CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Matter Title:	**Inquest into the death of Katherine Aurelia Alexander**
Citation:	**[2024] ACTCD 2**
Decision Date:	25 July 2024
Before:	Coroner Archer
Findings:	See [49], [87], [89], [96], [100], [103], [107]
Catchwords:	**CORONIAL LAW** - mental health – death by suicide – multiple drug toxicity – coronial proceedings – impact of delay in respect of public safety issues – hospital discharge planning – community-based care – transition of care between adult mental health teams – mental health policy and procedures
Legislation Cited:	*Coroners Act 1997* (ACT) ss 3BA, 13, 34A, 52, 55
Cases Cited:	*Inquest into the deaths of Bearham & Ors* [2021] ACTCD 1 *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 *Harmsworth v State Coroner* [1989] VR 989 *Doomadgee v Deputy State Coroner Clements* [2006] 2 Qld R 352
Counsel Assisting:	X King
File Number:	CD 35 of 2017

CORONER ARCHER:

1. Ms Katherine Aurelia Alexander died between 7 and 8 February 2017. I respectfully refer to her as ‘’Kath’’ in these findings. At the time of her death, Kath was 34 years old and was receiving voluntary mental health treatment in the Australian Capital Territory ("ACT"). Professor Johan Duflou, forensic pathologist, found that the cause of Kath’s death was multiple drug toxicity. Toxicology testing revealed the presence of multiple prescription medications at therapeutic to lethal levels. In the last few months of her life, Kath’s mental health had deteriorated and resulted in two inpatient admissions to the Canberra Hospital (“TCH”). She died shortly after her last admission. It is clear she intended to take her own life.

PART 1 – BACKGROUND

Jurisdiction

2. Kath’s death was reported to the Coroner, in this instance, Coroner Peter Morrison, on 8 February 2017. Her death was considered "violent" or "unnatural", for the purposes of s 13(1)(a) of the *Coroners Act 1997* (ACT) (“the Act”).

3. Having assumed jurisdiction, the Court was required to hold an inquest[1] into the manner and cause of her death, and make the findings required by s 52 of the Act:

> **52 Coroner’s findings**
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> (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

4. My findings are set out below.

Section 34A of the Act

5. In arriving at the findings I am required to make, I have a discretion as to whether to hold a hearing (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:

[1] In the Act, an "inquest" is an 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 the Chief Coroner and a member of the deceased's immediate family written notice of the decision, including the grounds for the decision.

6. In the circumstances that are outlined below, I reached the view that a hearing was not necessary and could therefore be dispensed with.

Evidence

7. A full coronial brief was prepared. The brief included statements from treating clinicians, and the extensive records subpoenaed from Canberra Health Services ("CHS"). I was also greatly assisted by the information provided by Kath's friends and family.

Parties

8. 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 agencies had in providing for Kath's care. Throughout the inquest process, HD, Kath's close friend, advocated loyally and thoughtfully on her behalf. HD sought through the coronial process, an examination of what she regards as the failings of the mental health system in the ACT in the context of Kath's care. HD provided a "Background Statement" to the Court that provided a timeline of Kath's treatment within the mental health system, and a detailed analysis of Kath's mental illness, relationships, care arrangements and protective structures in her life.

9. At the time of her death, Kath was estranged from her parents, JS and TS. JS and TS have been involved and consulted throughout the coronial proceedings.

The Delay

10. In correspondence with the parties, the Court has conceded that the history of the inquest is very unfortunate. The disposition of Kath's inquest was deferred pending the outcome of a series of inquests that dealt with the suicide of inpatients at TCH. Those deaths occurred between January 2015 and December 2016. Findings in relation to those

deaths were handed down by Coroner Margaret Hunter on 4 March 2021*: Inquest into the deaths of Bearham & Ors [2021] ACTCD 1.*

11. Kath's matter was not advanced in any meaningful way after the hearing for that inquest took place. As I have recorded in other findings, I can offer no reasonable explanation of why such a situation was permitted. Since I assumed the role of the Territory's "dedicated coroner", I have sought to address that backlog whilst still discharging the day-to-day role of a coroner.

12. The delay has caused distress to those who have waited so many years for the process to complete. Section 3BA of the Act requires that inquests 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.

The Concerns of Kath's Advocates

13. The *Background Statement* by HD, presented an analysis of the progression of Kath's mental illness and the treatment she received. HD described the source of her information as conversations with Kath and Kath's close friend, KW, and access to Kath's journals from her teen years and onwards. The *Background Statement* developed a narrative of Kath's life, and the significant and supportive relationships Kath experienced (particularly with KW and HD).

14. Kath's difficult relationship with her parents was described. Kath's description of being abused in her mid-teens was noted.

15. An account of Kath's work history and significant level of community involvement was given, including her skating endeavours.

16. In respect of Kath's mental illness, the document traced its history from the time of her first diagnosis of depression in 1997 until the date of her death. The role played by clinicians and a Public Advocate was described and analysed. Their expertise and generosity were acknowledged.

17. The systematic issues arising from the analysis of Kath's interactions with the mental health system over the period of 2013 to 2017 in the ACT were addressed. I summarise them as:

    (a) Delays in accessing appropriate care

        Examples were provided of:

- delayed admissions to care facilities;
- delayed access to electroconvulsive therapy ("ECT");
- poor levels of therapeutic contact with caregivers during inpatient admission; and
- poor availability of psychiatrists.

(b) Disjointed care

Examples were provided of:

- the issues created by staff turnover and the lack of coverage provided during periods of leave;
- poor handover processes;
- difficulty communicating with day-to-day health care providers when an inpatient;
- poor levels of communication when appointments were cancelled; and
- rigid application of geographical allocation of patients to mental health teams.

(c) Failure to recognise deteriorating illness and need for symptom control

Examples were provided of:

- instances during 2016 and 2017 of behaviours or specific events not being considered as signs of an overall deterioration in mental health;
- Kath's high functioning and "presenting well" disguising the reality of being very unwell; and
- self-harming behaviours being attributed to situational stressors rather than reflecting a high level of suicidality.

(d) Poor communication with caregivers

Examples were provided of:

- poor engagement with friends who were in the best position to provide insights into Kath's health; and
- non-disclosure of treatment plans or significant events (e.g. the attendance of the CATT team).

(e) Lack of advocacy

Examples were given of Kath being unable to effectively advocate for herself when very unwell or when the complexities of presenting issues were overwhelming.

18. The *Background Statement* also made recommendations for change to the mental health system that might address the (above) issues that Kath encountered. Those suggestions are addressed at [112]–[116].

The Scope of the Inquest

19. In March 2023, I determined that I would limit the scope of the inquest to a consideration of events:

(a) during Kath's inpatient care from 25 November 2016 until 9 December 2016;

(b) the terms of her discharge from that care and the plans for her care within the community; and

(c) the care that was provided thereafter in the community until the time of her death.[2]

20. My reasons for doing that arise from a consideration of the terms of s 52 of the Act.

21. I find that s 52 of the Act constrains my capacity to investigate Kath's care in the mental health system in the ACT generally. The concept of "manner and cause" of someone's death is not capable of precise definition. What it does not permit, however, is an investigation that deals with all matters having a tangential connection to a death.[3] Concepts of "remoteness" must be borne in mind whilst still taking into account matters that properly contextualise the cause of death. Similarly, my power under s 52(4) of the Act is not a power to assume a power akin to a royal commission to review the ACT mental health system. Any matter of public safety must be found to arise in "connection with" the inquest, noting that the inquest is constrained by the scope of the findings I am required to make as to the manner and cause of Kath's death.

22. Similar considerations apply in relation to s 3BA of the Act. I have a responsibility to ensure that the objects of the Act are carried out in a way that recognises that the family and friends of a deceased person have an interest in having all reasonable questions about the circumstances of that person's death answered. However, that responsibility does not set aside the limitations s 52 of the Act places on my power to investigate.

23. Many of the issues detailed in the *Background Statement,* whilst of general relevance to the operation of the ACT mental health system, could not be said to be relevant to the manner and cause of Kath's death. If the matters identified by HD are fairly characterised as public safety issues, for the reasons given below at [50]–[54], my ability to comment on them is similarly constrained.

