CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Allyson Bailey
Hearing dates:	30 June to 4 July 2025, Tamworth Local Court
Date of findings:	13 August 2025
Place of findings:	Lidcombe Coroners Court
Findings of:	Deputy State Coroner, Magistrate Hosking
Catchwords:	Coronial inquest, death in hospital (not anticipated); interaction between provision of physical and mental health treatment, impact of Covid-19 on hospital care.
File number:	2020/200873
Representation:	Counsel Assisting the Inquest: Emma Sullivan of Counsel instructed by Mena Katawazi, Principal Solicitor, NSW Department of Communities and Justice. Hunter New England Local Health District (**HNELHD**) and RN Michael Babatunde: Richard Sergi of Counsel instructed by Sarah Schooley, NSW Crown Solicitor's Office Dr Jodie Reardon, Dr Brayden Varcoe and Dr Andrew Clift: Ben Bradley of Counsel instructed by Barbara Versace, Avant Law Dr Raeleigh Green: Tracey Stevens of Counsel instructed by Franjo Saric, Mills Oakley Dr Guyon Scott: Belinda Epstein of Counsel instructed by Nicky Speight, Meridian Lawyers Dr Sam Hume and Dr Clive Stanton: Kim Burke of Counsel instructed by Brianna Clark, Wotton Kearney

Dr Adam Smith: Peggy Dwyer SC instructed by Andrew Davey, Unsworth Legal

RN Shortie Gatsi: Katherine Doust of NSW Nurses and Midwives Association

Findings:

Identity of deceased: Allyson Bailey

Date of death: 7 July 2020

Place of death: Banksia Mental Health Unit (**Banksia MHU**) at Tamworth Rural Referral Hospital (**Tamworth Hospital**)

Manner of death: whilst involuntarily detained, in seclusion and under periodic observation.

Cause of death: from pneumonia with diffuse alveolar damage in the setting of mixed drug toxicity (Baclofen and Pregabalin).

Recommendations:

To the Chief Executive of the HNELHD:

(1) That there be a review of transfer of care/discharge processes and procedures in Tamworth Hospital for patients with complex mental health issues who are in high acuity areas (such as the Emergency Department (**ED**) or Intensive Care Unit (**ICU**)), whose care is then transferred to the Banksia MHU. The review should consider the issues raised in the evidence of Dr Clive Stanton and Dr James Zurek and involve relevant stakeholders / clinicians from high acuity areas within Tamworth Hospital (such as the ED and ICU) and from Banksia MHU.

(2) That there be a review of HNELHD documentation, policy and procedure relating to the management of acute behavioural

disturbance in mental health units (including as to the use of restraint and seclusion of patients), including as to the following matters:

(a) to ensure that the 'Seclusion Authorisation' form includes:

(i) provision for 'time stamps' on relevant forms (for example, the 'Seclusion Authorisation' document)

(ii) the number of seclusion orders made (i.e. whether the order is the first, second etc)

(iii) reference to the relevant procedures or policies in appropriately prominent terms.

(b) to ensure that, so far as practicable, the relevant policy provisions relating to seclusion, restraint (including rapid tranquilisation), vital sign observations and escalation (including where vital sign monitoring cannot be undertaken and/or there is no response to intramuscular parenteral treatment) are set out in a clear manner (for example, by reference to a flow chart or a single document).

(3) That there be consideration of how the lessons learned from Allyson Bailey's death could be used within HNELHD as a case study for

learning by other clinicians including in relation to transfer of care (and issues with the terminology of ‘medically cleared’ and ‘medical clearance’ as being potentially misleading regarding a patient’s physical health), monitoring and escalation issues (including potentially in a ‘reflective workshop’ forum).

(4) That consideration be given to a review of the Clinical Guideline ‘Mental Health: Management of Acute Behavioural Disturbance in HNE Mental Health Units (CG 22_06)’ concerning the Intramuscular (Parenteral) Treatment Rapid Tranquilisation protocol (p 52) by an appropriate person (or body/authority) to ensure:

(a) that it accords with current best practice (on the basis of the current literature); and

(b) that it reflects current prescribing practices within Banksia MHU.

Publication orders: Non-disclosure and non-publication orders apply to the evidence in this inquest. Copies of the orders made by Deputy State Coroner Hosking are available upon request from the Coroners Court Registry.

FINDINGS

Introduction

1 Section 81(1) of the *Coroners Act 2009* (NSW) (**the Act**) requires that when an inquest is held, the coroner must record in writing their findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

2 In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

3 These are the findings of an inquest into the circumstances of the death of Allyson Bailey (Ally) on 7 July 2020 while receiving treatment as an involuntary patient at the Banksia MHU at Tamworth Hospital.

4 Ally was the loved mother of three children. Sarah, Ally's eldest child, attended each day of the inquest. Ally also had a strong network of family including her mother, Heather, sisters, Jennifer, Kathy and Robyn, and brother, Ashley. Heather was a particularly strong advocate for Ally, regularly encouraging her to engage with care and supporting periods of involuntary admission.

5 This inquest is held pursuant to the general jurisdiction afforded to me as a coroner under s 21 of the Act.

6 The participants reduced to writing an 'Agreed Summary of Evidence' which was tendered as an *aid memoire* at the hearing. I am grateful for the work undertaken by the Assisting Team to prepare this Summary and for the contributions of the participants. I have drawn from this and from the submissions of Counsel Assisting in relation to non-contentious issues.

7 I wish to acknowledge the grace with which Ally's family approached this inquest. The generosity of spirit they displayed in embracing each of the

witnesses that had treated Ally in the context of her tragic death, was remarkable.

8 We heard from Ally's doctors and nurses that she was spirited and engaging. It was clear that she was a well-loved member of the Tamworth Hospital family. The tragedy of her death was felt by the team as well as by her family. Each of her treating doctors and nurses attended the inquest and gave full and frank evidence including as to their reflections on what could have been done better and how they would approach matters differently in the future.

9 In particular, Dr Swarmy presented with a commitment to policy improvements evidenced in his actions in the aftermath of Ally's death and his positive engagement in the inquest and his encouragement of others.

The issues examined at the inquest

10 An inquest into the circumstances of Ally's death was held in Tamworth Local Court between 30 June and 4 July 2025.

11 The issues identified in the coronial investigation to be explored in the inquest follow.

(1) Findings required pursuant to section 81 of the *Coroners Act*: the identity of the deceased; the time, date and place of death; the cause and manner of death.

(2) Whether the care and treatment provided to Ally by Tamworth Hospital between 5 and 7 July 2020 was appropriate and adequate. In particular:

(a) Whether Ally was correctly diagnosed and medicated.

(b) Whether a clinical toxicologist ought to have been consulted in the circumstances of Ally's presentation.

(c) Whether, having regard to Ally's complex presentation in the ED, further investigations should have been conducted as to other potential diagnoses or contributing causes.

(d) Whether input should have been sought from a specialist emergency physician during Ally's clinical management in the ED.

(e) Whether there was an adequate period of stabilisation and investigation of potential organic causes whilst Ally was in ICU, prior to her transfer to Banksia MHU.

(f) Whether the decision to 'medically clear' Ally and transfer her from the ICU to the Banksia MHU on 6 July 2020 was appropriate.

(g) Whether there was sufficient consultation that occurred between clinicians prior to her transfer.

(h) Whether the seclusion orders made for the three-consecutive four-hour periods in Banksia MHU on 6 July 2020 were appropriate.

(i) Whether there was adequate physical observations and vital sign monitoring performed by clinicians and nursing staff in the Banksia MHU.

(j) Whether clinicians ought to have sought further medical advice or conducted/requested further physical investigations, in light of the ongoing attempts to sedate Ally and her non-response to sedation.

(k) Whether there was compliance with applicable HNELHD/NSW Health policies and procedures and clinical guidelines regarding seclusion and restraint, and sedation.

(3) Whether any recommendations are necessary or desirable in connection with Ally's death.

