CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of LF, Merryn Ward and Shao
Hearing dates:	21 to 24 July 2025
Date of Findings:	30 June 2026
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Judge Teresa O'Sullivan, State Coroner of New South Wales
Catchwords:	Self-harm, suicide, Royal Prince Alfred Hospital, involuntary detention, voluntary detention, Mental Health Act 2007
File numbers:	2019/273880, 2021/347390, 2022/217530
Representation:	Mr Jake Harris, Counsel Assisting, instructed by Ms Ashliegh Heritage, Crown Solicitor's Office Mr Jason Downing SC, for the Sydney Local Health District, instructed by Mr Matthew Renwick, McCabes
Protective orders:	Non-publication orders prohibiting the publication of certain evidence and any matters that identify the deceased persons known by the pseudonyms "LF" and "Shao" pursuant to the *Coroners Act 2009* (NSW) have been made in this inquest. A copy of these orders can be found on the Registry file.
Publication order:	In accordance with s 75(5) of the *Coroners Act 2009* (NSW), I make an order permitting the publication of a report of the proceedings as I consider that it is desirable in the public interest to permit a report of the proceedings.

Findings made pursuant to section 81(1) *Coroners Act 2009* (NSW) in relation to LF	**Identity** The person who died was LF. **Date of death** LF died on 2 September 2019. **Place of death** LF died at the Royal Prince Alfred Hospital, 50 Missenden Road, Camperdown NSW 2050. **Cause of death** The cause of death was in keeping with hanging. **Manner of death** LF's death was intentionally self-inflicted at a time when she was voluntarily admitted to the Professor Marie Bashir Centre.
Findings made pursuant to section 81(1) *Coroners Act 2009* (NSW) in relation to Merryn Ward:	**Identity** The person who died was Merryn Ward. **Date of death** Merryn died on 5 December 2021. **Place of death** Merryn died at the Royal Prince Alfred Hospital, 50 Missenden Road, Camperdown NSW 2050. **Cause of death** The cause of death was ligature strangulation. **Manner of death** Merryn's death was intentionally self-inflicted while detained on an involuntary basis at the Professor Marie Bashir Centre.

Findings made pursuant to section 81(1) *Coroners Act 2009* (NSW) in relation to Shao:	**Identity** The person who died was Shao. **Date of death** Shao died on 22 July 2022. **Place of death** Shao died at the Royal Prince Alfred Hospital, 50 Missenden Road, Camperdown NSW 2050. **Cause of death** The cause of death was hanging. **Manner of death** Shao's death was intentionally self-inflicted while detained on an involuntary basis at the Professor Marie Bashir Centre.
Recommendations	<u>To the Sydney Local Health District, I recommend:</u> 1. That the LHD review and consider updating SLHD_PCP2021_024 in respect of serious incident management to provide guidance as to steps the person who initially takes the lead role in incident management might take or organise to be taken so as to: i. locate and preserve items or equipment used in the incident; and ii. identify staff who witnessed or have knowledge of the incident, and gather other information in respect of the incident.

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Introduction

1. From 21 to 24 July 2025, an inquest was held to examine the deaths of LF, Merryn Ward and Shao. These women were patients of the Professor Marie Bashir Centre (**PMBC**), at the Royal Prince Alfred Hospital (**RPAH**) in Sydney, New South Wales, who died between September 2019 and July 2022. Each died by way of self-harm within the PMBC and each self-harm occurred in a similar manner.

Why was an inquest held?

2. Under the *Coroners Act 2009* (NSW) (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

3. The deaths of three women who were patients of the same mental health facility, who died by similar means between September 2019 and July 2022 raised questions regarding their care and treatment, and the manner of each patient's death or, in other words, the circumstances surrounding their deaths. For those reasons, an inquest was held into their deaths.

The PMBC

4. Throughout the course of the coronial investigation and during the hearing, evidence was gathered and heard from several witnesses, including Dr Andrew McDonald, the Clinical Director of the Mental Health Service (**MHS**) for the Sydney Local Health District (**SLHD**).

5. Dr McDonald assisted the Court in providing information relating to the PMBC and its layout. The PMBC was opened in 2012 and is located within the RPAH campus, in a separate building.

6. The PMBC is located within a six-level building. The PMBC is comprised of four levels, being the ground floor, and levels 3, 4 and 5. Level 3 is the Acute Inpatient Unit. Level 4 contains separate male and female High Dependency Units (**HDU**), and Level 5 contains a unit for eating disorders and the Short Stay Unit (**SSU**). There is also a parent and baby unit located in a building next to the PMBC, which was opened in 2022.

7. Each room at the PMBC contains shelving to store patient belongings, an ensuite bathroom and there are motion sensors above each bed that can be turned on to detect patient movement if they leave the bed during the night.

8. Each of the PMBC units have dining and lounge areas, as well as outdoor courtyard areas. As provided in evidence, there is a focus on encouraging patients to spend more time in the open areas of the units, rather than in their rooms.

9. Each unit at the PMBC also contains a nurses' station and patients at higher risk are placed in rooms nearby for greater visibility. Nursing staff are also encouraged to spend more time in open areas with patients, rather than in the nurses' station.

10. As will be noted throughout these Findings, particularly for Merryn and Shao's matters, COVID-19 had an effect on the PMBC throughout 2021 and 2022.

What issues did the inquest examine?

11. Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

Relating to LF

The Findings required by s 81 of the Coroners Act 2009, regarding the identity of the deceased, the date and place of death, and the cause of death, are sufficiently disclosed. The following issues arise with respect to the manner of death.

1. *Was reasonable and appropriate care and treatment provided to LF during her admission to the PMBC, from 21 August to 2 September 2019? This includes but is not limited to:*
    a. *the decision to detain LF as an involuntary patient on 21 August 2019,*
    b. *the decision to re-classify LF as a voluntary patient on 30 August 2019, with a plan to discharge her to a private facility,*
    c. *the location of care,*
    d. *observation levels, and*
    e. *access to ligatures.*
2. *Was reasonable and appropriate action taken after the following events occurred:*
    a. *LF became distressed during the family visit on 2 September 2019, and*
    b. *LF's husband telephoned nursing staff to raise concerns?*
3. *What was the ligature used by LF? How and when did she obtain it?*

Relating to Merryn Ward

The Findings required by s 81 of the Coroners Act 2009, regarding the identity of the deceased, the date and place of death, are sufficiently disclosed. The following issues arise with respect to the manner and cause of death:

4. *Was reasonable and appropriate care and treatment provided to Ms Ward during her admission to PMBC from 28 November to 5 December 2021? This includes but is not limited to:*
    a. *the decision to detain Ms Ward as an involuntary patient on 28 November 2021,*
    b. *the location of care,*
    c. *observation levels, and*
    d. *access to ligatures.*
5. *Was reasonable and appropriate action taken on 1 December 2021 following Ms Ward's report of having strong thoughts to use her bed sheets to strangle herself?*
6. *What was the ligature used by Ms Ward? How and when did she obtain it?*
7. *What was the mechanism of Ms Ward's self-harm?*

Relating to Shao

The Findings required by s 81 of the Coroners Act 2009, regarding the identity of the deceased, the date and place of death, and the cause of death, are sufficiently disclosed. The following issues arise with respect to the manner of death:

8. *Was reasonable and appropriate care and treatment provided to Shao during her admission to PMBC from 10 June to 22 July 2022? This includes but is not limited to:*
    a. *the decision to detain Shao as an involuntary patient on 10 June 2022,*
    b. *the plan to discharge Shao into the community on 20 July 2022,*
    c. *the location of care,*
    d. *observation levels, and*
    e. *access to ligatures.*
9. *What was the ligature used by Shao? How and when did she obtain it?*
10. *Was reasonable and appropriate action taken after the following events occurred:*
    a. *the reported threat to self-harm on 18 July 2022; and*
    b. *the reported paranoia towards staff on 19 July 2022?*

Common issues

11. *Were adequate systems in place to prevent access to items that could be used for self-harm, including ligatures such as bed linen?*
12. *Were adequate systems in place to prevent access to locations that could conceal acts of self-harm, including bathrooms?*

13. *Were adequate steps taken to prevent patient access to hanging points?*
14. *Could further practical steps be taken to ensure evidence is preserved, following a self-harm incident which does not immediately result in a person's death?*
15. *What changes or improvements have been made at the PMBC since these deaths?*
16. *Is it necessary or desirable to make any recommendations in relation to any matter connected with these deaths?*

12. As part of the coronial investigation, an independent expert opinion was sought from Associate Professor Danny Sullivan (**Dr Sullivan**), consultant forensic and adult psychiatrist. Dr Sullivan provided two reports addressing questions regarding the circumstances of each of the three deaths and gave evidence during the hearing. His opinions are considered throughout these findings.

13. The circumstances of each of LF, Merryn and Shao's deaths will be examined separately, before turning to consider the common themes and issues considered at inquest.

LF

Introduction

14. LF was 33 years old when she died on 2 September 2019. She was admitted to RPAH as an involuntary patient on 21 August 2019. She was admitted to the Acute Inpatient Unit of PMBC as an involuntary patient on 22 August 2019. On 30 August 2019, her status as a patient changed to voluntary. The plan was to transfer LF to a private health facility on 3 September 2019 to continue her recovery. On 2 September 2019, LF was discovered hanging from the door of her ensuite bathroom at the PMBC and was declared deceased that day.

LF's life

15. LF's family, by way of their family statement, provided an understanding of what LF was like in her day-to-day life, prior to the events leading up to her death. They described that LF was full of love and energy and a fantastic mother who instilled love, joy and discipline into her daughter's life. She was wonderfully talented, with a love of the wild and exploring flora and fauna. LF's family conveyed that she was curious, brave, had a fierce spirit and made custom clothes and toys – all self-taught. She made meaningful relationships with her work colleagues and continued to participate in community activities, such as completing the City2Surf fun run.

16. LF was born in China. While in middle school, she attempted self-harm, twice.[1]

17. In 2005, LF met her husband, PF. They formed a relationship and in December 2006, they moved in together overseas. PF and LF lived together there for about a decade before moving to Australia. LF loved life here and was active in the community.[2]

18. They were married and welcomed the birth of their daughter soon after. LF was a wonderful mother.[3]

19. LF experienced poor mental health and suffered from post-natal depression. In about 2013, LF was prescribed an antidepressant, sertraline, for about a year.

20. From January 2015, she attended a cognitive therapist and reported occasional suicidal thoughts.[4]

[1] Tab 22, Statement of Nicholas Morton, [9].
[2] Tab 10, Statement of LF's husband, [13]-[14].
[3] Tab 10, Statement of LF's husband, [21].
[4] Tab 19, Letter from Dr Ann Elborn.

21. In January 2017, PF moved to Sydney to take up a job opportunity. LF and their daughter joined him in July that year. LF obtained work as a chartered accountant.[5]

22. From 13 to 21 July 2019, LF, PF and their daughter went on an overseas family holiday. No mental health concerns were raised.[6]

23. In the months prior to her death, LF's mood appeared to deteriorate.

24. On 9 August 2019, LF contacted her GP, who referred her to the Mental Health Access Line. She expressed thoughts of suicide and was referred to the Camperdown Community Mental Health Team (**CMHT**). LF was reluctant to engage with that service.

25. On 11 August 2019, LF participated in the City2Surf.[7]

26. On 16 August 2019, LF was reviewed by Dr Justin Ho, a psychiatrist of CMHT. He made a diagnosis of Major Depressive Disorder.[8]

27. On the same day, a nurse from the Acute Care Service (**ACS**), RN Therese Duong, also reviewed LF, who appeared highly emotional. LF said she had been stockpiling tablets with an intention to overdose. RN Duong did not believe LF was at immediate risk, and LF was given an antidepressant (15mg mirtazapine).[9]

28. Between 17 and 19 August 2019, PF travelled overseas to see his family. He offered to take LF and their daughter with him, but LF did not want to go.[10]

29. On 17 August 2019, the ACS attempted to visit LF, but she did not want to see them.[11] There was a further attempt on 18 August 2019, when LF said she would attend the clinic the following day. She did not do so.[12]

30. When PF returned from overseas, LF would not speak to him.[13]

31. On 20 August 2019, LF appeared emotional at work, and asked for a few days off.

32. That day, RN Duong came to the home again, as LF had not attended the clinic. LF appeared very flat. LF declined to attend hospital but agreed to come to the clinic the following day.

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[5] Tab 10, Statement of LF's husband, [24]-[29].
[6] Tab 10, Statement of LF's husband, [30].
[7] Tab 10, Statement of LF's husband, [32].
[8] Tab 20, Statement of Dr Justin Ho, [7].
[9] Tab 21, Statement of RN Therese Duong, [6].
[10] Tab 10, Statement of LF's husband, [34].
[11] Tab 21, Statement of RN Therese Duong, [8].
[12] Tab 21, Statement of RN Therese Duong, [9].
[13] Tab 10, Statement of LF's husband, [35].

33. However, again, LF did not attend the clinic.[14] Accordingly, in the evening of 21 August 2019, RN Duong and social worker Nicholas Morton attended LF's home. LF appeared depressed and expressed themes of hopelessness and helplessness. She disclosed suicidal ideation and said she had stockpiled medications, but she was evasive when asked about this. She said, "*nothing will get better and it will be like this forever*".[15] She declined a voluntary admission and declined to be taken to hospital.

34. The ACS team were concerned for LF, and so Mr Morton completed a schedule, pursuant to s 19 of the *Mental Health Act 2007* (**MH Act**), noting he was of the opinion that LF was a mentally ill person.[16] PF was contacted and agreed with the plan.[17] LF was then conveyed by ambulance to RPAH.

Admission to RPAH

35. LF was admitted to RPAH at 7:05pm on 21 August 2019. She was detained as an involuntary patient.[18] She was initially in the Emergency Department (**ED**) with a nurse special, meaning one-to-one care by a nurse. She was permitted escorted leave only.

Admission to PMBC

36. The following day, 22 August 2019, LF was transferred to PMBC. She remained an involuntary patient and was placed in Room 2 on level 3, being the Acute Inpatient Unit.

37. LF remained in PMBC for eleven days until her death on 2 September 2019.

38. During the admission, LF came under the care of psychiatrist Dr Azadeh Azadi. She reviewed LF four times: 23, 26 and 30 August 2019, and 2 September 2019.

39. Dr Azadi noted that the standard practice at the PMBC involved a morning handover, which was attended by the medical team, allied health and nursing staff. During this time, new patients are discussed and allocated care to medical staff. The handover also covered progress, changes and events that occurred in the previous 24 hours.[19] LF's care was allocated to Dr Azadi as her consultant psychiatrist and to Dr Timothy Ghan, psychiatry registrar.

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[14] Tab 21, Statement of RN Therese Duong, [11]
[15] Tab 21, Statement of RN Therese Duong, [12].
[16] Tab 33C, PMBC and RPAH records, pp 13-18.
[17] Tab 22, Statement of Nicholas Morton, [9]-[13].
[18] Tab 33C, PMBC and RPAH records, p 8.
[19] Tab 29, Statement of Dr Azadeh Azadi, [2a](ii).

40. LF engaged well at Dr Azadi's first review during ward rounds, on 23 August 2019. Dr Ghan and a registered nurse (**RN**) attended the review. LF reported experiencing low mood and suicidal ideation. Dr Azadi's general impression of LF was that she was very well spoken. LF spoke about stressors. Dr Azadi spoke with LF's husband to gather collateral information and the possibility of LF being transferred to a private facility once her mental state was stable, was raised.[20] Dr Azadi's working impression of LF's condition was Major Depressive Disorder.[21]

41. The plan was to care for LF at Care Level 3 (requiring 30-minute observations).[22] She was to be nursed by female staff where possible. She was commenced on Lexapro (escitalopram, an antidepressant). There was also a plan to consider transfer to a private hospital the following week, if LF's mental state was stable, which is what LF preferred.[23] LF hoped this hospital admission would create an opportunity for change.[24]

42. PF and LF's daughter visited her on the ward, and were able to take LF out on escorted leave a few times.

43. From 25 August 2019 onwards, LF spent time on a craft project.[25] This was something she had done in the community. LF was initially asked to hand back the items, but later it appears she was allowed to keep them in her room.[26]

44. Dr Azadi gave evidence that accessing craft activities is therapeutic. Whilst she felt LF was still at risk, Dr Azadi did not consider this warranted giving specific instructions to nursing staff as there were already processes in place aiming to prevent access to things that may cause harm.[27] Dr Azadi gave evidence that part of caring for patients in a mental health facility is about building trust with patients using items on the ward, transitional practices and to build rapport as to what is allowed.[28]

45. Dr Azadi reviewed LF on 26 August 2019 with Dr Ghan, a registered nurse and LF's husband. Prior to reviewing LF, Dr Azadi reviewed her medical notes which stated that LF had been engaging well with staff and some patients, had spent time doing crafts, and effectively utilised her leave with her husband. During this review, LF

[20] Tab 29, Statement of Dr Azadeh Azadi, [2a](ix).
[21] T18.40-41.
[22] However, the progress note incorrectly recorded that LF was to be observed on Care Level 4 (hourly observations).
[23] Tab 29, Statement of Dr Azadeh Azadi, [2](a)(x).
[24] Tab 29, Statement of Dr Azadeh Azadi, [2](a)(vii).
[25] Tab 33C, PMBC and RPAH records, p 90.
[26] Tab 33C, PMBC and RPAH records, p 90.
[27] T22.10-15.
[28] T28.31-34.

appeared less engaged and guarded. She expressed some feelings of hopelessness, stating *"I don't know what the solution is"*.[29] They again discussed possible discharge to a private hospital. The plan included referral to a psychologist.[30]

46. LF was also seen by an interim clinical psychologist on 26 and 30 August 2019 and 2 September 2019.[31]

47. Dr Azadi's registrar, Dr Ghan saw LF on her own, on 28 August 2019. The plan as discussed with Dr Azadi was for a referral letter for a private hospital to be prepared so LF could be placed on a waiting list for a bed.[32]

48. Dr Azadi reviewed LF again on 30 August 2019. LF said she had noticed the effects of the medication. She felt it was not making her happy, but was flattening her changes in mood. LF did not appear markedly distressed and she denied suicidal ideation. LF was willing to be discharged to another facility, and had made contact with St John of God at Burwood.

49. Accordingly, Dr Azadi decided to end LF's involuntary patient schedule, and continued LF's admission as a voluntary patient, with a plan for her to be admitted to the private hospital. Dr Azadi also reduced the care level to Care Level 5, which required formal observations to be taken every two hours.[33] Dr Azadi noted LF knew she still needed to stay in hospital even though she wanted to be at home, which demonstrated that LF had better insight and judgement, and was future focused. Dr Azadi noted that transfer to a private facility showed that LF still required care, but the least restrictive form of care appropriate for LF at the time.[34]

50. The psychologist who saw LF that day noted that LF's previous protective factors were no longer protective. This was a concern, and the information was immediately passed on to the psychologist's supervisor and handed over to nursing staff.[35]

51. LF was visited by PF and their daughter over the weekend, with no issues.

[29] Tab 29, Statement of Dr Azadeh Azadi, [2](a)(xiii).
[30] Tab 29, Statement of Dr Azadeh Azadi, [2](a)(xiv).
[31] Tab 31, Statement of Narelle Spinks, [18], [29].
[32] Tab 33C, PMBC and RPAH records, p 98.
[33] Tab 29, Statement of Dr Azadeh Azadi, [2](a)(xxii); Tab 33C, PMBC and RPAH records, pp 102-103.
[34] T24.45-T25.2.
[35] Tab 31, Statement of Narelle Spinks, [26]-[28].

Events of 2 September 2019

52. During the morning of Monday, 2 September 2019, LF texted a work colleague, explaining she was going to move to a private hospital. LF appeared positive in these messages.