24. My decision regarding the scope of the inquest was communicated to the parties in a letter dated 10 March 2023.[4] Included with that correspondence were:

(a) a list of the issues that were intended to generally define the parameters of the findings that would be made as to the "manner and cause" of Kath's death; and

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[2] The analysis below also involves a consideration of the quality of Kath's care during the February 2017 hospital admission.

[3] See *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74.

[4] The correspondence was directed at Canberra Health Services, but sent through and addressed to the ACT Government Solicitors Office.

(b) a summary of events from 25 November 2016 and 8 February 2017.

25. I attach the summary of events as Annexure A, updated to reflect the information subsequently received from CHS in their response.

26. The letter also indicated a provisional intention to publish findings, and invited parties to consider the summary document and make submissions as to any inaccuracies it might contain. My intention to rely on that document to make my findings was foreshadowed.

Response of the Parties

27. A response to the Court's letter was received from CHS, on behalf of the Territory, on 22 May 2023. No submissions from CHS, HD, or Kath's parents were made to seek amendment to the summary of events document, other than two typographical errors. HD expressed her disappointment with the CHS response.

Provisional Findings and s 55 notices

28. Provisional findings were sent to the parties on 18 June 2024. To the extent that they involved findings adverse to CHS, the Territory were given an opportunity to make submissions to the Coroner pursuant to s 55 of the Act. On 8 July 2024, CHS responded to the matters raised in the s 55 notice and acknowledged, as I have found, that aspects of the treatment and care received by Kath in the months prior to her death were suboptimal.

PART 2 – A CHRONOLOGY OF RELEVANT EVENTS

Kath's Life and Mental Health

29. Kath was born on 5 May 1982 to JS and TS. She had a younger brother, DS. Her relationship with her family was complicated, and, at the time of her death, she chose to have minimal contact with them.

30. Kath began struggling with her mental health from the young age of 16 in 1997. She had been diagnosed with several mental illnesses, including bipolar affective disorder type II, borderline personality disorder, bulimia, schizophrenia, post-traumatic stress disorder, and major depressive disorder.

31. In 2010, Kath moved from Melbourne to Canberra. In Canberra, her mental health care was primarily managed by the City Mental Health Team ("City Team") until late 2016, when it was transferred to the Woden Mental Health Team ("Woden Team"). Kath also received significant mental health care and support from her private psychologist, Mr Staniforth, and her regular General Practitioner.

32. In Canberra, Kath was a committed member of the Canberra Roller Derby League ("CRDL"), through which she reconnected with her high school friend, HD. In 2013, she sustained a head injury during a roller derby event. HD associated that accident with the start of a pronounced decline in Kath's mental health.

33. Over the years, Kath received a variety of mental health treatments, including medication and electroconvulsive therapy ("ECT"). HD says that while the first course of ECT in 2014 seemed to have good results, the second course was not successful, and that thereafter, Kath "had poor symptom control, and resorted to self-harming behaviours, sedation, and occasionally alcohol to alleviate her distress".

34. In medical records and statements provided to the Court, Kath's treating clinicians described her as chronically suicidal. She had a documented history of inpatient admissions in Victoria, Sydney, and Canberra (addressing acute suicidality, or related medical issues), and attempts at taking her own life. Her level of acute risk fluctuated, but the chronic nature of her thoughts of suicide was a constant background feature of her life. Kath reported to clinicians a history of childhood sexual and emotional abuse. That experience was an important factor underlying her mental health condition.

35. Kath sometimes relied on friends to provide support and accommodation at times of crisis (sometimes as an alternative to inpatient admission). As described above at [17], Kath expressed frustrations to her friends about what she regarded as (at times) unstructured, inconsistent, and unreliable mental health supports received through the City and Woden teams, and the limitations that existed in the ACT for supported accommodation.

36. While her mental illness was severe and longstanding, Kath was highly intelligent and motivated to get well. She was academically gifted, receiving multiple academic scholarships, and completing university degrees in computer science and environmental sustainability. She gained employment in youth work, and later in policy work at the Murray Darling Basin Authority from 2013 to mid-2016. She was described by those who knew her as clever, artistic, environmentally conscious, and a committed member of CRDL.

37. Clinicians and friends observed a deterioration in Kath's mental health from mid to late 2016. In the last four months of her life, Kath presented to TCH twice with suicidal intent (in November 2016 and February 2017) and was admitted as an inpatient. She took her own life following her last admission, within 27 hours of being discharged.

38. A detailed description of the state of her mental health and contacts with mental health services and providers from 25 November 2016 to the time of her death is set out in Annexure A.

Kath's Death – 7 to 8 February 2017

39. On 7 February 2017 at 1140 hrs, Kath was discharged from the Mental Health Short Stay Unit (‘”MHSSU”) at TCH. Following her discharge, at approximately 1310 hours, Kath met her friend KW for lunch, before returning home alone. Throughout the evening, she texted KW, HD, and Mr Staniforth, expressing her disappointment with the treatment she had just received in the hospital, and her intention to lodge complaints against the Crisis Assessment Treatment Team (“CATT”) and TCH. Kath lodged those complaints at 1837 and 2027 hours respectively. At 2330 hours on 7 February 2017, Kath posted to Instagram a picture of a pot plant next to a light. That was her last known activity before her death.

40. On 8 February 2017, at about 1045 hours, KW texted Kath to check on her welfare. Concerned when she did not answer, KW and her roommate entered Kath's residence (Unit 8 of 30 Glenorchy Street, Lyons, ACT) with a spare key at 1415 hours. Upon entry, they noticed a sign on the unit which said, “Don't come in, call someone”. They proceeded to enter the unit and observed Kath lying face down on the bed in the master bedroom, cold to the touch and purple. ACT Ambulance Services (“ACTAS”) arrived shortly after, and confirmed there were no signs of life.

41. ACT Police attended the scene and found several documents in the unit which indicated Kath's intent to end her own life. In the dining room, there was a blue folder containing several documents, including what appeared to be two suicide letters, a will, and instructions on how to look after Kath's pets. A "post-it" note was stuck to the front of the blue folder, and stated that her phone was unlocked, and a video was on it. Police accessed Kath's phone, and located a video of Kath, date and time stamped 7 February 2017 at 2122 hours. In that video, Kath looked at the camera and said, “I am at peace, love you all”.

42. The two suicide notes were undated. However, it is apparent that one was prepared sometime in September 2015. The terms of the “post-it” note, and the video on Kath's phone suggest that Kath considered the notes to reflect her intent at the time of her death.

43. Various medication packets were found at the scene, including Phenergan 25 mg tablets[5] (40 out of 60 left) and Dothiepin 75 mg tablets[6] (0 out of 60 left).

PART 3 – FINDINGS AS TO MANNER AND CAUSE OF DEATH

44. On 10 February 2017, Coroner Morrison directed a post-mortem examination be conducted to the extent that is necessary to determine the cause of Kath's death. That examination was conducted on 14 February 2017 by Professor Duflou. The toxicology results revealed the presence of:

Ethyl alcohol:	0.021 g/100mL
Promethazine:	0.6 mg/L (approx.)
Dothiepen:	11 mg/L (approx.)
Fluoxetine:	0.5 mg/L (approx.)
Quetiapine:	Metabolite detected
Lamotrigine:	Indicated but not confirmed.

45. Professor Duflou prepared a post-mortem report dated 20 March 2018, and opined that:
    (a) The direct cause of Kath's death was multiple drug toxicity.
    (b) Toxicology testing revealed the presence of multiple prescription medications consistent with the medication found at the scene. This included promethazine, dothiepin and fluoxetine.
    (c) The combination of the prescription drugs could have caused death, although the level of dothiepin was sufficiently high to cause death alone.

46. The examination did not suggest another possible cause of death.

47. I accept Professor Duflou's opinion as to the cause of Kath's death.

48. I am satisfied, based on the evidence before me, that Kath ingested the medications with the intent to end her own life.

