

## CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

**Matter Title:** Inquest into the death of Catherine Maree Broadbent

**Citation:** [2024] ACTCD 1

**Decision Date:** 17 June 2024

**Before:** Coroner Archer

**Findings:** See [46]–[49], [50]–[62]

**Catchwords:** **CORONIAL LAW** – mental health – death by suicide – multiple drug toxicity – coronial proceedings – impact of delay – Multi-Agency Response Guide – intermediate residential services

**Legislation Cited:** *Coroners Act 1997* (ACT) ss 3BA, 13, 34A, 52

**Cases Cited:** *Inquest into the deaths of Bearham & Ors* [2021] ACTCD 1

**Counsel Assisting:** X King

**File Number:** CD 233 of 2018

## **CORONER ARCHER:**

1. Ms Catherine Maree Broadbent died between 17 and 18 September 2018. She was 39 years old at the time of her death. I respectfully refer to Ms Broadbent as “Cathy” in these findings. Professor Johan Duflou, forensic pathologist, found that the cause of Cathy’s death was multiple drug toxicity. Toxicological testing revealed the presence of multiple psychoactive medications, which, in combination, resulted in death, with Etizolam and Carisoprodol being the major components. As I address below, I find that Cathy intentionally took her own life.

## **PART 1 – BACKGROUND**

### **Jurisdiction**

2. Cathy’s death was reported to the Coroner as “violent” or “unnatural” for the purposes of s 13(1)(a) of the *Coroners Act 1997* (ACT) (“the Act”).
3. Having assumed jurisdiction in relation to Cathy’s death, I was required to hold an inquest<sup>1</sup> into the manner and cause of her death, and make the findings required by s 52 of the Act. That section of the Act relevantly provides:

#### **52 Coroner’s findings**

- (1) A coroner holding an inquest must find, if possible—
  - (a) the identity of the deceased; and
  - (b) when and where the death happened; and
  - (c) the manner and cause of death; and
  - (d) in the case of the suspected death of a person—that the person has died.

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- (4) The coroner, in the coroner’s findings—
  - (a) must—
    - (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
    - (ii) if a matter of public safety is found to arise—comment on the matter

### **Section 34A of the Act**

4. In arriving at the findings I am required to make, I have a discretion as to whether a hearing should be conducted (s 34 of the Act). I can dispense with a hearing in the circumstances and according to the processes set out in s 34A of the Act:

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<sup>1</sup> The Act is inconsistent in its use of the concept of an “inquest”. In s 52 of the Act, “inquest” is effectively synonymous with a process of investigation.

**34A Decision not to conduct hearing**

- (1) A coroner may decide not to conduct a hearing into a death if, after consideration of information given to a coroner relating to the death of a person, the coroner is satisfied that—
  - (a) the manner and cause of death are sufficiently disclosed; and
  - (b) a hearing is unnecessary.
- (2) A coroner must not dispense with a hearing into a death of a person, if the coroner has reasonable grounds for believing the death is a death in care or death in custody.
- (3) A coroner who decides not to conduct a hearing into a death must give to the Chief Coroner and a member of the immediate family of the deceased written notice of the decision including the grounds for the decision.

5. In the circumstances that are outlined below, I reached the view that a hearing into Cathy's death was not required in order for me to make the findings required by s 52. I therefore dispensed with a hearing. In accordance with s 34A (3) of the Act, I gave written notice of my decision not to conduct a hearing to Cathy's friends, Katherine Crawford and James Collier, whose interest in the matter is discussed below.

**Evidence**

6. A full coronial brief was not prepared. The information that is relied upon in making these findings emerged from the extensive records subpoenaed from ACT Health Services, and the information provided by Cathy's friends.

**Parties**

7. No hearing was convened, and appearances from those claiming to have a sufficient interest were not sought. I acknowledge the obvious role that the Territory's agencies had in providing Cathy's care. Throughout the inquest, two of Cathy's friends were remarkable in their advocacy for Cathy. Katherine Crawford had become friends with Cathy in 2003, and I accept that they considered themselves to be sisters. James Collier was a friend of Katherine, and through that friendship, he met Cathy in 2011. In a health sense, James faced many of the challenges that confronted Cathy, and offered insights into the issues I address in my reasons from his personal experiences.