The evidence

12 Tendered to the court was a 13-volume brief of evidence[1] compiled by the NSW Police Officers in Charge of the coronial investigation, Senior Constable Alyce Russell and Senior Constable Trent O'Rourke and supplemented by the Assisting Team.

13 I also received into evidence photographs depicting the Tamworth Hospital and the Banksia MHU[2].

14 A schedule of the witnesses that gave oral evidence at the inquest is Annexed and marked '**A**'.

Findings

15 I have concluded that:

(1) Ally died at 12.34am on 7 July 2020 from pneumonia with diffuse alveolar damage in the setting of mixed drug toxicity (Baclofen and Pregabalin) whilst involuntarily detained, in seclusion and under periodic observation, in the Banksia MHU in Tamworth Hospital.

(2) As to the care and treatment provided by Tamworth Hospital:

(a) Ally was not correctly diagnosed in respect to her underlying pneumonia infection. In relation to her drug toxicity, this was suspected though not confirmed.

(b) The investigations undertaken in the ED were appropriate including not consulting a toxicologist. This is particularly so given

[1] Exhibit 1.
[2] Exhibit 2.

the results of testing for pregabalin and baclofen would not have been available before Ally died.

(c) Ally's transfer from the ICU to the Banksia MHU was inappropriate and there should have been consultant to consultant discussions prior to any transfer taking place.

(d) The seclusion orders made for Ally in Banksia MHU were appropriate. However, the monitoring of physical observations and vital signs was inadequate and in circumstances where nursing staff were not able to perform appropriate observations, there should have been an escalation/review of Ally's care plan.

(e) While there was not strict compliance with HNELHD policies and procedures and clinical guidelines regarding seclusion and restraint, ambiguity in these have been identified and addressed so as to provide more appropriate guidance to junior medical staff.

16 I make the following recommendations:

To the Chief Executive of the HNELHD:

(1) That there be a review of transfer of care/discharge processes and procedures in Tamworth Hospital for patients with complex mental health issues who are in high acuity areas (such as the ED or ICU), whose care is then transferred to the Banksia MHU. The review should consider the issues raised in the evidence of Dr Clive Stanton and Dr James Zurek and involve relevant stakeholders/clinicians from high acuity areas within Tamworth Hospital (such as the ED and ICU) and from Banksia MHU.

(2) That there be a review of HNELHD documentation, policy and procedure relating to the management of acute behavioral disturbance in mental

health units (including as to the use of restraint and seclusion of patients), including as to the following matters:

(a) to ensure that the 'Seclusion Authorisation' form includes:

(i) provision for 'time stamps' on relevant forms (for example, the 'Seclusion Authorisation' document)

(ii) the number of seclusion orders made (i.e. whether the order is the first, second etc)

(iii) reference to the relevant procedures or policies in appropriately prominent terms.

(iv) to ensure that, so far as practicable, the relevant policy provisions relating to seclusion, restraint (including rapid tranquilisation), vital sign observations and escalation (including where vital sign monitoring cannot be undertaken and/or there is no response to intramuscular parenteral treatment) are set out in a clear manner (for example, by reference to a flow chart or a single document).

(3) That there be consideration of how the lessons learned from Ally's death could be used within HNELHD as a case study for learning by other clinicians including in relation to transfer of care (and issues with the terminology of 'medically cleared' and 'medical clearance' as being potentially misleading regarding a patient's physical health), monitoring and escalation issues (including potentially in a 'reflective workshop' forum).

(4) That consideration be given to a review of the Clinical Guideline 'Mental Health: Management of Acute Behavioural Disturbance in HNE Mental Health Units (CG 22_06)' concerning the Intramuscular (Parenteral)

Treatment Rapid Tranquilisation protocol (p 52) by an appropriate person (or body/authority) to ensure:

(a) that it accords with current best practice (on the basis of the current literature); and

(b) that it reflects current prescribing practices within Banksia MHU.

Background

17 Ally was born on 14 May 1978. Ally suffered a lengthy history of substance abuse which commenced with cannabis in her teenage years and was exacerbated after she had a horse riding accident and was prescribed pain medication.

Hospital admissions

18 In the 2 years prior to her death, Ally presented to Tamworth Hospital ED on more than 60 occasions. Between 14 January 2019 and 7 July 2020, Ally had 11 admissions to Tamworth Hospital's ICU and on 4 occasions she was admitted to Banksia MHU.

19 On 7 February 2020, Ally was admitted to Banksia MHU under the care of Dr Stanton with a view to Dr Stanton observing her for a longitudinal period to check for any mental illness that may have been contributing to her presentation. Ally was weaned from benzodiazepine and opiates. She required chemical sedation and intubation for severe behavioural disturbance.

20 On 22 April 2020, Ally was brought before the Mental Health Review Tribunal. It was determined that Ally was a mentally ill person pursuant to s 35 of the *Mental Health Act 2007* (NSW) (**MH Act**), and that she was to be detained as an involuntary patient in Tamworth Hospital for observation and/or treatment until a date no later than 20 May 2020. The Tribunal's determination noted that 'no less restrictive order is appropriate for safe care'.

Odyssey House NSW

21 On 11 May 2020, Ally was discharged from Banksia MHU to Odyssey House[3].

22 Unfortunately, Ally was required to leave Odyssey House after she presented in an intoxicated state at a group therapy session and was found to have alcohol in her possession. Ally was determined to be a suicide risk and transferred to Campbelltown Hospital.

23 Ally absconded from Campbelltown Hospital and attempted to return to Odyssey House. She was returned to Campbelltown Hospital involuntarily under the MH Act by Police. However, she was assessed as 'low acute mental health risk' and therefore not detainable.

General practitioner

24 Ally attended Belmore Surgery on approx. 48 occasions between 7 January 2019 and 7 July 2020. Dr Chris Fay, GP, noted Ally as having suffered depression, anxiety, pain/polyarthralgia and migraines. Dr Fay also noted concerns re polypharmacy and drug abuse and refused to prescribe benzodiazepines indicating a prescription of that nature should be provided by the hospital.

25 During her stay at Odyssey House, Ally was also seen by Dr Manku who operated privately but sees patients at Odyssey House.

26 On 9 June 2020, Ally had her last consultation at Belmore Surgery. A number of prescriptions were printed for Ally: Baclofen 10mg; Effexor XR (venlafaxine) 75mg and 150mg; Lyrica (pregabalin) 150mg; MagMin 500mg; Naprosyn 250mg; Phenergan (promethazine) 25mg; Quetia XR (quetiapine) 50mg; and Seroquel (quetiapine) 25mg.

27 Importantly, on 9 June 2020, Dr Fay prescribed 100 tablets of baclofen and 56 tablets of Lyrica (pregabalin). The script for baclofen was filled on 27 June 2020

[3] A specialist substance dependence rehabilitation unit.

and the script for pregabalin was filled on 5 July 2020 at Terry White Chemmart, Southgate.

Circumstances leading to Ally's admission to Tamworth Hospital on 5 July 2020

28 On 2 July 2020, Ally moved into temporary accommodation at the Central Motel Tamworth[4].

29 On Sunday, 5 July 2020 at 4:28pm, the Manager of the Central Motel Tamworth contacted triple-0 to report Ally screaming. NSW Ambulance dispatched a team of paramedics at 4:33pm who arrived at 4.40pm. Ally was screaming and would not engage in conversation. Cst. Bailey observed that when Ally screamed 'her eyes would roll back in her head and her hands and arms would clinch'. S/Cst. Witchard made similar observations.

30 At 4:42pm, NSW Ambulance paramedics arrived on site and 'tried multiple times to de-escalate with her and chat to her and it wouldn't work' before transferring Ally to Tamworth Hospital under s 20 of the *MH Act*. Chemical (10mg droperidol at 4:45pm), physical, and mechanical restraints were applied.

31 Multiple medications, including a packet of pregabalin (150mg) with 11 tablets missing were found with Ally by clinicians at Tamworth Hospital upon her arrival to ED. A 'bong' was also found by NSW Police in Ally's room at the Central Motel Tamworth indicating the potential of recent cannabis use.