49. Accordingly, I find that Katherine Aurelia Alexander died between 7 and 8 February 2017, at Unit 8 of 30 Glenorchy Street in the ACT, as a result of multiple drug toxicity. Kath ingested some or all of those drugs with the intention of taking her own life. I do not find that acts or omissions of particular individuals who were involved in Kath's care in the period leading up to her suicide contributed to the cause of her death.

[5] Phenergan is an antihistamine. It contains the active ingredient Promethazine.
[6] Dotheipin is an antidepressant used in the treatment of depression. It can be fatal at relatively low doses. Kath was prescribed Dotheipin until late 2016 by her psychiatrist. The medical records indicate that Dothiepin prescriptions were ceased following her overdose in hospital in November.

PART 4 – MATTERS OF PUBLIC SAFETY

Introduction

50. The terms of s 52(4) of the Act require me to consider whether a matter of "public safety" arises from the inquest (investigation) into Kath's death. I adopt a commonsense definition of that term as meaning the protection of the public. The power to comment on a matter of public safety is set out in s 52(4), and the ability to make recommendations about the promotion of general public health and safety (s 3BA (1)(d) of the Act) point to the important preventive and protective role a coroner plays in our community.

51. My role in that regard is not without limitations. I have no power to address public safety issues by comment or recommendation unless they "arise" from the inquest. The power to conduct an inquest is one limited to determining the "manner and cause" of a death, in respect of which a coroner has jurisdiction. A coroner does not have the power to investigate, comment and recommend generally.[7]

52. Further, the concept of "public safety" is a forward-looking concept. The passage of time, and, here, the 7-year gap between the consideration of my findings and Kath's death, makes the process of making recommendations, or comment about public safety issues more complex. Governmental responses to the care of those suffering from mental illness and the prevention of suicide are dynamic. As a result of the Productivity Commission's Inquiry,[8] and the Victorian Royal Commission into Mental Health,[9] the policy framework surrounding those issues, and consideration of how optimal outcomes for those with mental illness and chronic suicidality are best achieved have been significantly reviewed. Whilst the outcomes and recommendations of that inquiry and the Victorian Royal Commission provide conceptual insights as to best practice around providing support to those who are chronically suicidal, because of the significant passage of time, there is an element of artificiality in using them to assess the practice and procedures seen in Kath's case.

53. Since Kath's death, there has also been an audit of the procedural guidance that was relevant to Kath's care, and significant progress has been made in re-writing and consolidating that guidance for the whole of mental health services in the ACT. I discuss this further at [56]–[60].

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[7] *Harmsworth v State Coroner* [1989] VR 989 at 997 per Nathan J, *Doomadgee v Deputy State Coroner Clements* [2006] 2 Qld R 352.
[8] Commonwealth Productivity Commission, *Mental Health Inquiry* (Report No 95, 2020).
[9] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021).

54. The changes to the mental health system since Kath's passing imposes some practical restraints on my ability to make recommendations and comments in this case.

The Context of Kath's Care

(a) Description of Inpatient Services at TCH

55. In late 2016 and early 2017, there was a range of inpatient facilities in the ACT that addressed various specific needs. Three facilities are relevant to these proceedings – the Adult Mental Health Unit ("AMHU"), the Mental Health Short Stay Unit ("MHSSU"), and the Medical Assessment and Planning Unit ("MAPU"). The AMHU provided short-term specialised acute clinical intervention, treatment and care for persons experiencing moderate to severe mental illness or mental dysfunction, where less restrictive options have been deemed unsuitable or were unavailable. The MAPU was a short-stay unit for patients with medical conditions likely to require less than 72 hours of inpatient management, or, for undifferentiated illnesses, where a short inpatient stay to establish diagnosis would be useful. The MHSSU, which opened in January 2016, was an inpatient facility located adjacent to the TCH'S Emergency Department ("ED") to provide short-term care for someone experiencing a mental illness or disorder, who was likely to require a mental health admission (at that time) up to 48 hours.

(b) Relevant Policy and Procedural Guidance

56. In response to the Court's letter of 10 March 2023, CHS produced a significant array of policies and procedures that were said to be relevant to my consideration of the governance that set the parameters of CHS's response to Kath's care needs, both in an inpatient setting, and in respect of her discharge into the care of community-based clinicians. Some of those documents were quite old, and pre-dated the enactment of the *Mental Health Act 2015* (ACT) in 2015. Some were not relevant to the delivery of Kath's care. They did not explain the principles that governed where care should have been provided. Collectively, they presented a disjointed picture of the principles and procedures that purportedly governed Kath's care.

57. The state of the procedural guidance that existed within those inpatient facilities at the time of Kath's passing has been the subject of analysis by both this Court[10] and, in more detail, by the ACT Audit Office in its Performance Audit Report titled *Mental Health Services – Transition from Acute Care.*

58. Some of the key findings made in the audit report were:

[10] *Inquest into the deaths of Bearham & Ors* [2021] ACTCD 1.

> An integrated, comprehensive and contemporary framework, encompassing the ACT Mental Health Act 2015 (the Act), for managing the transition of people from acute care services to community-based services is lacking. Not all the requirements of the Act are captured in policies and procedures, and many are outdated. This compromises the ability of public health practitioners and carers to manage a person's transition effectively.
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> ……..
>
> There is a need to review, rationalise and re-issue mental health services policies and procedures as many are outdated or were drafted before the passage of the *Mental Health Act 2015* (the Act). These do not give full effect to the Act, notably the different treatment regimes for people with mental illnesses and mental disorders.[11]

59. In respect of record keeping, case plans, and discharge planning, the audit found:

> In only 5 percent of cases were records found that showed that planning commenced during the initial phase of hospitalisation for discharge and the support required after inpatient care.
>
> Recovery plans were found in only one third of the records examined. There is evidence that mental health staff have not regularly and systematically recorded discharge and recovery planning in MHAGIC. Records have similarly not been made of clinical meetings that involve the sharing of information and clinical decision making about a person's care and treatment.
>
> This failure of practice means that the MHAGIC records of recovery planning are incomplete. Reliable and complete records of recovery planning are not available to be given to the person, their family or to other carers. Neither are they available to other staff or other support organisations to help in their care of the person, including after discharge from acute care. The responsibility for creating, reviewing and maintaining a person's discharge and recovery plan is not clearly assigned.[12]

60. It is evident that, around the time of Kath's death, the ACT Health Directorate was reviewing its relevant guidance. Revised models of care, including those applicable to inpatient care facilities, were being rewritten and subject to consultative processes.

Analysis of Kath's Mental Health Care and Treatment

(a) The 29 November to 9 December 2017 Admission

61. Annexure A sets out the chronology of events that describes this admission. During this admission, Kath surrendered two Stanley blades and a jumper cord. Staff became aware that she had surrendered her dog on 28 November 2016.

62. At some time overnight on 28 to 29 November 2016, while in the MHSSU, Kath overdosed on dothiepin, an anti-depressant she was prescribed at the time. A suicide note addressed to her partner at the time was found. It is apparent from the medical

[11] ACT Audit Office, *Auditor-General's Report: Mental Health Services-Transition from Acute Care*, (report no 6, 2017) 1-2.
[12] Ibid 5. MHAGIC was the shared digital integrated patient record system within mental health services.

records that the dothiepin she ingested was her own supply, which she brought into the hospital, and it had not been seized by clinicians upon admission. Following her overdose, Kath was transferred to the MAPU for medical management (associated with the overdose) and was placed on an Emergency Detention Order on 30 November 2016.

63. HD called TCH at about 1000 hours on 29 November 2016, and was informed of Kath's overdose during that call.

64. Despite being medically cleared on 2 December 2016, Kath remained in the MAPU until 9 December 2016, due to a bed not being available within the AMHU. She was psychiatrically reviewed during this period, and she was given her usual prescribed medication, except dothiepin, which was withheld. It is not clear otherwise what the care plan was, and what clinical interventions were undertaken to address the acuity of her presentation.

65. Frustrated with not being able to be admitted to the AMHU, arrangements were made between HD and Kath for Kath to be released into HD's care in Sydney. As noted in Annexure A, the documented psychiatric review on 9 December 2016 before Kath's discharge did not contain any information about Kath's mental state. The discharge plan was brief, and is extracted at [11] in Annexure A.