53. LF was reviewed by Dr Azadi and Dr Ghan during the ward round. LF engaged well, and appeared comfortable, polite and cooperative. She denied thoughts of self-harm. The plan to transfer LF to the private hospital was noted, and it was recommended that she see a psychologist or counsellor in the community.[36] Although LF had been offered a bed at the private Sydney Clinic, LF wished to be transferred to St John of God, as this was closer to home, and expressed optimism that a bed at St John of God would become available soon. Dr Azadi considered LF to be truthful in her communication of her suicide risk as she was able to speak about this without being evasive or defensive, and she was not guarded. Consequently, Dr Azadi's evidence was that she had no reason to doubt what LF was telling her.

54. Later that day, LF saw the psychologist again, who thought LF appeared brighter in mood. LF continued to express feelings of hopelessness but denied any suicidal ideation.[37]

55. The afternoon nursing shift commenced at 1:30pm and a handover between the outgoing and incoming nurses occurred. RN Xiaonan 'Mandy' Wang was the oncoming nurse, who was going to care for LF that afternoon. This was the first time RN Wang had cared for LF.

56. Between 3:00pm and 4:00pm, RN Wang introduced herself to LF. LF appeared happy with the plan to discharge her to a private hospital. The discharge papers had been faxed to St John of God, and there was a bed available the following day around midday.[38]

57. Between 5:40pm and 6:00pm, RN Wang offered LF dinner, which she declined.

58. At 6:00pm, LF was observed to be in her bedroom by nursing staff.[39] Around this time, LF had a visit from PF and their daughter. This occurred in the family room. RN Wang was asked to supervise other patients in the dining room during dinner. From the dining room, RN Wang was not able to see the family room.

[36] Tab 29, Statement of Dr Azadeh Azadi, [2](a)(xxiii).
[37] Tab 31, Statement of Narelle Spinks, [31].
[38] Tab 24, Statement of Xiaonan 'Mandy' Wang, [19].
[39] Tab 33C, PMBC and RPAH records, p 65.

59. LF was taken to the family room. According to PF, she was upset because she had wanted him to bring her some noodles, but he brought her other food. LF started crying, and wanted time alone with her daughter.[40]

60. Between 6:00pm and 6:30pm, the ward's phone group commenced. This is a time, usually 30 minutes in duration, twice a day, where patients on the ward have access to their phones under supervision of two nursing staff in a common room.[41] RN Madelyn Wilson and Assistant in Nursing (**AIN**) Edwina Chilcott were allocated to supervise the phone group.

61. At about 6:20pm, AIN Chilcott saw LF's daughter consoling her mother in the family room.

62. Approximately five minutes later, whilst RN Wilson was heading to the nurses station to collect the phone chart, AIN Chilcott approached her and said she could see LF looked "*very distressed and was crying*".[42] As the more senior nurse between the pair, RN Wilson went and checked on LF. She noted that LF was "*quite hysterical and crying and she said she was just – she was very upset"*.[43] RN Wilson asked her if she was okay and LF replied that PF had not brought her dinner. RN Wilson reminded LF that family visits were meant to be happy occasions. LF replied *"[e]verything's fine, I'm fine, I just want to stay with [my daughter]*".[44]

63. RN Wilson then walked outside of the family room and spoke to PF. He confirmed that he did not have time to grab LF dinner and that was why she was upset. RN Wilson ran to the kitchen and got a meal for LF. When she returned with the meal, she asked LF if there was anything she could do to help. RN Wilson noted that LF appeared less upset and that she wished to spend more time with her daughter.

64. AIN Chilcott also told RN Wang about what she had seen. RN Wang recalled that she asked AIN Chilcott whether LF was "*okay*", and AIN Chilcott said she was "*okay*". Accordingly, RN Wang stayed in the dining room to continue supervising the other patients and thought she would speak with LF after dinner. After dinner, RN Wang walked to the family room and saw RN Wilson speaking with LF in the family room. She decided not to interrupt and wanted to ask RN Wilson to see what the situation was.

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[40] Tab 10, Statement of LF's husband, [46].
[41] Tab 28, Statement of AIN Edwina Chilcott, [13].
[42] T36.10; Tab 28, Statement of AIN Edwina Chilcott, [17]-[18]; Tab 24, Statement of RN Xianon 'Mandy' Wang, [24].
[43] T38.33-34.
[44] T36.36-37.

65. Whilst she was unable to recall the conversation in oral evidence, RN Wilson noted in her statement that she had a conversation with RN Tori Peden, who asked RN Wilson whether it was okay for LF to be alone with her daughter as LF had previously voiced thoughts of suicide to her daughter.[45] Following this, RN Wilson gave evidence that she spoke with LF's husband again and asked if he was concerned; to which he said he was not. The plan following this was to end family time as LF and her daughter had not eaten dinner. LF and her daughter said goodbye and RN Wilson escorted PF and their daughter from the ward.

66. RN Wilson saw LF in her room afterwards and LF "*seemed fine"* compared to during the family visit. RN Wilson thought it "*was just a normal interaction I guess*".[46] LF did not express any thoughts of harming herself to RN Wilson.

67. RN Wilson then told RN Wang what had occurred when they were in the medication room.[47] In evidence, RN Wang told the Court that RN Wilson had said LF was not happy about the food that her husband had brought her and that "*maybe she shouldn't cry in front of her daughter*".[48] RN Wang was not aware that LF had previously voiced thoughts of suicide to her daughter, nor did she recall RN Wilson telling her that RN Peden advised that LF previously voiced thoughts of suicide to her daughter.

68. RN Wang also tried to speak with LF, although LF did not want to talk about it. RN Wang noted LF was not crying and she asked LF whether she had been arguing with her husband. LF said "*no*",[49] and reassured RN Wang that she was okay. As it was a concern of her colleague, RN Wang suggested to LF that it would be good if LF could "*keep her cool in front of her daughter*",[50] and LF said, "*okay"*.[51]

69. At about 7:00pm, LF was observed to be leaving her bathroom.[52]

70. While in the car on their way home, LF's daughter told her father that LF said she was not going home, and that she just wanted her daughter to be happy. PF was concerned by this and called PMBC. He spoke to RN Eloise Johnson, the nurse-in-charge of the evening shift.

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[45] Tab 27, Statement of RN Madelyn Wilson, [22], Tab 28, Statement of AIN Edwina Chilcott, [20].
[46] T38.32, 37.
[47] Tab 24, Statement of RN Xiaonan 'Mandy' Wang, [28]; Tab 27, Statement of RN Madelyn Wilson, [26].
[48] T55.17-18.
[49] T55.43.
[50] T55.44.
[51] Tab 24, Statement of RN Xiaonan 'Mandy' Wang, [32].
[52] Tab 33C, PMBC and RPAH records, p 65.

71. RN Johnson recalled the night was busy for her and she had worked a total of 18 hours that day. RN Johnson gave evidence that she thought that this information from LF's husband was a *"red flag which is why I, I did write it down, I gave it to [RN Wang] and I said, "Can you please go and check on her?" I was very clear in my instruction that she go and check on her"*.[53] RN Johnson recalled telling PF: *"Don't worry, sir. We will look after her"*.[54] According to PF, RN Johnson said, "*it sounds like there is an increased risk of suicide"*. RN Johnson did not recall that in her evidence.[55]

72. This was the last contact staff had with PF prior to LF's death.

73. RN Wang recorded a progress note at 8:39pm, which documented that the call had taken place.[56] RN Johnson indicated in her evidence she believed it was later, between 9:00pm and 9:15pm. However, RN Johnson conceded that her shift was very busy as nurse in charge, and it felt to her as though she was moving from event to event, and so the call may have been made earlier.[57]

74. Unfortunately, the note that RN Johnson passed on to RN Wang could not be located, to be admitted into evidence in this inquest.

75. RN Johnson was adamant that there was not a delay between her taking the phone call and handing the note to RN Wang.[58]

76. RN Wang did not share this recollection and told the Court that RN Johnson had informed her that PF had called. A progress note prepared by RN Wang at 8:20pm (signed at 8:39pm) noted "*after husband left the ward he called, was saying that [LF] was asking the child to tell daddy "I won't be bothering him anymore""*.[59]

77. RN Wang assumed the note was with reference to what had happened during the visit. As she had already spoken to LF, she decided to give LF some space, rather than confronting her about the call.[60] In evidence, RN Wang noted that "*partners argue and get in - like, you know, argue and not argue, you know. I thought just a normal, you know - how to say - partnership, like you know what I mean, marriage relationship*".[61]

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[53] T73.39-31.
[54] T73.41.
[55] Tab 25, Statement of RN Eloise Johnson, [22]; T73.33-37.
[56] Tab 33C, PMBC and RPAH records, p 112.
[57] T74.4-15.
[58] T74.22-25.
[59] Tab 33C, PMBC and RPAH records, p 112; T64.42-43.
[60] Tab 24, Statement of RN Xiaonan 'Mandy' Wang, [36].
[61] T59.47-49.

78. RN Wang further stated that:[62]

> *Because I have already asked her about the visit before. She, she didn't seem to want to tell me anything so, you know, and this is marital, seems to be marital issues so, you know, it's not unusual for someone to not want to talk about their, you know, personal relationship issues to someone they just met.*

79. When RN Johnson was asked whether she had considered speaking with LF directly, she said: "*Honestly I assumed that [RN Wang] – I had no reason in my mind to think that she wouldn't act on something like that because if it was me I would"*.[63]

80. RN Wang noted that she went on a scheduled meal break between about 7:15pm and 8:00pm. She believed that approximately five to ten minutes after returning from her break, RN Johnson handed her the note relating to LF, rather than speaking with her, because the call came in whilst RN Wang was on her break. My findings with respect to the call from PF are addressed below under Issue 2.

81. LF was observed by nursing staff over the course of that evening. At about 7:30pm, AIN Chilcott checked on LF, who was sitting in her chair in her room. She was teary but less distressed.[64]

82. At about 8:00pm, RN Wilson attended LF's room to provide dinner.[65] LF requested to eat the vegetables from her dinner. LF joined RN Wang in the dining room with another patient, to eat her dinner. RN Wilson recalled LF was "*calmer, more settled… she seemed back to feeling herself"*.[66]

83. Around this time, AIN Chilcott said in her statement that she spoke to RN Johnson about LF crying. According to AIN Chilcott, RN Johnson said she did not believe a higher care level was required for LF, as LF was now a voluntary patient, had a planned transfer to the private hospital, and appeared future-focussed.[67] In her supplementary statement and in evidence, RN Johnson did not recall this conversation, but does not believe she would have dismissed the concerns of AIN Chilcott.[68] Whilst AIN Chilcott's statement is contained within the brief of evidence,

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[62] T60.46-49.
[63] T77.9-10.
[64] Tab 28, Statement of AIN Edwina Chilcott, [22].
[65] Tab 28, Statement of AIN Edwina Chilcott, [22]; Tab 27, Statement of RN Madelyn Wilson, [28]; Tab 33C, PMBC and RPAH records, p 65.
[66] T40.47-50.
[67] Tab 28, Statement of AIN Edwina Chilcott, [23].
[68] Tab 25, Statement of RN Eloise Johnson, [23]-[28].

she was not called to give oral evidence at hearing. I am unable to make a finding as to whether this conversation occurred or not.

84. RN Wang saw LF at about 8:30pm during a ward round, sitting on her sofa.[69]

85. At 9:00pm, an observation was recorded by RN Wilson in the observation chart. RN Wilson saw LF standing in her room with an iPad, and she appeared to be reciting something. She did not look distressed.[70]

86. At 9:30pm, RN Wilson walked past LF's room on the way to record another patient's observation form. She saw LF pacing around the room, holding a white iPad.[71] This did not cause RN Wilson concern, as *"[a] lot of patients pace around the room*",[72] and she was not required to record this observation of LF as her Care Level was 5, meaning formal observations were to occur every two hours. This was the last time LF was observed alive.

87. The night shift was due to commence at 9:30pm. It comprised three nurses who were present at the start of the shift,[73] and a fourth nurse who was called and was going to attend from Concord Hospital.[74]

88. At around 9:38pm, another patient on the ward suffered chest pains and required assistance.[75] Several nursing staff were involved in this medical emergency, including RN Johnson. RN Wilson noted in her statement that she was involved in providing assistance to this patient, although was unable to recall this as at the time of her evidence during the hearing.

89. The nursing handover proceeded at about 9:40pm. RN Wilson commented that the handover did not start on time and felt *"quite rushed"*.[76] She was not present for RN Wang's handover of LF's care.

90. RN Wang stated she told the incoming nursing team at handover that LF had used escorted leave with her family, and that she was due to be transferred to the private facility, St John of God the next day. It was noted LF had been upset that evening when her husband was at the PMBC.[77]

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[69] Tab 24, Statement of RN Xiaonan 'Mandy' Wang, [38].
[70] Tab 27, Statement of RN Madelyn Wilson [33]; Tab 33C, PMBC and RPAH records, p 65.
[71] Tab 27, Statement of RN Madelyn Wilson [35].
[72] T42.44.
[73] Being RN Eloise Johnson, RN Jason Collins, and RN Xiaonan 'Mandy' Wang.
[74] Tab 9, Statement of Plain Clothes Senior Constable Andrew Davidson, [15]; Tab 25, Statement of RN Eloise Johnson, [30].
[75] Tab 42A, De-identified medical records of patient who had chest pains, p 6.
[76] T44.36.
[77] Tab 24, Statement of RN Xiaonan 'Mandy' Wang, [41].

91. At 10:12pm, RN Collins began to administer PRN ('as needed') medications to patients, finishing at 10:18pm.

92. At 10:15pm, RN Johnson began a headcount of the patients on the ward.

93. At 10:26pm, RN Johnson attended LF's room. The light was off. She shone a torch into the room through the window, but could not see LF. She went to the lounge room and then returned. She unlocked the door, and on opening it felt some resistance. A chair had been placed against the door inside. She observed LF, hanging from the bathroom door from a ligature which appeared to be made from pieces of wool-like material.[78]

94. RN Johnson lifted LF up and activated her duress alarm. RN Collins attended, and went to get the arrest trolley. He handed a noose cutter to RN Wang, who took it to the room and cut the ligature. CPR then commenced.

95. A Clinical Emergency Response System (**CERS**) call was made at 10:32pm by RN Collins.[79] The CERS team attended and attempted resuscitation. However, efforts were unsuccessful.

96. Tragically, LF was pronounced deceased at 11:22pm.[80]

97. Expert psychiatrist, Dr Sullivan opined that at the time of her death, LF's diagnosis was major depressive disorder, recurrent episode of moderate severity, and was in partial remission at the time of her death. He observed that this episode was characterised by tearfulness, hopelessness, helplessness, guilt, and planning for overdose with suicidal intent. At the time of assessment by the ACS team, there was ambivalence about engagement, with efforts to avoid the team.

The post mortem examination

98. A limited autopsy was performed on 6 September 2019 by Dr Istvan Szentmariay.

99. He recorded the cause of death as "*Hanging*". The ligature was described as being made from three pieces of tapestry. Non-toxic levels of citalopram (0.17mg/L) were found on toxicology.

The issues

100. As noted above, an issues list was circulated amongst the sufficiently interested parties. The issues relevant to LF are considered below.

[78] Tab 25, Statement of RN Eloise Johnson, [34]-[35].
[79] Tab 33C, PMBC and RPAH records, p 30.
[80] Tab 33C, PMBC and RPAH records, pp 9, 32.

Issue 1: Was reasonable and appropriate care and treatment provided to LF during her admission to the PMBC, from 21 August to 2 September 2019?

101. LF was admitted under the care of Dr Azadi, who saw LF four times during her short admission. On 30 August 2019, Dr Azadi formed the view that LF's condition had improved and that she was future focused. LF was agreeing to medication and the plan was to proceed to discharge her the next day from the PMBC, to be transferred into the care of a private facility, St John of God.

102. Dr Sullivan was not critical of the care provided to LF, both in the community and throughout her admission, noting the standard of care was good, with appropriate investigations and documentation to suggest staff were respectful and sought to work collaboratively with LF to provide clear informed consent for medication. According to Dr Sullivan, LF responded well to the medication and her treatment planning focused on her immediate, medium and long-term needs.[81]

103. Dr Sullivan also noted that there was no apparent deviation from the policy and the observations appeared to be more than cursory visual sightings.[82]

104. In relation to Issue 1, counsel assisting submitted that overall, "*reasonable and appropriate care was provided*" to LF, with reference to Dr Sullivan's expert opinion.

105. Senior Counsel for the SLHD submitted:[83]

> *In my submission, when one considers that balance and it arises in a number of respects in the management and the care provided to each of [LF], Ms Ward, and [Shao], the submission I make, consistent with the evidence of Dr Sullivan, is that ultimately reasonable and appropriate care was taken for each of the three women, and I'll come to some of the specifics in a moment. I do acknowledge that in retrospect and knowing the outcome, of course, there are things that you could and no doubt would have done differently. But I do make the submission that prospectively, that when one considers the issues that arise in respect of the appropriateness of the care and management for each of the patients, that it was overall reasonable and met the appropriate standard.*
>
> *… consistent with what I've said in a general sense, make the submission that the evidence supports a finding that [LF] was provided with thoughtful,*

[81] Tab 111, Expert report of Dr Danny Sullivan, [59]-[60].
[82] Tab 111, Expert report of Dr Danny Sullivan, [70].
[83] T288.26-35; 37-41.

compassionate, and adequate and appropriate care while she was a patient in the acute inpatient unit.

106. I accept Dr Sullivan's expert evidence and I consider that reasonable and appropriate care was provided to LF.

107. I also make findings in relation to each of the sub-issues within Issue 1 below.

a) the decision to detain LF as an involuntary patient on 21 August 2019

108. LF was not willing to engage with the CMHT members who visited her home. Additionally, LF agreed to attend the CMHT, but continually did not do so. LF was ambivalent and poorly engaged with community intervention. This ambivalence manifested in agreeing to further review with the CMHT but not attending, as well as reluctance to disclose information to the CMHT team. LF disclosed hopelessness about the future and decided not to trial medication.

109. Dr Sullivan opined that the CMHT had two choices. Firstly, they could have left LF to her own devices, or, secondly, to invoke the mental health legislation and compel LF to be transferred to hospital against her wishes.

110. Mr Morton and RN Duong consulted LF's husband in the decision-making process to schedule LF.

111. Counsel assisting's submissions referred to Dr Sullivan's opinion regarding it being:[84]

Obviously appropriate to detain [LF] at the outset on an involuntary basis where she was pretty ambivalent to receiving care in the community and not engaging with the team.

112. I accept the expert opinion of Dr Sullivan who noted that the clinical assessment undertaken by Mr Morton and RN Duong was clear and provided a rationale for compulsory treatment. I consider the decision to detain LF as an involuntary patient on 21 August 2019 was reasonable and appropriate in the circumstances.

b) the decision to re-classify LF as a voluntary patient on 30 August 2019, with a plan to discharge her to a private facility

113. LF was initially admitted to the PMBC as an involuntary patient on 21 August 2019. On 30 August 2019, she was re-classified as a voluntary patient.

[84] T279.17-T280.4.

114. Dr Azadi felt LF had been engaging, truthful and open about her thoughts of self-harm and suicide throughout her admission to the PMBC. Dr Azadi therefore considered she could rely on LF's responses and judged it was appropriate to step-down LF to voluntary status and for LF to be transferred to a private facility.

115. At no point did Dr Azadi consider LF would be immediately discharged into the community once her patient status had changed.