Ally's final admission to Tamworth Hospital

Tamworth Hospital ED

32 On 5 July 2020 at 5:09pm, the ambulance arrived at Tamworth Hospital. Ally was triaged in the ED, her 'observations [were] within normal limits' and she remained agitated.

[4] Arranged by the NSW Department of Communities and Justice, Housing (as it then was).

33 At approximately 6:00pm, Ally was seen by Dr Reardon, Emergency Registrar, who recorded:

> On arrival to ED intermittent bursts of screaming but now GCS[5] 3.
> Multiple ED/hospital admissions with agitation/yelling
> → likely 2 opioid/benzo abuse
> Recent admission to Odyssey House (detox)
> 29 April – early June
> → discharged as felt not helping.

34 Ally presented with the following medications on her person: venlafaxine, promethazine, baclofen, pregabalin, clonidine, doxylamine, paracetamol and aspirin. Pregabalin (150mg), dispensed that day, had been found on Ally's person, however 11 tablets were missing.

35 Nursing progress notes indicate that whilst in the ED, Ally received one to one nursing care, was managing her own airway with the assistance of oxygen administered via nasal prongs and generally remained sleepy with intermittent episodes of yelling while awake.

36 At 8:00pm, Ally was seen in the ED by Dr Varcoe who noted his impression of an acute behavioural disturbance triggered by emotional stress or recent benzo/opioid detox. He recorded that an empty sheet of pregabalin was found at Ally's residence.[6] He noted concern regarding pregabalin intoxication and determined that Ally required monitoring by the High Dependency Unit (**HDU**) given current level of consciousness and concern for overdose. The plan was discussed with Dr Stephen May, Admitting Medical Officer. An indwelling urinary catheter was inserted at 8:30pm.

Tamworth Hospital ICU

37 On 5 July 2020 at 9:45pm, Ally was transferred to the ICU. Prior to this occurring, Ally was reviewed by Dr Emad Ahmed, the ICU Registrar. Dr Ahmed

[5] Glasgow Coma Scale.
[6] There was some inconsistency in various records as to whether the pregabalin was found at the residence or on Ally's person. I accept that the pregabalin was found on her person having been filled that day and having 11 tablets missing. This is not a controversial issue in that it was clear to those treating Ally that she had potentially consumed 11 pregabalin tablets on the day of her admission.

stated that he discussed Ally's presentation with Dr Sebastiaan Blank, Intensivist and on-call ICU Consultant, and recommended her admission to the ICU for further management. Dr Blank then accepted Ally's admission.

38 Dr Ahmed then reviewed Ally following her admission to the ICU. He noted Ally to 'have a fluctuating level of consciousness with agitation,' the cause of which was unclear. Dr Ahmed stated, 'the possibilities that were being considered were polysubstance ingestion, including 11 tablets of Pregabalin.' Dr Ahmed also noted that on examination, Ally's vital signs were normal: heart rate was regular at 60 beats per minute and her blood pressure was 130/80; she was afebrile and her oxygen saturation was 99% on 2 litres of nasal oxygen; her pupils were reactive on both sides; her blood sugar level was 6.4; and her GCS score was fluctuating.

39 Dr Ahmed arranged for blood tests and a chest x-ray as part of the work-up to determine the cause of Ally's symptoms; Ally was also given short acting sedating agents to reduce her agitation (dexmedetomidine and propofol). Ally's chest x-ray taken later at 2:15am on 6 July 2020 indicated no abnormalities.

40 Whilst Ally was not intubated during this admission to the ICU, she was nursed 'head up' at thirty degrees, closely monitored with continuous end tidal nasal capnography, oxygen saturations, telemetry (cardiac monitoring) and periodic non-invasive blood pressure, blood sugar and temperature measure. Additionally, frequent neurological observations were recorded.

41 On Monday, 6 July 2020 at 1:45am, Ally was given 10mg droperidol intravenously by the ICU medical team to manage her behaviour/agitation.

42 At 5:00am, a single fever of 38 degrees was recorded, seven hours after Ally's ICU admission. This was consistent with prior presentations. Leukocytosis[7] (present in 10 of Ally's previous 11 admissions) was recorded at 21. While this was high, it had been higher in four other admissions.

[7] An elevated white blood cell count.

43 At 8:00am, Dr Ahmed handed Ally's care over to the 'ICU day team' for 'ongoing investigation and management.' Dr Andrew Clift, Locum Consultant Intensivist, was rostered on the ICU on 6 July 2020. However, Dr Guyon Scott, Director ICU and Intensive Care Specialist, who was rostered as the Consultant Intensivist on the HDU[8] of the ICU, volunteered to see Ally due to the complexity of her presentation.

44 Dr Scott's impression of Ally's presentation was severe behaviour disturbance of unclear trigger that was not consistent with drug intoxication or withdrawal.

45 Dr Scott stated:

> As a group, the intensivists in our ICU were all very familiar with [Ally's] presentations and concerned about adverse events from repeatedly intubating and extubating her. This was why she was not intubated on this admission.

46 Dr Scott's proposed treatment plan (documented at 10:44am) included:

(1) early referral to the liaison psych service

(2) awaiting consultant liaison psychiatry opinion

(3) continuing supportive care until a clear plan with mental health was made; and

(4) the need for a long term management plan for future presentations.

47 According to Dr Green, Psychiatry Registrar, at around 9:00am, she was forwarded a call from Dr Scott. Prior to taking the call, Dr Green had been informed that Dr Scott wanted to speak about Ally's case with Dr Zurek, Psychiatry Clinical Director, however he was unavailable. During the call, Dr Scott advised Dr Green that Ally had been admitted to the ICU on 5 July 2020 with acute behavioural disturbance and that he was seeking psychiatric review and input into Ally's ongoing care. Dr Green understood that Dr Scott was

[8] High dependency unit.

'looking to formulate a comprehensive multi-disciplinary plan to guide her care and allow her to be managed outside of ICU in the hospital during this admission.'

48 At 9:40am, Dr Scott ordered mechanical wrist and ankle restraints for agitation.

49 Dr Green arrived at the ICU sometime between 9:00am and 9:30am and reviewed Ally's medical records and the most recent discharge summary from the Banksia MHU. Dr Green became aware:

(1) of Ally's longitudinal history of severe polysubstance use disorder;

(2) that Ally had recently undergone a long admission to the Banksia MHU with the aim of detoxification and facilitation of transfer to a drug and alcohol rehabilitation facility; and

(3) that the cause of Ally's severe behavioural disturbance remained unclear (i.e. whether it was the result of drug toxicity/drug withdrawal or a combination of these).

50 Dr Green understood that Ally had previously been diagnosed with comorbid borderline personality disorder but no major mental illness for which effective psychiatric treatment would be available. However, she stated that 'psychiatry services continued to try and support Ms Bailey, to minimise her modifiable risks and to advocate for drug and alcohol treatment'.

51 Dr Green stated:

> I was witness to her condition/state while engaging with multiple ICU staff about her care over several hours. She continued to alternate between being sedated following the administration of sedative medications by the ICU staff and demonstrating extreme psychomotor agitation (screaming with nonsensical content and presenting with a markedly irritable affect.

52 Dr Green formed the impression that Ally was 'clearly at high risk of physical harm to herself in her current mental state' and scheduled Ally as a mentally disordered person under s 19 of the MH Act.

53 Dr Green noted that Dr Scott had requested a consultant psychiatric review, so that a plan could be made for transferring Ally from the ICU to the Banksia MHU, and also to prevent future ICU admissions in a similar clinical scenario. She stated that Dr Scott informed her Ally was 'medically cleared' for ICU discharge – that is, that the underlying medical issues had been investigated and were being managed at a level suitable for non-ICU care, and that Ally should be reviewed for admission to the Banksia MHU. Dr Green was not aware of any outstanding issues or any requirement for continuous cardiac monitoring (which is not available in Banksia MHU). Dr Green noted that whilst Ally was medically cleared for discharge from the ICU, her behaviour was too disturbed and dysregulated for discharge to her home or a normal medical ward.

