot be forced in the absence of agreeme*nt".[112]

72. There was no evidence from an addiction specialist.

73. It is unequivocal that JC had refused a referral to and engagement with a drug and alcohol specialist. He was subject to supervision in the emergency department for a period of four hours where his physical observations remained stable. I am satisfied that it was appropriate to have been cleared from a toxicology perspective.

74. I accept that it would have been preferable had there been further engagement with JC by a member of the Toxicology Team at the time of his discharge, in order to ascertain if he had changed his mind in relation to engaging with a drug and alcohol specialist. This however is not a criticism of the Doctors

[109] Transcript 15/07/25 at page 98.38
[110] Written submission by Prof N Buckley dated 1 September 2025 at [5]
[111] Ibid at [6]
[112] Ibid at [7.4]

involved in this instance, particularly in the context of a busy emergency department.

Was JC's mental health adequately assessed, and should he have been discharged despite expressing self-harm and suicidal ideation?

112. In her oral evidence, Dr de la Piedad stated that in her experience it:

> "*is usually a nurse practitioner, or sometimes they use a nurse who specialise in psychiatry and mental health assessment. It could be a psychiatric registrar*" [113]

who conducted the mental health assessments in the CMH Emergency Department.

113. Furthermore, it was the evidence of Associate Professor Anne- Maree Kelly, that in at least NSW, Queensland and Victoria, mental health assessments are commonly provided by non-medical mental health clinicians[114].

114. As set out in paragraphs 55 to 56 JC's mental health assessment was carried out RN Simeon Evans.

115. RN Evan's "scope of practice" as recognised by the hospital was to provide "specialist autonomous mental health care and assessment" in the Emergency Department. RN Evans described his work in the Emergency Department as primarily performing one off crisis assessments.[115]

116. RN Evans was and is employed by the Hunter New England Mental Health Service as a Mental Health Nurse Practitioner ("**MHNP**"). He was and is an "accredited person" under the Mental Health Act ("**MHA**") meaning that he was empowered to schedule "mentally ill" and "mentally disordered" persons under the MHA.[116]

117. The HNELHD Director of Mental Health Services, Dr Swamy gave evidence that a MHNP does <u>not</u> have to consult with a psychiatrist for all assessments, this being similar to the expectations set for Psychiatry Registrars.[117]

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[113] Transcript 15/07/25 page 115.26-32
[114] Tab 50 page 22
[115] Transcript 16/07/25 page 161.21
[116] Tab 47 at [8]-[10]
[117] Tab 47 at [39]

118. RN Evans' formal "Scope of Practice" ('**SoP**") dated 11 June 2019[118] also contains certain "exclusions from care". These include "Patients with any presentation that he MHENP feels is outside his scope of practice and/or requires further consultation".[119]

119. In relation to "Supervision", RN Evans's SoP states:

- *As deemed necessary by the MHENP assessments completed in CMNED or PECC where significant risk is identified will be discussed with a consultant psychiatrist prior to the person leaving the CMNED or PECC; and*
- *Assessments where there is no acute mental illness/disorder or risk identified do not necessarily need to be discussed.*[120]

120. The SoP therefore leaves a high degree of discretion in the hands of the MHNP to determine which matters he should regard as "exclusions from care", and which matters he should discuss with a psychiatrist.

121. The evidence indicates that RN Evan had regard to the following sources of information prior to meeting with and assessing JC in the Emergency Department:

a. NUM Blaydon;
b. The Toxicology team namely Professor Buckley and Dr Reimann; and
c. The records of JC's past presentations in hospital.[121]

122. After being called the Emergency Department RN Evans gave evidence that he:

a. spoke with NUM Blayden who provided some details of JC's initial presentation;
b. spoke with the Toxicologists who were still in the Emergency Department and then reviewed the records of JC's past presentations to the Hospital; and
c. was aware that JC was very keen to be discharged.

123. RN Evans described his discussion with the toxicologists as "in depth" and therefore had most of the relevant information available to him from JC's

[118] Tab 47C
[119] Tab 47 page 54.
[120] Ibid at page 53
[121] Transcript 16/07/25 page 161.38-48

presentation that morning from that discussion, rather than from the records that had been made.[122]

124. Apart from his interaction with the Toxicology team prior to his assessment, and his discussion with Dr Sharma after his assessment, RN Evans stated that he did not recall having any other significant contact with clinicians in the Emergency Department. Although not certain, he believed that he advised NUM Blayden that JC had been cleared from a mental health perspective and would not be detained.[123]

125. RN Evans acknowledged having the ambulance record and triage form for the purposes of his assessment of JC. He did not know, however, whether or not he had seen the Toxicology Admission Form at the time of his review of JC and he could not offer a reason as to why it would have been inaccessible to him.[124]

126. Relevantly, those documents disclosed the following information:

a. The Triage note: that JC had a low mood for the past two days per his father; that he had taken an overdose of Etizolam that morning, that he had a history of anxiety and depression and previous self-harm attempts and that he was "Currently suicidal";[125]

b. The ambulance record: that JC had been speaking to his father on the phone at the time of the ambulance response to his overdose that morning; that JC had self-administered the medication with an intention to harm/kill himself; that he lived with his partner and that he had a history of depression and deliberate self-poisoning;[126]

c. The Toxicology Admission Form: In addition to the above, that JC was "currently suicidal"; had polysubstance use disorder and experienced seizures on withdrawal from benzodiazepines; and had made two previous suicide attempts – once by Xanax overdose and once by attempted hanging.[127]