8. I shall, with respect, refer to them as Katherine and James.

**Procedural History**

**(a) *The Delay***

9. As the Court has conceded in correspondence with Cathy's friends, the history of the inquest has been very unfortunate. The disposition of Cathy's inquest was deferred, pending the outcome of a series of inquests that dealt with the suicide of inpatients at

The Canberra Hospital (“TCH”). Those deaths occurred between January 2015 and December 2016, and were dealt with together, as they aggregated issues concerning the treatment of mentally ill people at TCH. Findings in relation to those deaths were handed down by Coroner Margaret Hunter on 4 March 2021.<sup>2</sup>

10. Cathy’s matter was not advanced in any meaningful way before and after that hearing took place. In March 2022, I assumed the role of what was called the “dedicated coroner”, and sought to address a substantial backlog of cases, including about 30 matters that involved deaths that occurred before Cathy died. I can offer no reasonable explanation as to why such a situation was permitted.
11. The delay in progressing Cathy’s inquest has had a number of consequences. At the first instance, it has caused distress to those who have waited for so many years for the process to be completed. Section 3BA of the Act requires inquests to be carried out in way that recognises that the death of a person, and an inquest into the person’s death, has a significant impact on the person’s family and friends. That statutory obligation has not been discharged in this case. It is appropriate that my findings record that failure, and my apology for it. I am sorry.
12. Second, my responsibility to make the findings required by s 52(4) of the Act is impacted by the passage of time. I do not have an open-ended authority to investigate a death as if I was exercising the powers of a royal commission. My findings must relate to public safety issues that arise in connection with the inquest. The inquest is directed at establishing the manner and cause of Cathy’s death. It is beyond my power to investigate the adequacy of the complete response of public health authorities to Cathy’s mental health issues during her adult life.
13. Within that framework, and pursuant to s 52(4) of the Act, I must state whether a matter of public safety arises. In that context, public safety has a temporal significance. It involves a consideration of systemic issues that might affect, relevantly, the treatment and care of people today who suffer from mental illness of the kind that afflicted Cathy. The passage of time inevitably limits my capacity to draw parallels between Cathy’s experiences with the mental health system and how that system operates at the present time.

**(b) *Defining the Issues***

14. At my direction, the Court contacted Katherine and James in November 2022 to invite from them submissions regarding their concerns as to Cathy’s care. I am aware that the

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<sup>2</sup> *Inquest into the deaths of Bearham & Ors* [2021] ACTCD 1

request was confronting, and I acknowledge that that request, and the Court's ongoing contact with them, has forced them to relive the trauma associated with Cathy's passing. Their response was received on 3 August 2023. It is appropriate that I summarise the nature of those concerns, noting the context for them is set out in the factual findings that follow.

15. Katherine and James submitted that the overall management of Cathy's mental health care by ACT mental health services was not appropriate. In particular, they considered the Multi-Agency Response Guide ("MARG") process to impose a treatment protocol that involved the withdrawal of mental health care and support from Cathy when she was in crisis. They submitted that Cathy also interpreted the MARG in this manner, and experienced it as a form of punishment and abandonment from mental health services. In their view, the MARG was the final straw in Cathy's deterioration and contributed to her death.
16. Katherine and James suggested that the treatment indicated was a lengthy involuntary hospital admission, which would have facilitated a period of recovery and crisis stabilisation.

**(c) *The Scope of My Investigation***

17. The Court wrote to the affected parties, including the ACT Government Solicitor, on 27 September 2023. The letter had several purposes:
  - (a) It communicated to the affected parties my view that an examination of the care that Cathy received in the mental health care system would be limited to the last two months of her life. That period was determined with regard to the limiting factors set out above, but also to allow the manner of her death to be properly contextualised.
  - (b) Parties were given notice that the factual findings set out in the letter were, subject to a process of submission that was invited, likely to reflect the findings I would make.
  - (c) To allow the affected parties to make submissions as to a number of issues, including:
    - (i) Whether a hearing was necessary?
    - (ii) What s 52 findings should the Coroner make?
    - (iii) In respect to Cathy's mental health care and treatment, was there a need for some form of long-stay residential mental health service?