54 Dr Green and Dr Scott discussed the potential need for ongoing sedation and airway support (intubation); Dr Scott did not think that intubation and ICU level sedation was needed for this admission. There was also discussion around the iatrogenic risks of harm (that is, harm caused by medical treatment/intervention), including ventilator-related pneumonia and other airway complications. Dr Green stated that there was 'no indication that the usual medications used for severe behavioural disturbance in Banksia would pose any additional risk' to Ally.

55 Dr Scott wanted, during a bedside review, to wean propofol with both the ICU and psychiatric consultants present, so that the consultant psychiatrist could indicate to ICU whether they felt the behavioural disturbance (which Dr Scott expected would recur on weaning) could be managed in Banksia MHU or not. This detail is not in his note, but his intention was for a multidisciplinary plan to be formulated prior to Ally's discharge from ICU.

56 At 10:16am, Dr Green recorded that:

> This lady has a severe substance use disorder and behavioural disorder that is likely fuelled by substance use and withdrawal. She has likely comorbid cluster B personality disordered… She has extremely high risks.

57 Dr Green spoke with Dr Taylor[9] about Ally's presentation. Dr Green conveyed that she felt 'out of my depth' in terms of a workable management plan given Ally's history, frequency of admissions and behaviour state. Dr Green stated:

> By way of background, there was less consultant psychiatrist cover at the time due to Covid 19 related staffing shortages. Many of our consultant psychiatrists [fly into] to Tamworth when providing onsite cover, but due to Covid, many flights were cancelled, meaning they had to drive (if they could attend at all). This had impacted consultant coverage and availability.

58 Dr Taylor instructed Dr Green to contact Dr Bratten, as he was the only available Consultant Psychiatrist in Tamworth. Dr Green called and spoke with Dr Bratten on three separate occasions on the morning of 6 July 2020. Dr Bratten was not able to examine Ally due to other clinical commitments. Dr Green said that she needed additional support and advice, as the situation was 'difficult and complex with no easy solution.'

59 At 10:44am, the ICU medical ward round notes record that in the ICU, Ally needed, 'max dose dexmedetomidine inf and propofol infusion to control agitation. She has been close to need intubation and invasive ventilation again.' It was also noted that 'without propofol infusion running she became agitated. Mostly screaming and not communicative. Required 40mg of propofol in 20mg aliquots to settle.'

60 Sometime after midday, after sedation had been ceased, Ally was observed to have become agitated and was thrashing loudly. Dr Clift was prompted to review Ally's record as Dr Scott was not in the ICU at this point and Dr Clift considered that Ally's behaviour 'would make transfer to the MHU very challenging.' Dr Clift did not feel it reasonable for this to be left to the nursing or junior medical staff, and given Dr Scott was unavailable, he volunteered to transfer Ally to Banksia MHU with her bedside nurse.

61 According to Dr Clift, after examining Ally, he contacted Dr Scott by telephone to clarify the plan. Dr Clift informed Dr Scott that Ally was yet to be seen by a

[9] Consultant Liaison Psychiatrist, (who was in Sydney at the time).

MHU consultant and Dr Scott stated that he would arrange this as a matter of priority.

62 Dr Scott accepted the possibility that this phone call took place though he could not recall it. Dr Scott's evidence was to the effect that even if the call had been made he is unlikely to have said what is alleged and that the alleged substance of the conversation is not consistent with the notes he has made in relation to Ally's care.

63 Given Dr Clift's clear recollection, I accept that the call was made. However, given the passage of time, I am unable to make a finding about precisely what was said. I accept that Dr Clift understood that Dr Scott would be arranging for Ally to be reviewed by the mental health team.

64 At 12:07pm, a nursing assessment note records that:

> when awake [Ally] unable to communicate, screaming, currently sedated with preecedex [sic] running @ 24.4ml/hr (1.5mcg/kg/hr) + Propofol @ 1ml/hr + boluses as required.

65 Sometime between 11:00am and 2:00pm, Dr Green participated in a teleconference with Dr Bratten and Stacey Doosey, the NUM of Banksia MHU. The specific detail of what was discussed is unclear, beyond what had happened since Ally's last admission, how she presented, the severity of the behavioural disturbance, her mental state and 'that ICU was keen for her discharge out of ICU now that she had been medically cleared'. The plan was to 'use a deescalating benzodiazepine regime' with other issues to be attended to by the ICU and psychiatry team including weaning the ICU sedation, removal of IV access, and arranging transfer and specific management on the ward. A psychiatry progress note indicates Ally was accepted for admission to the Banksia MHU by Dr Bratten, provided she was 'medically cleared.'

66 Dr Green contacted Dr Sam Hume, Psychiatric Registrar, and discussed Ally's pending transfer and admission. Dr Hume was informed that the ICU team 'asserted' to Dr Green that Ally had been 'medically cleared' – meaning they were 'satisfied that reversible medical causes for the patient's presentation had

been excluded and there was no further need for monitoring in a medical environment.'

67 At 2:27pm, Ally was discharged from the ICU and escorted to the Banksia MHU.

68 Following Ally's discharge from the ICU, at 3:02pm, Dr Green entered a psychiatry progress note in the ICU notes recording that Ally:

> Requires long term plan by psychiatrists, ED and ICU directors once in Banksia. Accepted for admission by Dr Bratten. Issues about weaning current propofol and dexmedetomidine, behavioural escalation, screaming and danger to self and others, removal of PICC line, transfer to Banksia and management there. Dr Scott, director requesting psychiatrist on site to attend. Dr Bratten aware and will attend.

Banksia MHU

69 Ally was escorted to the Banksia MHU on a hospital stretcher with mechanical restraints by Dr Andrew Clift, an ICU nurse and two security guards.

70 Upon Ally's arrival at the Banksia MHU, Dr Hume found that her level of agitation at this time 'prevented completion of a physical examination and measurement of vital signs'. During his review, Dr Hume noted symmetrical mydriasis[10]. This made Dr Hume:

> … concerned that Ally's behavioural disturbance may have had, at least partially, a contributory organic aetiology that would benefit from further assessment and monitoring in a medical, rather than psychiatric environment.

71 Dr Hume spoke with Dr Clift and asked for a clinical handover. Upon doing so, Dr Hume states that he was 'firmly instructed' that 'there [was] nothing medically wrong with her ... it's just mental illness … just treat her behaviour' and this was said to him several times. Dr Hume stated that he did not feel comfortable escalating his concerns about Ally's mydriasis due to the presence of Dr Clift and his clinical seniority as 'he was satisfied that she was medically cleared.' Dr Clift accepted that he may have said that Ally was 'medically cleared' and that there was no reason for her to remain in the ICU. Dr Clift said that he told

[10] The dilation of both pupils equally.

Dr Hume to contact the ICU Outreach team if he had any concerns. Dr Hume stated that he was advised by Dr Clift that further information regarding Ally's medical status and management could be acquired through her online electronic record.

72 Dr Clift's evidence was that he had reflected on Dr Hume's statement and he regretted that Dr Hume did not feel comfortable escalating his concerns. Dr Clift also reflected on the circumstances of Ally's transfer and regretted that he did not follow up to ascertain whether there were any subsequent issues.

73 Dr Clift stated that upon arriving to Banksia MHU, he personally handed Ally over to the Registrar on duty (i.e. Dr Hume). Dr Clift stated that there were no residual questions and that he confirmed with all present that medical escalation would be through the standard early warning system-based escalation process requesting a clinical review with an urgency determined by circumstance. After confirming that everyone present had been updated in regard to Ally's condition, Dr Clift left the Banksia MHU with the ICU nurse and heard nothing further regarding Ally.

