CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Gordon Brian Parmenter**
Citation:	**[2026] ACTCD 20**
Decision Date:	17 November 2026
Before:	Coroner K J Archer
Findings:	See [56]–[59], [91]–[95]
Catchwords:	**CORONIAL LAW** – manner and cause of death – deceased subject to psychiatric treatment order – death from urosepsis after discharge from hospital – ability of physical health clinicians to communicate with mental health case manager – access to Digital Health Record
Legislation Cited:	*Coroners Act 1997* (ACT) ss 13, 34A, 52, 55 and 74 *Health Records (Privacy and Access) Act* 1997 (ACT) *Mental Health Act 2015* (ACT) ss 6 and 58
Texts Cited:	Canberra Health Services, *Providing Physical Health Care Across Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS)* (CHS23/329, 30 November 2023) Canberra Health Services, *Procedure, Canberra Health Services (CHS, Discharge Summary Completion, Inpatients* (CHS24/617, 16 December 2024)
File Number:	CD 164 of 2022

CORONER ARCHER:

Introduction

1. Mr Gordon Brian Parmenter died on a date between 17 May 2022 and 8 June 2022 in his apartment in Braddon, ACT. I will, with respect, refer to Mr Parmenter as Gordon in these findings. Gordon was aged 73 at the time of his death. He was subject to a Psychiatric Treatment Order (PTO) made by the ACT Civil and Administrative Tribunal (ACAT) under s 58(2) of the *Mental Health Act 2015* (the *Mental Health Act*) on 2 December 2022 for a period of 6 months.

2. Gordon died from urosepsis, a condition that occurs when a urinary tract infection (UTI) or kidney infection spreads into the bloodstream. It can cause low blood pressure, organ failure, and death if not treated with antibiotics and fluids. Symptoms associated with the condition can progress quickly.

3. Gordon had been discharged from the Canberra Hospital Emergency Department (TCH ED) on 17 May 2022 following a medical procedure to insert a stent in his ureter. That was the last time he was seen alive by any clinician within the Canberra Health Services (CHS).

4. The mental health aspects of Gordon's illness involved a history of non-compliance with medication when not on a PTO. He was assessed as lacking decision-making capacity with regard to his psychiatric treatment. Ceasing medication had, in the past, led to serious consequences for his accommodation, reputation and the safety of himself and others. He had few social connections and lived on his own. Given the nature of his treatment at the hospital, he warranted a "check-in" after his discharge from hospital. That did not occur. One reason for this was that health providers across Gordon's mental and physical healthcare teams did not consider that it was open to them to exchange information about him.

5. I ultimately find that information sharing processes that were in place within CHS at the time did not and will not today operate in a way consistent with patient safety.

Jurisdiction and hearing

6. The death of a person who is subject to a PTO is considered to be a death in care within the meaning of that term in s 3BB of the *Coroners Act 1997* (the Act). Section 13(1)(i) of the Act requires me to hold an inquest into the manner and cause of Gordon's death and a hearing must be held: s 34A(2).

7. The hearing into Gordon's death was held on 13 March 2026. Gordon's brother, Sydney, attended the hearing remotely and offered his insights into the circumstances of Gordon's death.

8. I must make the findings required by s 52 of the Act. I must establish the manner and cause of Gordon's death and state whether a matter of public safety is found to arise in connection with my inquest. Section 74 of the Act requires me to make findings about any shortfalls in the quality of care, treatment and supervision of the deceased person that, in my opinion, contributed to the death.

The inquest investigation

9. The Australian Federal Police (AFP), on behalf of the Coroner, conducted inquiries into Gordon's death and prepared a brief of evidence. That brief includes an interview with Sydney, and records subpoenaed from CHS, The Canberra Hospital (TCH), Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS), and the Australian National University (ANU) Health Service. There are also photographs of the medications that were found by police in Gordon's apartment and a Cellebrite extraction report in respect of his mobile phone (the Cellebrite Report). MHJHADS provided two letters responding to questions I had asked of them.

Gordon Brian Parmenter

10. Gordon was born on 2 February 1949 and was one of five brothers to parents Francis Norman Parmenter and Eliza Joyce Goodwin. He had lived for periods in Sydney and Perth and had studied at Murdoch University. At Murdoch University he was conferred a Bachelor of Arts with Honours in 1981, a Bachelor of Science in 1986 and a Doctor of Philosophy in 2001. He moved to the ACT in 2007 and continued studying at the ANU. He was conferred a Bachelor of Science in 2015.

11. At the time of his death, Gordon was living in a one-bedroom apartment that he was renting in Braddon. According to Sydney, Gordon was active and was well engaged with his university studies

12. Gordon was a person who faced significant mental and physical health challenges in his life. Gordon had a diagnosis of schizophrenia, and a history of psychotic symptoms, including persecutory delusions and auditory hallucinations. The acuity of Gordon's mental health issues varied and were generally treated with medication in the community. He had a history of not complying with his medication regime and in-patient care was sometimes required. He had multiple psychiatric admissions to Fremantle

Hospital and since residing in Canberra had psychiatric admissions in 2008, 2009, twice in 2019, 2020 and 2021.