127. RN Evans gave evidence that:

[122] Ibid at page 162.3
[123] Ibid at page 163.32-41
[124] Ibid at pages 174.42-47 - T175.10
[125] Tab 36 page 5
[126] Tab 19 page 2
[127] Tab 36 page 19

a. he was aware of the reported overdose in 2020 or 2019 that was recorded as a “recreational overdose”;
b. he interrogated JC regarding the history of deliberate self-poisoning as noted in the ambulance record; and
c. his discussions with JC and review of the clinical history suggested to him that there had not been any serious suicide attempts.[128]

128. In cross-examination by Counsel Assisting RN Evans acknowledged and conceded the following:

a. That he had seen the relevant discharge referral for JC’s 27 October 2020 admission to CMH, which indicated that JC on that occasion spoke of a recent deliberate self-poisoning involving 20 tablets of Alprazolam (Xanax).[129]
b. That it would have been helpful if he had sought out the file from the 27 October admission given the contents of the discharge referral, and that it was JC’s most recent admission to the Hospital.[130]
c. He did not contact or attempt to contact either:

(i) JC’s GP, who had been involved in the implementation of the discharge plan made in November 2020 and whose contact details he accepted were available to him[131]; or
(ii) Dr Walton – who had seen JC as recently as 17 December 2020 and was JC’s “preferred pathway to mental health support”.[132];

and that contacting the above sources may have been useful.

129. Relevant policies make plain that such avenues of corroboration should at the very least be explored by clinicians undertaking mental health assessments. During his evidence RN Evans was taken to the Calvary Mater Guideline that sets out the various matters to be taken into account when conducting an initial clinical assessment of a patient who has been identified as a risk of suicide

[128] Transcript 16/07/25 pages 175.44-176.4
[129] Ibid at page 177.25-50; Tab 38 page 24
[130] Ibid at pages 178.36-T179.2
[131] Ibid at page 182.39-183.6
[132] Ibid at pages 181.30-T182.3

via expressed thoughts or behaviour (including those who present following DSP). These include:[133]

vi) assessment of the availability of support networks; and

vii) relevant information from the patient's family (with the consent of the patient) general practitioner and other involved treatment services. Corroborative history must be sought wherever possible to confirm the clinician's assessment, confirm the level of support available to the person and promote collaboration with the person and his/her support person/s. It is important to involve the family and/or other carers in obtaining corroborative history, as they can be an important source of information, including recent behaviour of the person and his/her usual coping capacity. If the patient refuses consent for family or carers to be contacted for corroborative history, then this may impact on the reliability of the information obtained from the patient. It may also influence whether the patient needs to be referred to a mental health unit as an involuntary patient under the Mental Health Act 2007 (NSW).

130. In relation to the adequacy of JC's mental health care and discharge at CMH on 20 January 2021, I had the benefit of expert evidence from:

a. Professor Matthew Large, Psychiatrist; and
b. Associate Professor Kerri Eagle, Psychiatrist.

131. Both experts, gave evidence in conclave on the penultimate day of the inquest, and expressed the view that JC was a complex presentation that warranted assessment by more senior clinician and opportunities were lost in relation to JC's care and treatment. In particular:

a. Obtaining further information from those closest to JC and having them involved in his discharge planning
b. His substance abuse disorder, Benzodiazepine withdrawal and the risk of further psychotic episodes.

[133] Exhibit 2 page 75 (Policy version as at 2021) and page 81 (current policy)

132. I note that the evidence of these eminent experts was given with the benefit of hindsight and material which was not available or if available not used or relied upon by the treating clinicians.

What was the nature of the contact that occurred with JC's parents, and should they have been contacted more extensively?

133. When considering these "lost opportunities" with respect to JC's care it is important at first instance to resolve the factual dispute as to what contact JC's parents, in particular his father had with CMH and its staff in relation to JC's history and mental health.

134. It is uncontroversial that JC's parents were extremely concerned for his health and safety. They had called the ambulance that transferred him to CMH on the morning of 20 January 2021, and JC's father gave evidence that:

> *"I called the Hospital and spoke to the Mental Health Admin and I told him that my son [JC] is coming in by Ambulance and I would like to speak with the Doctor on Duty because my son would tell him what they want to hear, they said that I could not speak to the doctor at that moment but would inform them and get a doctor to call me back".*[134]

88. There is no evidence that this request made its way to any of the clinicians involved in JC's care at CMH.

89. Regardless, RN Evans phoned JC's father. JC's father's evidence of this conversation was inter–alia that:

a. During their discussion, JC's father was under the impression that RN Evans was a Doctor. The contents of their phone discussion was the subject of significant discrepancy, as reflected in their respective statements. In particular, JC's father indicated that the following occurred[135]:

i. JC's father said that JC would tell (RN Evans) "what he wants to hear" and that RN Evans "needed to keep him in".

ii. RN Evans said that JC wasn't psychotic, seemed pretty good and that they had done a "health and safety report." He further said that there was "nothing they could hold him there for". RN Evans gave

[134] Tab 10 page 4
[135] Tab 10 page 4

JC's father his phone number and said he could give him a call if he had any more problems.

iii. JC's father said he could not believe that JC was being let out, that he needed to be kept in to "dry out" and that he needed sleep. JC's father says he told RN Evans that JC had a psychology appointment at 2pm to which RN Evans responded that JC was not in a state of mind to attend. JC's father could not believe what he was being told and said to RN Evans that "we will have to go through this whole problem again" if JC was let out.