74 Ally was extracted from the hospital stretcher and Dr Hume observed that she 'continued to thrash about' and 'attempted to remove her hospital gown and then began pacing around the ward in a disorganised fashion.' This presented a risk to Ally, staff and to other patients. After 'attempts at verbal de-escalation were unsuccessful,' Ally was physically restrained and administered with sedating injections (promethazine 50mg, midazolam 5mg and droperidol 10mg), as authorised by Dr Hume.

75 Ally was transferred to a seclusion room (room 23). A seclusion order was authorised at that time by Dr Hume for four hours[11] with observations required every 10 minutes.

76 After seeking access to Ally's medical records, Dr Hume telephoned his supervisor, Dr Stanton, to seek advice regarding Ally's management. After this

[11] to 6:30pm.

discussion, a provisional diagnosis of 'stimulant intoxication with associated behavioural disturbance' was made. Dr Hume noted this was consistent with previous presentations.

77 Doctors Hume and Stanton formulated a plan for Ally to be managed symptomatically for behavioural disturbance in accordance with serial risk assessments. This involved use of as-required chemical restraint[12] and seclusion, opting for less restrictive alternatives when possible. This plan was formulated with the view that 'the behavioural disturbance would resolve once physiological clearance of the aetiological substance occurred.'

78 Dr Hume requested that nursing staff obtain a set of vital signs from Ally as soon as feasible, so as to monitor for possible adverse effects of chemical restraint such as tachy-dysrhythmias.

79 From 2:30pm to 3:30pm, RN Michael Babatunde stood outside Ally's door to observe her for an hour following administration of the sedating medication. Observations every ten minutes were also noted on the relevant form. RN Babatunde noted Ally was:

> Restless, agitated, and stripping herself naked, not aware of her environment, pt has been yelling/crying loudly, too agitated for physical obs.

80 From 3:30pm, RN Babatunde moved to the nurses' station and continued to observe Ally via the CCTV system.

81 At around 4:00pm, Ally's mother Heather Bailey telephoned the hospital to speak with Ally but was told that she 'was locked in a room because she wasn't settling down.'

82 At 5:10pm, RN Babatunde recorded that Ally was given 200ml of cordial. At 6:40pm, he recorded that Ally was given 50ml of water however remained 'too agitated for physical obs.'

[12] Intramuscular haloperidol 5mg and promethazine 50mg every 4-6 hours.

83 At around 6:45pm, Dr Hume was contacted by nursing staff at the Banksia MHU seeking a review of Ally's four-hour seclusion order, which had expired.

84 At around 7:00pm, Dr Hume reviewed Ally by viewing the live CCTV footage and attending the window to the seclusion room. He did not identify any behaviour of concern but noted that Ally had removed her hospital gown and was thrashing about indiscriminately. Dr Hume asked to examine Ally physically, but after a discussion as to the risk of injury to staff, the view was reached that this was unsafe due to Ally's level of agitation. Dr Hume noted that Ally's 'agitation had not been meaningfully modified by the … rapid tranquilisation' but that he did not consider this to 'herald medical concern.'

85 A second seclusion order was authorised by Dr Hume for four hours[13] with observations required every 10 minutes. The Seclusion Authorisation Form noted that Ally was:

> 'Mentating and moving all four limbs spontaneously indicating adequate ad-organ perfusion. No seizure-like activity, localising behaviours for pain, or signs of exhaustion. Indeed, amazingly she appears to have a level of self-control over her degree of agitation.

86 Dr Hume further authorised intramuscular injections of 5mg haloperidol and 50mg promethazine to be given immediately, and later in six hours if required. At 7:09pm, Ally was physically restrained and at 7:13pm, Ally was administered promethazine 50mg and haloperidol 5mg. Following the injection, RN Babatunde again stood outside the door and observed Ally for one hour. He also recorded observations every 10 minutes.

87 At 9:00pm, RN Campbell passed the seclusion room and could see Ally 'moving around on the mattress on the floor.' She was trying to understand if Ally's movements were voluntary or involuntary. RN Campbell said to Ally through the door 'Ally, can you control those movements? Can you stop doing that?' Ally

[13] To 10:40pm

looked towards RN Campbell in response to her voice and stopped moving briefly but did not reply. She then continued moving her body.

88 At approximately 10:30pm, whilst at home, Dr Hume recalls receiving a phone call from nursing staff advising that Ally's seclusion order would need to be reviewed, and likely renewed, as her 'level of agitation had persisted without any change in quality or severity'. Dr Hume advised the nursing staff member that in accordance with protocol for clinical reviews after 10:00pm, the After-Hours RMO needed to attend to this clinical review.

89 At approximately 10:30pm, Dr Adam Smith, Resident Medical Officer, attended and examined Ally via CCTV footage of the seclusion room for 10 minutes for the purpose of determining whether to cease or extend the seclusion order. Dr Smith noted that Ally was naked, rolling around on the floor and muttering and yelling out randomly.' He asked the nursing staff about Ally's condition and, in particular, what she had been like prior to then. He was advised that Ally's presentation at the time of his examination was consistent with her presentation earlier in the day.

90 Dr Smith determined that the seclusion order should be extended for a further four hours from 10:40pm[14] with observations to be conducted every 10 minutes. This determination was made on the basis that Dr Smith would physically review and examine Ally at the next review after making arrangements for security staff to attend with him. He advised nursing staff that he would make a 'detailed medical record entry following the next assessment' as he was required to attend on another patient on another ward. Dr Smith did not make any contemporaneous medical record of his assessment of Ally at the relevant time, however made a retrospective record based upon his recollection.

91 At 10:40pm, RN Shortie Gatsi completed a 'Nursing Observation – Seclusion Form.' Ally's mental and physical condition was observed to be 'restless, agitated and stripping herself naked not aware of her environment … Pt yelling loudly.' The form also noted that Ally had 200ml of orange juice at 10:40 pm.

[14] To 2:40am on 7 July 2020.

Observations were recorded on this form every 10 minutes for the next hour and 20 minutes.

92 At 12:00am on 7 July 2020, RN Gatsi observed that Ally was less restless. He recalled that Ally became quiet for a few seconds before falling to her side on the mattress. RN Gatsi realised there was something wrong and immediately opened the door to the seclusion room to physically check on Ally while activating a duress alarm.

93 RN John and RN Piquit attended the seclusion room to assist. RN Gatsi assessed Ally and found that she was not breathing. CPR was commenced and at 12:03am, a call was made to the MET[15]. The MET arrived in less than 10 minutes and took over resuscitation efforts from the Banksia MHU nursing staff.

94 At 12:34am, resuscitation efforts were ceased and tragically, Ally was pronounced deceased.

Post-Mortem: report of Dr Loots dated 8 October 2021

95 Dr Loots opined that Ally died from pneumonia with diffuse alveolar[16] damage in the setting of mixed drug toxicity (Baclofen and Pregabalin).

96 Toxicology analysis confirmed the presence of cannabinoids and non-toxic levels of the anti-depressant venlafaxine and its metabolite desvenlafaxine, as well as midazolam (a sedatory benzodiazepine) and droperidol (an antipsychotic agent used for sedation in acute psychosis).

97 Significantly, baclofen and pregabalin were present in toxic levels.

98 Dr Loots commented that on Ally's initial presentation to hospital her vital signs (heart rate and blood pressure) were reported to be within the normal range which suggested that initially her body was compensating for her underlying respiratory failure and systemic sepsis caused by the infection. Her respiratory

[15] Medical Emergency Team.
[16] Air sacs in the lungs.

failure was exacerbated by the baclofen and pregabalin toxicity. Those drugs, Dr Loots explained, can independently and in combination, cause acute confusion and respiratory failure. Dr Loots opined that the underlying significant pneumonia coupled with the complications of toxic levels of baclofen and pregabalin has caused Ally to acutely decompensate and that is her most likely cause of death.

Issues

Findings required pursuant to section 81 of the Coroners Act: the identity of the deceased; the time, date and place of death; the cause and manner of death.

99 Ally died at 12:34am on 7 July 2020 from pneumonia with diffuse alveolar damage in the setting of mixed drug toxicity (Baclofen and Pregabalin) whilst involuntarily detained, in seclusion and under periodic observation, in the Banksia MHU in Tamworth Hospital.