13. He had attempted suicide twice in his 20s.

14. So far as his physical health was concerned, Gordon had a history of aortic and valvular stenosis, and kidney stones.

Physical and mental health care before death

15. The records suggest that established patterns of physical and mental unwellness were apparent in the 12 months or so before Gordon died.

16. On 10 June 2021 Gordon presented to the City Police Station expressing delusional thoughts and reporting persecution from a neighbour. In light of the acuity of his presentation, Gordon was brought to TCH ED by ambulance on that day. In TCH ED, an echocardiogram (an ultrasound of the heart) confirmed that Gordon had severe valvular stenosis.

17. Aside from that, no other acute issues concerning his physical health were identified, and Gordon was referred to the Adult Mental Health Unit (AMHU) for an assessment. A Comprehensive Mental Health Assessment was undertaken and the clinical impression from the assessment was that Gordon was experiencing a relapse of a psychotic illness and that his presentation suggested "a relapse of Schizophrenia/Schizoaffective Disorder with acute psychotic features including paranoid, persecutory and grandiose delusional ideas."

18. On 12 June 2021, Gordon was transferred to the Older Persons Mental Health Inpatient Unit (OPMHIU) at Calvary Public Hospital Bruce (Calvary) and was placed on an Emergency Detention three-day order (ED3 order), then an Emergency Detention 11-day order (ED11 order), followed by a PTO.

19. While at the OPMHIU, Gordon responded well to treatment of oral olanzapine and was discharged from the OPHMIU on 23 July 2021, to be followed up and supported in the community by the Older Persons Mental Health Community Team (OPMHCT).

20. The OPMHCT made several attempts to contact Gordon on 27 July 2021 for a post discharge review, however, he did not respond to that contact.

21. On 30 July 2021, the OPMHCT conducted a home visit and post discharge review. The patient progress notes from that review comment, amongst other things, that Gordon reported feeling good overall and that he was "happy with the Olanzapine, no side effects reported or observed."

22. On 5 August 2021, a psychiatrist from the OPMHCT reviewed Gordon at home. Gordon said that he had been compliant with the prescribed olanzapine so far, but he was ambivalent about taking it. At that time, OPMHCT discussed an upcoming PTO hearing with Gordon and that, because there were concerns about his compliance with treatment, a further PTO would be sought to mitigate risks to himself and others.

23. Gordon was due to be assessed again by the OPMHCT on 13 August 2021, however that visit was cancelled due to a mandatory COVID-19 lockdown.

24. Gordon's treating practitioners and clinicians held a Multi-Disciplinary Team Review (MDTR) meeting on 18 August 2021. At that meeting, it was discussed that Gordon did not have an active phone, and the plan was "for visual contact at his place of residence, via Gordon's intercom… attempt MSE and risk ax, leave pathology slip to check for evidence that Gordon is using his olanzapine."[1]

25. On 20 August 2021, the OPMHCT went to Gordon's apartment complex and contacted him through the intercom. The patient progress notes record that Gordon engaged well in that conversation and that his mood was good.

26. The OPMHCT conducted telehealth appointments with Gordon on the following dates:

    (a) 27 and 30 August 2021;

    (b) 3, 10, 17 and 24 September 2021; and

    (c) 13 October 2021.

27. On 9 September 2021, ACAT made a PTO for three months.

28. On 24 October 2021, Gordon was transported to Calvary ED by ambulance, after "feeling scared" to stay in his apartment because he felt "intimidated" and thought he "was being followed" by his neighbour. Gordon was discharged home the same day. He was referred to a face-to-face review with the OPMHCT.

29. A psychiatric registrar and Gordon's case manager from the OPMHCT undertook a home visit to Gordon on 25 October 2021, the day following his discharge from Calvary ED. The clinical notes from that home visit record that Gordon was likely experiencing a worsening of his psychotic symptoms and that he would benefit from an increase in his olanzapine. It was noted that Gordon had a history of depression, that he appeared to respond well to escitalopram and that it may be reasonable to re-start this to see if it would be beneficial. The plan from that visit was that nocte (at night) olanzapine was to

[1] "MSE" means "Mental Status Examination" and "risk ax" likely means risk assessment.

be increased to 7.5mg, escitalopram re-started at 5mg and titrate gradually to effect. Follow up was to occur in one weeks' time to check on Gordon's progress.

30. Further home visits were conducted by the OPMHCT on the following dates:

    (a) 20 October;

    (b) 1, 8, 19 and 30 November; and

    (c) 14 and 23 December 2021.

31. On 2 December 2021, the ACAT granted a 6-month PTO, to be reviewed in May 2022 prior to its expiry (the December PTO).