90. In contrast, the evidence of RN Evans regarding this phone call was that:

a. He called JC's father and "asked him if he had any concerns about his son being discharged or if he had any further information that could or would change my assessment and he stated he did not"[136]

b. "[JC's father] did not "please" or "demand" or even request that I keep JC in hospital".[137]

91. In the note of his assessment that RN Evans made at around 11:00am on 20 January 2021, he noted as follows:

"Conversation with [JC's father]: Concerned re drug use but understanding change cannot be forced. Does not believe there is a primary MH issue".

92. In his later statement dated 13 October 2021[138], RN Evans denied telling JC's father that JC was not fit to attend a psychology appointment. He denied that JC's father had requested that his son remain at the hospital and that JC's father had expressed disbelief that JC would be discharged rather than remaining at the hospital to "dry out and sleep".[139]

93. JC's father gave an account of his phone contact with RN Evans in his oral evidence that was in similar terms to his statement.[140] He added that prior to informing him of the intention to release JC, RN Evans had not sought any information from him about JC and his history. He did not recall RN Evans at any stage ask any questions about JC's background or previous mental health

[136] Tab 26 at [15]
[137] Ibid at [16]
[138] Tab 26
[139] Tab 26 at [7], [16]-[19]
[140] Transcript 14/05/25 page 33.43ff

episodes.[141] Nor did RN Evans ask any questions or discuss the circumstances of JC's release and any appropriate support person, including any role JC's mother and father might play, nor could he recall any questions being asked about JC's living circumstances.[142] If he had been asked to do so, JC's father indicated that he and his wife could have promptly travelled to the hospital.[143]

94. RN Evans gave evidence and elaborated on the evidence in his statements. Of note he stated that:

a. the purpose of the call to JC's father, as explained to JC, was to:

"talk about how things have been with you, to talk about what supports are available to you"[144].

b. He was aware at the time that he contacted JC's father that JC's parents lived "in Queensland"[145].

c. in hindsight it would have been sensible for him to think about contacting someone who knew JC who was local to the area;

d. in retrospect he wished he had contacted the friend of JC's who he understood was going to pick him up from the ED; and

e. he may have "respected JC's autonomy too much" and "placed too much emphasis on what JC was telling" him.

95. It is particularly noteworthy that RN Evans conceded/agreed to the following in cross-examination by Mr De Mars, Counsel Assisting:

a. He could not recall whether JC's father had told him that "JC would tell him what you'd want to hear and that you needed to keep him in" and he could not specifically recall being told that "JC would tell you what you want to hear", but said that it was not unusual for family members to make comments of that nature. He accepted that JC's father may have made those comments.[146]

b. He could not discount the possibility that JC's father expressed some degree of reservation about the fact that JC was not going to be detained,

[141] Ibid at page 34.34-50
[142] Ibid at page 35.3-27
[143] Ibid at page 35.21
[144] Transcript 16/07/25 page 183.43-44
[145] Ibid at page 183.49
[146] Ibid at page 186

and that he (RN Evans) did not "*receive that as strongly as Mr[JC's father] felt he was saying it*".[147]

c. He did not ask JC's father for information more generally about JC's background, family history, and past drug use and mental health history. Nor did he ask JC's father about his understanding of JC's social situation in Newcastle, including friendships and the status of his relationship with his girlfriend. He also had not asked JC's father about the phone call he had had with JC that morning, in which he reported that he was suicidal.[148]

d. That with hindsight it would have been helpful for him to have explored those matters referred to in the preceding paragraphs. In particular, he volunteered that he could have been more explicit than asking JC's father the broad question as he asserts he did as to whether there was anything that might change his opinion to discharge JC, particularly by way of seeking further information concerning JC's immediate social circumstances.

96. Mr Thomas, solicitor for RN Evans provided detailed written submissions dated 1 September 2025, about the conversation between his client and JC's father. In essence, he submitted that RN Evans' account of that phone call should be preferred for the following reasons:

a. The version of RN Evans is corroborated and based upon his contemporaneous notes[149];

b. JC's father's account and memory may have been impacted by the trauma of his son's death[150]; and

c. JC's father was not subject to cross examination regarding to the details of the phone call.