Whether the care and treatment provided to Ally by Tamworth Hospital between 5 and 7 July 2020 was appropriate and adequate.

Whether Ally was correctly diagnosed and medicated.

100 On 17 April 2020, Dr Hume wrote[17] that Ally:

> …does not have a mental illness. She does, however, have an extremely serious drug addiction: benzodiazepines and cannabis.

101 On 22 April 2020, the MHRT[18] determined that Ally was a mentally ill person pursuant to s 35 of the *Mental Health Act* 2007 (NSW) (**MH Act**).

102 On 9 June 2020 Dr Fay[19], recorded in his clinical notes, diagnosis of depression and anxiety amongst other things.

103 On 5 July 2020, Dr Reardon considered Ally was suffering from an acute behavioural disturbance triggered by emotional stress or recent benzo/opioid detox. Dr Varcoe was also concerned about pregabalin intoxication given an

[17] In a letter supporting Ally's admission to Odyssey House.
[18] Mental Health Review Tribunal.
[19] Ally's General Practitioner at The Belmore Surgery.

empty sheet of pregabalin was found on Ally's person. Dr Ahmed[20] also expressed this concern.

104 On 6 July 2020, Dr Scott opined that Ally was suffering from severe behavioural disturbance of 'unclear trigger'.

105 On 6 July 2020, Dr Green determined that Ally was a 'mentally disordered person' such that she could be involuntarily detained pursuant to s 19 of the MH Act. Dr Green recorded in her clinical notes:

> This lady has a severe substance use disorder and behavioural disorder that is likely fuelled by substance use and withdrawal. She has likely comorbid cluster B personality disordered…She has extremely high risks.

106 While in Banksia MHU, Doctors Hume and Stanton considered that there was in effect stimulant intoxication with associated behavioural disturbance. They were unaware of the underlying pneumonia which they could not have been expected to identify, given Ally's 'medical clearance' from ICU.

107 At this inquest, I have the benefit of expert analysis including:

(1) Emergency physicians, A/P McCarthy and A/P Chalkley, who opined that Ally's presentation was consistent with acute severe behavioural disturbance with drug intoxication or withdrawal likely to be the primary or major contributing cause.

(2) Psychiatry experts Dr Eagle, Professor Large and A/P Sullivan, who agreed with the underlying diagnosis of borderline personality disorder and substance use disorder. They also ultimately agreed that on 5 July 2020, Ally had an activated delirium of multifactorial origin, including overdose of medications.

[20] Intensive Care Unit, Tamworth Hospital.

(3) ICU experts Doctors Macken and Seppelt who considered that Ally's diagnosis in the ED was adequate and appropriate.

108 Ally's diagnostic picture was complex. There was a degree of diagnostic overshadowing[21]. There was not a correct diagnosis because there was also the underlying pneumonia infection, which is implicated in Ally's death, in addition to the drug toxicity (particularly, pregabalin and baclofen).

109 Importantly, however, it is clear from Dr Andresen's reports that the pneumonia could not likely be diagnosed until after 5 and 6 July 2020, notwithstanding some signs including a raised temperature of 38C, and some coughing and sputum.

110 A further bar to Ally's diagnosis was the inability of nursing staff to safely take her observations while she was in the Banksia MHU. I make no criticism of this decision by those on the ground managing complex patients and on occasion, exposing themselves to risk of injury or harm.

111 While Ally's diagnosis was incomplete, I proffer no criticism of those treating her in the circumstances described.

Whether a clinical toxicologist ought to have been consulted in the circumstances of Ally's presentation.

112 Dr Scott gave evidence that he did not consider contacting a toxicologist or think it necessary to do so. He said he had no barriers to doing so, he regularly contacts toxicologists and sees merit in doing so.

113 While there may have been a benefit in engaging with a toxicologist, the evidence adduced indicated that results for testing for pregabalin for example would not have been available before Ally died.

[21] Professor Large explains that the identification of Ally's physical complaints were overshadowed by her perceived behavioural disturbance.

114 Professor Jones in her oral evidence was sympathetic to the clinicians in not seeking toxicology advice particularly in a patient where her presentation appeared to be the same as previous admissions.

115 I was not persuaded on the evidence before the inquest that a toxicologist ought to have been consulted.

Whether, having regard to Ally's complex presentation in the ED, further investigations should have been conducted as to other potential diagnoses or contributing causes.

116 Ally was assessed by Dr Reardon and Dr Varcoe who obtained a comprehensive history of Ally's presentation and past medical and social background from the ambulance officers and from her daughter.

117 Vital signs and venous blood gases were taken, blood testing was ordered, and physical observations were documented.

118 Ally's presentation was considered to be an 'acute behavioural disturbance triggered by emotional stressor or recent benzo/opioid detox' and 'concern with pregabalin intoxication' was noted.

119 Ally was determined to 'need HDU monitoring given current level of consciousness and concern for overdose' and her admission was discussed with on-call physician Dr May.

120 There were two significant factors which remained unknown or uncertain at the time of Ally's death, that she was suffering from pneumonia and her pregabalin and baclofen levels. As highlighted above, her pneumonia could not have been diagnosed until 5 or 6 July 2020 (see para 109) and the results of additional toxicology analysis would not have been available before her death. As such, I could not find that further investigations should have been conducted. That is not to say that on reflection, those involved in Ally's treatment have not reflected on what they may do differently if faced with a similarly complex case.

Whether input should have been sought from a specialist emergency physician during Ally's clinical management in the ED.

121 While this was raised as an initial issue, it became clear that Dr Jones, a specialist emergency physician, was consulted in relation to Ally.

Whether there was an adequate period of stabilisation and investigation of potential organic causes whilst Ally was in ICU, prior to her transfer to Banksia MHU and whether the decision to medically clear Ally and transfer her from the ICU to the Banksia MHU on 6 July 2020 was appropriate.

122 I find on the evidence that the decision to transfer Ally from the ICU to Banksia MHU on 6 July 2020 was not appropriate.

123 As articulated by Dr Macken:

> With hindsight, ongoing treatment of Ms Bailey in ICU would have been in her best interests, in view of her need for significant sedation whilst in ICU, and because of the subsequent lack of physical examination and vital sign recording during her time in Banksia MHU. A clearer understanding of the level of care and monitoring that could be provided to Ms Bailey in Banksia MHU would likely have given pause to the ICU staff before making the determination to discharge her from ICU.

124 Also, by Dr Seppelt:

> Her discharge from the ICU to the MHU on 6 July was somewhat precipitous and as a general statement a patient should not be cleared for discharge to the MHU until it had been demonstrated that he or she did not need anything that could not be provided in the MHU. As highly potent anaesthetic agents such as propofol and dexmedetomidine can only be safely administered in the ICU, they needed to be ceased for an adequate time (e.g. overnight) to be sure that Allyson could be safely managed without them.

125 That said, I appreciate that Ally was prematurely discharged from ICU in circumstances where Dr Scott and Dr Clift were genuinely and appropriately concerned with the risk of iatrogenic harm.

Whether there was sufficient consultation that occurred between clinicians prior to her transfer.

126 I find that there was insufficient consultation between clinicians prior to Ally's transfer from ICU to Banksia MHU. Given the particular complexities of Ally's

presentation, a direct discussion between the ICU and Psychiatric consultants ought to have taken place as sought by Dr Scott. I accept that this did not occur as a consequence of miscommunication and, to some extent, a lack of resources.

127 Subsequent policy changes require a consultant to consultant discussion where there is no clinical agreement as to the transfer of patients[22]. Further, given renovations, the location of the mental health unit is no longer a barrier to cross specialty discussions.[23]

Whether the seclusion orders made for the three-consecutive four-hour periods in Banksia MHU on 6 July 2020 were appropriate.

128 The expert evidence supported, and I find, that the seclusion orders made were appropriate for Ally's safety and dignity.