66. I am not able to say whether the medical care that was provided during this admission was consistent with the stated policy. For reasons associated with the availability of beds in AMHU, Kath was accommodated in the MAPU for an extended period of time. What the consequences were for her mental health is not clear. It may have added to her belief that the "mental health system" was not addressing or responsive to her mental health needs.

67. In respect of her discharge, the *Mental Health ACT Discharge Policy* ("MHACT discharge policy") applied.[13] The MHACT discharge policy sets out a structured discharge planning process involving 16 steps. Of note:

…

2. Involve the treating consultant, the consumer and their family and /or primary carer in discharge planning. Contact the consumers family and/or primary carer to keep them informed of the expected discharge date and times (where appropriate), unless expressly decline by the consumer. If consent is no authorised clinicians just document this fact in the clinical record.
3. Involved the relevant health or community support providers.
4. Developed the discharge care plan in line with the recovery plan detailing:

[13] *Mental Health ACT Discharge Policy* (Issued June 2008, Reviewed June 2012).

a. Medical and community support follow -up arrangements;
b. Medical and community support follow -up arrangements;
c. Emergency contact numbers;
d. Consumer management plan (including coping strategies);
e. Key referral services and programs;
f. Contingency and Relapse Response plans; and
g. Advance Agreements

5. Identify and formally contact the relevant Community Mental Health Team (General Practitioners, private Consultant and referral services and programs (where appropriate) to continue treatment and provide assertive follow up care.

6. Conduct a Mental State Assessment immediately prior to discharge including risk of harm to self and others and reassess discharge decisions at that time.

…

10. Check medication supply and prescriptions are provided to the consumer in accordance with the Medical Discharge Summary

11. On discharge, book an appointment for a follow up with a relevant health provider (i.e., GP, private Consultant, Professional, clinical manager) **within 7 days** of the discharge date, ensure that the time frame for the follow up appointment complies with the level of suicide risk determined. Establish steps to be taken by the General Practitioner or other health provider if the consumer misses the appointment.

…

68. The *Adult Community Mental Health Teams - Transitional Clinician - Standard Operating Procedure* also specifies prompt follow-up within seven days after discharge, and a consultation with a clinician for psychiatric review, ideally within 14 days.[14] This follow-up timeframe is consistent with the *National Standards for Mental Health Services 2010* ("National Standards").[15]

69. Kath was discharged from TCH into the care of HD on the 9 December 2016. It is not suggested that the decision to discharge her was inappropriate.

70. The discharge plan placed heavy reliance on HD to monitor and support Kath's wellbeing in the community. Apart from the call from the Woden team next week, there is no reference to any other confirmed follow-up appointment or contact from a relevant health provider, such as Kath's GP, psychiatrist, or the CATT. The discharge plan on 9 December 2016 was not comprehensive and did not put in place the assertive follow-up

[14] Mental Health, Justice Health, Alcohol and Drugs Services ("MHJHADS"), *Adult Community Mental Health Teams - Transitional Clinician – Standard Operating Procedure* (Issued November 2013, Review December 2018).

[15] The *National Standards for Mental Health Services 2010* are a resource for all Australian mental health care services 'to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services'. The National Standards were first issued in 1996 and were revised and re-issued in 2010. The National Standards are not mandatory, and the ACT Health Directorate has not sought accreditation against them. However, the ACT Health Directorate uses the standards to inform its policies, measure performance and the standards are extensively referenced in policy documents.

support required (particularly in the circumstances of a recent suicide attempt) by MHJHADS policies.

(b) Care Immediately Following Discharge

71. Notwithstanding the documented plan, Kath did receive follow-up support immediately after discharge. Three days after her discharge, on 12 December 2016, Kath called the Woden team, and spoke to the duty officer about the status of her case management. Records indicate that the duty officer used that call as an opportunity to do a welfare check on Kath.

72. On 20 December 2016, a City team clinician called Kath to advise her that a psychiatric review appointment with Dr H (her psychiatrist from the City team) had been arranged for 22 December 2016 (13 days after discharge). Kath attended this appointment.

73. This contact, albeit to some extent initiated by Kath, was within the period for follow-up contact set by MHJHADS and the National Standards.

(c) Care in the Community Following the November Admission

74. Kath stayed with HD in Sydney for three days after being discharged from TCH. She returned home to Canberra alone on 12 December 2016. At the time of her return, many of her usual support services were not available. Her care was still in the process of being transferred to the Woden team, and she was on a waiting list for a case manager. Mr Staniforth was still on leave, returning in early January 2017.

75. The analysis of her care in the community during this period requires consideration of how community mental health teams managed the transition of her care between teams.

76. LP was Kath's regular case manager at the City team from 2014. She departed as Kath's case manager in early November 2016. Prior to LP's departure, Kath received an intensive level of case management in the community. In her statement, LP describes having an "open door policy" with Kath. She met with Kath at least once, sometimes two to three times a week, in addition to phone calls throughout the week. LP says Kath viewed her as a support person and came to her when distressed. The medical records indicate that LP, on her departure, recommended that Kath be assigned to a new case manager, and that weekly reviews with Kath be continued.

77. LP says that at the time of her departure, she was aware that there was discussion about transferring Kath from the City team to the Woden team. At [18] of her statement, she says:

> There had been some discussion about transferring Kath to the Woden Mental Health team at the time I left to transfer to CATT. Kath also said to me multiple times she didn't want to be transferred. I made it very clear to my team leader that I wanted her to stay with the City team. I felt that it would be extremely disruptive to Kath's treatment for her to be transferred to another team as she had a significant trauma history particularly as she already had to change her clinical manager. Although her new clinicians would have read her clinical records, the general consensus from patients who transfer clinicians is that they have to tell their story again and feel like they are starting from scratch. I think it would have been even worse if she had had to change clinical manager, team and her psychiatrist. Staying with the city team would also allow her clinical manager to work closely with Andrew her psychologist, as I have detailed above.

78. Mr Staniforth also expressed concern about the transfer of Kath's care. At [67]–[68] of his statement, he says:

> It was problematic when LP no longer provided regular case management and I was going to be on leave for all of December 2016. In a conversation with [LC] on Thursday 1 December 2016 (as outlined above at paragraph 55), I advocated for the necessity of support for Kath during my absence because I had grown increasingly concerned regarding Kath's ongoing level of risk. I was informed that due to a number of reasons, including her changed residential address, it was unlikely they would be able to provide support. I was advised that Kath would need to move to a new community mental health team (Woden Mental Health) due to a change of residential address and I indicated that this should not occur until I had returned to work in January 2017. I emphasised my concern regarding the deterioration in Kath's mental health and advocated for continuity of care at least until I returned to work in early January 2017.
>
> I was exceptionally concerned that City Mental Health would not indicate they could or would provide case-management for the duration of my holiday despite Kath's suicide attempt while an inpatient a day earlier. I did not understand why the transfer could not wait until I returned from leave, given Kath's address had changed around a year before this telephone call.

79. Similar concerns were evident in Dr H's statement.

80. On 30 November 2016, despite the concerns expressed by LP and Mr Staniforth, the City team leader decided to transfer Kath's care to the Woden team. The documented plan was for Kath's care to be completely transferred by March 2017. The medical records indicate that the transfer of her care was discussed with Kath on 28 November 2016, and that she understood the continuation of clinical management with the City team would no longer be feasible.

81. The Territory was asked by the Coroner to explain how the transition of Kath's care was managed to ensure continuity of an appropriate level of care. CHS, in their response dated 22 May 2023, referred to a plan documented on 5 December 2016 by the City Medical Officer to continue to see Kath for medical reviews in the city, until she had built a relationship with the Woden team clinical manager. CHS said this arrangement "was in effect a warm handover, where transfer of care would be graduated from City to Woden

team's". The record of the plan contained in the medical records indicates the City Medical Officer was Kath's regular psychiatrist from the City team, Dr H.

82. Medical records confirm that, as per the plan, Kath continued to have regular psychiatric reviews (every 2 to 3 weeks) with Dr H during the transition of her care. Following the November admission and before her death, Kath saw Dr H on 22 December 2016, 11 January 2017, and 25 January 2017.