97. Dr Eagle observed that in her experience decisions about discharge are sometimes provisionally made and then the family is informed (and there then may or may not be an opportunity for the family to provide information that may change the assessor's view). However, in the case of JC's assessment, JC's father did appear to have been contacted at the point that RN Evans had

[147] Ibid at pages 190.28-T191.16
[148] Ibid at pages 188.44-190.26
[149] Submissions on behalf of RN Simeon Evans – nurse practitioner dated 1 September 2025 at [8]
[150] Ibid at [7]

already formed the view that JC was to be discharged. Dr Eagle considered there to be a flaw in approaching matters in this way stating:

"*the communication or liaison with the family should occur as part of the assessment, the comprehensive assessment that you're going to do, to determine what the person's clinical and treatment needs might be generally…. then once you've got that information, which would include information about their past, the person's past, how they've been presenting, you know, other information that might impact on your diagnostic formulation, what their care needs might be, the likelihood that they might engage in treatment and educating the family on sort of, for instance, what might benefit that person going forward, then you would discuss that with your clinical lead… then form an opinion based on that.*"[151]

She observed that where contact with a family is approached on the basis that the discharge of the person is a foregone or likely conclusion, rather than on a more open-ended basis, the conversations would be received very differently and would influence the nature of the information that could be elicited.[152]

98. Moreover, A/Prof Eagle opined that obtaining collateral information from sources outside the patient is essential, consistent with NSW Health Policy, and particularly in the circumstances of a complex presentation such as JC's.[153]

99. Professor Large was of the view that it would not necessarily have made a difference in this case[154] however, agreed that a more open-ended conversation with JC's father, may have elicited the information that JC was threatening "hanging himself" in a bunker that morning, and this information may have been relevant to an assessment of the rationality of JC's behaviour for the purposes of the MHA.[155]

100. The details of the telephone conversation between JC's father and RN Evans on 20 January 2021 are unclear. However, I note that most of JC's father's account is consistent with matters that RN Evans accepted were discussed. Moreover, RN Evans did not discount the possibility that he may have been told that JC would tell him what he wanted to hear. Given the clarity of JC's father's evidence on this point, I am satisfied on balance that RN Evans was told this. Ultimately though JC's father understood that JC's discharge was a fait accompli as a result of the call and RN Evans missed an opportunity

[151] Transcript 17/07/25 pages 245.49-246.13
[152] Ibid at 246.21-42
[153] Ibid at page 249.23-30
[154] Ibid at page 250.3
[155] Ibid at pages 250.50-251.4

conceding that he did not adequately seek pertinent background information from JC's father that may have assisted the formulation of his assessment. It is also clear that he made no real effort to explore the possibility that JC's parents could be directly involved in his discharge or provide relevant information to them concerning matters such as the risks of benzodiazepine withdrawal upon discharge.

101. I had the benefit of hearing from RN Evans on the third day of the inquest. He provided honest and forthright answers to the questions of Counsel Assisting. He impressed me as an empathetic and caring nurse practitioner who is both highly qualified and experienced. He made considerable concessions which can only be described as against his interest. He acknowledged that he has learnt from JC's death which clearly has deeply impacted him personally and professionally. Moreover, he accepts that there are opportunities for improvement, in the way communication and collaboration occurs with family and other clinical stakeholders in providing care.

102. Accordingly, I am satisfied that there was a missed opportunity to optimise the care JC received as a result of inadequate engagement with JC's family.

Was JC's benzodiazepine addiction and withdrawal recognised and managed?

135. Both experts agreed that based upon the hospital records from JC's October 2020 admission that JC's psychosis could be explained by JC's withdrawal from using benzodiazepines at that time[156] and that benzodiazepine withdrawal can be severe and very dangerous, and under-estimated by non-clinicians.[157]

136. My takeaway from the evidence in conclave is that benzodiazepine withdrawal is complex, dangerous and there is no one size fits all response that can be adopted, but it must be recognised and considered in terms of treatment and discharge.

137. Both Prof Large and A/Prof Eagle agreed that the best way to treat or deal with the withdrawal would be to prescribe benzodiazepines to JC in "an

[156] Ibid at pages 228.16-229.1
[157] Ibid at page 231.13

appropriately managed way" however Prof Large was of the view that this was not practically possible with JC as he had refused a referral to a Drug and Alcohol clinician.

138. In contrast A/Prof Eagle opined that:

a. This could be done by a doctor without recourse to a drug and alcohol clinician.

b. Although she agreed that Drug and Alcohol services are usually voluntarily based, they are not the only services that perform that type of work. She observed that a lot of people access support for substance use disorders through psychologists and private psychiatrists, and that it can be "artificial" to adopt a mentality that within health services only "drug and alcohol" services can deal with substance use issues.[158]

c. In assessing someone such as JC the seriousness of the benzodiazepine dependence and its withdrawal needed to be considered.[159]

d. Rather than its treatment at the time through carefully managed prescription, which evidently would have been challenging due to JC's unwillingness to engage with Drug and Alcohol services, this information and the risks of withdrawal should have been communicated to JC and steps should have been taken to ensure he had "ongoing psychiatric care and that this risk of benzodiazepine withdrawal needed to be communicated to family and others who might follow JC's father up into the community."[160]

e. That JC should have been seen by a psychiatrist because of the issues with benzodiazepine dependence and withdrawal, which may not be within the knowledge or scope of a nurse practitioner to manage.[161]

f. His family could have been provided with information concerning benzodiazepine withdrawal and its potential impact on JC's mental state,

[158] Ibid at page 269.4-270.12
[159] Ibid at pages 270.30-T271.1
[160] Ibid at page 272.6-10
[161] Ibid at page 236.24-32

with a view to helping manage his medication and his withdrawal symptoms pending consultation with a GP.