- (iv) What options for long-stay residential mental health facilities were available in 2018, for which Cathy might have been a candidate?
- (v) What options for long-stay residential mental health facilities are available now?
- (vi) Are there any other community-based mental health services available now to assist those that are severely and chronically disabled by mental illness?
- (vii) Any other comments or observations regarding the analysis contained in that letter, in respect to the MARG or the quality of care provided to Cathy by clinicians.

Regarding the voucher system that operated with respect to Hyson Green:

- (viii) What was the purpose of that system, and how did it operate?
- (ix) Does it still operate today in respect of Hyson Green and/or other mental health facilities in delivering a similar form of residential accommodation and support?

18. The Territory responded in terms that did not meaningfully engage with the questions asked.
19. Katherine and James responded and expressed their disagreement as to the conclusions set out in the Court's correspondence. Consistent with their original submissions, they reiterated their concerns with the MARG process. They submitted that the MARG process involved the withdrawal of engagement with Cathy, and had effectively represented a form of cost-saving. In their view, the chaotic pattern of treatment that was set out in the timeline of her engagements (Annexure A) demonstrated that the MARG process was neither safe nor effective. That timeline also, in their submission, demonstrated that Cathy was manipulating hospital staff when she told them she had no suicidal plans.

## **PART 2 – FACTUAL FINDINGS**

20. It was foreshadowed in the Court's letter of 27 September 2023 that the factual findings set out in the letter were those I had provisionally made. I had considered Katherine and James submissions before arriving at that point of view. The findings I now record closely reflect the provisional findings.

### **Cathy's Mental Health History**

21. Cathy's struggle with mental illness began when she was a child. A timeline of the significant events in her life has been prepared by Cathy herself, presumably for clinicians, and is contained in the medical records.

22. It is evident from that timeline, that her early childhood was marked by significant instability and trauma. She reported her first suicide attempt, and the beginning of self-harming behaviour, between the age of 10 and 13. At age 15, she was placed in the foster care system, and by age 16 or 17, she was living alone in ACT government housing.
23. At the time of her death, Cathy had been diagnosed with borderline personality disorder (“BPD”), and complex post-traumatic stress disorder (“C-PTSD”). She was assessed by clinicians as being at a chronically high risk of suicide. While her mental illness was long-standing, its acuity fluctuated. Prior to the last two years of her life, she had been significantly more functional for about a decade. A specific cause for the deterioration in her mental health is not evident from the medical records.
24. From mid-2016, City Mental Health (“CMH”) primarily managed Cathy’s mental health care. Her treating team at CMH included Ms Deidre Thompson (“Deidre”, Clinical Manager and Social Worker), Ms Annelise McQualter (“Annie”, Case Manager and Clinical Psychologist) and Dr Ingrid Butterfield (“Dr Butterfield”, Psychiatrist). Ms Christine Phillips (General Practitioner) and Ms Christine Halsey (Public Advocate) also provided important support to Cathy.
25. Cathy’s life had many positive aspects. Friends and clinicians involved in her care described her as a highly intelligent individual, who, while suffering from her chronic illness, had obtained two university degrees, including a Bachelor of Arts with first-class honours. At the time of her death, she was employed by the Commonwealth Government as a policy writer. She at once enjoyed the challenges of her work and the company of her colleagues, whilst finding that it added to the stresses of her life.

### **Mental Health Care in the Last Two Months of Cathy’s Life**

26. Cathy was considered by clinicians to be at a chronically high risk of suicide. The timeline of the last couple months of her life (Annexure A) demonstrates that she struggled with suicidal thoughts almost daily, and frequently self-harmed by cutting. Usually, treatment of the resulting injuries was administered at the Belconnen Walk-In Centre (“walk-in centre”). She also regularly overdosed on medication, often on Carisoprodol and Alprazolam (Xanax) sourced from the “dark web”. Overdosing on those medications resulted in weekly presentations to TCH, and occasionally the then-Calvary Hospital.
27. A MARG in respect of Cathy was signed on 27 July 2018. Published governance in respect of the MARG process refers to it in these terms:

MARGs are defined as ‘collaborative management guides for persons with a mental illness or mental disorder, and whom, because of their illness pose a serious and imminent risk to themselves or others, and whom regularly come into contact with multiple stakeholders including emergency services’.