116. Dr Sullivan agreed with Dr Azadi's reasoning and noted that the change in LF's status as a patient reflected her adherence to treatment and engagement in her treatment planning. Additionally, LF had not engaged in behaviours as an inpatient which raised a concern about her ongoing risk of self-harm or suicide. LF was noted to have had an improved mood and reported changes in her mood fluctuations due to the new medication. LF had also appropriately utilised leave with her husband and daughter. Additionally, a transfer to a private facility, such as St John of God, could not be facilitated whilst LF was an involuntary patient. Accordingly, Dr Sullivan noted that a change in LF's patient status was a necessary precursor to enable her discharge to a private facility.[85]

117. Counsel assisting's submissions referred to Dr Sullivan's opinion regarding "*the move to voluntary admission itself being an appropriate step",* and also submitted that:[86]

> *In considering the reasonableness of the steps taken at that stage, one would bear in mind that Dr Azadi only felt it was going to be appropriate to discharge [LF] and step her down to a voluntary admission in circumstances where she was agreeing to go to a private hospital. And she was clear in her evidence, she didn't think she was well enough to just be discharged home. So when considering the appropriateness of the care provided as a whole, that's an important point to bear in mind. Dr Azadi also felt that [LF] had been truthful and open about feelings of self-harm and suicide risk, an assessment she made because [LF] had engaged and discussed that openly, and she felt that was therefore something she could rely on when [LF] was talking about it.*

118. I accept the expert evidence of Dr Sullivan, who agreed with Dr Azadi's evidence. I consider it was adequate and appropriate to re-classify LF as a voluntary patient with a plan to discharge her to a private facility. I accept the reasoning that the change in LF's status as a patient reflected her adherence to treatment and engagement in her treatment planning.

[85] Tab 111, Expert report of Dr Danny Sullivan, [63].
[86] T279.17-T280.4.

c) the location of care

119. Upon her admission to PMBC, LF was placed in Room 2 on level 3, being the Acute Inpatient Unit, and remained there until her death.

120. Dr Sullivan opined that LF's initial placement, or location of care, reflected that her risk of suicide was considered to require involuntary treatment. In his opinion, maintenance on a locked ward was appropriate because of LF's preceding poor engagement with ACS and her expressed suicidal ideation, with means to carry out such thoughts.[87]

121. I accept the expert evidence of Dr Sullivan and consider the decision for LF to be cared for at the PMBC was adequate and appropriate.

d) observation levels

122. On her admission to the PMBC, LF was assigned to Care Level 3 (30-minute observations) by Dr Azadi. Dr Azadi gave evidence that the care level within the medical record was incorrectly recorded as "4" (meaning observations taken at hourly intervals); although this did not affect the level of observations LF received, as she was continually observed on Care Level 3.

123. Observation levels were continually recorded by nursing staff, and there were many 'informal' interactions between LF and nursing staff.

124. Dr Sullivan opined that the levels of observation provided appeared appropriate, initially at Care Level 3 and reducing in frequency (to Care Level 4) after six days. In any event, the staff on the unit observed LF more frequently than required at that level of observation. Staff were engaged with her during the evening. From the descriptions in the notes, LF tended to keep to herself and although she engaged in planned activities on the unit, was generally quiet or passive during these.[88]

125. Dr Sullivan advised that prior to 2 September 2019, LF's observation levels were appropriate.

126. I accept the expert opinion of Dr Sullivan and find the observation levels assigned to LF from 21 August to 2 September 2019 were reasonable and appropriate in the circumstances.

e) access to ligatures

[87] Tab 111, Expert report of Dr Danny Sullivan, [61].
[88] Tab 111, Expert report of Dr Danny Sullivan, [62].

127. Counsel assisting submitted that:[89]

> *I remind your Honour that [Dr Sullivan]'s only described it a few moments ago, a thing that comes from all the inquests, and that is when your Honour considers the access to ligatures that each of these women had, there is that tension between providing a very sterile, austere environment that has nothing in it and something which allows patients autonomy and the usual comforts that they would have.*
>
> *I say comforts in a very broad sense, but given the ligature that it appears [LF] was able to obtain, it was part of something that was very therapeutic for her during her admission, continuing what PF has spoken about, her love for craft, costuming, creating things. That was something the notes make very clear she was very keen on doing through her admission to PMBC. Tragically, the amenity of that therapeutic work also, in my submission, there's an available inference that that's where she got the ligature from. But the tension that's been described by Dr Sullivan I think is in very clear terms between balancing the therapeutic and the benefits of giving somebody amenity and restricting their access to things that might cause them harm.*

128. LF was creative and engaged positively with crafts available on the ward, as she did in the community. Nursing staff also engaged positively with LF on the ward in relation to her crafting skills. This activity was clearly, very therapeutic for LF.

129. It is apparent LF obtained the ligature whilst participating in a crafting activity that she loved.

130. Details of the item that LF used as a ligature to harm herself, and the changes made in the PMBC since her death, are further considered below at Issue 3.

Issue 2: Was reasonable and appropriate action taken after the following events occurred:

a) LF became distressed during the family visit on 2 September 2019

131. Following the family visit by LF's husband and daughter on the evening of 2 September 2019, RN Wilson observed LF being distressed. Whilst she was not allocated care of LF, being a thoughtful and careful nurse, she went and spoke with LF and asked if there was anything she could do to help LF.

[89] T279.17-T280.4.

132. RN Wilson reported this to the nurse allocated care of LF that evening, RN Wang. RN Wang understood that LF was a voluntary patient, and due to her previous interactions with LF, believed the information was due to her thoughts regarding her husband not bringing her dinner. RN Wang checked in with LF at dinner.

133. Dr Sullivan noted that LF was reviewed after her visit and confirmed with nursing staff that she was "*fine*" and that LF:[90]

> *did not express suicidal ideation and she had not been observed to make any plans or attempts while on the unit. She was a voluntary client. It was approaching bedtime. Even though staff were preoccupied with a medical emergency, I doubt that a change in observation level to increase the frequency of observations would necessarily have prevented her suicide*.

134. In relation to LF's distress after the family visit, Dr Sullivan "*didn't see it as something that would change the management plan*".[91] Dr Sullivan noted that LF was reviewed after the visit, but she did not express suicidal ideation and had not been observed to make any plans or attempts while on the unit.[92]

135. I accept the evidence of Dr Sullivan that in all circumstances, the staff's management of LF following the family visit was appropriate, noting she was reviewed by staff.

b) LF's husband telephoned nursing staff to raise concerns

136. As noted above, following the family visit on the evening of 2 September 2019, LF was distressed. Dr Sullivan opined that in retrospect, this may have been because her plans for suicide had crystallised, although she had not disclosed these to anyone.[93]

137. LF had used leave from the ward on a number of occasions without concern. Dr Sullivan noted that it appeared "*that her unhappiness in the marriage – whether reality-based or seen through the perspective of her depression – was an ongoing stressor"* to LF, and addressing this stressor was acknowledged by the treating team as a necessary stage in treatment.[94]

138. PF's telephone call was taken by RN Johnson and information passed on to RN Wang.

[90] Tab 111, Expert report of Dr Danny Sullivan, [68].
[91] T252.39.
[92] Tab 111, Expert report of Dr Danny Sullivan, [68]
[93] Tab 111, Expert report of Dr Danny Sullivan, [66].
[94] Tab 111, Expert report of Dr Danny Sullivan, [66].

139. RN Johnson was working a double shift. In evidence, RN Johnson noted that the "*shift was busy*" and "*as far as incidents on the ward goes, it was literally boom boom boom… the night was busy and it became increasingly busier from the moment PF rang right through until 7 o'clock the next morning".*[95] When LF's husband called, RN Johnson gave evidence she was concerned and asked RN Wang to check on LF. RN Johnson recalled the night's events in sequence and therefore initially believed the telephone call occurred at 9:00pm, however, conceded in oral evidence that it may have been earlier in the night.

140. RN Wang believed she received the note when she returned from her break after 8:00pm, and signed a progress note at 8:39pm noting that the call took place.[96] However, RN Johnson believed she handed the note to RN Wang immediately after the call, which she believed to have been at around 9:00pm.

141. RN Wang gave evidence that she was told LF had said she was "*not going to bother him [LF's husband] anymore*" and did not believe this was a concern as "*partners… argue and not argue, you know. I thought [this was] just a normal… partnership*".[97] RN Wang did not accept in evidence that she was asked by RN Johnson to speak with LF.

142. In hindsight, when asked if there was anything different RN Wang could have done, she told the Court that "*I would talk to [LF's] husband - about the phone call … And I would have talked to [LF] again and asked what she really meant*".[98] I note the concession made by RN Wang.

143. Similarly, when asked if there was anything RN Johnson would have done differently, she said "*It was a busy shift. I can't be everywhere. I did the best I could that night with what I had…"*,[99] and "…*given everything that went on that night I did the best job I could possibly do given the circumstances"*.[100]

144. RN Johnson was asked in evidence, in relation to the reported conversation between AIN Chilcott and RN Johnson, about whether LF crying was enough to increase her observation levels. RN Johnson noted that was not enough to increase observation levels.

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[95] T74.8-14.
[96] Tab 33C, PMBC and RPAH records, p 112.
[97] T59.47-T63.3.
[98] T62.26; 30-34.
[99] T76.7-9.
[100] T83.39-40.

145. When considering both the events of the family visit and the telephone call, Dr Sullivan did not consider that there was sufficient indication of concern to warrant a change in observation levels. LF's statement was equivocal and not a clearly expressed intention to harm herself. She was reviewed after the visit, but LF did not express suicidal ideation and she had not been observed to make any plans or attempts while on the unit. She was also a voluntary client, and it was approaching bedtime. Dr Sullivan noted that:[101]

> *I didn't see it as something that would change the management plan. And perhaps if I can just break down the steps in this. The first is that there was a family visit in which [LF] continued to display difficult attitudes towards [PF], her husband, and obviously was perhaps distressed by the, the family visit context and liaised with her daughter. The second was that [PF], not unreasonably, formed concern that she had made statements which could be interpreted as suggesting that she might harm herself.*
>
> *Those statements were somewhat ambiguous, they weren't an explicit, expressed desire to harm herself, but they could certainly be read as, as indicating perhaps that things would be changing in the future and I, I looked through the notes, I looked through [PF's] statement, I looked through the medical records and I think there was a degree of ambiguity there and I think that ambiguity was in the way that [LF] had expressed the situation at the time. PF communicated that to staff. It's clear that staff received the telephone call and understood it. It's not clear that they interpreted it as a statement of finality or that she intended to harm herself, but it's clear that they regarded that they needed to review [LF] and just see how she was travelling, what was, what was on her mind.*
>
> *The staff documented that they observed her after that call, but were also distracted by [other] events occurring on the ward and it's perhaps the case that the staff did not necessarily interpret [PF's] communication as saying, "I'm really worried that she's going to do something drastic", but simply that, that he was concerned that her mental state was worsened after that visit.*
>
> *So, in that sense, I think that the staff took on board the concern. In retrospect, maybe there could've been more clarity either in the, the expression or the way in which the staff expressed it but, but I, on my reading of the materials, I thought that actually reflected the ambiguity of [LF's] utterances and, therefore,*

[101] T252.39-T253.42.

the difficulty of saying, "This requires an immediate change in management plan". The sorts of changes in management plan that would've occurred as a result would only have been at observation level.

So, it would've been of an increased level of observation, perhaps the opportunity to ask [LF] about her mental state and see whether there were any concerns that she wished to express. It's unlikely that you would've administered any medication acutely, it's unlikely that you would have altered her voluntary status to involuntary, unless she explicitly said that she had thoughts of harming herself, and it's unlikely that you would've moved her to a different unit that offered perhaps greater restrictions. So, in that sense, I think that the, the staff's management of [PF's] communication was appropriate.

…

Q. PF, subjectively certainly, appears to have felt the information that he had was of sufficient..(not transcribable)..that he contact the hospital about it. Acknowledging, as you have in your report, that there was some circumstances that evening which may have affected the staff outcome, do you hold the view that the information that PF relayed to the hospital should've been discussed with YT in some way that evening, or not?

A. Look, it would've been ideal to do so, but, but if you want to reflect about what that would mean in practice, it's probably, given what I understand of or interpret of [LF]'s personality from the medical records and the statements and the materials, it would not have been sufficient simply to poke one's head around the corner and say, "Are you okay?"

146. Dr Sullivan noted amongst other things that nurse staffing levels were low as several nursing staff worked double shifts.[102] He further noted that "*it is not clear that staff would have had the luxury of time to reflect on it or to spend extra time with [LF] immediately*".[103]

147. Dr McDonald explained the policies, procedures and guidelines applicable to the PMBC where family members or a loved one raise concerns about a patient's risk of self-harm or suicide. The "REACH" (Recognise, Engage, Act, Call and Help) initiative was developed by the Clinical Excellence Commission. This was a system which helps loved ones escalate their concerns to staff. The SLHD has policies which

[102] Tab 111, Expert report of Dr Danny Sullivan, [67].
[103] Tab 111, Expert report of Dr Danny Sullivan, [67].

aligned with the REACH initiative, such as *Consumers and Carers As Partners in Clinical Care*, published in February 2024.

148. During his evidence, Dr McDonald advised that in addition to the REACH initiative and policies, there has been higher emphasis placed upon comments by a patient's family, given that they know their loved ones best. He also gave evidence about working with families and how families and carers can be empowered to escalate care where they have concern about their loved ones.

149. In his second statement of 5 September 2024, Dr McDonald noted two SLHD policies applicable to the PMBC, published in May 2021 and November 2023 respectively,[104] which relate to sharing information with families and carers and considering family and carer concerns as part of clinical assessments. It is pleasing to see the two policy changes after LF's death in which more emphasis is placed upon considering family and carer concerns as part of the clinical assessments.

150. Dr McDonald confirmed in oral evidence that training about suicide prevention had been introduced since 2019 as a result of the Zero Suicides In Care Initiative. This training addresses situations where a staff member receives information from family or carers and how to escalate that when the staff member feels that the risk to the patient may be changed. The training consists of a two-day course that all transitioning and new mental health nurses complete, as well as a one-day refresher course for nurses who have previously completed suicide prevention training.

151. In relation to Issue 2, amongst other things, counsel assisting's submissions included (in summary) the following:[105]

    i. RN Johnson *"recalls a very busy night, lots of jobs she's described having to do in addition to the usual patient care, and that particular difficulty with the patient who suffered chest pains. She received the call from PF, wrote down a note, subjectively obviously interpreted it as something of concern, and handed it on to the nurse who had [LF]'s care, Nurse Wang. The timing of that call, your Honour in my submission would accept it was a call made around about 7 o'clock. That's backed up by not only PF's statement, but also the phone records that he's attached following his statement in the brief";*

[104] Being SLHD Mental Health Services Policy: *Working with Families and Carers* (MH_SLHD_PD2021_004) published in May 2021, and SLHD Mental Health Services Policy: Assessment Policy (MH_SLHD_PD2023_048) published in November 2023.
[105] T280.6-T281.33.

ii. The timing of the note being provided by RN Johnson to RN Wang is uncertain. RN Wang may have been on break at the time of the call, and when she came back from break the note was handed over to her;

iii. *"Nurse Johnson says she asked Nurse Wang to go to speak to [LF]. That's not something Nurse Wang specifically recalls";* and

iv. There were differences in recollection as to exactly what the note said. However, *"even on Nurse Wang's account, the note said, "I'm not going to bother him anymore", which certainly has an implication of, if not a threat of, suicide, something that may be of concern"*.

152. Senior Counsel for the SLHD's submissions included, amongst other things:[106]

i. *"I do accept that … it wasn't correct that the call was made at about 9 o'clock and that very rapidly after that there was the incident with the other patient whose de-identified records we have at tab 42A. The evidence indicates, first of all, consistent with Counsel Assisting submissions, that the call seems to have been made at or about 7 o'clock. We do have a form of phone records from PF which suggests that the time the call was made at about, I think, 7.03. When one translates the actual call log to UTC, which is universal time, whatever the precise time it was made, we do know for a fact that it was made before 8.39, because that is the time of Nurse Wang's entry in the notes, which refers to the fact at that point that there was a call that was made by PF"*;

ii. *"I accept on the evidence that it in fact must have involved a call earlier and then some period before the note was handed to Nurse Wang"*;

iii. *"… there is some lack of clarity about what was contained in the note. We don't now have the note as evidence in this inquest, but given the evidence that Nurse Johnson gave and the consistency between what she recalled the note containing and what PF himself says about what was conveyed, that is something on the lines of either a goodbye being said or - that's the evidence of PF - or Nurse Johnson's evidence, which is at para 22 of her statement, that [LF] had said, as conveyed, something about not coming home, that the more likely position and the finding that, if your Honour feels comfortable in making one, is that the note did record something to the effect that [LF's daughter] had raised with PF and he had conveyed to Nurse Johnson a*

[106] T288.41-T292.12.

concern that [LF] had said something that raised a concern about her perhaps saying goodbye or not coming home. Not in clear terms…"; and

iv. *"… [RN Johnson] accepted that her perception at the time was that it was an important note that involved PF conveying a concern, and that it was something she wanted to have passed on to Nurse Wang.*

There is a lack of clarity on a couple of aspects of the evidence of Nurse Johnson and Nurse Wang in terms of the actual contents of the note and whether something was said. It may be that ultimately your Honour doesn't feel in a position to make a specific finding about that. Can I just say in respect of that evidence, there are certain reasons to find that something must have been said at the time as to why Nurse Johnson was making the note. It wasn't just a case of her speaking informally to Nurse Wang. She saw it as important enough to make a note, and she also indicated that the fact that she'd received a call was something that she regarded as significant as well. She accepted that there was a concern conveyed.

…

But the more likely finding, in my respectful submission, if [her] Honour feels that the evidence is sufficient to make one, is that something was said along the lines of that Nurse Johnson did want a check to be made on [LF] at the time. Sadly, it seems that what then occurred, though, was the instance of another patient suffering chest pains and having a collapse in the unit, the staff including Nurse Johnson being involved in that, and there was then, over the period of time that then passed, a lost opportunity to actually go and speak to [LF] about what had occurred".

153. I accept the submissions of counsel assisting and Senior Counsel for the SLHD, that the call from PF on 2 September 2019 occurred at around 7:00pm, in accordance with PF's telephone records.

154. Further, I accept the submissions of counsel assisting that an exact time cannot be identified as to when the note was handed over, however I make no criticism of any delay given this occurred in the context of a busy, dynamic environment.

155. I accept the submissions on behalf of the SLHD that *"there is some lack of clarity about what was contained in the note*", however that:

the note did record something to the effect that [LF's daughter] had raised with PF and he had conveyed to Nurse Johnson a concern that [LF] had said

something that raised a concern about her perhaps saying goodbye or not coming home. Not in clear terms…

156. I cannot be certain as to exactly what was said between the nurses or what was contained in the note, however it appears that the content of the note expressed a degree of concern.

157. Overall, it is unknown whether LF would have engaged in any discussion after that phone call or whether there would have been any significant change to her management plan. I make no criticism of any individual.

Issue 3: What was the ligature used by LF? How and when did she obtain it?

158. During the police investigation, images were taken of LF's room in situ. These images included the material that she used as a ligature and formed the basis of Exhibit 2 in these proceedings. The material is green in colour and appears to be long knitting wool or craft materials, which was tied in multiple strands over the whole of her bathroom door.

159. It is not clear when LF obtained the ligature. Only one progress note specifically mentioned that this material was returned to nursing staff upon request on 25 August 2019.

160. Dr McDonald gave evidence that crafting was a "*very therapeutic activity*", but following LF's tragic death, "*it was judged that the risk was too great and, and not, not sufficiently mitigatable. So it's something that we don't provide to people during their admissions anymore*".[107]

161. In his second statement, Dr McDonald advised that craft materials were removed from the PMBC units following LF's death. Crafting materials, including pencils and paint, are now only to "*be used under supervision in the art room and then removed at the end of the session*".[108]

162. Dr Sullivan noted that the balance between providing amenity in a mental health unit or rendering it austere and "suicide proof" is a challenge. He commented that patients determined to die by suicide will do so in unpredictable ways. Reducing access to all patients may decrease engagement, meaningful occupation, and the capacity for the ward to function therapeutically.

[107] T230.46-50.
[108] T231.10-15.