139. Additionally, A/Prof Eagle was critical of the mental health assessment JC received while in the care of CMH on 20 January 2021. Her evidence in that regard can be summarised as follows:

a. a comprehensive mental health assessment, must consider all relevant information. While observing that what the patient says is of course very important, A/Prof Eagle emphasised the importance of taking into account what other people have said.

b. In particular she referenced that JC had:

i. not simply expressed suicidal ideation but was thought to have taken 48 Etizolam tablets with the expressed intention of ending his life;

ii. indicated that he had attempted hanging in the past and was known to have taken another overdose (in October 2020).

Putting aside questions of the utility of such matters as a "predictor" of JC's future intentions (a matter Prof Large continually returned to), Dr Eagle viewed those matters as important in informing

"*the need to inquire further, other than just check in with him an hour later as to whether he was still suicidal and see if there were other concerns from family and put - really, put in place a management and a treatment plan that would address those concerns.*"[162]

b. It was necessary to look at all the information available (including the documentary records) rather than emphasising what JC was saying at the point of discharge.[163]

c. Dr Sharma had not been given all the information that was relevant, and had she been given that information she may well have determined that JC "*was complex enough to warrant a psychiatric assessment*".[164] Prof Large allowed that had information about past suicide attempts been

[162] Ibid at pages 234.30-235.8
[163] Ibid at page 237.15-19
[164] Ibid at page 239.13-18

transmitted to Dr Sharma, it is conceivable that that may have caused a second person to assess JC.[165]

d. Dr Eagle observed that "it does come down to how much information he was given, whether he was aware of the risks of withdrawal and the opportunities to come off the medication in a graduated way if he'd accessed drug and alcohol services." She stated inter-alia that most psychiatrists have this knowledge, but that RN Evans may not have, in which case it would have been appropriate for the drug and alcohol service to explain such matters to him.[166]

e. The psychiatrist and registrar (from the PECC Unit), "if they were available and had been aware of the additional complexities of [JC]'s presentation, should certainly have assessed [JC]."[167]

f. That JC should have been seen by a psychiatrist because of the issues with benzodiazepine dependence and withdrawal, which may not be within the knowledge or scope of a nurse practitioner to manage.[168]

140. Prof Large also opined that:

a. in presentations like JC's which involve suicidality and intoxication:

> "*decisions about assessment and disposal should never really be left to one clinician because of the vagaries of, you know, how different people interact and it's, you know, decision making under uncertainty.*"[169]

b. and:

> *"my position has always been, and I've always encouraged my doctors to do with - my CNCs is to do joint assessments. That isn't the policy of New South Wales Health, and there is not the staffing for it at the present time. But in my view, that should be - that's what should be - that should be the standard, that assessment should be a multidisciplinary assessment".*[170]

[165] Ibid at page 239.36-40
[166] Ibid at page 275.7-16
[167] Ibid at page 243.43
[168] Ibid at page 236.24-32
[169] Ibid at page 239.42
[170] Ibid at page 240.8

c. Particularly, in the case where a patient, like JC is unknown to the assessor.[171]

141. More generally both experts referenced that when a decision is made to detain a patient, it is a statutory requirement (under s27 of the MHA) that two persons be involved in that decision, one of whom is a psychiatrist.[172] Prof Large submitted the same should apply (the assessment by two people) in relation to a decision not to detain.[173] A/Prof Eagle agreed subject to resource constraints, this could be a good idea. She stated that:

"*And I completely agree with Professor Large that in a complex presentation where there are potential risks such as [JC], the perspective of one person is potentially inherently, you know, subjective and is always benefit in consulting a second person about that decision and if possible, having another person assess so that an appropriate management plan can be put in place."*[174]

142. This is an opportune moment to consider in detail the decision made by RN Evans that JC could not be detained under the *Mental Health Act 2007*.

143. Prof Large allowed that had all of the information been available to RN Evan's he might have formed the view that JC was irrational (and hence may have fallen within the "mentally disordered" provision providing for involuntary detention).[175]

144. Dr Eagle stated inter-alia that:

a. the application of the mentally disordered provision as a basis for detaining someone can tend to be confusing for people. In her experience, a number of people who present like JC have been detained under the Act, and case examples published by the Mental Health Review Tribunal are consistent with detention occurring under those provisions in comparable circumstances.[176]

b. it is difficult to say that JC should have been detained (in the sense of there being an absolute requirement or obligation to do so), as opposed

[171] Ibid at page 240.32-35
[172] Ibid at page 241.36-44
[173] Ibid at page 241.14
[174] Ibid at pages 241.48-242.2
[175] Ibid at page 251.34-36
[176] Ibid at page 252.17-25

to could have been detained given the individual clinical judgment that is involved.[177]

c. if JC was not to be detained in these circumstances:

> *"then you need to be able to work out a way to try to manage those risk factors and provide care in a safe way, and one way of doing that would have been to involve the family in the discharge planning, because they were in - they had an opportunity to support him on discharge, and also if he wasn't going to be safe, to - to then bring him back to hospital or - or do - take some other step."*[178]

145. I cannot be certain that if a more thorough mental health assessment was carried out which took into account additional information from JC's family it would have resulted in JC being considered mentally disordered under the MHA however, in it may have resulted in better and safer discharge plan.