MARGs are designed to reduce risks to the clinically managed person by providing coordinated and practical guidance for service providers when interacting with high risk clinically managed persons. The overarching aim of a MARG is to help reduce the number and intensity of clinically managed person’s crisis contacts with community, Government, and emergency services and to support least restrictive care practices.<sup>3</sup>

28. The signatories of the MARG included the CMH treating team and two representatives from ACT Health. The overriding approach of the MARG in this case reflected the general aim of MARGs – to minimise hospitalisation and lengthy crisis interventions, in favour of therapeutic engagement in the community. In accordance with that approach, the MARG contained a suggested approach for services in contact with Cathy in crisis (including TCH, Calvary, walk-in centre, and the Crisis Assessment and Treatment Team (“CATT”)) to restrict their treatment of her to physical injuries (either toxicity from overdose or skin lacerations from cutting), and medically clear her as soon possible, with a plan for follow-up from the CMH team.
29. In line with the MARG, the nature of Cathy’s hospital presentations (usually at TCH) in the two months prior to her death were usually voluntary, short, and limited to medical treatment. The general course of hospital presentations involved the treatment of her physical injuries in the emergency department (ED) rather than an admission to a mental health unit. Once medically cleared (usually on the same day or the next day), she was promptly discharged into the community with follow-up support from CMH or CATT. The timeline demonstrates the frequency (sometimes back-to-back) and duration of Cathy’s hospital presentations in the last two months of her life.
30. During this period, Cathy had nearly daily contact (except over weekends) with the CMH team. She had scheduled weekly appointments with Deidre, and fortnightly clinical reviews with Annie and Dr Butterfield respectively. In addition to the scheduled appointments, the CMH team (usually Deidre) provided regular supportive care to Cathy over the phone and in-person following crisis presentations at the hospital or the walk-in centre. Additionally, a voucher system at Hyson Green was set up to allow Cathy access to 3-day in-patient admissions twice monthly. Records indicate that the voucher system was in place from 7 May 2018 until the time of her death. In the two months prior to her

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<sup>3</sup> Canberra Hospital and Health Services Operation Procedure, Multi-Agency Response Guide (CHHS17/2118 , issue date 9.09.17, review date 1.07.20).

death, Cathy and the CMH team utilised the voucher system for short-stay admissions on two occasions, on 6 to 8 August 2018, and on 24 to 28 August 2018.

### **Events Leading up to Death**

#### **(a) Last Hospital Presentation**

31. Cathy's last presentation to TCH was on 9 September 2018, being eight to nine days prior to her death. She had presented voluntarily on the day prior (8 September 2018), to the Calvary's Emergency Department following an overdose on Alprazolam, and had been subsequently transported to TCH on an emergency apprehension order for management. At TCH, she was medically treated and discharged on the same day at 2215 hrs.
32. She re-presented to TCH's ED in the early hours of 9 September 2018. Records suggest that she had overdosed again on Alprazolam. When asked to stay in the ED due to her being unsteady on her feet, she attempted to leave. As a result of that, she was sedated by clinicians, and was held under a duty of care in the ED. A psychiatrist assessed Cathy in the ED at around midday. She was co-operative during that assessment, and denied having suicidal thoughts. She agreed to call Lifeline, CATT, and CMH if needed. As per the MARG, Cathy was discharged from TCH following medical clearance at around 1329 hrs on 9 September 2018. The discharge plan was recorded as:

To be discharged from ED when medically cleared.  
Catherine is willing to contact CATT and Lifeline if needed.  
CMH follow up.

#### **(b) City Mental Health**

33. The CMH team had consistent contact with Cathy following her discharge from TCH on 9 September 2018. Medical records show that the CMH team had contact with Cathy (in-person or by phone) on 10, 11, 12, 13, 14 and 17 September 2018.
34. On 17 September 2018, at around midday, Cathy met with her case manager, Deidre, at the CMH office. She reported ongoing low mood and wanting to overdose. She said she was planning to go to work on Wednesday to Friday (18–19 September 2018), and had plans to clean her home and do meal preparation that afternoon. She confirmed that she was aware she had a meeting with clinical psychologist Annie on the next day.

#### **(c) Last Contact: Belconnen Walk-In Centre**

35. On 17 September 2018, at some time prior to 1900 hrs, Cathy presented to the walk-in centre with a laceration to her left arm, which required eleven staples. She denied having

intention to self-harm further, reporting that she felt that ‘the pressure had passed’. She declined to speak with CATT. Cathy was last seen alive by Registered Nurse Stachura, as she left the walk-in centre at about 1910 hrs.