163. Dr Sullivan opined that the sustained removal of all potential ligatures requires that a person be kept under constant observation, in a highly controlled environment, wearing a canvas gown, and using bedding made of rip-proof material. This is not considered therapeutic by patients or staff. It cannot be sustained in the long term and can realistically only be used while risk is acute, imminent and otherwise unable to be mitigated.[109]

164. Dr Sullivan further noted that:[110]

> *the ligature appears to be made of material which was obtained perhaps from one of the ward activities and as Dr McDonald pointed out, those activities have now been modified such that some materials are no longer available and others are provided but then locked away after, counted and checked. So, I think that's a reasonable compromise… we know that those activities are healthy for people and it's unfortunate that part of the responses to, to deaths in inpatient care do involve these sorts of modifications. But again, it's also a reflection of the fact that we have to learn from these incidents and develop ways of reducing the likelihood that they recur.*

165. Additionally, Dr McDonald gave evidence in relation to searching patients and their environments. He told the Court that as part of the ongoing in-service training, staff within the PMBC and the SLHD Mental Health Service undergo education and training on searching patients, their property and the clinical environment.

166. During his evidence, Dr McDonald was asked about the policy for searching patients and the environment that was in place from 2019 until it was replaced in 2025. He confirmed that that policy provided guidance on instances when a search ought to be conducted, including on admission or transfer, if a patient is considered a risk to safety of themselves or others, if a patient needs to be placed in seclusion, where there is a suspicion a patient may be in possession of a weapon or other item, and where there is a suspicion a patient may be in possession of contraband. Dr McDonald agreed that these situations required a judgement call to be made by staff as to the elevated risk or reasonable suspicion.

167. When taken to the current policy, Dr McDonald agreed that it appears to identify the same circumstances in which searches should occur as the previous policy (from 2019). He then noted that the main change in the current policy is that it emphasises the need for searches to be focused on the nature of the individual patient, what the

[109] Tab 111, Expert report of Dr Danny Sullivan, [64]-[65].
[110] T251.46-T252.8.

risks are, and balancing the need to ensure the patient is safe without further traumatising them.[111]

168. When asked about how compliance with this policy can be monitored, Dr McDonald indicated that an audit has been scheduled. This is addressed further with respect to proposed recommendation 3.

169. Dr Sullivan did not think that a room search of LF's belongings would have necessarily been undertaken given LF's settled behaviour and absence of any concerns for her behaviour on the night of her death.

170. In relation to Issue 3, counsel assisting submitted:[112]

> *The third issue is what was the ligature used, how and when did [LF] obtain it. On the basis of exhibit 2 and the reports we have, in my submission, your Honour can find it was wool or craft materials, and the inference is available that she obtained it as a consequence of engaging in that craft activity during the admission. She was observed doing it numerous times in the nursing notes, and only on one occasion, the first occasion, was it specifically recorded that stuff was being taken back off her.*
>
> *As a somewhat unfortunate consequence, those sort of items aren't, of course, being used at PMBC anymore, simply not getting access to wool or the various other items that Dr McDonald identified, which is unfortunate but an appropriate response, in my submission.*

171. Senior Counsel for the SLHD did not submit specifically in relation to Issue 3.[113]

172. I find that the ligature used by LF was green wool or craft materials. By inference, it appears she obtained it as a consequence of engaging in a crafting activity during the admission to the PMBC. I agree with the evidence of Dr Sullivan that finding a balance between providing amenity in a mental health unit or rendering it austere and "suicide proof" is a challenge, and this appears to be appropriately considered in the current policy relating to searching patients. Dr McDonald gave evidence that crafting was a "*very therapeutic activity*", but following LF's tragic death, "*it was judged that the risk was too great and, and not, not sufficiently mitigatable. So it's something that we don't provide to people during their admissions anymore*".[114] Dr McDonald indicated that an audit had been scheduled, and was in the development process at

[111] T228.23-26.
[112] T281.35-50.
[113] T288.26-T290.13.
[114] T230.46-50.

the time of giving his evidence. This is addressed further with respect to proposed recommendation 3.

Merryn Ward

Introduction

173. Merryn Ward was 26 years old when she died on 5 December 2021. Merryn was admitted to RPAH as an involuntary patient on 28 November 2021 and was managed in the HDU of PMBC on Level 4, South. She remained an involuntary patient throughout the admission. On 2 December 2021, she he was found inside her bathroom with a ligature tied around her neck. Merryn was transferred to the Intensive Care Unit (**ICU**), but she had sustained an unsurvivable injury. Brain death was declared on 5 December 2021.

Merryn's life

174. Merryn's family painted a picture of the daughter and sister that they cherished, through the family statement process. They described that Merryn was a vibrant, quirky and creative young woman. From an early age, Merryn was on the move and loved to dance. She played a wide variety of sports and represented her schools at the district and regional levels. Merryn was also a gifted crafter and artist. After school, she decided she wanted to help others and completed her Enrolled Nursing certificate, despite her own ongoing health struggles. Merryn's ability to form meaningful relationships was a credit to her; after her death, people contacted her family and told them how much she had encouraged and supported them through their own mental health journeys.

175. Merryn was described by those who knew her, including her treating clinicians, in very warm terms. Merryn was bright, engaging and perceptive, and she was thoughtful about others. She sought out help and worked very hard to overcome her health problems.

176. Merryn had a very complex mental health history. She developed anorexia in her teens. She began to restrict her diet and overexercise. She was admitted to an adolescent inpatient unit at Concord Hospital. Several further admissions followed, to private and public facilities. She received care from a range of clinicians, including psychiatrists, psychologists and allied health professionals.

177. She completed her Higher School Certificate and enrolled in a nursing course, but was not able to complete her studies.

178. From her early 20s, Merryn became increasingly unwell. She self-harmed by various means. She made serious and sustained efforts to harm herself, both while in the community and while in hospital.

179. It was ultimately considered Merryn had developed anorexia nervosa, and borderline personality disorder and post-traumatic stress disorder (**PTSD**). She also had features of a recurrent depressive disorder.

180. There were about 30 admissions to hospital in the last year of Merryn's life, mainly to the RPAH and PMBC, usually in the context of deliberate self-harm. This represented a decrease in the number of admissions from the year before.

181. Merryn had been trialled on a variety of treatments, including a range of first, second and third-line psychoactive medication, and electroconvulsive therapy (**ECT**).

182. At the time of her last admission, Merryn was engaged with a community psychiatrist, psychologist, and had an NDIS coordinator and community supports. She was in receipt of the Disability Support Pension. She had received care coordination from the Marrickville Community Mental Health Team from 2020. Regular case conferences were held, on a monthly to bi-monthly basis, involving her inpatient and outpatient treating teams.

183. Merryn's penultimate admission to PMBC commenced on 19 November 2021. She was admitted on this occasion following self-harm. She was admitted as an involuntary patient under the care of Senior Staff Specialist Psychiatrist Dr Hassan Mehdi, and was managed in the HDU. Merryn was discharged home on 26 November 2021.[115]

184. During that admission, on 24 November 2021, a multidisciplinary team (**MDT**) meeting and a complex care meeting were held. There was consensus about the approach for this, and other admissions. Merryn was to be supported by a brief involuntary admission. It was recognised that longer inpatient admissions were triggering for Merryn, and detrimental for her recovery. Throughout her admission, she was to be supported to develop skills to manage her own emotional dysregulation and suicidal behaviour, and to achieve her goals.[116]

185. Just two days later, on 28 November 2021, Merryn took another overdose of medication, with the intention to harm herself. Merryn told her mother what she had done, who took her to RPAH.[117]

[115] Tab 65A, Electronic records for admissions/presentations, pp 2-171.
[116] Tab 65A, Electronic records for admissions/presentations, pp 37-39.
[117] Tab 49, Statement of Merryn's mother, [8]; Tab 59, RPAH and PMBC medical records, pp 134, 142-144.

Admission to RPAH

186. During triage at hospital, Merryn became combative and attempted to abscond. She was stopped by security. A schedule was completed, and Merryn was detained as an involuntary patient.[118]

187. She was reviewed at 7:19pm by Dr Fotheringham (a Drug and Alcohol trainee specialist). Merryn had been given diazepam (Valium), and the plan at that stage was to admit Merryn under the Drug and Alcohol team, to keep Merryn as an involuntary patient, and to arrange for a mental health review.[119]

188. Merryn said she wanted to leave so she could jump off the hospital balcony. Four security officers were required to restrain her, and she was given a large amount of sedative medication. From that point, Merryn was given a nurse special (one-to-one nursing).[120] This was a traumatic event for Merryn and she recounted it in the days after to nursing staff.

189. Merryn remained in the ED the next day, 29 November 2021. She continued to attempt to self-harm.[121] Merryn was reviewed by consultation liaison psychiatrist Dr Laura Cashman at about 11:10am. She told Dr Cashman that she had been feeling acutely unwell at the time of her prior discharge, but had said whatever necessary in order to be allowed home. She felt an overwhelming urge to kill herself. The schedule was continued, and the plan was to admit Merryn to the PMBC.[122]

Admission to PMBC

190. Merryn was transferred to PMBC at about 11:00pm on 29 November 2021.[123] She was placed in the HDU on level 4 in room 13. She was moved to a high observation bed, room 16, on 30 November 2021.[124]

191. Merryn was admitted under the care of consultant psychiatrist Dr Viktoria Sundakov, who knew Merryn well. Dr Sundakov was the Director of Psychiatry at RPAH. She was one of two psychiatrists under whose care Merryn had been admitted frequently in the past, the other being Dr Mehdi. Dr Sundakov had participated in the regular (monthly or bi-monthly) complex care reviews with a team of clinicians, including Dr Matthew Holton from the consultation liaison psychiatric team, Dr Aparna Menon from Marrickville Community Centre and Merryn's case manager. The team would meet

[118] Tab 59, RPAH and PMBC medical records, pp 145-146.
[119] Tab 59, RPAH and PMBC medical records, p 134.
[120] Tab 59, RPAH and PMBC medical records, pp 145-146.
[121] Tab 59, RPAH and PMBC medical records, p 147.
[122] Tab 59, RPAH and PMBC medical records, pp 136-137.
[123] Tab 59, RPAH and PMBC medical records, pp 153, 154.
[124] Tab 59, RPAH and PMBC medical records, p 164.

regularly to discuss Merryn's care to ensure optimal care and a consistent approach throughout the providers.

192. Merryn's medication remained as it had been on previous admissions: quetiapine (50mg morning and midday, 100mg night), clonidine (100mcg day, 200mcg night), desvenlafaxine (50mg daily), melatonin (5mg bedtime), pantoprazole (40mg) and pregabalin (150mg three times per day). Chlorpromazine was also added on 30 November 2021.[125]

193. Dr Sundakov reviewed Merryn with trainee specialist Dr Zoe Campbell on 30 November 2021. Merryn was cooperative and polite, but she described her mood as "*terrible".*[126] She had ongoing suicidal ideation about jumping from a building. The impression formed was that Merryn required short inpatient admission. The plan was to remain on Care Level 1 for another 24 hours.[127]

194. Between 2:40pm and 3:20pm, Merryn caused a superficial injury to her own left index finger, using nursing equipment while a nurse was dressing her wounds.[128]

195. On 1 December 2021, Dr Sundakov was unwell, and so Merryn was reviewed by Dr Mehdi with Dr Campbell. Merryn said she did not want to be alive, but then conceded that perhaps a very small part of her did want to be alive. She complained of poor sleep. The impression was that Merryn had ongoing suicidal ideation which was slightly worse than her baseline. She was not able to safety plan and was not future-focused. Dr Mehdi decided to progress Merryn to Care Level 2 (15-minute observations) in the day, and Care Level 1 at night (requiring staff to be in the room with Merryn continuously). This was consistent with her usual care plan.[129]

196. At 12:01pm, the occupational therapist Tanya Campedelli reviewed Merryn. Merryn advised that the routine developed prior to discharge on 26 November 2021 "*worked*" until 28 November 2021. Merryn said she wanted to change, and wanted to use her NDIS support more. Merryn also said she foresaw an escalation that evening, and wanted to use bedsheets to strangle herself.[130]

197. At 2:03pm, RN Pradhan recorded a note including:[131]

[125] Tab 59, RPAH and PMBC medical records, p 227.
[126] Tab 53, Statement of Dr Zoe Campbell, [9]; Tab 58D, Statement of Dr Viktoria Sundakov [14]; Tab 59, RPAH and PMBC medical records, p 130.
[127] Tab 59, RPAH and PMBC medical records, pp 129-130.
[128] Tab 59, RPAH and PMBC medical records, pp 113, 157.
[129] Tab 59, RPAH and PMBC medical records, pp 131-132.
[130] Tab 59, RPAH and PMBC medical records, pp 170-171.
[131] Tab 59, RPAH and PMBC medical records, pp 171-172.

… Active thoughts of self harm by strangulation this afternoon using bed sheet; white linen removed from her room and made a bed with anti rip blanket. Left pillow case ; guaranteed she is not going to use it for strangulation …

198. At 2:30pm, a nurse entered Merryn's room and saw blood on the floor. Merryn had opened an old self-harm wound on her arm using her earring. The wound was re-dressed and Dr Campbell was called.[132] Dr Campbell recorded that Merryn said "*it was impulsive and there was no warning*", but that after PRN medication, Merryn was calm. Dr Campbell asked for her earrings to be removed, and Merryn agreed. Merryn remained on Care Level 2 during the day and Care Level 1 at night.[133]

199. That afternoon RN Mamata Pradhan Karmacharya (RN Pradhan) prepared a nursing care plan, which was consistent with her previous care plans. The plan included that Merryn's bathroom door should be locked 24 hours per day, and that linen skips were to be removed from the common areas, and only anti-rip blankets used on her bed.[134]

200. Ms Campedelli was approached to review Merryn that evening. Merryn asked for a different weighted blanket, which was provided to her, along with aromatherapy sprays.[135]

Events of 2 December 2021

201. On Thursday, 2 December 2021, an MDT meeting was held, with Dr Sundakov attending by telehealth. The previous day's self-harm was noted, and it was observed that Merryn had settled when a nurse sat with her, and that she liked to be on Care Level 1.[136] The plan was to continue Care Level 2 in the day, and require Merryn to be out of her room, with the door locked. It was thought unlikely that she would be discharged by the weekend.

202. About two hours later, Merryn reported to nursing staff that she had increasing negative thoughts and invalidation after being advised to stay out of her room as per her management plan. After speaking with RN Mamata, Merryn agreed to stay out in the common area for at least one hour in the morning and less time in her room.[137]

203. Shortly thereafter, Merryn attended an art group. She asked for a bag to keep her art supplies in, saying she would not do anything "*silly*" if she was given one. Merryn was

[132] Tab 59, RPAH and PMBC medical records, p 182.
[133] Tab 59, RPAH and PMBC medical records, p 132.
[134] Tab 59, RPAH and PMBC medical records, pp 176-179.
[135] Tab 59, RPAH and PMBC medical records, p 179-180.
[136] Tab 59, RPAH and PMBC medical records, p 186.
[137] Tab 59, RPAH and PMBC medical records, p 187.

provided with a paper bag. It was reported that Merryn also showed some of her artworks to her peers, who commented on how she could sell her art.[138]

204. The afternoon shift commenced at 1:30pm. Seven nurses were on duty, although the HDU usually had eight. There were 17 patients on the ward, which had capacity for 22.[139] However, there may have been impacts on the usual arrangements due to COVID, and there were also three patients who required extra care – one who was placed in seclusion, and two (including Merryn) who were considered high-risk.[140]

205. At 3:30pm, RN Brenda Tongowona commenced duty. She was allocated care of Merryn and one other patient. There was a nursing handover, in which RN Tongowona was told Merryn was settled, and there had been no incidents that morning. RN Tongowona then introduced herself to Merryn, who appeared much brighter than the day before.[141]

206. Dr Campbell reviewed Merryn at 3:49pm. Merryn said she had an "*OK*" day, and the pair discussed her future plans. Merryn said she wanted to move out from home before the end of the year. Dr Campbell's note refers to the need to keep Merryn's bathroom door locked.[142]

207. Merryn also saw Ms Campedelli that afternoon. Merryn said she had a plan to jump from a balcony but was able to distract herself. Merryn said she felt like "*failure at life, and a failure at death".*[143] Ms Campedelli advised RN Tongowona of her interaction with Merryn at about 4:00pm.[144]

208. At around 4:45pm, Merryn asked RN Danielle Whittle, the nurse-in-charge, for access to her bathroom, which was provided.[145]

209. At 4:45pm, Merryn knocked on the door of the nurses' station and asked for a visit to be booked with her mother and friend for the following day.[146]

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[138] Tab 59, RPAH and PMBC medical records, p 188.
[139] Tab 110C, Further supplementary statement of Dr Andrew McDonald, [10].
[140] Tab 58F, Statement of RN Danielle Whitte, [13].
[141] Tab 54, Statement of RN Brenda Tongowona, [5]-[9]; Tab 59, RPAH and PMBC medical records, p 192.
[142] Tab 59, RPAH and PMBC medical records, p 133.
[143] Tab 59, RPAH and PMBC medical records, p 189.
[144] Tab 54, Statement of RN Brenda Tongowona, [12].
[145] Tab 58F, Statement of RN Danielle Whittle, [29].
[146]Tab 59, RPAH and PMBC medical records, p 192; Tab 54, Statement of RN Brenda Tongowona, [14].

210. At 5:35pm, RN Tongowona and RN Rivadulla were involved in swapping a bed for another patient. Merryn approached and asked what was happening, and was told there were some room changes. She returned to her room.[147]

211. At 5:40pm, RN William Hayes completed observations for another Care Level 1 patient.[148] He then went to have a tea break.

212. At 5:45pm, RN Tongowona saw Merryn sitting in her room using her phone.[149] This was the last observation prior to Merryn's death.

213. At about 5:55pm, staff began calling the patients for dinner. RN Tongowona could not see Merryn in her room, and went to look in the sensory room, courtyard and family room. RN Hayes also assisted looking for her.[150]

214. RN Hayes entered Merryn's room, and knocked on the bathroom door. It was locked. He then opened it, and discovered Merryn lying on the floor in the right hand corner of the room, with a piece of white material, which appeared to be a scrap of bedsheet, tied around her neck.[151]

215. RN Hayes made a duress call. A noose cutter was obtained, and CPR commenced.

216. The Medical Emergency Team (**MET**) call occurred at 6:08pm.

217. Staff including Dr Maryssa Portelli attended in response. Dr Portelli was a psychiatrist who knew Merryn from previous admissions. She states that while she did not observe the ligature, she understood that the ligature was a crepe bandage from Merryn's wrist (per a conversation with RN Tongowona).[152]

218. Merryn had a return of spontaneous circulation at 6:25pm, and an ambulance was called.

219. Merryn was transferred to the RPAH ED at 6:56pm. On arrival, Merryn had fixed pupils and a suspected hypoxic brain injury. This was confirmed with medical imaging.

220. Merryn's family attended the hospital at 8:30pm.[153]

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[147] Tab 54, Statement of RN Brenda Tongowona, [15]; Tab 59, RPAH and PMBC medical records, p 192.
[148] Tab 59, RPAH and PMBC medical records, p 191.
[149] Tab 54, Statement of RN Brenda Tongowona, [18]; Tab 59, RPAH and PMBC medical records, p 119.
[150] Tab 54, Statement of RN Brenda Tongowona, [19]-[20].
[151] Tab 59, RPAH and PMBC medical records, p 191.
[152] Tab 52, Statement of Dr Maryssa Portelli, [7]; Tab 59, RPAH and PMBC medical records, p 189.
[153] Tab 49, Statement of Merryn's mother, [9].