129 That said, it is troubling that observations were not undertaken while rapid tranquilising medications were being administered.

130 Dr Eagle opined:

> I am of the view that given [Ally] was unable to be physically examined, was not responding to sedation, remained highly agitated and was not able to have vital observations done, further medical advice should have been sought by the junior medical staff. This could have been done after consultation with the on-call psychiatrist and/or medical registrar.

131 Consistent with Dr Eagle's view, I find that there ought to have been more consultation in circumstances where observations could not be performed.

Whether there was adequate physical observations and vital sign monitoring performed by clinicians and nursing staff in the Banksia MHU.

132 While nursing staff were seeking an opportunity to do so, physical observations and vital sign monitoring were not adequately performed on Ally.

[22] MH: Transfer of care from Tamworth Rural Referral Hospital Inpatient units to the Tamworth Mental Health Inpatient Unit
[23] Banksia MHU was previously in a different building.

133 It is concerning that Ally continued to receive sedating medications (with no effect) in an unmonitored environment at Banksia MHU.

134 Taking accurate observations on an agitated patient, even when restrained, is difficult to achieve and in some patients, attempts to do so may cause further agitation. However, Professor Large noted that while a patient is in restraints there is an opportunity to at least undertake some observations.

135 Dr Hume in his oral evidence acknowledged that nursing staff have the discretion to determine whether it is feasible or not to take vital signs. Safety of nursing staff is a concern and it is appropriate that they are empowered to make the call based on their own risk assessment about safety.

136 There was uncertainty in the Banksia MHU in relation to the escalation pathway in circumstances where physical observations and vital sign monitoring could not be performed.

137 Dr Macken's view, with which Professor Seppelt agreed, is that once it was clear that ongoing sedation was required, and that vital sign monitoring could not be performed on Ally, re-notification of, and discussion with, ICU clinicians would have been appropriate.

138 The psychiatric experts shared the view that observations ought to have been undertaken though I acknowledge that was not clear what such observations may have revealed and whether Ally's deterioration would have been apparent.

139 There have been beneficial reforms in this area by the HNELHD in terms of a structured escalation process where vital signs cannot be taken in particular circumstances; these reforms were approved and commended by the psychiatric expert panel.

Whether clinicians ought to have sought further medical advice or conducted/ requested further physical investigations, in light of the ongoing attempts to sedate Ally and her non-response to sedation.

140 Dr Hume accepted that there should have been escalation of Ally's care. However, he explained the reasons why this did not occur – in particular, because he had limited clinical experience and that point in time and was heavily reliant on Dr Stanton's clinical advice as to the plan and what to expect. Dr Hume understood his role was to look for any new behaviour or change in behaviour, and that non-responsiveness to the sedation medication was not to be unexpected. Dr Stanton was seeking to advise Dr Hume in circumstances where his clear view was that Ally should not have been transferred to Banksia MHU given she was not suffering from an underlying major mental health issue. I make no criticism of Doctors Hume or Stanton in these circumstances.

141 It was accepted by the individual clinicians, and the experts, that – with the benefit of hindsight – further medical review or escalation should have been sought during Ally's admission to the Banksia MHU. Her severe and unremitting agitation was unusual and the inability to take vital signs, as well as her non-responsiveness to parental sedation (which is rare), warranted escalation. Further evidencing the complexity of Ally's case:

(1) In Dr Macken's view was that it is difficult to determine at what point there should have been escalation but that it should have been before the second dose of parenteral sedation. Dr Macken considered that the second dose should not have been given in circumstances where vital signs could not be taken.

(2) Professor Large's oral evidence was that it is hard to work out when an escalation of Ally's care should have occurred. There was the first dose of parenteral sedation, and the second dose was at a more cautious level. In Professor Large's opinion, it was still reasonable to wait and observe for a period.

142 Following Ally's tragic passing, the HNELHD have updated their policies[24] to include a list of actions to take (including when to seek clinical review) where there is no clinical response to intramuscular sedation or a reduction in a SAT[25] score despite maximum pharmacological therapy.

Whether there was compliance with applicable HNELHD/NSW Health policies and procedures and clinical guidelines regarding seclusion and restraint, and sedation.

143 RNs Babatunde and Gatsi were knowledgeable about the requirements of seclusion and were plainly concerned to adhere to all the requirements, including the one hour of close observation after the giving of IM sedation.

144 Dr Smith did not strictly adhere to the policy and procedure relating to the seclusion policy. He was a very junior doctor in his first shift as the After Hours RMO. To his credit, Dr Smith asked about the applicable policies and was not assisted. Dr Smith frankly accepted aspects of non-compliance by him, and that with the benefit of hindsight there ought to have been escalation of Ally's presentation by him.

145 Unfortunately, the policies did not contain clear guidelines as to what a clinician should do where vital sign monitoring cannot be undertaken and when escalation should occur, as with what should occur if there is non-response to IM sedation.

146 Commendably, the HNELHD instituted policy reform well in advance of this inquest, followed up by recent audits directed by Dr Swamy.

Whether any recommendations are necessary or desirable in connection with Ally's death.

147 Helpfully, much of the focus of the inquest was on what improvements could be made to assist in the management of complex cases like Ally's case.

[24] Clinical Guideline Mental Health: Management of Acute Behavioural Disturbance in HNE Mental Health Units and The Mental Health: Seclusion and Restraint Policy.
[25] Sedation Assessment Tool.

148 The discussion centred around three areas in respect of which recommendations may be necessary or desirable:

(1) Whether patients should only be transferred directly to a mental health unit from ICU in exceptional cases.

(2) Whether documentation, policy and procedure relating to the management of acute behavioural disturbance in mental health units can be improved.

(3) Whether the phrase 'medically cleared' is appropriate.

149 In addition, given the complexities of Ally's presentation and the support of Ally's family, the use of Ally's as a 'case study' was also discussed in the course of the inquest.

Whether patients should only be transferred directly to a mental health unit from ICU in exceptional cases.

150 Dr Stanton outlined the benefits of specialist mental health intensive care units, prevalent in Britain but relatively new to Australia. There is one specialist mental health intensive care unit in Newcastle which does take state-wide referrals. These wards enable patients to commence in seclusion pods (housing 2 patients) with higher staffing ratios to larger pods (housing 4 patients) and then onto wards like Banksia MHU. Given the number of staff, it is easier to manage the taking of observations in a 'high risk' environment. The difficulty with having one unit in NSW is that it can take days to transfer a patient and the transfer of a distressed patient is not always possible or practical.

151 Dr Stanton considered that patients should only be transferred directly from an intensive care unit to a mental health ward like Banksia MHU in exceptional cases. Such cases to be determined following consultant to consultant discussions.

152 Dr Stanton outlined that a mental health ward is the 'least monitored medical bed in the entire hospital.' He considered a mental health unit to be akin to sending a patient home to the extent that it signifies they are medically or physically well enough to go home. To his mind, 'Banksia [MHU] is not a safe place for someone that has a medical problem.'

153 In the context of post hearing discussions between legal representatives in relation to the formulation of recommendations, Dr Stanton asserted that persons who are labelled 'mental health patients' and who require monitoring, such as vital sign observations, should be afforded the same safety measure as all other patients who are transferred out of ICU to another ward, what he referred to as a 'step down' ward. He recognises that this is not always appropriate and therefore considers a 'save for exceptional circumstances' proviso should accompany any otherwise 'blanket' rule.

154 Doctors Macken and Seppelt disagreed that a patient transferring from ICU to a mental health unit like Banksia MHU should be the exception. Dr Macken said that patients often transfer from ICU to a mental health ward safely. Dr Macken considered there is a risk in making a 'blanket' rule as he favoured a resolution which goes to the root cause. Dr Seppelt agreed and considered that for the vast majority of mental health patients who come through the ICU, a step down approach is not necessary. In particular, he highlighted mental health patients that may take an overdose. Once they have recovered from their acute intoxication it is appropriate that they be transferred to a mental health ward.