**(d) Discovery**

36. On 18 September 2018, Cathy missed a scheduled appointment at the CMH office. Annie and Deidre, concerned about her welfare, attended her home address at 8 / 8 Owen Crescent, Lyneham, ACT. They entered the property at approximately 1145 hrs, and located Cathy face-down on her bed, unresponsive. ACT Ambulance Service (“ACTAS”) arrived at 1200 hrs, and found no signs of life present.

**(e) Post-mortem Examination**

37. Coroner Peter Morrison gave directions as to the post-mortem process. At Coroner Morrison’s direction, Professor Duflou conducted the examination on 25 September 2018. Relevantly, his findings were:

At autopsy, there was evidence of extensive remote and more recent self-harm with a very large number of healed, healing and more recent incisions on the body. These would unlikely have contributed to the death in any significant way. Internal examination of the body revealed no obvious pathology likely to cause death.

Toxicological testing revealed the presence of multiple psychoactive medications, which likely in combination resulted in death due to overdose, with etizolam and carisoprodol being the major components in this case.

**PART 3 - ANALYSIS OF THE QUALITY OF CARE AND TREATMENT**

38. I find that the mental health care and treatment provided to Cathy by clinicians, in the two months prior to her death, was reasonable and appropriate. There is no evidence, within the care structures in place then, of any shortfalls in that care that contributed to Cathy’s death.

**The Multi-Agency Response Guide (MARG)**

39. Analysis of the care provided to Cathy by clinicians requires consideration of the MARG. The MARG formalised an approach of minimising in-patient hospital admissions. Cathy’s medical records demonstrate that the MARG was consistently referred to by clinicians responding to her being in crisis, and that it influenced the treatment she received from services prior to her death, particularly in respect of the nature and duration of her hospital presentations.
40. I find that the MARG was a reasonable response by clinicians to evidence that involuntary and frequent hospital admissions were not therapeutic for Cathy. Cathy

frequently reported to clinicians that she found admissions punitive, and that the trauma she experienced in hospitals influenced her thinking towards further self-harm. This is supported by observations in her medical records. When involuntarily admitted, Cathy was observed to continue to self-harm at the ward, and/or became combative towards treating clinicians. On several occasions in early 2018, this resulted in her being physically and chemically restrained in hospital.

41. The medical records demonstrate that by early 2018, the clinicians involved in Cathy's care, including the CMH team and a Consultant Psychiatrist from TCH, had become concerned by the frequency of her hospital admissions. Several case conferences were held (prior to the formalisation of the MARG) to discuss Cathy's repeated admissions. There was consensus amongst clinicians involved in those meetings that hospital admissions did not keep Cathy safe, and they were not therapeutic. It is against this background that the MARG was signed on 27 July 2018.
42. Cathy's friends suggest that the MARG process could be inflexible and led her to feel abandoned because certain services would not engage with her when she was in crisis. I am satisfied that the MARG was an advisory, and not a binding, document for the agencies involved, and it did not override the situational assessment of clinicians dealing with Cathy in crisis. Cathy was still involuntarily admitted for treatment when she was unable to engage in safety planning, and/or was voicing thoughts of suicidal ideation with a plan. The MARG did direct a form of response in the context of crisis, which involved the CATT and ACTAS being viewed as the appropriate response agencies. That was done to ensure that treatment was appropriately streamed, and that therapeutic interventions occurred outside the context of crisis presentations. Records demonstrate that Cathy was informed by clinicians of the MARG's development and its purpose, and that she was in general supportive of its aim to minimise her in-patient hospital admissions.
43. I find that the development of the MARG was well-informed by the judgement of the clinicians involved in Cathy's care, and that it was developed based on sound therapeutic assessments.

### **The Canberra Hospital**

44. It follows from this assessment of the MARG, that TCH's treatment of Cathy, and its practice of promptly discharging her, was appropriate in the circumstances. There is no evidence to suggest that her repeated overdoses and presentations to hospital were due to either her being prematurely discharged, or her discharge being inadequately planned. Cathy's medical records demonstrate that TCH clinicians consistently engaged with

CMH and/or CATT prior to discharge to ensure appropriate follow-up support for Cathy in the community was available.