83. On 16 January 2016, Kath was introduced over the phone to her new case manager from the Woden team, HU. Kath and HU met once in-person on 2 February 2017 before her death. Prior to this, Kath had been without regular case management since LP's departure (approximately 3 months ago).[16] The only interim support Kath received from community teams following the November admission and during the transition was the welfare call on 12 December 2016, and the three psychiatric reviews with Dr H.

84. This is not to suggest that Kath was not supported otherwise.

Crisis Assessment Treatment Team ("CATT")

85. Kath was aware that she could contact the CATT for support when distressed. It is evident from the medical records that the CATT was not a service she found very helpful and sought assistance from. This was likely due to the nature of the CATT's role in providing crisis intervention, rather than therapeutic support.[17] Kath's dissatisfaction with the CATT is reflected in her complaint on 7 February to CHS, regarding the CATT call on 4 February 2017.

Private Psychologist – Mr Staniforth

86. By 6 January 2017, Kath's weekly to fortnightly appointments with Mr Staniforth had resumed. She saw him on 6 January, 27 January, and 2 February 2017.

Conclusion Regarding Care in the Community

87. I find that the treatment and care Kath received from the community mental health teams in the months prior to her death was suboptimal. The loss of her regular case manager in early November 2016, and the approximate three months without a case manager

[16] Following LP's departure as Kath's case manager in early November 2016, BN stepped in as Kath's case manager for the week of 21 November 2016. Following this, Kath did not have a case manager until HU was assigned on 16 January 2017.
[17] In the ACT, the CATT has been replaced by the "Access Mental Health Team", who provide a 24 hour a day crisis service that consumers can call.

while being transferred to a new team was a significant break in the continuity of her mental health care.

88. It is acknowledged that changes to a patient's treating team are inevitable. Given the importance of the therapeutic relationship between a clinician and a patient in mental health care, it is expected that the departure of regular clinicians will cause some level of distress and disruption to patients. Given this, the issue in this inquest is not whether the decision to transfer Kath's care to the Woden team was correct; rather, it is whether the transfer was managed appropriately to facilitate, as far as practicable, the continuity of Kath's care.

89. I find that the fortnightly psychiatric reviews with Dr H were not on their own an adequate level of support during the transition, given the level of intensive case management Kath was used to, and the increase in her acute risk of suicide following the November admission and suicide attempt. Despite Dr H's continued involvement, Kath did not receive ongoing and assertive case management from the community mental health teams for approximately three months.

90. It is likely that this gap in care was disruptive to Kath's treatment and had a destabilising impact on her mental health. Both the transition of care and the loss of case manager LP were situational stressors that were documented in the medical records of the November and February admissions. The records from Mr Staniforth 's consultations reflect that Kath, in general, was dissatisfied with the contact and treatment she was receiving from the community teams following the November admission.

(d) The February Admission: 5–7 February 2017

91. The 5 to 7 February 2017 admission at TCH was Kath's last inpatient admission before her death. On 5 February at 1827 hours, Kath presented voluntarily to TCH with suicidal ideation, intent, and a plan to overdose on stockpiled medication and eucalyptus oil at home. She was admitted to the MHSSU. On 7 February at 1140 hours, she was discharged home alone. Shortly after discharge, Kath filed complaints with the ACT Health Directorate against TCH and the CATT at 1837 and 2027 hours.

92. Her complaint against TCH was in respect to the February admission. She reported that:

> I didn't see a psych reg until 10:30 am Tuesday 7 February. I was discharged an hour later without even being asked if I was safe to go home. That was 41 hours in hospital, 40 of them waiting to see a psychiatrist, and then the psychiatrist didn't even do her job properly.[18]

[18] Due to Kath's death, MHJHADS did not provide a response to either of her complaints.

93. Kath's distress regarding the delay in psychiatric review, and not being asked if she was safe before discharge is also evident in her text messages to HD, KW, and Mr Staniforth following discharge.

94. Medical records demonstrate that Kath was not reviewed in-person by a psychiatrist until the morning she was discharged, approximately 42 hours after being admitted to the MHSSU. Kath was first reviewed in the ED by the Consultant Psychologist at 2040 hours on 5 February 2017 (approximately two hours after presentation). Later that day, at 2300 hours, the Psychiatric Registrar, Dr N, completed a Clinical Risk Assessment. Kath was assessed as an At-Risk Category level 2 ("ARC 2") and was admitted voluntarily to the MHSSU at 2320 hours. From 5 to 7 February 2017, Kath remained in the MHSSU, and was subject to ARC2 hourly observations. Nursing observations stated that she "maintained a low profile and was guarded in nature". On 7 February 2017, sometime before her discharge at 1140 hours, Kath was reviewed first by the Psychiatric Registrar on duty, and then by the Consultant Psychiatrist, Dr NV. Dr NV assessed Kath as suitable for discharge, and she was discharged at 1140 hours.

95. The delay in an in-person psychiatric assessment of Kath was not in line with MHJHADS policy, which provided that all inpatients were to be reviewed by a psychiatrist daily.

96. I find that there was no causal or contributory link between the delay in assessing Kath and her death. The psychiatric assessments (notwithstanding the fact that the first was not documented), which did occur on 7 February prior to discharge, contained a comprehensive evaluation of her risk level and mental state.

97. The initial psychiatric review by the Registrar on 7 February 2016 was not documented. The Consultant Psychiatrist, Dr NV, who subsequently reviewed Kath, provided a statement, and said that the Registrar provided a handover of Kath's presentation, which included that she (Kath) wanted to be discharged from the hospital to go to work the next day, and denied having imminent suicidal ideation.

98. Dr NV's own review of Kath before discharge is comprehensively documented in the medical records and addressed in her statement. During that review, Kath again said she wanted to go home so she could work the next day. She denied having stockpiled medication at home. She declined a referral to the CATT but was aware of the service and confirmed that she would attend an appointment with her case manager the following week. The medical records also indicate that clinicians were aware Kath had an appointment with her psychiatrist, Dr H, on the following day (8 February 2017) and encouraged her to attend. Dr NV assessed Kath as having a "currently stable mental

state and no imminent risk but the chronic risk of DSH/suicide attempts". Dr NV documented in the medical records:

> Management
>
> - discharge home
> - medication to continue as is (no medication supply from the hospital, has still all her medication at home) - no changes to her medication management has been made
> - Katherine is aware of available 24/7 community support
> - Is happy to continue seeing current Woden CMHT case manager.
> - DBT specific or similar psychotherapeutic interventions to continue as is
> - Lithium monitoring via the community team
> - Psych reg to issue sickness certificate, will return to work tomorrow
> - Discharge letter to GP/Community as per psych reg

99. At [15] of her statement, Dr NV says:

> Katherine's assessment by myself, in addition to the Registrar's, medical student's and morning handover by mental health staff, appeared to be consistent with the view that she did not reveal symptoms suggestive of a severe depressive, manic or psychotic episode. She was rational and reasonable, her answers were intelligent, coherent and logical. Repeatedly she expressed her desire of wanting to go home and even requested a sickness certificate for her employer in order to return to work the next day. She agreed to keep her appointment the following week with the treating community team and was aware of the option to contact CATT at any time should she start feeling worse again. She denied any imminent self-harm/suicidal ideation or non-compliance with treatment. Under these circumstances, we had to allow her to go home as there were no identifiable imminent risk factors or non-compliance with treatments. This decision was consistent with the contemporary medico-legal and ethical framework and guiding principles of patients' autonomy and providing least restrictive care.

100. I find that the decision to discharge Kath on 7 February 2017 was reasonable and appropriate. Dr NV's questions regarding Kath's intent, the availability of medication at home, and her willingness to engage with support in the community were questions about her safety. In the absence of identifiable imminent risk, there were no grounds for involuntary detention.

The Discharge Plan

101. The discharge plan in respect of the last admission is recorded in Dr NV's review of Kath, and it is extracted above. The records indicate that Kath's new treating team at Woden were appropriately informed by TCH clinicians about her admission and were asked to be involved in discharge planning. Clinicians tried to contact HU, but he was on leave until 12 February. While the documented discharge plan does not confirm any future appointment with the Woden team, it is apparent from the information available that TCH clinicians were aware that Kath had an appointment with Dr H on the following day.