32. Between 15 and 17 December 2021, Gordon was treated as an inpatient at Calvary after presenting to Calvary ED with a four-week history of intermittent left flank pain. A left vesicoureteric junction (VUJ) stone[2] was found with mild hydroureters. He underwent a urology procedure, being a "cystoscopy + left retrograde pyelogram + left stent insertion"[3] at Calvary on 16 December 2021 (the First Procedure) and was discharged on 17 December 2021.

33. The OPMHCT conducted a telehealth welfare check on Gordon on 7 January 2022. The clinical notes from that welfare check provide that "Gordon appeared to be flatter in affect and spoke about having decreased motivation and passive suicidality", and that he "described a fleeting plan of using a knife to cut his wrists", but he stated that he did not think he would do this because "he [did] not have the courage". After that welfare check, Gordon's clinical manager sent him information by email about how to access ANU Counselling, the Suicide Call Back Service, Lifeline, and information about how to purchase a cheap mobile phone. There was to be a follow up telehealth appointment the next week.

34. The OPMHCT conducted a welfare check on Gordon on 10 January 2022, where the clinical notes record that he appeared to be brighter in affect than at the telehealth appointment the previous week, but still stated that he had decreased motivation and passive suicidality. Gordon was provided psychoeducation and engaged in safety planning during the welfare check, and it was confirmed that he had the contact numbers for the OPMHCT and Access Mental Health. The plan was that Gordon was to be

[2] A VUJ stone is a kidney stone that has become lodged in the point where the ureter connects the bladder.

[3] A cystoscopy is a medical procedure that uses a thin, hollow tube with a lens (a cystoscope) to examine the inside of the bladder to check for abnormalities. A retrograde pyelogram is an imaging test that uses x-rays and a contrast dye to look at the bladder, ureters and kidneys. A stent insertion places a small tube in the ureter to help urine flow from the kidney to the bladder.

referred to the Adult Mental Health Day Service (AMHDS) for further Cognitive Behavioural Therapy (CBT) and his Pilot Care plan would be updated.

35. The OPMHCT had follow up discussions and appointments with Gordon on the following dates:

    (a) 17 and 24 January;

    (b) 11 February;

    (c) 3, 15, and 31 March;

    (d) 4, 14, and 28 April; and

    (e) 9 May 2022.

36. Gordon's clinical manager at the OPMHCT last saw Gordon on 9 May 2022, with a psychiatrist. It was reported that Gordon appeared to be in good physical and mental health at that time.

37. Gordon underwent an elective urology procedure at TCH on 16 May 2022. The procedure was to replace a stent in his ureter and is described in the TCH records as a "cystoscopy + removal of left stent + left ureteroscopy + insertion left sent + left RPG" (the Second Procedure).

38. Gordon was discharged from TCH on 17 May 2022 at 12:12pm. Prior to his discharge, Gordon was seen by a urology intern who gave verbal confirmation for his discharge and charted the trimethoprim. The Discharge Summary notes there was "routine post-operative care". The discharge plan was for Gordon to continue with oral antibiotics (trimethoprim for 7 days). He was to be contacted for a date with a return procedure to change or remove the stent, and he was advised to attend an Emergency Department or his General Practitioner if he had any major concerns (e.g. fevers, nausea, vomiting, increasing pain, internal bleeding).

39. Although not referred to in the Discharge Summary, a Discharge Medication Chart confirms that Gordon was also discharged with 20 paracetamol 500mg tablets, presumably for pain relief.

40. During his admission at TCH, Gordon did not receive any treatment in relation to his mental health. The Discharge Summary refers to Gordon having schizophrenia (diagnosed in 2005) and being estranged from family, and it appears that he stayed at TCH overnight for social reasons, as he had no appropriate mode of transportation home after the procedure on the 16 May 2022.

41. At the time of his death, Gordon was still being treated and supported by the OPMHCT. The medications he had been prescribed by MHJHADS (through the OPMHCT) were olanzapine 7.5mg (antipsychotic medication) and escitalopram 10mg to treat depressive symptoms. His compliance with olanzapine was being monitored through periodic olanzapine blood levels.

The post discharge period

42. Nothing is known of Gordon's movements after his discharge from hospital on 17 May 2022. As noted below it is likely that he had died around 20 May 2022.[4] It is clear that he made no approach to any clinician to report the post procedure complications that are likely to have arisen. The classic symptoms of his terminal condition include a fast heart rate, heavy or fast breathing, confusion, dizziness, fever, low blood pressure, and low body temperature (some of which are referred to in the discharge documentation). The extent to which any of these symptoms were present after his discharge and prior to his death is not known, nor is it possible to say when the symptoms may have manifested themselves.

43. Gordon's clinical manager at the OPMHCT attempted to contact him on 23 May 2022, after he had not attended his PTO review that day. A condition of that PTO was that Gordon would be reviewed fortnightly, and he would attend the lobby of his apartment complex for that review.