221. Merryn was maintained on life support until 5 December 2021. At 4:57pm that day, brain death was declared, and support was withdrawn.[154]

222. Police were called and attended RPAH at 7:25pm.[155]

223. Upon review of the medical records, Dr Sullivan considered Merryn's diagnoses were as follows:[156]

    a. Anorexia nervosa, restricting type, in partial remission;

    b. Borderline personality disorder, although he noted Merryn considered this diagnosis stigmatising;

    c. PTSD and other anxiety disorder not otherwise specified; and

    d. May have met the criteria of a diagnosis of recurrent depressive disorder with anxious distress.

Police investigation

224. On 3 December 2021, Nurse Manager (**NM**) Tenille Pouw attended PMBC to support the staff. She contacted the Director of Clinical Governance about cleaning Merryn's room. She stated she was advised it was okay to clean the room, as it was not a crime scene. She therefore arranged for the bathroom to be cleaned and removed Merryn's belongings. NM Pouw did not observe any hanging points in the bathroom to be broken (there are hooks which are designed to fail if weight is placed on them).[157]

225. NM Pouw cannot recall if she, or another nurse, obtained the ligature. It was taken to her office at Concord Hospital. It was collected from there by Constable Morrow on 5 December 2021. It was described as a ripped white bedsheet. It has not been identified how Merryn was able to obtain it.[158]

Post mortem investigation

226. A limited autopsy was performed by Dr Van Vuuren on 9 December 2021. She records the cause of death as "*hanging",* however, there was no ligature mark. Dr Van Vuuren later explained that the ultimate cause of death was asphyxiation.[159]

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[154] Tab 44, Form A – Report of Death of a Patient to the Coroner; Tab 59, RPAH and PMBC medical records, p 340.
[155] Tab 48, Statement of Leading Senior Constable Tanya Bietresato, [3].
[156] Tab 111, Expert report of Dr Danny Sullivan, [130]-[137].
[157] Tab 58, Statement of NM Tenille Pouw, [7].
[158] Tab 48, Statement of Leading Senior Constable Tanya Bietresato, [13]; Tab 58, Statement of NM Tenille Pouw, [12].
[159] Tab 47, Autopsy report; Tab 47A, Letter from Dr Van Vuuren.

Issues

227. As noted above, an issues list was circulated amongst the sufficiently interested parties. The issues relevant specifically to Merryn are considered below.

Issue 4: Was reasonable and appropriate care and treatment provided to Merryn during her admission to PMBC from 28 November to 5 December 2021?

228. Dr Sullivan opined that Merryn did receive reasonable and appropriate mental health care and treatment during her admission, as follows:[160]

> *In my opinion, Merryn received reasonable and appropriate mental health care. It is critical to acknowledge that in saying that, she had repeatedly engaged in repeated, high risk, serious attempts at self-harm with suicidal intent. Regardless of the ambivalence in these actions, I consider that much of her self-harm over 2021 could have resulted in her death without assertive and intensive medical intervention. Many medical interventions were conducted when she either resisted, or was ambivalent about, health care.*
>
> *There was an ongoing tension between Merryn's quality of life, efforts to prevent her death, and her efforts to die. The prevention of her death as an inpatient required invasive medical care and the highest levels of restriction of her liberties possible in mental health care, outside prison or forensic systems. In the long term, while she continued actively to harm herself, it was inevitable that she would eventually die or suffer profound medical consequences such as hypoxic brain damage, liver failure irremediable without transplant, or gastrointestinal perforation requiring significant life-saving surgery.*
>
> *Mental health and other medical staff were engaged in repeated interventions both with and without Merryn's immediate consent, to prevent her death. The presumption was that she was ambivalent or lacked capacity to make decisions about her health care to preserve her life. On review of the records, I consider this was repeatedly the correct medical and ethical approach to take in Merryn's case.*

229. Dr Sullivan also noted that Merryn:[161]

> *… was resourceful and I consider it inevitable that she would have managed to harm herself with suicidal intent at some stage. For staff undertaking constant*

[160] Tab 111, Expert report of Dr Danny Sullivan, [144]-[147](p).
[161] Tab 111, Expert report of Dr Danny Sullivan, [148]-[149].

(1:1) observations, there will always remain a balance between observation and privacy. Close proximity and observation are very distressing and intrusive for patients, and when a patient necessarily covers themselves or obscures view of their body with bedding, it is a continual tension for staff between the need to be therapeutic and the need to observe them.

230. Counsel assisting submitted with respect to Issue 4:[162]

… In Merryn's case, I'll now turn to hers, a similar set of issues, the first being the reasonableness and appropriateness of care provided to her during that admission commenced on 28 December through to her death on 5 December 2021. Adversely, Merryn had a very complicated mental health history, not one that should define her, your Honour's heard the beautiful words of her family that have described in warm terms those other aspects that we haven't been dwelling on this week. Her mental health history was complex. Dr Sullivan describes it as anorexia nervosa, a borderline personality disorder, PTSD, and a recurrent depressive disorder. He's in agreement with the treating team who found very similar diagnoses.

Tragically, as a consequence of those conditions, she was a very determined and resourceful young woman when it came to harming herself. And when considering the appropriateness of care provided to her, she was obviously very dysregulated at the time she first presented to RPA at the time of her admission. Had taken an overdose, which she had done frequently in the previous 12 months, but then became very dysregulated in the emergency department, required sedation and restraint and so on. And in those circumstances, the fact that she was placed in that very highly restrictive environment in the HDU is clearly reasonable and appropriate care, in my submission.

Your Honour did hear from Dr Sundakov, who'd been involved in [Merryn]'s care for a couple of years. She spoke about the efforts to support Merryn, the complex care meetings, the coordination between the various treating teams. Obviously the staff, both Dr Sundakov and Dr Campbell, did describe Merryn in very warm terms. On an interpersonal level, they related with her very well, but she nonetheless presented a very difficult case from a medical perspective. Dr Sullivan's view, reasonable and appropriate care. So he recognised the tension there between the very, very restrictive circumstances of Merryn's

[162] T283.5-22.

> *containment in the HDU, which she really, really didn't like and in some ways contributed to her distress but were absolutely necessary in terms of the threat that she posed to herself. It was necessary to step her down from one-to-one nursing because ultimately she's going to need to be released back to the community. That inevitably meant she was under less observation at the time when she was able to self-harm. But Dr Sullivan, in his evidence just given a moment ago, recognised that even patients who are under constant observation are able to harm themselves…*

231. It was submitted on behalf of the SLHD that the care provided to Merryn was reasonable and appropriate, and that Dr Sullivan opined a such (as extracted at [105] with respect to LF).[163]

232. I accept the expert evidence of Dr Sullivan that Merryn received appropriate care and treatment during her last admission to the PMBC.

233. My findings with respect to the sub-issues within Issue 4 are set out below.

a) the decision to detain Merryn as an involuntary patient on 28 November 2021

234. As noted above, Merryn was admitted to the RPAH on 28 November 2021, following a medication overdose, just two days after she was discharged from the PMBC. Whilst at the RPAH, treating staff noted "*difficulties with behaviour management in emergency department over the course of the evening, multiple doses of benzodiazepines... aliquots of ketamine... vomited post usual nocte quetiapine".* She was reviewed by psychiatry registrar Dr Laura Cashman, noting that Merryn was *"acutely distressed, suicidal and trying to abscond from emergency department last night and required four-point manual restraint and chemical sedation*". Merryn was managed with one-to-one nursing and security staff support.[164]

235. Dr Sullivan opined that:[165]

> *The decision to detain Merryn involuntarily in the last admission was appropriate. She had crescendoing self-harm, often occurring on the same day she had been discharged from the previous episode, and she was unable to deploy effective coping strategies to mitigate these herself*.

236. Dr Sullivan also noted:[166]

[163] T288.26-35.
[164] Tab 111, Expert report of Dr Danny Sullivan, [100].
[165] Tab 111, Expert report of Dr Danny Sullivan, [147](k).
[166] Tab 111, Expert report of Dr Danny Sullivan, [146], [103]-[106].

Mental health and other medical staff were engaged in repeated interventions both with and without Merryn's immediate consent, to prevent her death. The presumption was that she was ambivalent or lacked capacity to make decisions about her health care to preserve her life. On review of the records, I consider this was repeatedly the correct medical and ethical approach to take in Merryn's case.

…The impression was of complex post-traumatic stress disorder and/or borderline personality disorder and dissociative symptoms. Involuntary status was upheld, with one-to-one nursing and security special and a management plan for her emergency department stay. "She had tried to abscond, was de-escalated by Tox [toxicology] registrar... settled with a further 5 mg po olanzapine... has been thinking of numerous plans for escaping the ward and is even contemplating threatening staff members with a plastic knife... agreed with my assessment this evening. She is currently far too distressed and dysregulated to consider discharge, and thus the only option is to plan for readmission to Professor Marie Bashir Centre."

Other documentation on 29 November 2021 in the Emergency Department noted that she "has required strict [1:1] special, cannot be left [alone], approaching stock and removing drawing up needles... attempt to abscond upon learning she was scheduled... insisting she could not go to ICU as she is traumatised by her experiences there..."

It was noted "we discussed the fact that although discussions were underway last week about altering her management plan to consider a change of ward, this does not seem possible tonight given the acuity of her recent presentation and the risks involved."

Merryn was admitted as a mentally ill person under the Mental Health Act 2007, noting she was distressed, dysphoric in affect and had strong suicidal urges as well as thoughts about assaulting or threatening staff and absconding, and could not engage with safety planning. A management plan was noted."

237. I accept the expert evidence of Dr Sullivan that the decision to detain Merryn as an involuntary patient on 28 November 2021 was appropriate given her level of self-harm.

b) the location of care

238. Throughout Merryn's admissions to the PMBC, including her final admission, she was allocated a room close to the nurses stations, so staff could keep a close eye on her.

239. RN Pradhan noted in her statement:[167]

> *Merryn was very intelligent and very clever. She knew the ward environment inside and out. She knew the ward routines and how the ward worked. When she was admitted to the HDU, we had to be vigilant and had to keep an eye on her at all times. She was unpredictable. When she was on care level 2 (15 minute observations) we had to keep an eye on her and do random checks. She was usually placed in a high observation bed, which is a bed directly outside of the nurses' station, so that we could keep an eye on her. We encouraged her to spend time outside of her room and in the common areas for increased visibility.*

240. In his expert report of 4 November 2024, Dr Sullivan opined that Merryn was placed in an appropriate room. When giving evidence Dr Sullivan noted that staff had identified which room would be safest to place Merryn in, being one close to the nurse's station.

241. I accept the evidence of Dr Sullivan that Merryn's placement and location of care was appropriate.

c) observation levels

242. Merryn was designated to Room 16 in the PMBC, which was a high observation bedroom. She was assigned to Care Level 2 during the day (15-minute observations) and Care Level 1 during night shift, with staff required to sit near her room door rather than near her bed during night shift observation, as Merryn felt intimidated by staff sitting next to her. It was also noted that Merryn's ensuite bathroom door was to be locked 24-hours a day.

243. In his report of 4 November 2024 and while giving evidence, Dr Sullivan opined that Merryn was placed on appropriate observation levels as the intention was to maintain her safety and prevent further self-harm on the ward. However, he noted that upon leaving the ward environment, Merryn would be immediately discharged into a situation without observation. Dr Sullivan said this inevitability necessitated reducing Merryn's observation levels prior to discharge, to test Merryn's capacity to maintain her own safety outside of the ward environment.

[167] Tab 58B, Statement of RN Mamata Pradhan Karmacharya, [13].

244. Merryn's ensuite door was locked so as to reduce the risk of self-harm by removing an area where Merryn could not be observed.

245. Dr McDonald, in his statement and when giving evidence, stated that the current practice at PMBC is not to lock the ensuite bathroom doors, following all the bathroom doors in the PMBC being modified to remove ligature points. Dr McDonald noted that for high-risk patients, such as Merryn, the practice used to be to lock bathrooms, whereas the current practice is to keep the bathroom door unlocked at all times.

246. When asked about how this practice interacts with the fact that persons in their bathroom would then be out of view, creating an opportunity to self-harm, Dr McDonald said that one-on-one observation and locking a patient out of the bedroom entirely are still available solutions.

247. I accept the evidence of Dr Sullivan that Merryn was placed on appropriate observation levels as the intention was to maintain her safety and prevent further self-harm on the ward. The modifications to the bathroom doors are considered below at Issue 13.

d) access to ligatures

248. Dr Sullivan, in his expert report of 4 November 2024, stated that it would be incredibly difficult to deny Merryn access to ligatures in circumstances where she was wearing clothes and using sheets. He went on to say that while measures such as removal of clothing and provision of a rip-proof canvas gown and rip-proof bedding can be implemented, it is only a temporary solution due to it being demoralising and inhumane, and therefore unsustainable. Dr Sullivan was of the view that even in circumstances where these measures had been implemented, he was satisfied that Merryn would have sought out other means by which to harm or kill herself.

249. Dr McDonald, in his second statement of 5 September 2024, and during evidence, agreed that as at the time of Merryn's death in December 2021, there was no policy or formal process that required the removal of linen skips/trolleys from common areas when a high-risk patient was on the ward. This changed in December 2022 with the publishing of the *SLHD Mental Health Service Guideline: Caring for consumers at risk of deliberate self-harm and suicide in SLHD MHS Inpatient Psychiatric Units*. Relevantly, under Environmental Safety (section 4) staff are required to keep linen trolleys in a visible location (so that staff can see if a patient is accessing the linen trolley) or remove the linen trolley from the ward where possible.

250. However, Dr McDonald also gave evidence it was common for linen skips to be removed from the ward, as a matter of clinical judgement when high-risk patients were on the ward, such as Merryn Ward. The decision to provide patients with anti-rip bedding is also a clinical decision.

251. Further, Merryn's nursing care plan as at the day before her death included that that linen skips were to be removed from the common areas, and only anti-rip blankets used on her bed.

252. In his statement of 30 April 2025, Dr McDonald stated that consideration had been given to removing linen skips from inpatient units. However, it had been determined that this complete removal would create issues in relation to hygiene and storage.

253. The current practice at PMBC is for linen skips/trolleys to be placed in a visible location and removed where possible, and Dr McDonald in his evidence confirmed that staff are aware and vigilant about the risks associated with patient access to linen. When pressed as to whether all staff being aware of this creates a diffusion of responsibility for removal of the linen skips/trolley, Dr McDonald said that while there is an understanding that the nurse in charge (the NUM) is responsible for ensuring that that is done, all staff have a responsibility to act on their concerns in relation to this issue.

254. I accept the evidence of Dr Sullivan that it would have been very difficult to deny Merryn access to ligatures in circumstances where she was wearing clothes and using sheets, and the practice of the removal of clothing and provision of a rip-proof canvas gown and rip-proof bedding can be implemented, although demoralising. I note that per Merryn's nursing care plan, linen skips were to be removed from the common areas, and only anti-rip blankets used on her bed. Even if all of these measures were implemented, sadly, it appears that Merryn may have sought out other means to harm or kill herself. The current PMBC practice for linen skips/trolleys is further considered below.

Issue 5: Was reasonable and appropriate action taken on 1 December 2021 following Merryn's report of having strong thoughts to use her bed sheets to strangle herself?

255. During the morning of 1 December 2021, Merryn was reviewed by Dr Mehdi and Dr Campbell. During this review, Merryn stated that she did not want to be alive, but conceded a very small part of her wanted to be alive. She also noted she wanted to move out of home before the end of the year. The impression formed by Dr Mehdi was that Merryn had ongoing suicidal ideation, slightly worse than her baseline, and was not able to safety plan. The plan was for Merryn to receive Care Level 2 (15

minute observations) during the day, and Care Level 1 (one-to-one observations) at night.

256. Later that day, at 12:01pm, occupational therapist Ms Campedelli reviewed Merryn. Ms Campedelli recorded in her progress note that:[168]

> *… Merryn reported foreseeing 'escalation' this p .m . - when asked , reported strong thoughts to use bedsheets to strangle self, and wanting to self harm. Discussed strategies for same ie. attending groups, remaining near NS station, speaking to staff when feeling distressed, using sensory items including ice (NS reported to have same available).*
> *Discussed previous strangulation attempts which were unsuccessful - Merryn acknowledged same but reported despite this, continues to have this thought.*
> *Author finished session with Merryn seated at desk near NS utilising her mobile phone.*
> *Above information handed over to RN Mamata in NS .*

257. The plan was for Ms Campedelli to return to Merryn in the afternoon with sensory items.

258. At 2:03pm, RN Pradhan noted that there was nil significant change in Merryn's mental state. She recorded the following:[169]

> *… Active thoughts of self harm by strangulation this afternoon using bed sheet; white linen removed from her room and made a bed with anti rip blanket. Left pillow case; guaranteed she is not going to use it for strangulation*
>
> *Lots of 1 :1 reassurance, validation required. RN clopramazine 50 mg at 1130 hrs with regular quetiapine to minimal effect… insight present in her mental state but judgement impaired*

259. At about 2:30pm, RN Edwards entered Merryn's room and noticed that she had opened her self-harm scar on her arm. The wound was re-dressed and Dr Campbell was called.[170] When Dr Campbell reviewed Merryn, Merryn had accessed PRN medication and other calming strategies. Merryn was calm and engaged, and she was able to reflect on what happened. She told Dr Campbell that the incident was

[168] Tab 59, RPAH and PMBC medical records, pp 170-171.
[169] Tab 59, RPAH and PMBC medical records, pp 171-172.
[170] Tab 59, RPAH and PMBC medical records, p 171.

impulsive and quick, but that it was also over quickly. Dr Campbell asked for her earrings to be removed, which Merryn agreed to hand over to staff.[171]

260. Dr Campbell gave oral evidence at the hearing and agreed with the proposition that there was no need to escalate Merryn's plan at this stage, other than to take her earrings away.[172] Additionally, an MDT meeting was to occur the following day (2 December 2021).

261. The applicable policy in effect at the time in relation to searches was that searches ought to be conducted where it is considered that a patient is a risk to the safety of themselves or others. Merryn had a long history of self-harm and so would arguably always be considered to be a risk to her own safety. In practicality, her person and environment could not be searched on an ongoing basis. However, on 1 December 2021, Merryn expressed a desire to strangle herself with her bedsheets and she opened a self-harm scar on her arm.

262. As noted above, Dr McDonald confirmed that at the time of Merryn's death, in December 2021, there was no policy or formal process in place at PMBC requiring the removal of linen skips/trolleys from common areas when a high risk patient is on the ward. He went on to say that in December 2022, the SLHD published a guideline, applicable to the PMBC, which requires staff to keep linen skips/trolleys in a visible location (so that staff can see if a patient is accessing the linen trolley) or remove them from the ward where possible.

263. At 3:15pm, RN Pradhan documented a nursing care plan in Merryn's electronic medical record. A nursing care plan was created each time Merryn was admitted to the PMBC, with input from Merryn. The nursing care plans were largely unchanged between each admission to promote consistency in care, noting that linen skips were to be removed from the common areas, and only anti-rip blankets used on her bed. RN Pradhan was unable to recall why she documented her nursing care plan, as this was usually completed by the ward Clinical Nurse Consultant (**CNC**). RN Pradhan commented that the ward CNC may not have been available, and nonetheless, she knew Merryn well and that she was a high-risk patient. RN Pradhan noted that in preparing her nursing care plan, she would have reviewed Merryn's records and spoke with her to obtain information about her stressors and goals.[173]

[171] Tab 59, RPAH and PMBC medical records, p 132.
[172] T127.1-6.
[173] Tab 58B, Statement of RN Mamata Pradhan Karmacharya, [18]-[19].

264. As set out above, following Merryn's commentary that she wished to strangle herself with bedsheets on 1 December 2021, she was observed every 15 minutes (during the day), received a review by Dr Campbell, and had a nursing care plan recorded by RN Pradhan, which, required Merryn's input. Dr Sullivan did not consider this to be inappropriate nor unreasonable.