102. There is no documentation in the discharge plan or the medical records that Kath's friends, carers, or advocates were involved in her discharge planning. Whether this reflected Kath's wishes is unclear. The evidence does suggest that Kath was in contact with HD, KW, and Mr Staniforth during the admission, and informed them of her discharge. KW, in her interview with police, indicated that on 7 February 2017, Kath texted her that she was being discharged. KW, not wanting Kath to be alone after discharge, met with Kath at approximately 1310 hours on that day for lunch. Mr Staniforth said, in his statement, that Kath texted him that she was being discharged from the hospital. Mr Staniforth replied, reminding Kath that she had an appointment with him on Friday (10 February). Kath responded that she had an appointment with Dr H on the following day.

103. I find that whilst the discharge plan in respect of Kath's last admission was not comprehensively documented, appropriate discharge planning at TCH did occur. A discharge plan was in place, which involved a psychiatric review on the next day.

104. Following discharge, Kath had supportive contact with friends and Mr Staniforth. Her text messages from 7 February demonstrate that she was aware of future appointments in place and did not contain clear indicators of suicidal intent.

(e) Conclusion

105. The deterioration of Kath's mental health in the period before her death occurred in the context of a lengthy mental health history, including an established diagnosis of complex PTSD, depression, and borderline personality disorder. At the time of her death, Kath had been chronically suicidal for many years.

106. Mr Staniforth opined that since October 2016, there had been a slow deterioration in Kath's mental health, possibly attributable to the challenges she was experiencing in navigating her relationship with her parents. The medical records demonstrate that in the months prior to her death, she was experiencing distress due to ongoing trauma memories, and she was dealing with multiple acute stressors, including the loss of a close friendship, a breakup with her partner, the loss of her pet, financial pressures, and the loss of her usual supports from the community teams.

107. Whilst I have found aspects of the hospital discharge planning and management of the transition of Kath's care between the community mental health teams suboptimal, I do not find that they contributed to her death.

108. In the documentation Kath left behind at the scene of her death, she did not attribute her decision to end her life to a specific event or failure of the mental health system. Her

explanation for her decision was general, that she was in immense pain, and had been so for a long time. She stated in her suicide letters that she felt let down by the public mental health system, and that people had done unspeakable things to her in the past.

109. The evidence that some of the documentation had been prepared back in September 2015 reflects that Kath had been struggling with suicidal thoughts for some time before.

110. Her experiences with ACT Mental Health before her death were difficult, and I have made findings that in some respects they were not optimal.

111. For reasons previously indicated, I make no finding that public safety issues arise from the inquest. For similar reasons, I do not include information usefully provided by CHS in my findings as to how a client in circumstances similar to Kath would be treated today. As I have indicated, the mental health system has changed significantly since Kath's passing. The statutory and practical restraints that confront me do not permit me to assess whether those changes, if in place at the time, would have changed the outcome in Kath's case.

PART 5 – SUGGESTIONS MADE BY KATH'S ADVOCATES

112. HD, in her *Background Statement*, advanced some ideas as to how to address the difficulties Kath found in dealing with her mental health providers.

113. HD suggested that CHS should aim to improve communication with caregivers throughout the care process, subject to appropriate consents being in place.

114. The *Victorian Mental Health and Wellbeing Act 2022*, enacted in light of the Victorian Royal Commission, may encapsulate the reform that HD envisages in recognising a non-legal advocacy service provider for mental health clients. As HD acknowledged, the Human Rights Commission in the ACT, through the Public Advocate, discharges a similar responsibility and provides a similar service. HD advocated for an increase of funding for that office.

115. HD also urged greater flexibility in geographical divisions to maintain continuity in care, and to ensure that staff movements or shortages do not create issues similar to what Kath experienced.

116. Whilst I do not make any formal recommendations arising from the identification of a matter of public safety, I acknowledge that HD's suggestions reflect matters that have been raised in previous inquests, as well as common sense. They reflect the consideration and care she has brought to her advocacy, and reflection in respect of Kath's life and death.

POSTSCRIPT

117. I express my sincere condolences to Kath's family and friends.

I certify that the preceding one hundred and seventeen [117] numbered paragraphs are a true copy of the reasons for findings of his Honour Coroner Archer.

Counsel Assisting: Xiao Lin King

Date: 25 July 2024

ANNEXURE A

CD 35/2017

Inquest into the death of

Katherine Aurelia Alexander

Summary of Events 25 November 2016 to 8 February 2017

A. Admission 25 November 2016 – 9 December 2016

1. On 25 November 2016, Katherine Alexander ('Kath') attended an appointment with Mr Staniforth, her private psychologist. Mr Staniforth observed she was 'teary' and 'despondent'. Kath reported an escalation in cutting herself in the last few weeks. During the session, Kath abruptly left to go to the bathroom. When she did not return 10 minutes later, Mr Staniforth went to check on her and she reported she had again cut herself. Mr Staniforth assessed Kath's safety risk and called the Crisis Assessment and Treatment Team ('CATT'), due his concern for her imminent safety.[1] This call resulted in ACT Ambulance Services ('ACTAS') attending and transporting Kath to The Canberra Hospital ('TCH') emergency department ('ED') at about 1854 hrs. In TCH ED, Kath was asked to wait for a mental health review but self-discharge later that night before the review occurred.[2]

2. On 26 November 2016, Mr Staniforth, aware that Kath had self-discharged from TCH ED, called the CATT, and expressed his 'serious concerns' for her safety. Mr Staniforth told the CATT clinician he spoke to, that he had been working with Kath for the past three and a half years and had 'never seen her this bad'.[3] Following this call, the CATT clinicians attended Kath's house and she agreed to be transported back to TCH for further review.[4]

Admission to the Mental Health Short Stay Unit

3. Kath was admitted into the Mental Health Short Stay Unit ('MHSSU') later that day.[5] A completed 'Clinical Risk Assessment' form, dated 26 November 2016 at 1630 hrs, records she was assessed by Dr K, a psychiatrist, as an 'At Risk Category 2' ('ARC2'). An ARC2 categorisation indicates the patient is considered 'low to medium risk' and subject to hourly observation.[6]

4. On 28 November 2016, at about 1640 hrs, Kath was clinically reviewed by Dr D, a psychiatrist, and Dr HI. The notes from that appointment state that Kath was 'very stressed and anxious' during the review. She was unable to organise and express her thoughts and was vague about her suicidal ideation. The interview was terminated early due to her stress and a plan was made to review her again in the morning when she had settled.[7]

[1] Staniforth records, 546.
[2] ACTMH Folio 2, 217-218.
[3] ACTMH Folio 2, 218; Staniforth records 545.
[4] ACTMH Folio 2, 219.
[5] ACTMH Folio 2, 221;
[6] ACTMH Folio 3, 301.
[7] ACTMH Folio 2, 228.

Overdose in the Mental Health Short Stay Unit

5. The observation chart notes from the evening of the 28 November 2016 indicate that Kath went to bed at about 2200hrs. Subsequent hourly visual checks document her sleeping. The next day (29 November 2016 at 0810hrs) a nurse tried to wake Kath for breakfast. Kath was unable to sit up and her speech was slurred. When asked by nurses if she had ingested her own medication, Kath said she had. A search of her room produced a card of 10 Diazepam 5mg tablets, 30 Dotheipin 75mg tablets, and a photocopied suicide note addressed to her partner. Kath was promptly transferred to the ED and then to the Medical Assessment and Planning Unit ('MAPU') for medication management.[8] Pathology tests later confirmed Kath had overdosed on Dotheipin.