44. A PTO review by the ACAT occurred on 26 May 2022. Gordon was provided with the details for that review but did not attend. The PTO was renewed. The reasons given by the ACAT for making the order were that Gordon had a documented history of non-compliance with medication when not on a PTO, and there was concern that Gordon may have been at risk of harm to himself or others if he did not continue to take his antipsychotics. Gordon's treating team continued to be of the opinion that he lacked decision-making capacity with regard to his psychiatric treatment, and that in the past his ceasing of medication had led to serious consequences for his accommodation, reputation, and the safety of people around him.

45. On 26 May 2022, the clinical manager attempted to call Gordon again and left text messages and a voicemail on his phone. On 8 June 2022, some three weeks after his elective procedure, the clinical manager became concerned that Gordon had not

[4] MHJHADS records contain an entry that Gordon was seen at his GP (at ANU) on 23 May 2022. There are, however, no entries in the GP records from Gordon's attendance on that date. Gordon's GP last saw Gordon prior to his death on 10 May 2022. Other than the reference to this in the MHJHADS records, there is no other evidence to suggest that Gordon may have attended the GP practice on 23 May 2022.

returned his calls and verified with TCH and Calvary that Gordon was not currently admitted anywhere. Later that day, the clinical manager contacted police and requested that they conduct a welfare check.

46. Police gained access to Gordon's apartment in the afternoon and found him deceased, lying face down on the floor.

47. From the Cellebrite Report, Gordon missed a call (from the Calvary Surgical Bookings team) that was made to him on 20 May 2022 at 11:23am and thereafter did not answer any calls. It appears that he last answered a call on 9 May 2022. Before 20 May 2022, he had not missed a call for 45 days. The mobile phone was found plugged in and fully charged when police attended.

48. The Calvary Surgical Bookings team sent him a text message on 20 May 2022 at 11:27am, requesting that he contact Calvary regarding a date for his next stent procedure. It appears that message was not responded to, and the Cellebrite Report describes the message as "unread". Calvary sent several follow-up text messages to Gordon over the next few days, which were also not responded to and "unread". A text message from HotDoc on 22 May 2022 at 3:15pm suggested that Gordon had an appointment at the ANU Medical Centre on 23 May 2022. That message is described in the Cellebrite Report as "unread". The fact of his failure to answer messages about this future procedure was not communicated to MHJHADS.

49. The quantity of medications found at the unit indicated some use after his discharge from TCH. Gordon was discharged from TCH with an antibiotic - trimethoprim (alprim) - for consumption once daily for seven days. The blister pack found by investigating police had four tablets remaining. If Gordon was taking one tablet per day as per his prescription, it is possible that he may have passed away about three days after his discharge from TCH, which would have been 20 or 21 May 2022.

50. Gordon was also discharged from TCH with paracetamol tablets. The relevant label directed:

> "Take 2 tablets in the morning, 2 tablets at midday, 2 tablets in the evening, and 2 tablets at bedtime".

51. The blister pack contained 20 tablets. Of those, 16 tablets were found to be present by police.

52. Given Gordon's previous history of non-compliance with taking medication for his mental health conditions, it is possible that he was not taking his discharge medications as prescribed.

The post-mortem examination

53. On 15 June 2022, Forensic Pathologist, Professor Duflou, performed a post-mortem (PM) examination, which included an external and internal examination, microscopic examination of tissues, medical records review, and toxicological testing.

54. The central features of his written report dated 25 July 2022 (the PM Report) were:

    (a) The primary cause of death was urosepsis, which was potentially precipitated by his renal procedure.

    (b) There was evidence of significant urosepsis, with multiple abscess within both kidneys, the left more so than the right.

    (c) There were typical changes of hypothermia, with areas of hypothermia-typical ulceration in the stomach, and typical abrasive type injury on the knees.

    (d) Previously diagnosed aortic stenosis was confirmed.

55. Toxicological testing of Gordon's blood showed the presence of medication typically used for the treatment of mental illness at levels consistent with therapeutic use. There was:

    (a) Citalopram (found as escitalopram) at approximately 0.05 mg per litre; and

    (b) Olanzapine at 0.02 mg per litre in a sample from Gordon's blood.

56. As to when Gordon may have died, Professor Duflou opined that there was a degree of decompositional change suggestive of death having occurred "in excess of a week prior to being found".

57. Professor Duflou indicated that the urosepsis was potentially precipitated by the procedure, but that "cannot be stated with any degree of certainty".

Manner and cause findings - Section 52 of the Act

58. The available evidence suggests that Gordon Parmenter died at his unit at 304/1 Elouera Street Braddon, in the Australian Capital Territory:

    (i) on a date between 17 May 2022 and 24 May 2022; and

    (ii) he died of urosepsis (pyelonephritis).