103. The circumstances in which JC was taken to the hospital by ambulance was also raised with the experts. It was the evidence of Paramedic Stark that she had formed the view that JC was a danger to himself and that she "most definitely" would have completed a certificate and exercised her power under s20 of the MHA to detain JC for the purpose of transport to the hospital had he not agreed to do so voluntarily.[179]

104. That course would have enlivened a requirement under the MHA for JC to be further assessed within 12 hours – ie in effect JC's detention at the Hospital would have been authorised for a period of up to 12 hours if necessary, simply by virtue of the s20 certificate.

105. Prof Large stated in evidence that there:

a. was *"nothing coincidental*" about the fact that JC had been discharged by the Hospital about three and a half hours after his arrival. He observed that "*[t]here's a KPI that patients should be moved out of emergency departments within four hours*"[180]; and

b. proffered that there may have been less pressure in relation to decision-making had JC been detained by virtue of a s20 certificate of the ambulance officer resulting in there being a period of 12 hours within which relevant inquires and assessments would have had to have been

[177] Ibid at page 252.34-38
[178] Ibid at page 252.39-44
[179] Transcript 14/07/25 page 53.1-13
[180] Transcript 17/07/25 page 238.1-3

made, and that this is how it works "in practice". Had JC arrived in those circumstances it may have "ratcheted things up a bit".[181]

106. A/Prof Eagle was of the view that if ambulance officers are of the view that exercise of their s20 power was justified on the basis that the person is suicidal and at risk, the better practice would be to exercise that power, because it would not be safe to let the person go if they changed their mind about voluntarily attending the hospital. She observed that in a lot of situations such patients then just walk out of the Emergency Department.[182]

107. However, notwithstanding his view as to the practical effect that JC's arrival at the hospital under certificate may have had, Prof Large expressed some concern as to whether or not such a practice would be appropriate, as it may involve "a big change to ambulance practice" and run contrary to a patient's decision-making capacity.[183]

108. In the context of JC's assessment at CMH and the decision to discharge him after three and a half hours, this issue, arising as it did during the course of the inquest, is of considerable significance. Given the circumstances in which it arose, I did not have the ability to explore it with the input of the NSW Ambulance. Accordingly, it would not be appropriate for me to consider a recommendation in this regard.

Was there adequate planning and consultation in relation to JC's discharge?

109. JC left CMH unaccompanied at approximately 11:00am on 20 January 2021.

110. The only discharge plan that was documented, was the following note made by RN Evans:

"Numbers for AOD and MHS provided and advised he can return to ED".[184]

111. Mr Evans stated in oral evidence in relation to his notes regarding JC's discharge:

[181] Ibid at page 253.10-19
[182] Ibid at pages 253.23-36; 254.37-T255.9
[183] Ibid at pages 255.21-256.29
[184] Tab 36 page 8

"Look, in retrospect and reading my notes, it was not as robust a plan as I would have liked to have made. The plan, in as far as it was, was - was to have contact with his family; to return to the emergency department if - if he was distressed; that he was being picked up by a - by a friend; that - that he had arranged that and that he would make contact with his psychologist, which he'd told me he would do; and that he would contact the - drug and alcohol service if he decided to do that. So that - that was the plan, as much as it was, but it was all very loose. I - I - I concede that and that it was very reliant on [JC] making those decisions for himself."[185]

112. Dr Sharma also gave evidence regarding her understanding of the discharge plan for JC:

a. There was a "referral to local drug and alcohol team";[186]

b. JC was willing to engage with the local drug and alcohol service but not on 20 January 2021;

c. In those circumstances she said that she had an expectation that a booking would be made for JC to attend that service on a specific date, and that this was a general expectation in relation to a presentation of this nature in the ED.[187]; and

d. *"Simeon had spoken to [JC]'s father who was happy with the plan and agreed to contact and meet [JC] yesterday evening*"[188]; and

e. RN Evans had told her that there had been a plan arranged for JC's father to drive down to Newcastle.[189]

113. Dr Sharma accepted that:

a. it is necessary for there to be a clear and understandable discharge plan that is documented in instances such as these.[190] She agreed that based on her understanding, the plan here should have documented:

- that JC was not to be discharged until the arrival of his friend who was to pick him up;
- that he be discharged into the care of his friend until such time as his father arrived to take over his care;
- the plan should have indicated where JC was going to be living;

[185] Transcript 16/07/25 page 198.12-20
[186] Exhibit 4
[187] Transcript 16/07/25 pages 147.39-148.6
[188] Exhibit 4
[189] Transcript 16/07/25 page 150.16
[190] Ibid at page 150.45-50

- the plan should have referred to attendance at a specific appointment with the Drug and Alcohol Unit, that should have been arranged.[191]

b. in the absence of any arrangement being made with JC's friend and father, at the very least she would have an expectation that follow up would have been arranged through the Acute Care Team. In agreeing with this she observed that he "*could not have been discharged without any support network around him*".[192]

c. contrary to her understanding at the time, JC was discharged without any contact having been made with his friend by hospital staff, and that the plan did not make reference to JC being in the care of either his friend or his father.[193] In such circumstances, she had an expectation that at least JC would have received some post discharge follow up via phone call or appointment[194] When it was pointed out to her that no such follow-up had been arranged Dr Sharma agreed that, being now aware of the actual circumstances of his discharge (and contrary to her understanding at the time), it had not been safe to discharge JC, as had occurred, in the absence of any support or follow-up being in place.[195]