### **The City Mental Health Team**

45. The CMH team, consisting of a social worker, clinical psychologist and psychiatrist, provided Cathy with ongoing, intensive, and holistic care. Consistent with the MARG, they made efforts to coordinate the care Cathy was receiving from other service providers. They consistently provided Cathy with follow-up support after crisis presentations, and took steps to try and reduce her risk of self-harm by ensuring support was available over weekends for her; for example, through CATT contact, or by Hyson Green admissions. It is evident from Cathy's medical records that, in the months prior to her death, her treating team, within the care delivery structures that were available, were trying to focus on providing therapeutic and recovery-oriented care to Cathy, rather than crisis management. The evidence suggests that the CMH team provided Cathy with a high level of care, and took appropriate steps to address her chronic risk of self-harm and suicide.

## **PART 4 – FORMAL FINDINGS AND MATTERS OF PUBLIC SAFETY**

### **Manner and Cause of Death**

46. Some of the finding required by ss 52(1)(a) and (b) of the Act are straightforward. I find that, on or about 18 September 2018, Catherine Maree Broadbent died at a residence at 8 / 8 Owen Crescent, Lyneham, in the Australian Capital Territory, of multiple drug toxicity.
47. In respect of the manner of her death, I find that Cathy took the medications in doses and circumstances that reflected an intent to take her own life. The finding of suicide in this case has evidential complexity, given the pattern of self-harming (falling short of suicide) that was apparent in Cathy's life for so long.
48. However, the following matters suggest that Cathy did intend to take her own life:
- (a) Cathy was assessed as being at a significant chronic risk of suicide. That assessment was repeated in the assessment made by CMH the day before she died.
  - (b) Many of her previous attempts at self-harm could have resulted in her death. She described her pattern of drug overdosing in her consultation with Dr Butterfield on 7 September 2018, as calling for help when medications taken in overdose quantities began to take effect. Her capacity to make that call

obviously related to the quantity of medications consumed, and her level of intoxication. At best, those self-harming events suggested that at the time of the consumption of those drugs/medications, Cathy was, when overdosing or self-harming, indifferent as to whether she lived or died.

- (c) Her presentation at the walk-in centre in the early evening of 17 September 2018, and the lacerations that were present suggested that she was in an episode of crisis.
- (d) The autopsy results suggested the presence of a wide range of medications (Alprazolam, Etizolam, Carisoprodol, Quetiapine, Meprobamate, Lignocaine, and Lamotrigine), as well as alcohol. Etizolam, Carisoprodol, and Meprobamate were found at significant levels. Etizolam, a benzodiazepine analogue which has sedative and hypnotic effects, was not available on prescription in Australia at the time of Cathy's death, and it was probably sourced by Cathy on the "dark web", where she was known to source medications, including fentanyl.<sup>4</sup> Adverse outcomes have been noted in respect of its use, particularly when combined with other drugs, such as alcohol and medications that also depress the central nervous system.

49. As such, I find that Cathy did intentionally take her own life.

### **Public Safety Issues – Intermediate Residential Services**

- 50. Despite the best efforts of the CMH team, the frequency of Cathy's hospital presentations indicate that her mental health was not being effectively managed in the community. While a lengthier period of hospitalisation was neither appropriate nor available, it is apparent that in between hospital presentations, Cathy's mental health had remained unstable, and she required a level of support that the CMH team were unable to provide. Her need was not for a step-down facility providing a bridge between acute care in a hospital setting and care in the community, but a form of intermediate therapeutic respite and short-term recovery service.
- 51. Records indicate that the CMH team recognised the need for some type of 'sub-acute', or 'non-acute' form of residential care for Cathy, and were exploring options for in-patient admission to the Brisbane Unit for Complex Trauma and Hyson Green. Cathy herself reported to clinicians that she wished to have a safe place away from the razor blades

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<sup>4</sup> On 31 August 2018, the AFP were contacted by ACT Mental Health to check the welfare of Cathy, who had allegedly told her GP that she sourced Fentanyl from the dark net and was intending on using it. On that occasion, a search warrant was obtained, and several Fentanyl patches were seized.

and medications that was not the Adult Mental Health Unit (“AMHU”), and that she felt she needed a three-week admission to a place like Hyson Green to break her trauma cycle. That would have been a form of residential crisis respite.