59. The manner of his death was natural causes. It is likely that he succumbed to the effects of urosepsis (pyelonephritis) within 3 to 4 days of being discharged from TCH, having undergone a procedure to replace a stent that was present in his ureter. The urosepsis

may have been an infection that arose from that procedure. Such a complication is a known to arise from this procedure. The general risk of infection was acknowledged by the prescription of antibiotics to be taken after discharge. However, it is not possible to know if the urosepsis was a pre-existing condition, arose as a result of the procedure, or developed after and independently of the procedure.

60. The autopsy findings suggest that Gordon may have become unconscious or incapacitated before death such that he suffered some degree of hypothermia in the cold of a Canberra winter. The minor injury to his knees may suggest he had been crawling in the period before his death.

Public safety issues – Section 52(4) of the Act

61. It is clear that there was no attempt made by his mental health treating team to contact Gordon until 6 days had passed after his discharge from hospital. The attempt at contact was not prompted by considerations of post procedure "follow-up" but by his failure to attend a PTO review on 23 May 2022.

62. It is not suggested that the failure to contact Gordon after his discharge contributed to his death. The sequence of events after leaving TCH and the progress of symptomology that led to his death is not known. However, the lack of follow-up contact with Gordon or his GP suggests a possible shortfall in the coordination of his care in the post discharge setting.

Information sought from the General Manager of MHJHADS

Request and Response No 1

<u>The state of knowledge – mental and physical health clinicians</u>

63. From the evidence that was initially available to me, it was unclear whether clinicians at TCH were aware that Gordon was subject to a PTO. It was also not clear what the extent of their knowledge was as to the current state of his mental illness.

64. Similarly, questions arose from the evidence as to the extent of the knowledge possessed by mental health clinicians and case managers of the procedure conducted at TCH and its timing. It is clear that his mental health case workers knew he was to receive hospital-based treatment for kidney stones. A letter sent to Gordon's GP from his case manager in relation to a review that occurred on 9 May 2022 notes, amongst other things, stated that *"[Mr Parmenter] has a booking to go to hospital next week for further treatment of kidney stones".* It is understood that this was the last time Gordon was seen by MHJHADS prior to his passing.

65. It is not clear where the information the MHJHADS case manager did have about his prospective admission, came from. However, the fact he was to undergo a kidney stone procedure is likely to have at least been confirmed by Gordon in the context of the above consultation.

66. On 8 December 2026, correspondence was sent to the ACT Government Solicitor seeking to establish:

    (a) to what extent mental health clinicians responsible for the care of a person subject to a PTO are required to identify the physical health care needs of that person and make arrangements for them to be addressed;

    (b) whether a mental health clinician would expect to be notified of a procedure conducted at (as here) TCH; and

    (c) whether a mental health clinician would have a responsibility of ensuring that someone subject to a PTO was receiving adequate medical follow-up after a medical procedure of the type Gordon underwent at TCH on 16 May 2022.

67. A response was received from Mr Bruno Aloisi, the General Manager of MHJHADS (the GM) by letter dated 25 February 2026.

Mental health clinicians and physical health

68. The GM indicated that at the time of Gordon's death, the operational guidelines that governed the responsibilities of mental health clinicians to deal with physical health issues of MHJHADS clients were contained in the document entitled *Providing Physical Health Care Across Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS)* (the Guidelines).[5] Relevantly, the document applies the principles of the *Mental Health Act*, including in s 6 which provides that "a person with a mental disorder or mental illness has the right to be assumed to have decision-making capacity".

69. The aim of the Guidelines is "to provide a framework that allows 'people accessing MHJHADS [to] be supported with their physical health care needs' and MHJHADS clinicians collaborate with primary healthcare providers to ensure that the individual's physical healthcare needs are met, to the extent that the patient consents to the same". The GM noted that, in practice, the patient's GP would be the patient's primary health care provider. The aim of the MHJHADS clinician (within their scope of practice) is "to ensure the patient receives care from an appropriate treatment provider (general

[5] The document with minor amendments is still in operation today

practitioner, physiotherapist, other medical specialist etc)." The MHJHADS clinician will collaborate with the primary treating team to deal with physical health conditions suffered by someone subject to a PTO. In particular:

> This may include communication initiated by that treatment team or by the MHJHADS clinicians depending on the circumstances, but in any event involves each treating team aiming to understand how they can assist with the patient's care in each particular area. MHJHADS Clinicians do not act as a substitute for any other physical healthcare provider and will rely upon the other treatment providers with appropriate specialisations to treat the individual's physical care needs.