114. The evidence in my view also indicated a lack of process and rigour concerning the completion of relevant discharge documentation. In particular:

a. NUM Blayden and Dr de la Piedad signed their authorisation as "safe for departure" from the ED at 11.20am and 11.15am respectively.[196]

By these times the evidence indicates that JC had already departed the Emergency Department unaccompanied; and

b. The "Departure Checklist – ED to usual place of residence" that requires or prompts consideration being given to the appropriateness of the time of departure, the awareness of next of kin and the completion of a discharge/referral letter, had not been filled out.[197]

[191] Ibid at page 151.3-20
[192] Ibid at page 151.32
[193] Ibid at page 151.34-41
[194] Ibid at page 152.6
[195] Ibid at page 152.10-24
[196] Tab 36 page 16
[197] Tab 36 page 16

113. Additionally, I note that RN Evans had not used and does not use the MH-OAT form. The evidence in relation to these forms is that:

a. he does not use the form because an exception has been made in his agreed "scope of practice" document to this effect. This was because the MH-OAT was a "cumbersome" and "large" document and not appropriate to many of the "low acuity" presentations in the ED. Nevertheless, Mr Evans maintained that the review he conducted of JC amounted to the same assessment he would have performed if using the "MH-OAT" document.[198]

b. it is standard practice for assessments conducted of patients presenting directly to the PECC, to be conducted by use of the MH-OAT.[199] Consistent with this, when JC had presented to the PECC on 24 October 2020 (and was not admitted), his assessment was conducted by use of the MH-OAT.[200] When he again presented to the PECC on 27 October 2020, his assessment was again conducted by use of the MH-OAT.[201] On the latter occasion the assessment was performed by a Psychiatry Registrar.

114. In terms of who was responsible for preparing JC's discharge documentation the evidence was unclear. I note that following:

a. Dr de la Piedad was of the view that it was the responsibility of both toxicology and mental health to formulate and sign off on a discharge plan for JC.[202] At the same time she appeared to acknowledge that a doctor in her role has a responsibility for overseeing the discharge process.[203]

b. However, RN Evans did not regard himself as having a role in producing the discharge documentation as JC was under the care of Emergency Department physicians, and not under his care.[204]

[198] Transcript 16/07/25 pages 165-166
[199] Ibid at page 166.18-21
[200] Tab 37 pages 2-9
[201] Tab 38 pages 30-42
[202] Transcript 15/07/25 page 117.48
[203] Ibid at page 118.2
[204] Transcript 16/07/25 pages 197.49-198.8

I do note however, that RN Evans conceded that the discharge documentation did require his input given he was responsible for the assessment and decision making that was key to JC's discharge[205].

115. Both Prof Large and A/Prof Eagle endorsed the merits of a discharge plan that would have involved JC staying with his friend after discharge, until such time as his father arrived that evening in order to stay with JC.[206] They both agreed that such a plan would have to be predicated on appropriate discussion by the clinicians with the friend. Furthermore, the preparation and the discussion with friends and family of a discharge plan may have also informed the clinicians and potentially given rise to a decision to detain JC on the basis of irrationality if the friend indicated an unwillingness to be involved on the basis that it would be too difficult to monitor JC.[207]

116. Moreover, such a plan would need to:

a. be properly documented in hospital records.[208]

b. ensure that the friend and family be advised of risks and be provided with some psychoeducation so that they could escalate things if concern arose[209]. In JC's case his friend should have been advised that JC should not be driving;

c. discharged summaries be prepared at the time of discharge and such a summary sent immediately to JC's GP and his treating psychologist.[210]

117. Emergency departments are, in there very nature, stressful and busy. JC was by all accounts a complex presentation and required the input of clinicians from different areas of expertise. Unfortunately, what is clear was there was no chain of command or person who ensured or took responsibility that JC's discharge plan and paperwork summary was properly prepared and produced in a timely manner. It also demonstrated a failure by RN Evans to recognise

[205] Ibid at pages200.8-36
[206] Transcript 17/07/25 page 258.13 – Dr Large described this as a "good plan"
[207] Ibid at page 259.30-38 and 259.42
[208] Ibid at page 258.34
[209] Ibid at page 257.15-22
[210] Ibid at pages 260.30-49; 261.49-262.17

the important role someone in his position had in contributing to the discharge summary.

Are there any recommendations that should be made?

118. On the final day of the inquest, I had the benefit of evidence in conclave from the following witnesses:

    a. Dr Anand Swamy, the executive director of Mental Health Services for the HNELHD; and
    b. Dr Ralph Gourlay, the director of Medical Services at CMH.

    They gave evidence in relation to the lessons learned from JC's death.