52. In Cathy’s case, attempts were made by CMH to deliver a form of respite care through Hyson Green, a private mental health care provider. The Hyson Green voucher system was ultimately utilised by Cathy, and the CMH team, to facilitate short-term sub-acute in-patient care, often over the weekends, when she was the most vulnerable without the support of the CMH team. The voucher agreement that appears to have been in force was for 72-hour stays twice a month.
53. That voucher agreement was clearly insufficient to meet Cathy’s needs. Shortly before her death, the possibility of a longer admission to Hyson Green was being discussed to facilitate her commencing EMDR therapy to address her early trauma in a safe environment. It is not known if such a placement would or could have been funded beyond a few days. Her clinicians feared that the acuity of her condition may have been disqualifying, so far as Hyson Green was concerned. The voucher agreement included admission conditions that suggest Hyson Green would not treat her when she was acutely unwell.<sup>5</sup>
54. The Royal Commission into Victoria’s Mental Health System’s final report (2021) is quoted at length to best conceptualize the policy development that might be needed in this space. As to crisis respite services, the Commission said this:

#### 9.6.2 Residential crisis respite

Crisis respite is a core element of the National Mental Health Service Planning Framework but no longer exists in any meaningful way in Victoria’s mental health system. Respite programs are currently only available through the National Disability Insurance Scheme for eligible participants as ‘short-term accommodation packages’. This service offering recognised that, from time to time, participants may require temporary supports that are different from their usual arrangements.

The Commission has heard from consumers, carers, families, supporters and service representatives that a range of flexible, time-limited respite services would be a welcome addition to Victoria’s mental health system. For example:

People who are in distress or who are feeling on the edge of suicide often feel much more comfortable going to respite centres than to places where they are likely to be locked up and possibly secluded. There are many people who will do anything to stay out of an inpatient unit, but who will willingly approach a respite centre. They will come in under their own steam if they are allowed to, because they feel that there will be people there who understand them, and see it as a place of refuge. The UK studies have shown that people with similar levels of

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<sup>5</sup> For example, the voucher agreement contained an admission condition that Cathy would not self-harm 24 hours prior to admission.

psychopathology and risk find respite centres more acceptable environments to receive treatment in, and the clinical outcomes are at least as good.

Witness Elizabeth Porter who reflected on her experiences of mental illness as a young person, highlighted the transformational potential of respite programs:

I feel like these kinds of models are hard for the current system to comprehend, because the system is so focussed on pathologising, medicating and getting people out the door. So it is hard to convey how different and transformational it can be to have a non-clinical space where people can physically go and take themselves away from whatever chaos is happening in their lives. A key feature also is that peer spaces are not coercive ... I have recently set up networks to run informal peer respite.

The Commission's recommendation to establish crisis respite services is informed by evidence of good outcomes in other states and internationally. Reports have suggested that peer-led respite services may lead to: reduced hospital admissions; reduced emergency department presentations; reduced utilisation and expenditure on health services generally; reduced feelings of stress and suicidality; and improvements in carers' resilience and ability to cope with the demands on them.<sup>6</sup>

55. Later in the Commission's report, the idea of a greater diversity of bed-based services was developed:

Victoria's current continuum of bed-based services has large gaps, leaving many consumers without access to essential mental health treatment, care and support before or after an admission to an acute inpatient setting.<sup>7</sup>

.....

An innovative and diversified mix of bed-based services is needed. The Commission has identified four broad categories of bed-based service types that must be available across the state in the future mental health and wellbeing system. The best composition of these bed-based services will be determined at the statewide and regional levels as part of the broader planning process that the Commission has recommended.<sup>8</sup>

56. The revised continuum of bed-based services was defined in these terms:

- Therapeutic respite and short-term recovery services will provide a range of time-limited community-based support options for consumers living with mental illness who do not need an acute hospital admission but would benefit from a period of care in a supportive environment. These services include a range of time-limited residential respite services and Prevention and Recovery Care services.<sup>9</sup>

- Supported housing services will deliver a wide variety of safe, secure and affordable housing options for certain mental health consumers with additional housing support needs, providing integrated, multidisciplinary and individually tailored supports on site.

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<sup>6</sup> *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 552-3.