Admission to the Medical Assessment and Planning Unit

6. In the MAPU, Kath was reviewed by a psychologist and placed on an ED3 order on 30 November 2016. The ACTMH records indicate she was to remain in the MAPU until medically cleared and then to be transferred to the AMHU.[9]

7. Kath was medically cleared from the MAPU on 2 December 2016. Consultant Liaison Psychiatrist, Dr LV, reviewed her and observed that her mental state had improved. Kath reported still having chronic thoughts of self-harm, but had no immediate plans to act on them, and was agreeable to a voluntary admission to the AMHU. Dr LV determined the ED3 could lapse and Kath could be transferred to the AMHU when a bed became available.[10]

Management in MAPU while awaiting a bed in the AMHU

8. Kath remained in the MAPU, waiting for a bed to become available in the AMHU, from 2 to 9 December 2016. The ACTMH records indicate that the MAPU clinicians called the AMHU bed flow manager on 2, 5, 6, 7 and 8 December 2016, to enquire about the availability of a bed for Kath. On each occasion they were advised that no beds were available. File notes of these phone calls suggest that, at the time, the AMHU had a practice of prioritising ED patients when allocating beds.[11]

9. Whilst awaiting inpatient admission to the AMHU, Kath was reviewed by a Consultant Liaison Psychiatrist in MAPU on 5, 7, 8 and 9 December 2016. The general impression documented from these reviews was that Kath was still feeling depressed and had fleeting suicidal thoughts but with no specific plans. Kath wanted to be admitted to the AMHU but was becoming increasingly reluctant to stay in the MAPU waiting for a bed.[12]

10. On 9 December 2016 at about 1700 hrs, Kath was discharged into the care of her friend, HD. HD had heard that Kath was still waiting for a bed in the AMHU and had travelled to Canberra earlier that day in order take Kath home with her to Sydney for a week. Prior to her discharge, Kath was reviewed by Consultant Liaison Psychiatrist, Dr B, with HD present. The file note of this psychiatric review, produced in the ACTMH records, does not contain any information about Kath's mental state at the time beyond that she was agreeable to being discharged in HD's care.[13]

[8] ACTMH Folio 2, 232.
[9] ACTMH Folio 2, 234.
[10] ACTMH Folio 2, 236.
[11] ACTMH Folio 2, 236 – 342.
[12] ACTMH Folio 2, 236 – 342.
[13] ACTMH Folio 2, 241-242.

B. Post November 2016 Discharge

11. The discharge plan of 9 December 2016 is recorded in Dr B's file note of the review[14]

    Plan

    1. *Discharge home with [HD], [HD] will drive her to Sydney this evening will drop her back when she feels she is safe but will at least remain with her for a week*

    2. *WMHT to organise CM and provide a call to Katherine next week*

    HD

12. HD was Kath's main support in the week immediately after her discharge from TCH. Kath stayed with HD in Sydney until the 12 December 2016.

    Community Mental Health Team

13. The Community Mental Health Team's in Kath's post discharge care is not clearly ascertained from the ACTMH records. This is likely a reflection that at the time of discharge, the provision and management of Kath's care was being transferred from the City Mental Health Team ('CMHT') to the Woden Mental Health Team ('WMHT'). This transfer required the allocation of a new case manager and psychiatrist at the WMHT, which at the time of discharge had not yet occurred.

    Case Manager

14. On 12 December 2016, Kath the called the WMH duty officer and enquired about her new case manager and whether her care had been transferred to the WMHT yet. The duty officer confirmed that Kath's care had been transferred and that Kath was still on a list for a case officer. The duty officer advised Kath that she would be given a 'post hospital discharge' by the WMHT. No records of a 'post hospital discharge' by the WMHT could be found in the ACTMH records.[15]

15. At some point between 12 and 20 December 2016, the exact date not being recorded in the ATCMH records, HU from the WMHT was assigned as Kath's new case manager. Kath was advised she would not be able to see HU until the new year in March.[16]

16. The ACTMH records indicate that in fact, Kath had a phone call with HU on 16 January 2017, where he introduced himself as her new case manager.[17] On 2 February 2017, Kath had her first 'clinical review' appointment with HU. Kath reported during that appointment, chronic feelings of emptiness and anxiety. She stated she was disappointed when her last suicide attempt was not successful. She disclosed she had continuing suicidal thoughts with plans but had no immediate intention to act on them. HU's assessment of Kath's risk at this appointment was 'multiple instances of self harm, multiple suicide attempts most recently in November 2016. Chronic suicidal thoughts with plan and varying degrees of plan and intent'. Kath agreed at the end of the session to fortnightly appointments with HU, the next one being on 16 February 2016.[18]

[14] ACTMH Folio 2, 242.
[15] ACTMH Folio 2, 244 -245.
[16] ACTMH Folio 2, 245.
[17] ACTMH Folio 252.
[18] ACTMH Folio 2 257 -258.

Psychiatrist

17. TCH records around Kath's November 2016 discharge do not contain reference to future psychiatric appointments with the CMH or WMH team. The need for psychiatric review is first raised in a file note from a CMHT clinician, dated 20 December 2016, that states 'need for Kath to have a psychiatric review ASAP' and 'Dr [H] (Kath's CMH Psychiatrist) has kindly agreed to review her on Thursday 22/12 at 1130 hrs'.[19]

18. On 22 December 2016, Dr H saw Kath and observed that she seemed less depressed than during the last appointment on 25 November 2016, but her mood disorder and thoughts of death were ongoing. In response to her residual symptoms of depression, Dr H increased her dose of Lamotrigine to 300mg per day for one week and then 200mg BD thereafter. He noted in his file note of this clinical review the 'need to determine if she will remain a patient of the author or if a psychiatric care will be transferred to Woden Mental Health'.[20]

19. Dr H reviewed Kath again on 11 and 25 January 2017. Kath reported during the appointment on 11 January 2017, that her relationship with her girlfriend had broken down on New Year's Day and she was grieving the loss of this support. Despite this, Kath had returned to work part time and, in general, Dr H's opinion was that her mood had improved.[21]

20. On 25 January 2017, Kath appeared 'angry' and 'demoralised' in her appointment with Dr H. She accused Dr H of not trying hard enough during their last review to figure out that she was still depressed. She listed all her recent losses including, a close friend in Sydney pulling back, the loss of a regular clinical manager, breaking up with her girlfriend, returning her dog to foster care, struggling with work, and being transferred to a different mental health team. Dr H assessed Kath as 'chronic risk of self-harm and completed suicide'. He intended to review her again in two weeks and until her care was fully resumed by the WMHT in March 2017.[22]

C. Private Psychologist – Mr Staniforth

21. Mr Staniforth was on leave from December 2016 to early January 2017. Following Kath's attempted overdose in TCH, and prior to commencing his leave, Mr Staniforth visited Kath at TCH on the 2 December 2016. During that visit, Mr Staniforth reaffirmed his commitment to working with her and confirmed their next appointment on 6 January 2017.[23]

22. On 6 January 2017, Kath's weekly appointments with Mr Staniforth resumed. It is evident from Mr Staniforth's progress notes from the appointments throughout January 2017 that, Kath was struggling with experiencing traumatic memories, which she reported at times would cause her to dissociate. Accordingly, Mr Staniforth's priority during the January 2017 appointments was the stabilization of her acute mental health and suicide risk rather than processing traumatic memories.[24]

23. On 27 January 2017, Kath disclosed to Mr Staniforth that she felt suicidal and had a plan, but no immediate intention, to jump off a tall building. Kath agreed to Mr Staniforth alerting the CATT of her plan but did not want the CATT to contact her. The ACTMH records confirm the CATT received this call. [25]

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[19] ACTMH Folio 2, 245.
[20] ACTMH Folio 2, 446-247.
[21] ACTMH Folio 2, 249 -251; 253-255
[22] ACTMH Folio 2, 253-255.
[23] Staniforth, 541.
[24] Staniforth. 553-560.
[25] Staniforth, 558.

24. Kath's last appointment with Mr Staniforth was on 3 February 2017. During this appointment, she reported her continued distress about having sexual thoughts that were related to her past trauma. She said she had been punishing herself for masturbating by inserting broken glass into her vagina. Kath articulated a clear plan of suicide by various methods including, slitting her throat, taking an overdose of tricyclic antidepressants, drinking eucalyptus oil, and jumping from a building. She said she had no immediate intention to act on those plans. During this appointment, Mr Staniforth assessed Kath's suicide risk as 'acute' and called the CATT in her presence. Mr Staniforth advised the CATT clinician he spoke to of Kath's plan to commit suicide and requested they organise a home visit for her later that evening.[26] This phone call is discussed further below.