Notification to MHJHADS clinician of in-patient care for physical care issue

70. The GM referenced a procedure document entitled *Canberra Health Services Discharge Summary Completion – Inpatients.* The GM indicated that a MHJHADS case manager "is not usually or routinely notified of a PTO patient's treatment in relation to their physical health at the Canberra Hospital of North Canberra Hospital". Discharge summaries are provided to a MHJHADS case manager only with the consent of the patient. They may learn of an admission through incidental contact with people who may know of that admission or from the patient themselves. As to why the MHJHADS case manager is not told, the GM said this:

    (a) as per the Guidelines, a patient's General Practitioner is relied on as an individual's primary health provider;

    (b) it is the practice of specialised treating teams to interact with other treatment areas only to the extent necessary to provide necessary and appropriate care. It is possible for a patient to have two separate specialised treating areas that do not interact with each other. A specialised medical health treating team may not consider it necessary to inform MHJHADS clinicians of an admission unless a particular issue has arisen which directly relates to the individual's mental healthcare; and

    (c) hospitals including TCH and NCH have Mental Health Consultation Liaison teams who are available to review patients while they are admitted under medical or surgical teams. These teams can provide advice and support with respect to mental health needs, including medication during the patient's admission, and therefore the medical or surgical teams may not be required to contact a community team such as those including MHJHADS clinicians or case managers.

71. The GM noted that in respect of Gordon's admission, his GP received the discharge summary. It included a recommendation that the GP follow up on Gordon's care, noting the antibiotics that had been prescribed.

Responsibility of MHJHADS case manager or clinician to ensure compliance with a physical health care plan

72. The GM stated that MHJHADS clinicians do not have a responsibility for ensuring that a person subject to a PTO is adhering to a physical health care plan, but will "support" them in relation to their physical health in accordance with the Guidelines.

73. The GM noted that it is now possible for MHJHADS case managers to access and review a person's discharge summary from TCH or NCH in the Digital Health Record (DHR).

Analysis of GM's first response

74. It is not clear what the content of this "support" was in circumstances where Gordon had undergone a surgical procedure. To give that "support" meaning, there had to be a sufficient information base available to MHJHADS:

    (a) Having learned that Gordon was to undergo a kidney stone procedure, MHJHADS should have established what the nature of the procedure was and when it was scheduled. It did neither.

    (b) Similarly, and subject to what follows, if it was known that Gordon was subject to a PTO, as part of the discharge process from TCH, his case manager should have been notified of the nature of the procedure that had been conducted and any follow up issues that arose in the context of his discharge (including changes to his medication). This was particularly so given his lack of social supports had been a reason for keeping Gordon at TCH longer than would be clinically required.

    (c) The MHJHADS case manager should have been sent or obtained a copy of the discharge summary. Operational guidance in respect of Discharge Summaries, (*Procedure, CHS Discharge Summary Completion – Inpatients*) was referenced by the GM (CH24/617). The document is dated as issued on 16 December 2024 (after Gordon's death). The GM asserted that this guidance would now prevent a MHJHADS case manager from obtaining a discharge summary if Gordon had been discharged from TCH today in similar circumstances. Section 8 of that guidance does not assert, as is suggested by the GM, that discharge summaries can only be provided to other clinicians only with the patient's consent. Further, disclosure to MHJHADS clinicians by their colleagues at TCH was not precluded by the *Health Records (Privacy and Access) Act 1997* (ACT) (*the Health Records Act*). See below.

Request and Response No 2

75. In light of this response and the factual matters raised at the hearing, the Court wrote to the GM to:

    (a) seek clarification around a number of factual issues (dealing with the state of knowledge of his MHJHADS clinician and those at TCH responsible for the kidney stone procedure);

    (b) seek advice as to whether (in the present day) the DHR could be used to allow mental health clinicians to be alerted to contacts with CHS clinicians dealing with physical health issues; and

    (c) seek confirmation that today a MHJHADS clinician would be entitled to use the DHR record to inform themselves as to the nature and outcome of a contact with CHS concerning the care provided in respect of a physical health issue.

76. The response of the GM was received in a letter dated 17 April 2026. In respect of factual matters, the GM:

    (a) accepted that the MHJHADS case manager may not have been aware of the exact nature of the procedure conducted at TCH on 16 May 2022; and

    (b) indicated that a MHJHADS clinician will only be provided with a copy of a discharge summary if a client consents.

The Digital Health Record

77. The DHR was introduced within CHS in November 2022 and therefore was not in operation at the time of Gordon's death.

78. DHR is a single unifying clinical records system that operates within CHS. Clinical and administrative records are now directly entered into the DHR by doctors, nurses, and clerks and can, subject to what follows, be accessed by others working within the CHS. Once a person with access to DHR logs in, they are able to access records entered onto the system, including entries made by CHS clinicians. Those records include discharge summaries which are a status summary produced when patients are, for example, transitioned from one CHS facility to another or from a CHS facility to the community.

79. In respect of the DHR, the GM advised that the DHR does not have an "alert" capacity. It does, however, have a range of communication tools that allows for the exchange of patient related information between CHS clinicians.

80. In relation to general issues concerning access to a DHR record when the particular act of care or treatment is not directly related to mental health issues, the GM qualified the advice he had previously given.