<sup>7</sup> *Ibid* 604.

<sup>8</sup> *Ibid*.

<sup>9</sup> The view of the Commission (at page 554) was that those who would likely be suitable for respite programs of the type described would not be those not at high, imminent risk of harm to themselves or others.

Supported housing models to be delivered in the future system are discussed in Chapter 16: Supported housing for adults and young people.

- Acute treatment, care and support services cover a broader spectrum of support options for people experiencing an acute phase of mental illness. These services comprise acute inpatient services, Hospital in the Home services and peer-led alternatives to inpatient care. In its interim report, the Commission recommended that the Collaborative Centre for Mental Health and Wellbeing be established. The Centre will also deliver acute inpatient services to its local population to reinforce the translation of research into high-quality service delivery.

- Extended rehabilitation services encompass three forms of longer-term care options for people living with mental illness or psychological distress and ongoing mental health support needs. These extended rehabilitation services comprise community rehabilitation units (or re-envisaged community care units), intensive rehabilitation units (or re-envisaged secure extended care units) and expanded capacity for civil consumers at Thomas Embling Hospital<sup>10</sup>.

57. The Royal Commission went on to say that:

The Commission expects that a range of different models will be established, including separate services for people experiencing mental illness and people in severe psychological distress due to situational crises and/or suicidality.<sup>11</sup>

58. The ACT does have a range of mental health services delivered across this spectrum, though limited by the smaller population size that is serviced. The response provided by the Territory to the Court's letter of 27 September 2023 did not contain a systematic review of service delivery today, or discussion as to whether the specific bed-based accommodation that Cathy required was available today, or, as a matter of policy, should be available.

59. The policy matrix in this area is complex. The Commonwealth Productivity Commission released the final report of its *Mental Health Inquiry* in November 2020. The Victorian Royal Commission published its final report in 2021. The Commonwealth Government's Suicide Prevention Advisor made recommendations to progress the implementation of the recommendations of those inquiries. The National Mental Health and Suicide Prevention Agreement ("the Agreement") sets out "the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve the mental health of all Australians, reduce the rate of suicide towards zero, ensure the sustainability of, and enhance the services of the Australian mental health and suicide prevention system". It came into effect in March 2022. Its stated goals have been described as seeking to deliver:

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<sup>10</sup> Ibid 606.

<sup>11</sup> Ibid 554.

a comprehensive, coordinated, consumer-focused mental health and suicide prevention system with joint accountability across all governments. Key priority areas under the National Agreement include regional planning and commissioning, priority populations, stigma reduction, safety and quality, gaps in the system of care, suicide prevention and response, psychosocial supports outside the NDIS, national consistency for initial assessment and referral, workforce, and data and evaluation.<sup>12</sup>

60. The ACT and the Commonwealth have entered into an arrangement on the *Bilateral Schedule on Mental Health and Suicide Prevention*, which sets out their shared commitments to give effect to the underlying principles of the Agreement, which include prevention and support strategies. Outside of that document, the ACT would otherwise provide mental health service, including accommodation services that are targeted at suicide prevention. The ACT has its own mental health and suicide prevention policies. Within this policy framework, it is unclear what priority is going to be given in the ACT to providing the residential respite and therapeutic service that was needed in this case, or to what extent it is feasible to develop therapeutic alliances with facilities in other States or Territories to provide these alternative care models.
61. Whilst it might be concluded that those who were delivering Cathy's care were constrained in accessing suitable accommodation respite placements in the ACT, I am not able to say, given the passage of time, whether a person suffering from the same challenges as Cathy did would find today that the position has changed. In my view, considering that passage of time, the further pursuit of that issue is not justified, as it could not be said to be a matter that arises from my investigation of Cathy's death.
62. For the purposes of s 52(4) of the Act, I make no finding that a matter of public safety arises.

## **POSTSCRIPT**

63. I acknowledge the difficulties Cathy faced in her life, the tragedy of her passing, and the grief suffered by those left behind. I offer my sincere condolences.

I certify that the preceding sixty-three [63] numbered paragraphs are a true copy of the reasons for findings of his Honour Coroner Archer.

Associate: Markus Ching

Date: 17 June 2024

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<sup>12</sup> Australian Institute of Health and Welfare, *Australia's Mental Health System* (Webpage, October 2023).