265. Dr Sullivan noted more generally that:[174]

> *The management plan ensured that she was managed in an appropriate environment, which was to reduce access to the means for self-harm. This was necessary given her history of absconding, self-strangulation or cutting herself with objects found in the unit.*
>
> *Merryn and her family considered that the high dependency unit of the Professor Marie Bashir Centre was not a therapeutic environment. Essentially, I agree, in that her management was highly restrictive. On the other hand, it was also clinically informed, multidisciplinary, and focussed as much as possible providing humane care. Merryn's self-destructive behaviours would not have been manageable in any less restrictive environment. While Merryn continued to engage in efforts to kill herself, the need to prevent this would always trump the provision of a therapeutic environment.*

266. In relation to Issue 5, counsel assisting submitted:[175]

> *I'll remind your Honour of a critical bit of Dr Sullivan's evidence, which is that in patients such as these, I'm not generalising… in patients who show their resourcefulness in terms of self-harming and self-harm to the extent that they're indeed, staff can become burnt out and feel in a sense apathetic about the possibility of caring for the patient. Dr Sullivan gave your Honour words to the effect that he did not think the staff in Merryn's case gave up, and there's evidence of them continuing to modify their plans, find different ways to engage with Merryn and continue to care for her despite her very frequent attempts at harming herself.*
>
> *There were points in Merryn's trajectory where she did escalate. She explicitly tells an occupational therapist on 1 December that she had thoughts of using bed sheets to strangle herself, and this is issue five on the issues list. In my submission, this was simply a feature of her presentation. It was really so*

[174] Tab 111, Expert report of Dr Danny Sullivan, [147](l), (n).
[175] T282.41- T283.7.

frequent that she was making similar threats that it didn't result in an immediate change to the plan, but it was incorporated in that very significant nursing plan that set out ways to protect Merryn.

267. Senior Counsel for the SLHD did not make any submissions specifically related to Issue 5, although noted that an MDT meeting occurred for Merryn on 2 December 2021.[176]

268. In the context of Merryn's complex mental health condition and her resourcefulness to attempt self-harm, I accept that reasonable and appropriate action was taken on 1 December 2021 following Merryn reporting having strong thoughts to use her bed sheets to strangle herself.

Issue 6: What was the ligature used by Merryn? How and when did she obtain it?

269. The ligature used by Merryn to harm herself, was described by RN William Hayes in a progress note as "*appeared to be a scrap of bedsheet, tied twice around the pt.s neck, author able to remove this by hand*".[177]

270. NM Pouw and RN Tongowona also shared this description of the ligature.[178] Whilst she did not observe the ligature, Dr Maryssa Portelli states she believed the ligature may have been from a crepe bandage from Merryn's wrist (per a conversation with RN Tongowona).[179]

271. During the hearing, images of the ligature used by Merryn, taken by police on 16 June 2025, was tendered.[180] These images showed a torn bedsheet and a towel. In relation to the torn bedsheet, Dr McDonald stated:[181]

The long, thin, piece of ripped white material appears to be a 'standard' HealthShare bed sheet. It is not anti-rip linen, as anti-rip linen is blue. The piece of material has a blue stitch along the seams, which is consistent with a 'standard' HealthShare bed sheet. I do not believe that the material is from a pillow case, as there is no edge that folds over as you would expect on the edges of pillow case. The piece of material also appears to be longer than I would expect for a pillow case.

[176] T292.45-T293.3.
[177] Tab 55, Statement of RN William Hayes, Annexure B, p 6.
[178] Tab 54, Statement of RN Brenda Tongowona, [2]; Tab 58, Statement of NM Tenille Pouw, [14].
[179] Tab 52, Statement of Dr Maryssa Portelli, [15], [19].
[180] Exhibit 4.
[181] Tab 110C, Further supplementary statement of Dr Andrew McDonald, [18].

272. Dr Sullivan noted:[182]

> *It is difficult to determine how she could be denied access to ligatures if she were to be wearing clothes or using sheets. Had these not been available, I am satisfied that Merryn would have sought other ways of killing herself. Removal of clothing and provision of a ripproof canvas gown, and of rip-proof bedding, can only be implemented for a short period. It is demoralising, inhumane and unsustainable for more than short periods, after which a reduction of restriction (with commensurate increased risk of self-harm) must be trialled.*
>
> *According to the management plan, the bathroom door in her room should not have been unlocked, and it is unclear where she obtained the linen with which she fashioned a ligature. However, it is clear that Merryn was resourceful and I consider it inevitable that she would have managed to harm herself with suicidal intent at some stage. For staff undertaking constant (1:1) observations, there will always remain a balance between observation and privacy. Close proximity and observation are very distressing and intrusive for patients, and when a patient necessarily covers themselves or obscures view of their body with bedding, it is a continual tension for staff between the need to be therapeutic and the need to observe them.*

273. In relation to Issue 6, counsel assisting submitted:[183]

> *On the basis of exhibit 4 and the evidence relating to it from Dr McDonald, your Honour could comfortably conclude it was a ripped bed sheet, a standard bed sheet. It's unclear where Merryn obtained it. I mean, it could have been one of those linen skips, but I don't venture that [your Honour] can make a clear finding about that. It could have been another patient or anywhere else in the ward.*
>
> *The circumstances in which she used it bear some comment. Obviously, she was able to gain access to the bathroom, and your Honour had Nurse Whittle's evidence about the circumstances in which that occurred…*

274. Senior Counsel for the SLHD submitted:[184]

> *…the evidence does not suggest that this was due to some problem of a systemic nature.*

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[182] Tab 111, Expert report of Dr Danny Sullivan, [147](p)-[148].
[183] T283.9-32.
[184] Written submissions for the SLHD in response to counsel assisting's proposed recommendations, [12]-[16].

275. I accept the evidence of Dr McDonald that the ligature Merryn used was part of a ripped standard bed sheet. I am unable to be certain as to how and when Merryn obtained this, although it may have been from a linen skip available on the ward.

276. In relation to the circumstances in which Merryn used the ripped bed sheet as a ligature in her bathroom, I am grateful for the concessions that were made by RN Whittle.

Issue 7: What was the mechanism of Merryn's self-harm?

277. The nursing staff who attended Merryn's resuscitation were able to remove the ligature from Merryn's neck by hand. The progress note of RN Hayes suggests that he was not required to 'cut' the ligature from a hanging point.[185] Additionally, NM Pouw, when she observed Merryn's bathroom did not locate any fixtures broken. NM Pouw provided in her statement that at the time of Merryn's self-harm, the fittings within the PMBC were weight limited, meaning they would break if they are placed under weight, in order to prevent them from being used as hanging points.[186] She went on to state that if Merryn had used a fitting or hanging point, NM Pouw would have expected to have seen that it was broken when cleaning the bathroom.[187]

278. Dr Van Vuuren initially advised that Merryn's death was due to hanging. Hanging is a form of asphyxia where a person is suspended from the neck with a noose or ligature.

279. Dr Van Vuuren also advised that ligature strangulation implies being strangled by another person where pressure on the neck is applied by a constricting band that is tightened by some force. The mark is usually circumferential.

280. During Merryn's autopsy, Dr Van Vuuren noted there was no ligature mark present, and proffered two reasons, being:[188]

- *The deceased was found soon after the event so the mark would not be very visible and she had been in hospital for three days prior to death; or*
- *The "ligatures" provided to me were a bloodstained towel and a torn bed sheet. These would leave very little marks around the neck as the pressure of these ligatures would be applied to a larger area on the neck and*

[185] Tab 55, Statement of RN William Hayes, Annexure B, p 6.
[186] Tab 58, Statement of NM Tenille Pouw, [9]-[10].
[187] Tab 58, Statement of NM Tenille Pouw, [10].
[188] Tab 47A, Letter from Dr Van Vuuren, p 1.

> *therefore the impression would not be as pronounced as a thin cord for example.*

281. Accordingly, Dr Van Vuuren was unable to answer whether the findings made during Merryn's autopsy were consistent with ligature strangulation rather than hanging, and advised that Merryn's death was due to asphyxia, which is the ultimate cause of death. The mechanism with the information provided to her from the hospital records and the police report, was hanging.

282. In relation to this issue, counsel assisting submitted:[189]

> *The mechanism that Merryn used for self-harm, it was described initially as hanging. I'd suggest your Honour could find it more appropriately being ligature strangulation…*

283. The mechanism of Merryn's death was more likely to have been ligature strangulation than hanging, given the nature of Merryn's presentation during autopsy, the lack of ligature mark and NM Pouw's evidence that no bathroom fixtures – which were weight limited and designed to break under weight to prevent them from being used as hanging points – were broken. The mechanism was pressure on the neck applied by a constricting band, in Merryn's case, a ripped bed sheet. However, there is no suggestion that another person was involved in Merryn's death.

[189] T283.34-37.

Shao

Introduction

284. Shao died on 22 July 2022. She was 59 years old at the time of her death. Shao had been admitted to RPAH as an involuntary patient on 10 June 2022. She was initially admitted to the HDU of PMBC. On 13 July 2022, she was transferred to the SSU on level 5, where she remained on an involuntary basis until her death. There was a plan to discharge her on 20 July 2022. However, on 19 July 2022, she was discovered hanging from the bathroom door in her room. Shao was transferred to the ICU, but her injuries were not survivable. Brain death was declared on 22 July 2022.

Shao's life

285. I recognise this inquest considered one of the most difficult times in Shao's life. However, this should not define her. Shao lived a successful life in the community and was generally well. She raised her daughter and lived with her husband for many years in Sydney.

286. Shao's family shared with the Court their memories with her, through the process of family statements. Shao is very missed by her daughter and her friends who loved her. Shao cared deeply about her loved ones, even if that was at a detriment to her own mental health. Shao wanted her daughter to live up to high expectations, and she sadly passed away before being able to see and experience those achievements. Shao loved to cook and hosted dinners for family and friends, which filled her home with laughter and good aromas. Shao was compassionate and cared for her husband when he became ill.

287. Shao was born in China. The family enjoyed a good standard of living. She had two siblings. She married and emigrated to Sydney. Shao and her husband had a daughter

288. Shao's husband died in 2021. Following his death, Shao was relatively isolated in the community. She spoke limited English, with her first language being Cantonese.

289. Shao had a long history of mental health issues. She had been hospitalised periodically from about 2000. She was diagnosed with bipolar disorder or schizoaffective disorder. She had previous admissions to Rozelle, Concord and St Vincent's Hospitals. Shao was generally treated in the community with lithium, and when compliant, her mental health was moderately stable.[190]

[190] Tab 106B, RPAH and PMBC medical records, p 238.

290. From May 2021, Shao was supported in the community by the Redfern Community Mental Health Team. Her care coordinator was Alison Li. Ms Li is fluent in Cantonese. She saw Shao about once a week. Ms Li recalls that Shao was initially very stable, and her only contact was to obtain medication from the Redfern Community Mental Health Team centre. However, after her husband's death in 2021, Shao's mental health began to decline.

291. Shao also had an NDIS plan to provide community support and occupational therapy.[191]

292. Ms Li noted that in May 2022, she interacted with Shao both at the Redfern centre and in Shao's home. She noted that Shao had become quite distressed about a debt. Whilst Shao was vague in the details of the debt, she eventually advised Ms Li that she had signed as a guarantor for a debt and showed her a court judgment relating to that. A decision was made to involve a financial counsellor. Ms Li also recalled calling Legal Aid for assistance. Shao advised Ms Li that she was not sleeping and was paranoid.

293. On 8 May 2022, Shao presented to Redfern police station in crisis. She spoke with Constable Max Gattas via an interpreter. Shao told him she did not feel safe, and that she was afraid she would jump from the roof of her unit block. Constable Gattas called an ambulance, and Shao was conveyed to St Vincent's Hospital pursuant to s 22 of the MH Act.[192]

294. Shao was admitted to the Caritas Mental Health Unit for three weeks, and was discharged on 3 June 2022. During this admission, Shao expressed suicidal ideation, and her medication was changed. Shao had previously been on lithium for a number of years, but had developed diabetes insipidus as a result of taking that medication. She was commenced on quetiapine (an antipsychotic) and valproate (a mood stabiliser) and was discharged home. Ms Li recalled attending the hospital on the day Shao was discharged, and notes she seemed a lot better and was stable, she was able to discuss her health and was grateful for the discharge as she did not want to be in hospital anymore.

295. Following the discharge, Ms Li saw Shao daily. Shao appeared quite distressed, and became increasingly paranoid about her neighbours, believing they were able to steal her things with magic and that her phone had been tapped. She was also "*very fixated on the money"* and was not able to engage in conversation about her mental state.

[191] Tab 106B, RPAH and PMBC medical records, p 238; Tab 101, Statement of Alison Li, [12]-[21].
[192] Tab 85, Statement of Constable Max Gattas, [5]-[11].

296. By 10 June 2022, Ms Li was quite worried as Shao was not improving. Ms Li asked for Shao to be reviewed by a Clinical Nurse Consultant (**CNC**) Alana Evans, and it was decided to transport Shao to hospital for assessment. Shao was conveyed to RPAH.[193]

Admission to RPAH

297. Shao was received at the Missenden Assessment Unit (**MAU**) at RPAH. She was reviewed by a psychiatrist with an interpreter.[194] The impression was that Shao was experiencing a mixed affective state, a combination of manic and depressive symptoms.[195] Shao was scheduled as a mentally ill person and remained an involuntary patient until her death. She was reviewed with the assistance of interpreters at the MAU until 16 June 2022, when she was transferred to the PMBC.

298. Throughout her admission, Shao called Ms Li multiple times a day stating that she wanted to get out of hospital. Ms Li also visited Shao during her admission and was involved in planning discussions with Shao's treating team at the PMBC.

Admission to PMBC

299. On 16 June 2022, she was placed in the HDU, under the care of Dr Peter Xie. Dr Xie noted that Shao presented in a significant crisis with delusional thoughts. There was also cultural shame associated with her forthcoming declaration of bankruptcy and guilt, which were significant factors for her. Dr Xie stated that these factors were at the forefront of his assessment of Shao.[196] The intention was to stabilise Shao's illness and titrate her medications.

300. Dr Xie noted that Shao was compliant in taking her medications and rarely missed taking them. Shao also had reasonable insight into medications which were helpful for her illness. During her admission, Shao raised the possibility of having injectable medication, as she felt that these may have more of an effect.[197]

301. Dr Xie reviewed Shao frequently during the admission, more often than he would usually do for a patient under his care. Dr Xie explained this was due to a number of factors, including that there was a Staff Specialist shortage at PMBC at the time, and that he was fluent in Cantonese and was able to speak with Shao without the need for an interpreter, as there can often be a long wait for an interpreter to be available

[193] Tab 106B, RPAH and PMBC medical records, p 70; Tab 101, Statement of Alison Li, [22]-[27] and Annexures A and B.
[194] Tab 106B, RPAH and PMBC medical records, p 241.
[195] Tab 95, Statement of Dr Peter Xie, [17].
[196] Tab 95, Statement of Dr Peter Xie, [22].
[197] Tab 95, Statement of Dr Peter Xie, [25].

(either in person or via telephone).[198] According to Dr Xie, Shao felt "*incredibly isolated on the wards*" as she did not like the food and felt like she could not communicate her needs on the ward,[199] and this was very distressing for her. Dr Xie commented that the non-Cantonese speaking nursing team "*tried their absolute best… But nevertheless it was very distressing for her*".[200] Dr Xie's review of Shao had been a source of comfort, and practically speaking, asking for a registrar to review a patient who would need an interpreter to be contacted would have taken time. When Dr Xie reviewed Shao with a registrar, Dr Xie translated her responses simultaneously.

302. Dr Xie noted that due to the difficulties of arranging an interpreter and Shao's isolation, the nursing team tried their best in rostering to have a Cantonese or Mandarin speaking nurse caring for Shao each shift. Dr Xie also believed the occupational therapist spoke Cantonese.

303. In addition to the regular reviews Dr Xie conducted of Shao, she was also discussed at the weekly MDT meetings, which generally included the psychiatry team, nursing staff, social workers and members of the Redfern Community Mental Health Team, such as Ms Li.[201]

304. During the initial reviews conducted by Dr Xie, Shao had consistently asked to be discharged from the ward. Dr Xie believed this was because she felt isolated in the environment, and did not want to feel locked in the ward. Additionally, Dr Xie noted that within the HDU, there are a lot of unwell patients who may be vocal at times, and so the team wanted to expedite her transfer to the SSU. Shao was also worried about her daughter.

305. On 17 June 2022, Dr Xie reviewed Shao. Shao presented as paranoid and delusional. She felt the nursing staff were saying bad things about her. Dr Xie noted that Shao was also suffering from disorganised thought process. She felt she could not get better, and she was worried about her daughter. Shao reported a significant debt (approximately $96,000), which seemed to have arisen as a result of a scam. She had plans to end her life by jumping out of her apartment on the 15th floor.[202]

306. Shao saw a financial counsellor, Mr Nicanor Odejar on 27 June 2022 via MS Teams, together with Ms Li. There was already a judgment entered against her. Mr Odejar

[198] Tab 95, Statement of Dr Peter Xie, [19]; Tab 98, Statement of RN Joel Herren, [14]; Tab 98A, Statement of Dr Tanya Ahmed, [18].
[199] T195.36.
[200] T195.35-40.
[201] Tab 95, Statement of Dr Peter Xie, [20].
[202] Tab 106B, RPAH and PMBC medical records, pp 220-222.

gave Shao advice about bankruptcy, which had been previously discussed with her. This made Shao distressed, saying "*it can't be solved even if I am dead"*. The session was ended shortly after. A subsequent session was cancelled.[203] Dr Xie noted that there is cultural shame in relation to debt and in Chinese culture, bankruptcy may be considered incredibly shameful, which may have affected Shao's perception and resistance to addressing her debt and managing her finances.

307. On 29 June 2022, Shao made a formal application under the MH Act to be discharged from hospital.

308. Shao was reviewed by Dr Xie and the team on 30 June 2022. Shao's mental state was improving, however, Dr Xie did not consider Shao was fit for discharge. This was because there were a number of things going on for Shao, including her debt which was yet to be properly addressed. A financial management order was also being considered. Dr Xie's concern was that Shao remained at risk due to her psychotic behaviour. Accordingly, he considered that Shao should remain in hospital, with an expectation that she would be discharged in one to two weeks.[204]

309. The same day, registrar Dr Nathan Jamieson prepared a report on behalf of Dr Xie for the Mental Health Review Tribunal (**the Tribunal**), to allow time to continue to review and titrate Shao's medications in a contained environment, while facilitating occupational therapy and social work support.[205] The Tribunal made a four-week Involuntary Patient Order on 1 July 2022 (meaning continued detainment at the PMBC until 29 July 2022). The Tribunal noted that Shao wanted to be discharged and said she was frightened in hospital. It recorded that she was to be transferred to a less restrictive environment as soon as a bed was available.[206]

310. Dr Xie next reviewed Shao on 4 July 2022. There had been a marked improvement in Shao's mental state, although she remained stressed about her debt. The plan was to continue her admission, but prioritise a move to the acute ward and contact Ms Li.[207]

[203] Tab 106B, RPAH and PMBC medical records, pp 81, 298; Tab 102, Statement of Nicanor Odejar, pp 1-2.
[204] Tab 106B, RPAH and PMBC medical records, p 225; Tab 95, Statement of Dr Peter Xie, [30].
[205] Tab 106B, RPAH and PMBC medical records, p 218; Tab 95, Statement of Dr Peter Xie, Annexure A.
[206] Tab 106B, RPAH and PMBC medical records, p 61.
[207] Tab 106B, RPAH and PMBC medical records, p 226.