D. Crisis Assessment and Treatment Team

25. The CATT's involvement in Kath's care following her November 2016 discharge appears ad-hoc and predominately facilitated by Mr Staniforth. There is not, for instance, any reference that could be found in the ACTMH records of the CATT's involvement in Kath's discharge from TCH in November 2016. The medical records also indicate that Kath rarely initiated seeking crisis support from the CATT herself.

26. Kath did call the CATT on 29 January 2017 at 1515 hrs. Kath reported she was struggling with thoughts of self-harm but did not want to die. She did not want a home visit but agreed to a follow up phone call later that day. The ACTMH records confirm that this follow up call did occur at 1734 hrs but Kath did not answer.[27] Kath later reported to Mr Staniforth that this was the first time she had ever called the CATT and she was very disappointed that they had not followed up with her.[28]

27. Mr Staniforth's call to the CATT on 3 February 2017 at 1713 hrs, is documented in his notes from his appointment with Kath that day and in the ACTMH records. Mr Staniforth expressed to SM his serious concerns for Kath's welfare, including the details of her suicide plan. Mr Staniforth requested the CATT organise a home visit that evening, which Kath was agreeable to. SM advised that HU had seen Kath the previous day and did not think she was at serious risk. Mr Staniforth replied that HU had not seen Kath previously and, therefore, did not understand her issues or risk. Mr Staniforth states in his notes from the call that SM initially refused to organise a home visit because Kath would not engage over the phone and instead advised Mr Staniforth to call the AFP or accept a follow up from the CATT the next day. Mr Staniforth was not happy with this suggestion and again advocated for a home visit that evening, which SM eventually agreed to. The home visit was to occur later that day and was to be preceded by a phone call.[29]

28. The ACTMH records confirm a call was made from the CATT to Kath at about 1943 hrs that day (3 February 2017). Kath told the clinician on the phone that she was home after having dinner with her friend and that she planned to kill herself in the next week after she had completed her 'preparations', such as rehoming her guinea pigs. She told the CATT clinician she had a commitment to volunteer at an event the next day but would not indicate whether she would attend or not. When asked whether she had planned how she would commit suicide, she reported she had plans to overdose on a combination of her anti-depressants and eucalyptus oil in The Canberra Hospital car park. The CATT clinician noted that during the phone call Kath punctuated the conversation with laughter and said, 'you have never been able to offer any thing

[26] Staniforth, 560. ACTMH Folio 2, 259.
[27] ACTMH Folio 2, 256.
[28] Staniforth, 559.
[29] Staniforth, 560. ACTMH Folio 2, 259.

that helped me so I find these conversations funny'. At the end of the call, Kath agreed to a follow up call from the CATT the next morning.[30]

29. The CATT follow up call occurred at about 1117 hrs the next morning (4 February 2017). During this call, Kath reported that she was doing okay and denied having a current suicide plan. Kath said she was looking forward to doing volunteer work that night. The file note of this call includes a reference to 'WMH to follow up'.[31]

E. The February Admission 5 February to 8 February 2017

30. On 5 February 2017 at 1827 hrs, Kath voluntarily presented to the TCH ED with her friend, KK. Kath had disclosed to KK that she planned to commit suicide later that evening by ingesting her stockpiled medication and a bottle of eucalyptus oil at home.[32]

31. At about 1640 hrs, Kath was reviewed by psychologist, BL. Kath reported that she had been feeling increasingly suicidal and helpless over the last two weeks and had tried accessing help from the WMHT and 'did not feel heard' when she rang the CATT for support. Kath said she felt invalidated when help-seeking with mental health services.[33] When asked if clinicians could remove her access to her stockpiled medication and eucalyptus oil, Kath said no because she did not want to give up her options yet, however, she agreed to stay in hospital to maintain her safety. At the end of the review, Kath disclosed she had self-harmed and was bleeding. She requested to see a medical doctor but would not disclose the location of the self- harm.[34]

32. BL's notes from this review, under a section titled 'impression and risk assessment' state:

> *Given current level of distress, active suicidal ideation, plan and access to means at home, as well as her attempt at self-harm, Katherine is at high risk of suicide if she was return home. To be considered for a review by the psychiatric registrar and for brief inpatient admission.*
>
> *…..*
>
> *Discussed with psych registrar [Dr N].*
>
> *For psyc reg review Preferable admission to MHSSU, currently full, although AMHU have one bed currently.*

33. Psychiatric Registrar, Dr N, assessed Kath later that day as an ARC2 (low to medium risk) using the Clinical Risk Assessment form. At 2320 hrs, Kath was admitted into the MHSSU.

34. From 5 to 7 February 2017, Kath remained in the MHSSU and was subject to ARC2 hourly observations. Nursing observations state that during this period she was 'maintaining a low profile and guarded in nature'. Kath indicated to nursing staff on 7 February 2017 that she wanted to go home. She said, 'there was nothing much (they) could do'. Nursing staff tried to contact HU about what the 'ongoing plan' was for Kath and were advised by the

[30] ACTMH Folio 2, 259 – 260.
[31] ACTMH Folio 2, 260.
[32] ATCMH Folio 2, 261.
[33] ACTMH Folio 2, 261.
[34] ACTMH Folio 2, 262.

WMHT that HU was on leave, returning 12 February, and that there was no plan in place as HU had only seen her once.[35]

35. On 7 February 2017 at about 1200 hrs, Kath was assessed by Dr NV, a psychiatrist. Dr NV assessed Kath's mental state as 'currently stable' with 'no imminent risk but chronic risk of DSH/suicide attempts' and determined she could be discharged home. Dr NV states in her file note of the assessment that she deliberately used an interview style starting with 'non affect laden' topics, such as Kath's dyed hair. Dr NV says she did not enquire about Kath's mood because she was responding in 'quite a reactive an appropriate manner to non-affect laden topics' and that the Psychiatric Registrar had already conducted a more formal interview with Kath prior and provided a handover.[36] A record of the Psychiatric Registrar's review of Kath, referred to by Dr NV, could not be located in the ACTMH records.

36. During the assessment with Dr NV, Kath denied having stockpiled medication at home and said she wanted to go back to work tomorrow. Dr NV's file note of the review states[37]

> ***Assessment***
>
> *currently stable mental state and no imminent risk but chronic risk of DSH/suicide attempts there appears to be a degree of pathological illness behaviour associated with a borderline personality structure No pervasive neurovegetative or manic symptoms identified - in remission*
>
> ***Management***
>
> - *discharge home*
> - *medication to continue as is (no medication supply from the hospital, has still all her medication at home) - no changes to her medication management has been made*
> - *Katherine is aware of available 24/7 community support*
> - *Is happy to continue seeing current Woden CMHT case manager.*
> - *DBT specific or similar psychotherapeutic interventions to continue as is*
> - *Lithium monitoring via the community team*
> - *Psych reg to issue sickness certificate, will return to work tomorrow*
> - *Discharge letter to GP/Community as per psych reg*

37. Kath was discharged by 1140 hrs on 7 February 2017.[38]

38. Following discharge, Kath filed complaints against the CATT and TCH. Those reports are dated 7 February 2017, and time stamped 1837 and 2027 hrs respectively.

F. 8 February 2017

39. On 8 Feb 2017 at 0141 hrs, HD called the CATT concerned that she had not been able to contact Kath since the previous day, and that Kath had not been active on Facebook for 14 hours. HD call was transferred to the WMHT who organized a home visit for Kath later that day.[39]

[35] ACTMH folio 3 (folder titled 04 Admission), 60.
[36] ACTMH folio 2, 268.
[37] ACTMH Folio 2, 268 – 269.
[38] ACTMH records, folio 2 270.
[39] ACTMH records, folio 2, 2700

40. At 1415 hrs that day, KW and her roommate attended Kath's unit. They immediately observed a sign on the front door of Kath's unit which read, 'Don't come in, call someone'. They entered the unit and located Kath face down in her bedroom, cold to the touch, and purple in colour.[40]

41. ACTCAS were contacted and arrived shortly after 1430 hrs. ACTCAS observed Kath was clearly deceased upon arrival and did not provide any treatment.[41]

[40] Police Report.
[41] Police Report.