81. He told the Court that in the ACT, personal health information is regulated by the *Health Records Act* and the Privacy Principles attached to it. The GM asserted that their combined effect would today prevent MHJHADS clinicians accessing a discharge summary in respect of an admission for treatment of a non-mental health condition.

82. The GM analysed the effect of the *Health Records Act* and the Privacy Principles in these terms:

> In accordance with the legal, policy and clinical frameworks within which CHS clinicians operate, CHS clinicians, including MHJHADS case managers, may have access to a person's personal health information, including information held by CHS, only to the extent that is necessary for them to provide the particular health service which that clinician is providing.
>
> CHS records generated from a contact with CHS for health treatment contain personal health information. The use of personal health information is regulated by the Health Records Act. In accordance with that Act, and in particular, the privacy principles at Schedule 1, CHS staff who are members of the treating team for a consumer may:
>
> • have access to the personal health information of the consumer so far as necessary for the provision of a health service to the consumer (Principle 6 paragraph 1), and
>
> • use and disclose personal health information by sharing it with other members of a treating team to the extent necessary to improve or maintain the consumer's health or manage a disability (Principle 9 paragraph 1; Principle 10 subparagraph 2 (a)).
>
> Access, use and disclosure may be permissible in other circumstances as outlined in Principles 6, 9 and 10.
>
> The Health Records Act defines a treating team as:
>
> > ***Treating team***, in relation to a consumer, means health service providers involved in diagnosis, care or treatment for the purpose of improving or maintaining the consumer's health for a **particular episode of care** (emphasis added), and includes—
> >
> > (a) if the consumer named another health service provider as the consumer's current treating practitioner—that other health service provider; and
> >
> > (b) if another health service provider referred the consumer to the treating team for that episode of care—that other health service provider.
>
> MHJHADS case managers are not members of the treating team for admissions to TCH for physical health care procedures and therefore accessing the discharge summary in relation to such an admission would not be directly clinically required, nor permissible in accordance with the Health Records Act.

Is the opinion of the GM to be accepted?

83. The analysis advanced by the GM has the effect of justifying the poor clinical outcomes in Gordon's case as being due to binding law and procedural guidance.

The effect of Principle 6 (Paragraph 1)

84. The exact wording of Principle 6 (Paragraph 1) should be considered:

> A health service provider who is a member of a treating team for a consumer may have access to the personal health information about the consumer so far as necessary for the provision by the provider of a health service to the consumer.

85. The GM's reference to this principle substituted "the" for "a" before the words "treating team".

86. Leaving that issue aside, the question arises as to what the relevant treatment team was for the episode of care that required admission to TCH. As noted above, the He*alth Records Act* defines "treating team" as (relevantly) "health service providers involved in diagnosis, care or treatment for the purpose of improving or maintaining the consumer's health for a particular episode of care".

87. Given the role adopted by MHJHADS to provide "support" to clients subject to a PTO order, there is no reason not to regard Gordon's case manager to be part of a "treating team" for the purpose of co-ordinating post discharge care.

88. I find that Privacy Principle 1 would provide, of itself, no obstacle to MHJHADS clinicians (as part of a treating team) accessing a discharge summary from TCH if Gordon's care needs were duplicated in the present day.

89. Certainly, this approach is likely to provide a safer care environment. If the CHS was providing care to Gordon today in the DHR record keeping environment, sharing information between MHJHADS clinicians and clinicians at TCH would be essential to safe clinical practice:

    (a) it would allow MHJHADS clinicians to know that Gordon is in the community and not in hospital (noting Gordon's case manager actions to call around to ACT hospitals after concerns as to his welfare emerged);

    (b) it would allow MHJHADS clinicians to know about the level of acuity of his condition and therefore is an indicator or what follow up and "support" might be required with Gordon and his relationship with his GP;

    (c) it would alert MHJHADS to the fact that he may be taking additional medications. Given's Gordon's history of non-compliance with medication regimes, it would

be safe practice to check with Gordon and his GP as to whether the antibiotics were being consumed in accordance with direction given the serious consequences that might flow from them not being so consumed; and

(d) it would allow TCH clinicians to check his prescription regime against these known risk profiles. The taking of antibiotic medications with anti-psychotic medication can be associated with adverse interactions and possible changes in how anti-psychotic medications are metabolised.

Other relevant privacy principles

90. Principle 10 of the Privacy Principle (amongst others) sets out a range of exceptions to, or qualifications of, Principle 1. The GM noted one such exception, noting that Principle 10 allows sharing of information with other members of a treating team "to the extent necessary to improve or maintain the consumer's health". Further, Principle 10(2) allows the sharing of information:

(a) with consent of the consumer (Gordon had already discussed the fact of his upcoming admission with a MHJHADS clinician); and

(b) where a record keeper "believes, on reasonable grounds, that the disclosure is necessary to prevent or lessen a serious and imminent risk to the life or physical, mental or emotional health of the consumer or someone else".