311. On 7 July 2022, a further review found Shao was at or close to her baseline. She was still preoccupied with her debt. She had difficulties with memory and recall, possibly related to her sedation.[208]

312. On 8 July 2022, Dr Xie reviewed Shao again. She did not want to talk about bankruptcy. She presented as frustrated and anxious, in the context of her ongoing hospitalisation, language barrier, separation from her daughter and difficulty using her mobile phone. The team planned to continue Shao's involuntary admission, but transfer her to the SSU or the Acute Unit. Meetings were proposed with the financial counsellor and Ms Li.[209]

313. At the next review, on 11 July 2022, Shao appeared distressed about her prolonged admission. It was believed she was delusional about the staff. She appeared over-sedated, and changes were made to the medication.[210]

314. A review the following day, 12 July 2022, found Shao anxious and expressing worries about people wanting her dead. Dr Xie was weighing up the benefits and risks of an ongoing admission, with an aim to discharge into the community.[211] Dr Xie was asked in evidence about whether he had considered transferring Shao to a "step-down" community facility prior to being released into the community. Dr Xie did not think this was appropriate, as Shao would have been a voluntary patient at that point in time, and he believed she would have declined to be transferred to another health facility, as she just wanted to be home.

315. On 13 July 2022, Shao was transferred, or "stepped down" to the SSU within the PMBC.[212] Dr Xie noted that Shao continued to be "*very consistent*" in expressing her desire to be discharged. Dr Xie noted this step down was part of the natural progression of Shao's admission towards discharge and a test of higher stimulus environment.[213]

316. By this stage of Shao's admission, Dr Xie had formed the view that preparing Shao for discharge was likely appropriate given she found the inpatient environment highly distressing. Dr Xie noted that it:[214]

> *is always difficult to balance the risks and benefits of continued detainment. Whilst continued detainment would allow for ongoing review and monitoring,*

[208] Tab 106B, RPAH and PMBC medical records, p 329.
[209] Tab 106B, RPAH and PMBC medical records, p 228.
[210] Tab 106B, RPAH and PMBC medical records, p 229.
[211] Tab 106B, RPAH and PMBC medical records, p 231.
[212] Tab 106B, RPAH and PMBC medical records, p 346.
[213] Tab 95, Statement of Dr Peter Xie, [35].
[214] Tab 95, Statement of Dr Peter Xie, [36].

ongoing detention was simultaneously increasing her distress, and this in itself was a risk.

317. Shao saw an occupational therapist, with whom she could speak in Cantonese, and provided some more details about her debt. According to Shao, it was related to a taxi driver who lived in her building, and who had scammed her and her relatives out of money.[215]

318. On 15 July 2022, Dr Xie reviewed Shao. She remained anxious about her finances, being in a restrictive hospital setting and her language barrier. Shao demonstrated akathisia (restlessness) which was believed to be a side effect of medication, and so changes were made to her medication regime. She appeared calmer when told about the plan to discharge her. Shao was also experiencing polydipsia (excessive drinking) and polyuria (excessive urination).[216]

319. Shao's sister and daughter visited her on 16 July 2022. Shao asked them to leave.[217] Shao's daughter said her mother had been calling her on the telephone repeatedly, saying someone was out to get her.[218]

320. On the morning of 18 July 2022, an incident occurred where Shao took a ceramic plate and knife and said she wanted to cut her wrist and kill herself. This was reported to Dr Xie.[219]

321. On the same day, Dr Xie discussed Shao's case with a senior colleague, Dr Hassan Mehdi, then the Acting Director of the PMBC. They agreed that her discharge should be expedited, given her language barrier, isolation and the impact of the ward environment on her mental state. They also considered other possible treatments, including clozapine and ECT. However, that would necessitate a longer admission. The plan was therefore to provide Shao support in the community.[220]

322. Dr Xie reviewed Shao for the final time that day. He was aware of Shao's threat to self-harm earlier that day. On questioning, Shao had "*no thoughts of ending her life or jumping from a balcony*". Dr Xie noted Shao had a tendency to ruminate and catastrophise, and the ward environment was exacerbating her distress. Shao spoke of the 18 levels of hell, which is a part of Chinese mythology, and described her mood as stable and she felt she had recovered quite a lot. However, Shao continued to

[215] Tab 106B, RPAH and PMBC medical records, p 347.
[216] Tab 106B, RPAH and PMBC medical records, p 234.
[217] Tab 83, Statement of Shao's daughter, [6].
[218] Tab 83, Statement of Shao's daughter, [7].
[219] Tab 106B, RPAH and PMBC medical records p 356.
[220] Tab 95, Statement of Dr Peter Xie, [37].

express a desire to leave the hospital. Dr Xie formed an impression that she was stable, and while she had residual paranoia, it was no longer to the extent that she required involuntary admission and treatment. The plan included changes to medication, blood tests and a discussion with Shao's care coordinator, Ms Li, about ongoing care. The plan was to discharge Shao on 20 July 2022. Shao was informed of the plan.[221]

Events of 19 July 2022

323. On Tuesday, 19 July 2022, Shao was in room 3 within the SSU, and was being observed on Care Level 3, which required at least 30-minute observations.

324. In the morning, Dr Jamieson spoke with Ms Li about the plan to discharge Shao the following day. Ms Li was agreeable to following up Shao in the community, had submitted paperwork for a Financial Management Order and confirmed NDIS supports were in place. Ms Li was going to try to contact Shao's daughter.[222]

325. Dr Jamieson also commenced preparing a draft discharge summary, in preparation for Shao's discharge. He did not review her that day.[223]

326. The nursing notes recorded for Shao on 19 July 2022 are unremarkable.

327. RN Hannah Taylor recorded at 12:04pm that Shao appeared more stable in her mental state and was self-managing her anxiety. She continued to refer to the debt, saying "*I didn't take the money*."[224]

328. During the afternoon, Shao's care was allocated to RN Mingjia (Oscar) Zhong. He could speak Cantonese. This was the first time RN Zhong and Shao had met. RN Zhong tried to engage with Shao and build rapport, but she appeared suspicious of him and did not want to answer his questions. Shao did not want to talk with him and stopped talking on the telephone when RN Zhong was near her.

329. RN Zhong stated that it was his usual practice to look out for any signs of hallucinations or delusions, and to ask his patients about this. He understood that Shao believed people were monitoring her phone and that people were using magic.

[221] Tab 106B, RPAH and PMBC medical records p 236; Tab 95, Statement of Dr Peter Xie, [44]-[48] and Annexure B; Tab 96, Statement of Dr Nathan Jamieson, [23] and Annexure B.
[222] Tab 106B, RPAH and PMBC medical records, p 359; Statement of Dr Nathan Jamieson, [25] and Annexure C.
[223] Statement of Dr Nathan Jamieson, [27] and Annexure D.
[224] Tab 106B, RPAH and PMBC medical records, p 360.

He noticed Shao looking out the window of her bedroom, with her eyes darting left and right. This appeared to be signs of her paranoia.[225]

330. The observation chart records that Shao was in the bathroom during three observation rounds between 1:30pm and 2:30pm. Shao was on the phone from 4:30pm to 5:30pm. Between 4:00pm and 5:00pm, Shao spent most of her time in the patient alcove and would stop talking on the phone whenever RN Zhong got close to her. Shao was "*very suspicious"* of RN Zhong.[226]

331. RN Joel Herren was undertaking observations from 5:00pm, while RN Zhong was on a break. He was the nurse-in-charge. At 6:00pm, RN Herren recorded that Shao was in the bathroom.[227] That was the last observation before Shao's death.

332. At about 6:30pm, RN Herren was performing observations. He saw Shao's room looked dark. He knocked, and there was no answer. He went to check on three other patients, and then came back.

333. At 6:36pm, he shone a light through the window, but could not see Shao in her bed. He then opened the door and turned on the light. He saw Shao hanging from a ligature which had been knotted and wedged at the top of the bathroom door, over the corner. He took Shao down, pressed a duress alarm and commenced CPR.[228]

334. The CERS team was called at 6:40pm and arrived at 6:43pm. A call was then made to Triple 0.[229]

335. An ambulance arrived and paramedics were with Shao at 7:05pm. Shao was conveyed across to RPAH, arriving at 7:37pm. RN Herren accompanied Shao during the transfer.

336. Shao remained in RPAH for the following three days. She was transferred to the ICU and ventilated. However, it became clear that she had suffered a non-survivable injury. On 22 July 2022, investigations confirmed that Shao had suffered brain death, which was declared at 3:35pm.[230]

337. Life support was withdrawn at 2:50pm on 23 July 2022.[231]

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[225] Tab 106B, RPAH and PMBC medical records, p 365; Tab 97, Statement of RN Minjia 'Oscar' Zhong, [13]-[19] and Annexure A.
[226] Tab 97, Statement of RN Minjia 'Oscar' Zhong, [18]-[19].
[227] Tab 106B, RPAH and PMBC medical records, pp 82, 210.
[228] Tab 106B, RPAH and PMBC medical records, pp 361-362; Tab 98, Statement of RN Joel Herren, [20]-[23].
[229] Tab 94, Transcript of Triple 0 call.
[230] Tab 99, Statement of Dr Clive Woolfe, [19].
[231] Tab 81, Statement of Constable Carla Rizk, [12].

Post incident events

338. On 20 July 2022, after Shao had been transferred to RPAH, staff cleaned her room at the PMBC. The ligature, which is described as a scarf, was located, placed in a plastic pathology bag, and placed in a locked cupboard in the nurses' station. NM Pouw attended and took the ligature, storing it in her office at Concord Hospital. The ligature was seized from that location by police on 23 July 2022.[232]

339. During the cleaning process, a nurse observed there was a small piece of glass missing from the bathroom mirror, and a clean cutlery knife in the sink. This was reported to the after-hours manager.[233]

340. Police were contacted for the first time on 23 July 2022, and arrived at RPAH at 1:33pm.

Post mortem investigation

341. A limited autopsy by way of external examination and CT scan was performed by Dr Elsie Burger on 26 July 2022. She records the cause of death as "*the effects of hanging*". No toxicology was performed, as there were no antemortem samples.[234]

Issues

342. An issues list has been circulated for Shao's inquest, as follows:

Issue 8: Was reasonable and appropriate care and treatment provided to Shao during her admission to PMBC from 10 June to 22 July 2022?

343. Dr Sullivan's expert evidence was that:[235]

> *In my opinion, [Shao] received reasonable and appropriate mental health care during her final hospital admission. Specific factors of relevance included the challenges of treating [Shao] when she had limited facility with English language, and also her increasing distress on the psychiatric inpatient unit.*

344. In oral evidence, Dr Sullivan again confirmed his opinion that the overall care and treatment of Shao's mental health was reasonable and appropriate.[236] Specifically, Dr Sullivan stated that the length of time that Shao was detained as an involuntary

[232] Tab 88, Statement of Leading Senior Constable Lachlan Coles, [3]; Tab 100, Statement of NM Tenille Pouw, [6]-[11].
[233] Tab 106B, RPAH and PMBC medical records, p 366.
[234] Tab 79, Autopsy report.
[235] Tab 111, Expert report of Dr Danny Sullivan, [190].
[236] T260.39-41.

patient, being six weeks, was appropriate in circumstances where she had continuing symptoms including clear evidence of delusional beliefs.

345. Further, he was of the view that changing Shao's medication, including a trial of risperidone, was appropriate considering that the consultant sought a second opinion and considered a variety of treatment options. Dr Sullivan stated that where there are a range of choices, appropriateness is ultimately determined by "*patient preference, side effect profile, and clinical response*", and therefore medication should be started at a low dosage and patients monitored for a clinical response.[237]

346. Dr Sullivan opined that the efforts made to overcome the language barrier with Shao, including to identify and have a psychiatrist, being Dr Xie, and mental health staff who spoke Cantonese, were reasonable.[238]

347. At the time of her death, Shao was still an involuntary patient, although she was not considered to be at very acute risk and again, regard must be had to the tension between giving people amenity and access to their personal property and protecting patients by removing things from them that might cause them harm. As Dr Sullivan has said throughout this inquest, in effect, you cannot remove all ligatures unless you remove everyone's clothing and put them in a very austere environment.

348. Counsel assisting submitted:[239]

> *… [Shao]'s issues commenced at issue eight, being the reasonableness and appropriateness of care that was provided to her during that admission from, well, 10 June, it actually commences on 16 June, she spends about six days in the assessment unit first through to 22 July. Your Honour heard again directly from [Shao]'s treating team, from Allison Lee in the community and Dr Xie in the hospital. I won't repeat what your Honour has just heard in terms of the context of her deterioration and the particular challenges that the team faced in caring for her. It was a very long admission, but it was appropriate, and Dr Sullivan gives your Honour this evidence, in light of the fact that she continued to display symptoms of her bipolar disorder, including psychotic symptoms, up until the day of and the day prior to her death.*
>
> *So it was necessary to detain her in PMBC for that period of time. Clearly, she was unwell at the outset, having felt thoughts of self-harm and so on. It is tragic that she found the process of hospitalisation to be so isolating and distressing,*

[237] T261.18-19.
[238] T261.29-28.
[239] T283.43-T284.23.

and yet, on Dr Sullivan's assessment, it was necessary, there was nothing else that really could have been done. Dr Xie in his evidence recognised that it was isolating for her and distressing for her, and therefore, your Honour would accept, was working very hard to try to effect her release back into the community, and had formulated a plan to do so when her death occurred.

Dr Sullivan is not critical of the care that was provided to [Shao] during the admission and acknowledges those challenges, the need to find a mix of medication that was going to work when she had to stop taking lithium in the community, the language barrier that meant she was very isolated and had difficulties communicating her needs, and the distress caused by the admission as a whole. But even accounting for those difficulties, in his view, reasonable appropriate care was provided, and I'd urge your Honour to accept that view.

349. It was submitted on behalf of the SLHD that the care provided to Shao was reasonable and appropriate, and that Dr Sullivan opined a such (as extracted at [105] with respect to LF).[240]

350. I accept the expert evidence of Dr Sullivan that the care and treatment provided to Shao during her admission to the PMBC from 10 June to 22 July 2022 was reasonable and appropriate.

351. I make findings in relation to Issue 8's sub-issues below.

a) the decision to detain Shao as an involuntary patient on 10 June 2022

352. As noted above, Shao was detained as an involuntary patient on 10 June 2022. This was on the background of her discharge from St Vincent's Hospital four days prior. Ms Li saw Shao each day after her discharge and became increasingly concerned for Shao, as she was becoming "*increasingly paranoid*".[241] On 10 June 2022, Ms Li thought there had been no change to Shao's mental state, and Shao appeared to have psychotic delusions, relating to her neighbours tapping her telephone. Ms Li also noted Shao had poor self-care. This was worrying to Ms Li, and she asked CNC Evans to review Shao with her. CNC Evans, like Ms Li, spoke Cantonese. After review, they agreed that Shao ought to attend hospital for an assessment, and CNC Evans scheduled Shao under the MH Act.

[240] T288.26-35.
[241] Tab 101, Statement of Alison Li, [24].

353. Whilst Dr Xie was not involved in scheduling Shao on 10 June 2022, he commented that the initial impression was that Shao:[242]

> *was experiencing a mixed affective state – having a combination of manic and depressive symptoms. There was no doubt that she was psychotically unwell and she required an involuntary mental health admission*.

354. Expert psychiatrist, Dr Sullivan considered the decision to detain Shao as an involuntary patient on 10 June 2022, as appropriate. He noted that Shao:[243]

> *…was distressed and suicidal. Her retraction of suicidal beliefs appeared inauthentic. She was unwilling to engage in community followup* [sic]*, to an extent that satisfied staff that followup would mitigate any risks she posed. She was reluctant to comply with medication. There were no other protective factors which could be employed to manage the risk of suicide. She met the criteria under the Mental Health Act 2007*.

355. I accept the expert evidence of Dr Sullivan that it was appropriate to detain Shao as an involuntary patient on 10 June 2022.

b) the plan to discharge Shao into the community on 20 July 2022

356. Although Shao was subject to an involuntary order from the Mental Health Review Tribunal, which provided for her detainment until 29 July 2022, her treating team formed the view that it was appropriate to discharge Shao earlier.

357. Dr Xie noted that during her stay at the PMBC, Shao continued to slowly improve and was stepped-down to the SSU. However, the ward environment continued to be highly distressing for Shao. As has been a common theme throughout these findings, balancing the risks and benefits of detainment of patients in mental health facilities is difficult, as the environment and detention can simultaneously increase distress and become a risk itself.[244]

358. On 18 July 2022, Dr Xie discussed Shao with the then Acting Director of PMBC, Dr Mehdi. They agreed that the language barrier, isolation and the ward environment was detrimental to Shao's mental state, and her discharge should be expedited, with ongoing supports in the community. Alternative treatments were also discussed,

[242] Tab 95, Statement of Dr Peter Xie, [17]
[243] Tab 111, Expert report of Dr Danny Sullivan, [195].
[244] Tab 95, Statement of Dr Peter Xie, [36].

however, these would likely have required Shao to be admitted for an even longer period of time.

359. Dr Sullivan opined that the plan to discharge Shao into the community on 20 July 2022 was appropriate. He noted:[245]

> *...There was discussion about the possible risks and benefits of detaining her further and it was agreed that the ward environment was not therapeutic for her. Although she reported distress at her accommodation, she also reported distress at detention in the inpatient unit where she was isolated from others and had limited Cantonese-speaking supports.*
>
> *It would have been worthwhile to determine if there were alternate places for discharge such as a halfway house or a step-down rehabilitation unit for voluntary clients. I do not know enough about Sydney services to determine if such an option was available. The benefit of a stepdown unit is that it can provide clinical support in a sub-acute setting and enable a graded and supported return to a community setting. Having said that, [Shao] did not seem to have significant impairments in adaptive functioning which required a supported setting.*
>
> *There was evidence of liaison with the community mental health staff during admission, as an element of prospective discharge planning. This also involved efforts to address [Shao's] financial stressors by linking her to financial counselling and considering whether a Financial Management Order was indicated.*

360. Dr McDonald advised that the SLHD operates two mental health inpatient rehabilitation units at the Concord Centre for Mental Health; being the Kirkbride Unit, and the Broughton Unit.[246] Additionally, the SLHD operates two co-locations which provide community-based residential support, being the Camperdown Units and Buduwa.

361. Dr Xie was asked in evidence whether he considered it was appropriate to consider further step-down facilities in the community for Shao, such as Buduwa in Burwood and the Camperdown Units. Ultimately, Dr Xie considered that discharging Shao home was most appropriate, as she had stabilised on her current medication regime and Shao was consistent in her requests to return home. The community step-down

[245] Tab 111, Expert report of Dr Danny Sullivan, [196]-[198].
[246] Tab 110B, Further supplementary statement of Dr Andrew McDonald, [7]-[8].

facilities were still health facilities, and patients stayed in these facilities on a voluntary basis. Dr Xie considered it likely that Shao would have declined this kind of facility, as she just wanted to return home.

362. In oral evidence, Dr Sullivan considered Dr Xie's contemplations as very reasonable in circumstances where Dr Xie was able to see Shao "*intensively over the duration of her admission*", had "*knowledge of local services*" and was able to consider those options, whether they were available, and assess their clinical relevance to Shao.[247] Dr Sullivan went on to say that "*there was no indication that a stepdown facility would've been preferable to what Dr Xie was recommending*."[248]

363. On the basis of the expert evidence of Dr Sullivan and the evidence of Dr Xie, the plan to discharge Shao into the community on 20 July 2022 was reasonable in the circumstances.

c) the location of care

364. After presenting to the RPAH on 10 June 2022, Shao was admitted to the HDU at PMBC as an involuntary patient. Shao was then stepped down to the SSU at the PMBC on 13 July 2022.

365. Dr Xie gave evidence about the decision to step down Shao down to the SSU. He noted that the ward environment was a high stressor for Shao, and she was isolated. Dr Xie considered this step down was *"part of the natural progression of her admission towards discharge and a test of a higher stimulus environment*".[249]

366. Dr Sullivan considered that the location of Shao's care was appropriate:[250]

> *… The placement in Professor Marie Bashir Centre was [appropriate], and I note that she was moved to the Short Stay Unit on 13 July 2022 as a step towards discharge. Given her age and the lack of significant behaviours which might have disrupted her care, she may have managed adequately in a less secure unit, although I have limited personal knowledge of the variety of inpatient psychiatric units available within the Local Health District. Having said that, the unit appeared appropriate and in particular was well able to meet her needs for Cantonese speaking staff.*

[247] T270.40-41.
[248] T270.43-45.
[249] Tab 95, Statement of Dr Peter Xie, [35].
[250] Tab 111, Expert report of Dr Danny Sullivan, [199].