155 While there appears to be a contest as to what procedures ought to be in place for the transfer of patients between the ICU and the Banksia MHU, it is apparent from the differing views and from Ally's case that a review of the current procedures is appropriate.

<u>Whether documentation, policy and procedure relating to the management of acute behavioural disturbance in mental health units can be improved.</u>

(1) Dr Hume found the pathway in the event that observations could not be taken was unclear.

(2) Dr Smith considered the documentation could be improved by the cross referencing of relevant policies and time stamping of when orders are made.

(3) Dr Stanton raised concerns around the use of Droperidol for rapid tranquilisation. Dr Stanton participated in the development of NICE guidelines 2015[26]. Dr Stanton considered more appropriate medications for rapid tranquilisation include Lorazepam (not readily available in Australia) and Haloperidol plus Promethazine. Dr Stanton gave evidence that Droperidol is banned in the United Kingdom. He also considered the 'Mental Health: Management of Acute Behavioural Disturbance in HNE Mental Health Units' clinical guideline to inappropriately refer to Haloperidol without reference to Promethazine as he considers they should always be used together.

(4) Dr Swarmy was asked to comment on Dr Stanton's opinion in relation to these medication protocols. He considered that there was not an 'international consensus' as suggested by Dr Stanton and noted that there had been a review of the medication protocols a few years prior.

(5) Professor Large gave evidence that Droperidol is used by ambulance officers and not readily used in mental health wards because it can cause a drop in blood pressure. He commented that the literature is not particularly good and open to interpretation. Based on the opinions proffered it was clear this is an area which would benefit from more research and the answer is not readily available.

Whether the phrase 'medically cleared' is appropriate.

156 The significance and meaning of this phrase was relevant to this inquest but also highlights the problem with compartmentalising the physical from the mental in providing medical treatment in complex cases.

[26] Evidence based recommendations for health and care in England in Wales.

157 When Ally was transferred from ICU to Banksia MHU, this was on the understanding that she was 'medically cleared.' It was apparent through the course of the inquest that this phrase meant different things to different people.

(1) Dr Green considered it to mean that Ally's medical issues had been investigated and were being managed at a level suitable for non-ICU care.

(2) Dr Hume understood it to mean that there was no organic cause underlying her presentation. In his treatment of Ally, Dr Hume relied on this purported 'clearance' which he now perceives may have given him a false sense of security as to her physical wellbeing.

(3) Dr Scott indicated it means that a patient can be discharged onto the ward they need to go to. On reflection he indicated that the word clearance alone may be more appropriate – simply indicating that there was no medical barrier to being discharged from ICU.

(4) Of the phrase, Dr Clift said:

> Well, I suppose the term is self-explanatory. So, there is no medical grounds to keep the patient in a particular part of the hospital, so for, for a patient, like [Ally] that would mean that she was safe to be transferred to Banksia unit. She didn't require any ongoing investigations, organ support, or therapies that would not be available in that part of the hospital. That's not to say that she didn't need monitoring and she wouldn't need further medication, because it was my clear understanding that those things would be available to her, but she didn't need intensive care and she, she didn't appear to need the ward.

158 Dr Eagle considered the term to be inappropriate[27], in her view the term:

> …doesn't…cover the complexity of an individual's physical health needs in any situation… it doesn't inform anyone as to what needs to occur at this point of time, and it's certainly the case that [Ally] was not healthy enough or physically stable enough, for instance, to go out into the community without any ability - you know, without any counselling about how she should keep herself physically safe.

[27] Dr Sullivan and Professor Large agreed with Dr Eagle's analysis.

Recommendations

159 To address the issues outlined above and with the benefit of the input of Counsel Assisting and each of the participants, I make the recommendations that follow.

160 To the Chief Executive of the HNELHD:

(1) That there be a review of transfer of care/discharge processes and procedures in Tamworth Hospital for patients with complex mental health issues who are in high acuity areas (such as the ED or ICU), whose care is then transferred to the Banksia MHU. The review should consider the issues raised in the evidence of Dr Clive Stanton and Dr James Zurek and involve relevant stakeholders/clinicians from high acuity areas within Tamworth Hospital (such as the ED and ICU) and from Banksia MHU.

(2) That there be a review of HNELHD documentation, policy and procedure relating to the management of acute behavioral disturbance in mental health units (including as to the use of restraint and seclusion of patients), including as to the following matters:

(a) to ensure that the 'Seclusion Authorisation' form includes:

(i) provision for 'time stamps' on relevant forms (for example, the 'Seclusion Authorisation' document)

(ii) the number of seclusion orders made (i.e. whether the order is the first, second etc)

(iii) reference to the relevant procedures or policies in appropriately prominent terms.

(b) to ensure that, so far as practicable, the relevant policy provisions relating to seclusion, restraint (including rapid tranquilisation),

vital sign observations and escalation (including where vital sign monitoring cannot be undertaken and/or there is no response to intramuscular parenteral treatment) are set out in a clear manner (for example, by reference to a flow chart or a single document).

(3) That there be consideration of how the lessons learned from Ally's death could be used within HNELHD as a case study for learning by other clinicians including in relation to transfer of care (and issues with the terminology of 'medically cleared' and 'medical clearance' as being potentially misleading regarding a patient's physical health), monitoring and escalation issues (including potentially in a 'reflective workshop' forum).

(4) That consideration be given to a review of the Clinical Guideline 'Mental Health: Management of Acute Behavioural Disturbance in HNE Mental Health Units (CG 22_06)' concerning the Intramuscular (Parenteral) Treatment Rapid Tranquilisation protocol (p 52) by an appropriate person (or body/authority) to ensure:

(a) that it accords with current best practice (on the basis of the current literature); and

(b) that it reflects current prescribing practices within Banksia MHU.

Concluding remarks

161 I will close by conveying to Ally's family members my sympathy for the tragic loss of Ally. As I acknowledged at the outset, their engagement in the inquest and the warmth they showed to others will ensure that this inquest will result in beneficial changes and that those who treated Ally were not re-traumatised in this process.

162 The Assisting Team, Emma Sullivan and Mena Katawazi, were outstanding. As is clearly evident on the transcript, the enormous amount of work undertaken by The Assisting Team allowed the inquest to run efficiently and within the time

allocated. The minimal need for submissions by the participants reflects the hard work of Counsel Assisting in both out of court engagement and in the submissions she delivered.

163 I thank SC Russell and SC O'Rourke for their work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting Team.

Statutory findings required by s 81(1)

164 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is Allyson Bailey

Place of death

Allyson died in Banksia MHU at Tamworth Hospital

Date of death

Allyson died on 7 July 2020

Cause of death

Allyson died from pneumonia with diffuse alveolar damage in the setting of mixed drug toxicity (Baclofen and Pregabalin).

Manner of death

Allyson died whilst involuntarily detained, in seclusion and under periodic observation.

I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe

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Annexure B

Lay witnesses	
Dr Jodie Reardon	Emergency Registrar, Tamworth Hospital
Dr Brayden Varcoe	Medical Registrar, Tamworth Hospital
Dr Andrew Clift	Locum Lead Intensivist
Dr Raeleigh Green	Consultant Liaison Psychiatry Registrar
Dr Guyon Scott	Director ICU and Locum Intensivist
Dr Sam Hume	Psychiatry Registrar
Dr Clive Stanton	Consultant Psychiatrist
Dr Adam Smith	Resident Medical Officer
Michael Babatunde	Registered Nurse
Shortie Gatsi	Registered Nurse
Dr Anandamurugan Muthukumaraswamy (Dr Swarmy)	Executive Director, HNEMHS
Dr James Zurek	Psychiatry Clinical Director
Experts	
Professor Alison Jones	Expert Clinical Toxicologist
Associate Professor Sally McCarthy	Emergency Physician
Dr Lewis Macken	Intensive Care Physician
Dr Kerri Eagle	Consultant Forensic Psychiatrist
Professor Matthew Large	Psychiatrist
Dr Danny Sullivan	Consultant Forensic & Adult Psychiatrist