119. I note that Dr Swamy was present for most of the inquest and heard the oral evidence of those involved in JC's care and the experts commenting on it from the benefit of hindsight. His evidence can be summarised as follows:

    a. He conceded that despite the clinicians being aware of JC's benzodiazepine addiction the risk of withdrawal posed and interesting challenge and that there was room for education for every clinician with respect to those risks.
    b. He welcomed a recommendation which sought the set-up of a multi-disciplinary unit within the Emergency Department of CMH namely a model of care designed for patients presenting with deliberate self-poisoning that sits separately within the Emergency Department and provides a calmer more therapeutic environment in which nursing staff, psychiatry and toxicology clinicians are brought together, allowing better systematic communication between the specialities.
    c. He accepted that the conversation between RN Evans and JC's father was to inform JC's father that JC was not going to be detained under the Mental Health Act rather than being used as an avenue for any further information about JC's mental health and history in order to determine what pathway to take. Accordingly, he conceded that further training was required in this area.
    d. Finally, he described the MH-OAT forms as:

        "*…essential to the extent that it's a very helpful framework, as you rightly put it, for people who need to do a comprehensive assessment. So to that extent, absolutely yes,*

and it's a standard practice across an expectation across New South Wales in terms of doing that."[211]

And that is something that could be endorsed within the Emergency Department of CMH.

Conclusion

120. In my experience, more often than not, care and treatment issues arise when there is a breakdown in communication between treating teams and staff particularly in a busy hospital setting like an emergency department.

121. When assumptions are made, proper notes are not taken or procedures that are put in place are not followed, the opportunity to provide appropriate care can be missed and vulnerable complex presentations may fall through the cracks.

122. No one involved in JC's care on 20 January 2021 went to work with malintent. All the witnesses were empathetic, kind and caring and were clearly affected by his death and reflected upon it. However, JC's care was not optimal on 20 January 2021. Firstly, the concerns raised by JC's father were not heard; secondly, the impact of his benzodiazepine addiction and withdrawal was not recognised or planned for; and finally, his discharge lacked coordination and planning.

123. Most of these things could simply have been improved by better communication.

124. I don't know if any of these things would have changed the outcome for JC however, I have made recommendations which I hope will ensure that procedures are put in place to hopefully ensure that complex presentations to CMH and NELHD are recognised and treated accordingly.

125. On behalf of my legal team and court staff I extended my condolences to JC's mother and father and JC's sister and brother on the untimely passing of their son and brother.

[211] Transcript 18/07/25 page 328.46-49

Findings required by s81(1)

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

The identity of the deceased

The person who died was JC

Date of death

The Deceased died on 20 January 2021

Place of death

The place of death is Bar Beach

Cause of death

The cause of death is hanging

Manner of death

The manner of death is intentionally taking of his own life

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death.

Counsel Assisting submitted that a number of recommendations were warranted and should be made. In relation to those draft recommendations, I had the benefit of detailed submissions on behalf of the CMH and HNELHD dated 29 August 2025. I note the latter supported the majority of the proposed submissions and proposed supplemental wording in relation to others.

As a result of those submissions, which I do not intend to repeat I make the following recommendations:

1) That the coronial findings be drawn to the attention of the NSW Ministry of Health by the HNELHD in support of the case, when further advanced, for the funding and establishment of a Behavioural Assessment Unit within the Emergency Department at Calvary Mater Hospital Newcastle, in order to provide more effective care and treatment to patients presenting with episodes of deliberate self-harm within the LHD.
2) That CMH and the HNELHD:

    a) provide training and education to clinicians involved in assessing patients presenting to the ED with Deliberate Self Poisoning (DSP) concerning the “red flag” of potential benzodiazepine addiction and withdrawal; and

    b) Provide training and education that encourages clinicians to seek advice from addiction medicine specialists when assessing patients presenting with benzodiazepine dependence and at high risk of withdrawal at discharge from the Emergency Department.

3) That the CMH require mental health clinicians assessing patients in the CMH Emergency Department to compete MH-OAT(A1) psychiatric assessment form, and that CMH require mental health clinicians assessing patients in the CMH general hospital wards to complete MH-OAT(A1) form when an admission is required to a mental health unit.

4) That the HNELHD ensures that the coronial findings in this matter are reviewed and taken into account by the Committees that next determine the appropriate “Scope of Practice” of Mental Health Nurse Practitioners who work in the CMH ED, including but not limited to:

   - whether it is appropriate for the MHNP to conduct assessments of patients presenting after an episode of DSP where a risk of benzodiazepine withdrawal after discharge has been identified;
   - requirements to use MH-OAT forms (or their equivalent) when assessing patients in the ED.

5) That CMH and the HNELHD take action to ensure that clinicians in the ED have a clear understanding of roles and responsibilities for the timely completion of discharge documentation in cases of multidisciplinary care.
6) That, as identified by the clinical heads during the inquest, the following aspects of policy be reviewed by CMH:

   - The Suicidal Behaviour policy in relation to who is responsible for the conduct of mental health assessments in the ED;
   - The Suicidal Behaviour policy in relation to the circumstances in which a patient with DSP is to be “admitted under Toxicology”;
   - The Deliberate Self Poisoning “Toxicology Pathway” in relation to who is to be contacted in connection with mental health assessment following toxicology clearance.

I close this inquest.

NSW State Coroner
1a Main Ave Lidcombe NSW 2141
Deputy Chief Magistrate Sharon Freund
Date 22 January 2026