91. Again, the issue arises as to who Gordon's "treating team" were. Discharge planning often requires the involvement of a range of clinicians or carers not involved in addressing, for example, an acute episode requiring in-patient care and which requires information to be shared to give effect to that process. Certainly, this would see a safer approach to patient care than was demonstrated in Gordon's case.

92. In practical terms, that would and should lead a TCH clinician to notify a MHJHADS clinician of the course of TCH treatment and the discharge plan. In the absence of such notification, it should be open for the MHJHADS clinician to read the discharge summary in the DHR.

The practical implications of the DHR system for the privacy principles

93. The Privacy Principles were developed before the DHR was created and implemented. The DHR is described by its CHS website as recording all interactions between a person and ACT public health services. It is not an opt out or opt in system. The information provided to the Court did not suggest that the records maintained by DHR would be, in cases such as Gordon's, siloed to deliberately exclude a class of clinicians from reading

his records. A MHJHADS case manager who in comparable circumstances opened a DHR record to record or view an outcome in the mental health aspect of his care, would likely be confronted with a record of a hospital admission dealing with his physical health. Is what is seen to be ignored?

Public safety findings

94. The role of a MHJHADS case manager is described by the GM as a facilitator in respect of his physical care needs. I make no criticism of that conceptualisation of the case manager's role. That sensible "light touch" care seems to have characterised Gordon's case management by MHJHADS until closer to the time before his death.

95. If that model had continued to work as it was designed in Gordon's case, there might reasonably have been:

    (a) some attempt to understand that the nature of the procedure he was to undergo at TCH;

    (b) discussion with Gordon to identify what post discharge care may have involved;

    (c) obtaining the Discharge Summary or care plan;

    (d) calling (if that was possible) or emailing (if that was possible) after discharge to check on his welfare; and

    (e) if necessary, confirming with his GP what if any contact the GP had, or was planning to have with Gordon.

Recommendations

96. I reiterate that even if the above had been done there was no guarantee that the outcome in Gordon's case would have been different.

97. However, the position put by the GM as to the obstacles to information sharing between clinicians potentially raises serious issues concerning the safety of mental health patients who find themselves in a position of needing help and support from clinicians across the physical and mental health divide. Gordon's case highlights how those obstacles might easily become life threatening.

98. I recommend that:

    (a) MHJHADS develop guidance to better facilitated information sharing between CHS clinicians dealing with the dual aspects of a PTO patient's health; and

(b) CHS develop guidance to put information sharing between CHS clinicians dealing with mental health patients particularly those subject to a PTO on a footing that acknowledges the reality and extent of information sharing that already exists in the DHR environment.

Section 55 process

99. In light of my findings and recommendations (which may have involved criticism of the Territory in its various manifestations) I sent them as provisional findings to the ACT Government Solicitors Office pursuant to section 55 of the Act. I invited the making of a submission or the provision of a written statement in relation to the proposed comment.[6]

The GM's statement

100. A statement was received from the GM dated 2 November 2026. I decline to include a copy of the statement in my findings but endeavour to summarise it fairly. He indicated that "he respected" the conclusion drawn in the provisional findings that the Heal*th Records Act* would not prevent mental health case managers from receiving information about treatment of physical conditions and would not now prevent them from having access to the DHR. However, he expressed "concern" about the "implied expectations" in the provisional findings "that suggest mental health clinicians should assume responsibility for management of a consumer's physical health conditions" and "should have "unfettered access to all of a consumer's personal health information".

101. The GM usefully reinforced a process issue he had highlighted in his response of 25 February 2026 (his first response). CHS has a Mental Health Consultation Liaison service (MHCL) "which can be consulted by the medical unit if there are concerns about a mental health status of a person undergoing medical treatment or a procedure, and regardless of whether or not they are subject of a PTO." The MHCL "would then share the information with a person's case manager around this contact and "information would be more easily identifiable in DHR for the case manager to review as coming from *another part of the mental health service*" [Emphasis added].

102. He went on to say that if there were concerns about "the person's ability to understand or give effect to instructions about their care then referrals can and should be made from the inpatient unit to other more relevant services", rather than to a mental health clinician.

[6] These findings are unchanged after the section 55 process but for the insertion of paragraphs 99 to 103

Analysis

103. These findings do not advance the proposition that mental health clinicians should assume responsibility for the physical care needs of someone who is subject to a PTO. The recommendation is made that guidelines should be considered that will enable mental health case managers to better facilitate the provision of physical health services by others when someone's mental health vulnerabilities make that appropriate. If the MHCL is the chosen vehicle for communication between two parts of the CHS, it should not always need to rely on referrals to discharge the duty of care owed by CHS as a whole.

I certify that the preceding one hundred and three [103] numbered paragraphs are a true copy of the findings of Coroner Archer

Associate: Miguel Kanissery

Date: 17 November 2026