367. Dr Xie's decision not to arrange a placement for Shao in a community-based facility upon discharge, was put to Dr Sullivan for his commentary. Dr Sullivan was of the view that Dr Xie's decision was appropriate. Dr Sullivan agreed that there was a tension between the need to contain Shao within the unit and the fact that this containment and the separation from her usual life and from her daughter was distressing for Shao. Dr Sullivan noted that in these circumstances, there was a clear rationale for discharging Shao.[251]

368. I accept the expert evidence of Dr Sullivan and the decision-making rationale of Dr Xie. I consider the location of Shao's care was reasonable in the circumstances.

d) observation levels

369. During her admission to the PMBC, Shao was assigned Care Level 3 observations, which meant she was to be observed every 30 minutes. Nursing staff at the PMBC undertake a two-hour block of observations for patients.

370. Dr Sullivan considered that the observation levels were appropriate. He noted:[252]

> *Increased frequency of observations actually appeared to increase [Shao's anxiety] and provided her with opportunities to question staff without reassurance from the responses. Being under observation exacerbated [Shao's] ideas of persecution and may have caused increased distress. Thus staff had to strike a balance between monitoring her and exacerbating her distress.*

371. In oral evidence, Dr Sullivan noted that in the absence of Shao displaying any concerning behaviours associated with her previously voiced suicidal ideation (from the morning of 18 July 2022), and as she was no longer voicing that ideation, he considered it appropriate that no change in management or observation level was made. Dr Sullivan noted that the treating staff could have immediately increased Shao's level of observations and reduce her access to objects if Shao demonstrated an ongoing suicidal ideation. However, Dr Sullivan qualified this response as needing to be "*balanced against the fact that these restrictions can in fact be provocative or distressing to a person and can exacerbate their mental state"*.[253] He went on to say that treating staff are likely to have an understanding of the appropriateness of responses for each patient and where there is a single incident, as opposed to an

[251] T262.3-12.
[252] Tab 111, Expert report of Dr Danny Sullivan, [200].
[253] T263.18-19.

ongoing ideation, keeping the environment safe, but not altering a patient's management plan, would be an appropriate response.[254]

372. I consider that the observation levels were appropriate.

e) access to ligatures

373. As noted above, it appears that the ligature Shao used to harm herself was a scarf. No witnesses were able to recall in evidence whether they saw Shao wearing this item on the ward.

374. In relation to access to ligatures in Shao's matter, Dr Sullivan noted that:[255]

> *It was not clear from her behaviour that there were significant grounds to prevent access to material which could have been used for ligatures. She had been an inpatient for over six weeks and there had not been evidence of ongoing suicidal planning or attempts. As noted earlier in this report, reducing access to ligature material, if taken strictly, requires profound restrictions in personal and ward amenity, and cannot be sustained long without increasing distress.*
>
> *Furthermore, despite design of units which reduce potential to suspend a ligature, patients of inpatient units can still kill themselves through asphyxiation without suspension, or can rig up a ligature effectively to kill themselves. Ligature-proof units offer reduced opportunity, but patients will always be able to bypass such measures, if sufficiently determined.*

375. I accept there is a need to create a balance between a therapeutic environment for patients, including access to personal belongings, and assessing the risk of having access to such belongings. In Shao's case, there were not any significant reasons to prevent access to her personal belongings and given she had been an inpatient for over six weeks, there had not been any evidence of ongoing suicidal planning or attempts. As Dr Sullivan noted, reducing access to anything that may be a ligature taken strictly would not have been able to be sustained for a long time long without increasing distress to Shao. In those circumstances, it was not unreasonable for Shao to have access to the scarf.

Issue 9: What was the ligature used by Shao? How and when did she obtain it?

[254] T263.20-24.
[255] Tab 111, Expert report of Dr Danny Sullivan, [201]-[202].

376. On the third day of evidence in this hearing, photographs taken by police of the ligature Shao used to harm herself were tendered. The images depict a light-weight white leopard-spotted fabric, over two metres in length. Counsel assisting submitted that it appears to have been a scarf.[256]

377. Due to the length of time since Shao's death, hospital staff who were called to give evidence at the hearing were unable to recall if they had seen Shao wear the item of clothing. Nor were staff able to recall whether Shao had the item in her possession when she arrived at the PMBC, whether it was brought in by a visitor, or whether it belonged to Shao at all.

378. In relation to issue 9, counsel assisting submitted with respect to the ligature:[257]

> *I think the inference is there that it [the scarf] was in her possessions or her own scarf. We don't have clear evidence on that topic. Nobody who was asked recognised it. She wasn't considered, of course, she was still detained at the point when she affected self-harm, still an involuntary patient, but she was no longer considered to be a very acute risk. And of course, Dr Xie had spoken to her and assessed her the previous day. He was cognisant of episodic threats of self-harm, episodic paranoia that she displayed towards nursing staff, and nonetheless he felt that she was on a trajectory that would allow her to be released as soon as Wednesday, this being the Monday when he saw her. And tragically it was on the intervening day that [Shao] used the ligature to cause herself harm.*

379. Senior Counsel for the SLHD submitted that:[258]

> *… Your Honour heard evidence from Dr Xie and also from Dr Sullivan today in terms of the issue counsel assisting raised of the access to the scarf that seems to have been used as the ligature.*
>
> *The effect of Dr Xie's evidence, and ultimately comment on by Dr Sullivan, was that with a patient like [Shao] where she was getting closer to discharge but there was a change in the way in which you would necessarily remove risk items, if I can describe it that way, items that weren't prohibited but might be used in some way in an attempt at self-harm, and Dr Sullivan's way of describing it in his evidence today was that in those circumstances, it wasn't*

[256] T284.25.
[257] T284.25-36.
[258] T292.17-29.

unreasonable not to have removed that item at that point in time, that is, just prior to the discharge.

380. I find that the ligature used by Shao was a scarf. I am unable to find when and how Shao obtained the scarf with certainty. It is unclear whether any of the staff knew that she was in possession of the scarf. As to whether staff knew of the scarf and whether a search of Shao's property would have made a difference to the outcome, that would only be speculation.

Issue 10: Was reasonable and appropriate action taken after the following events occurred:

a) the reported threat to self-harm on 18 July 2022;

381. On 18 July 2022, Shao took a ceramic plate and cutlery knife and voiced a desire to kill herself in the morning. This was documented in contemporaneous records made by PMBC staff. Nursing staff provided PRN (as needed) medication for her distress and notified senior medical staff. A cutlery count then occurred and all items were accounted for.

382. Dr Xie then reviewed Shao, which was the second time he had done so that day. Dr Xie discussed suicide following the morning's events, and Shao denied any thoughts of self harm or ending her life. Shao described her mood as stable and that she felt that she had recovered quite a lot. She continued to express a desire to leave hospital as she found it distressing and felt her mood would improve once she left hospital. Dr Xie formed the impression that Shao's mental state appeared stable, with residual paranoia, although not to the extent which required her to remain as an involuntary patient.[259]

383. Dr Sullivan noted:[260]

The threat to harm herself appeared based upon [Shao's] ongoing persecutory and depressive delusions, such as that she would be sent to jail, that she would die because of financial stress, that she was being persecuted by scammers, that she or her daughter would be killed, or that she was losing her memory. Given the absence of any concerning behaviours associated with the voiced wish, I consider it was appropriate that no change in management or observation level was indicated, once medical staff were satisfied that she was

[259] Tab 95, Statement of Dr Peter Xie, [45]-[47].
[260] Tab 111, Expert report of Dr Danny Sullivan, [204].

not voicing ongoing suicidal ideation or displaying behaviours which raised ongoing concern.

384. In relation to Issue 10(a), counsel assisting submitted that:[261]

> *… The self-harm was reported to Dr Xie, he accounted for it, he understood it. He saw it in the continuum of similar behavior that [Shao] had displayed, and he also asked [Shao] specifically about thoughts of self-harm and received a convincing denial. That was an appropriate response in Dr Sullivan's view.*

385. Based on the expert evidence and noting the actions taken by Dr Xie, I find that the response to the reported threat to self-harm on 18 July 2022 was reasonable and appropriate.

b) the reported paranoia towards staff on 19 July 2022?

386. On 19 July 2022, RN Zhong noted that Shao was very suspicious of him and exhibited signs of paranoia. This was the first occasion that RN Zhong had care of Shao, and the pair had not met before. He also spoke Cantonese. Accordingly, RN Zhong attempted to build rapport with Shao, however, she was unwilling to engage and did not wish to answer his questions.

387. RN Zhong also noted that when Shao was on the telephone, Shao would stop speaking when he came near her.

388. In relation to this, Dr Sullivan noted that:[262]

> *Paranoia towards staff on 19 July 2022 was noted in the entry of registered nurse Mingjia Zhong and in his statement, noting that despite his efforts to engage with her as the allocated nurse on 19 July, [Shao] was suspicious of him. This appears to have been consistent with her overall level of paranoia, but perhaps more specifically focused on one staff member. Mr Zhong's response to this paranoia was in my opinion appropriate and did not raise any concerns. I do not think there was any information related to her mental state on 19 July 2022 which foreshadowed or could have raised imminent concern that she would her kill herself. I also do not think that it can be gleaned from Mr Zhong's observations that there was any appreciable change in her mental state apart from that attributable to a new staff member who may have been incorporated into her delusional beliefs. I do not think there were any*

[261] T284.48-T285.2.
[262] Tab 111, Expert report of Dr Danny Sullivan, [205].

> *observations documented or made in retrospect by Mr Zhong which warranted a change in treatment, specific medication, that she be allocated a different nurse, or an alteration in [Shao's] location or observation level.*

389. In relation to Issue 10(b), counsel assisting submitted that:[263]

> *… in terms of the paranoia towards staff, Dr Xie points out this was something that was happening throughout the admission. She was paranoid about Cantonese-speaking staff because they could hear what she was saying, in particular on the phone to other people, and possibly incorporated them into a delusion. It didn't represent an escalation and didn't clearly require a change in her management plan.*

390. Senior Counsel for the SLHD did not make submissions specifically related to Issue 10(b).

391. Based on the expert evidence of Dr Sullivan, the response to the reported paranoia towards staff on 19 July 2022 was appropriate.

[263] T285.4-12.

Common issues

392. As noted above, this inquest investigated the deaths of three women who were inpatients of the PMBC at the time of their self-harm events. LF died in 2019, Merryn died in 2021 and Shao died in 2022. LF, Merryn and Shao each died by way of self-harm within the PMBC, and each event of self-harm occurred in a similar manner.

393. Accordingly, it is important to consider how and why LF, Merryn and Shao were able to self-harm using similar means in a mental health facility.

394. Dr McDonald, as a witness on behalf of the SLHD, has provided several statements addressing policies and procedures in place at the PMBC and changes made since the deaths of LF, Merryn and Shao. Dr McDonald also gave evidence at the hearing.

395. Issues 11-16 on the issues list address common issues that are relevant to more than one of the deaths. It is noted that there is some overlap in my consideration of each of these issues below, with my consideration above of the issues surrounding each individual's particular circumstances.

396. I now consider each of Issues 11-16 in turn.

Issue 11: Were adequate systems in place to prevent access to items that could be used for self-harm, including ligatures such as bed linen?

397. As set out above for Issue 1(e), LF used as a ligature an item of crafting material which was available for use on the ward. There is only one progress note available, which specifically details that LF handed back the items when asked. Following LF's death, most crafting materials were removed from the PMBC. Only items such as pencils and paint remain and are only available under supervision.

398. As set out above for Issue 4(d), Merryn used a ripped standard bedsheet as a ligature. It is unknown where, when or how Merryn acquired this piece of material, as according to her care plan, she was only permitted use of anti-rip bedding, which was blue in colour. It is also unknown how long Merryn had this item on her person.

399. As set out above for Issue 8(e), Shao used a long scarf as a ligature. No witnesses were able to give evidence as to whether they saw Shao wearing this on the ward.

Policies, procedures and training at the PMBC – Searches to identify ligatures

400. In May 2019 (before LF, Merryn and Shao's deaths), the SLHD MHS policy: *Searching Consumers and Their Property* (MH_SLHD_PD2019_015), was published.

401. In September 2019, the SLHD MHS policy *Environmental Inspections and the Searching of Consumers and their Property* was implemented. As at February 2021 (that is, the time of the first statement of Dr McDonald and prior to Merryn and Shao's deaths), that policy was under review.

402. On 4 April 2025, the SLHD MHS policy directive: *Searching Consumers and Their Property in Mental Health Environments* (MH_SLHD_PD2025_006) was introduced.

403. At the time of this inquest in July 2025, the SLHD MHS Procedure: *Environmental Inspections and the Searching of Consumers and Their Property* published in September 2019 remained in effect, and is kept in hard copy on all inpatient units. Dr McDonald advised that the information within this procedure is to be incorporated within the next iteration of the *Searching Consumers and Their Property* policy.[264]

404. As part of the ingoing training within PMBC, nursing staff undergo education and training on searching patients, their property and the clinical environment. Such training is not mandatory, but is run as part of an in-service program which is run on a monthly basis by the Clinical Nurse Consultants and the Clinical Nurse Educators. There are three training sessions relating to this subject, however, there is overlap between each of the sessions,[265] and accordingly the SLHD indicated it intended that updated training will be rolled into one session in the future. At the time he gave evidence on 24 July 2025, Dr McDonald confirmed that 84% of staff at PMBC had attended the training.[266] Dr McDonald also gave evidence that training regarding searches of patients, their property and the clinical environment would be reviewed by the SLHD to ensure that it aligns with the revised policy directive published on 4 April 2025.

405. Dr Sullivan stated that ligatures can be constructed from items of clothing and common items found on an inpatient unit. He gave evidence that it is challenging to restrict an individual, or with even greater difficulty, an entire ward from access to all potential ligatures without creating an environment which would have very limited amenity and could only prevent suicide in the short-term while a person was accommodated there. Dr McDonald gave evidence that it is likely that a suicidal person would then find other means to harm themselves or would seek to portray a clinical recovery sufficient to be discharged in order to engage in further suicidal behaviour.[267]

[264] Tab 110, Statement of Dr Andrew McDonald, [48].
[265] Tab 110, Statement of Dr Andrew McDonald, [52].
[266] T230.11-14.
[267] Tab 111, Expert report of Dr Danny Sullivan, [229].

406. Dr Sullivan opined in his expert report that the policies at the PMBC regarding searching are robust, however that in circumstances where related training is not mandatory, searches should be undertaken by staff who are verified as having completed the training. He also opined that rather than refresher training, it is better to have a program of audit by an observer, or random search exercises.[268]

Policies, procedures and training at the PMBC – Access to linen and bedding

407. In addition, information was sought from the SLHD regarding the processes for restricting access to linen and bedding within the PMBC's HDU as at December 2021 (being the time of Merryn's death) and currently.

408. Linen and bedding across the RPAH campus, within which the PMBC is situated, is managed in accordance with the SLHD RPAH policy *Linen: Services and Management* published in October 2022. There is no separate standalone policy relating to linen for the SLHD MHS, although that RPAH policy regarding linen applies to the PMBC, and other SLHD MHS policy material which addresses linen is referred to below.

409. At the time of Merryn's death, there was no formal policy or process that required the removal of linen skips (or linen trolleys) from common areas when a high-risk patient was on the ward.

410. However, from evidence gathered throughout the inquest, including from Dr McDonald, it was common for linen skips to be removed from the ward, as a matter of clinical judgement when high-risk patients were on the ward, such as Merryn. The decision to provide patients with anti-rip bedding is also a clinical decision. Merryn's care plan provided that anti-rip bedding be used.

411. In December 2022 (that is, subsequent to Merryn's death), the SLHD MHS Guideline: *Caring for consumers at risk of deliberate self-harm and suicide in SLHD MHS Inpatient Psychiatric Units* was published. This guideline provides that staff are required to keep linen trolleys in a visible location, where staff are able to monitor them, or to remove the linen trolleys from the ward, if possible, such as by locking them within specific areas.[269]

412. However, as noted by Dr McDonald, removing the linen trolley from the ward creates other issues, such as there being nowhere patients can discard their used linen, and the impact that has on the hygiene, health and safety, and cleanliness of the ward.

[268] Tab 111, Expert report of Dr Danny Sullivan, [230].
[269] T232.9-13.

413. In relation to linen skips, in his first report, Dr Sullivan noted that per the policy on linen skips, it remains at the clinical discretion of staff to remove these from areas accessible to patients. He considered this lacked rigour and should be amended to provide a consistent and robust process which is less reliant on staff vigilance.[270]

414. However, in oral evidence, having heard Dr McDonald's evidence about searches and potential issues (such as hygiene) with removing linen skips from the ward, Dr Sullivan further noted that:[271]

> *think it's, it's never perfect, from, from my background in forensic psychiatry, you know, I always marvel at how it is that people are able to obtain drugs or mobile telephones or weapons in, in conditions of the highest security, so searching is, is a, an important part but it's, it's a deterrent, it mitigates the risk to some extent, but as we've talked about today, there will still remain items which you can search for but you can't remove them from a person because they're critical to their, to their recovery, such as clothing*
>
> *…I think Dr McDonald makes it clear that it's, it's deeply understood by staff that it's a necessary aspect. It's always going to provide that tension between having an austere and locked environment with absolutely nothing available which isn't behind lock and key and demands that the staff get, get it out for every single use, and that's obviously not practicable.*
>
> *It's clear that the high dependency unit, the, the PMBC, has, has a different set of procedures from the other units, so look I accept that, that in striking that balance between having available linen skips and depriving patients of those entirely, they've, they've achieved a practicable balance. Having said that as well, I can point out that I suppose we - there's no evidence that the linen skip was the source of the ligatures in any of these cases, but it's simply, I suppose, a, a way in which patients who are determined can easily access the means to harm themselves and therefore it's worth paying attention to. I was satisfied that Dr McDonald's service had recognised that and, and had taken appropriate mitigating risks recognising that - sorry, mitigating processes, recognising that you can't mitigate that risk entirely.*

415. When questioned as to whether there had been consideration given to formalising a process to remove or limit access to linen skips, Dr McDonald noted that consideration had been given to permanently removing the linen skips from the

[270] Tab 111, Expert report of Dr Danny Sullivan, [234].
[271] T267.15-46.

inpatient units, however, the view was that this would create issues in relation to patient hygiene and storage. Dr McDonald noted that clean linen was presently stored in locked cupboards.[272]

416. Additionally, oral evidence of Dr McDonald was along the same lines. There was also evidence from RN Whittle that where linen skips have been removed due to a high-risk patient being on the ward, patients may dispose of their linen in the area or alcove where the linen skips usually reside, or leave them out the front of their rooms. This also creates opportunities for patients to obtain the linen to cause themselves harm. In terms of who was responsible for collecting the linen and taking it to the trolleys in the locked room, RN Whittle and Dr McDonald both suggested it was "*everyone's [nursing staff] responsibility*"[273] to keep an eye out for items which may be used for self-harm or to harm to others, and to remove the item as quickly as possible.[274]

417. Dr McDonald was also asked whether there has been any consideration of reporting information regarding ligatures to the Clinical Director or appropriate staff member when a self-harm incident occurred. Dr McDonald noted that:[275]

> *Ligatures that are used or discovered are reported to the Clinical Governance Unit through the incident process… The type and nature of any ligatures discovered is reported via the incident process, with daily incident screening by the Clinical Governance Unit which enables the identification of any 'new' ligature risks and appropriate escalation and management of same*.

Submissions

418. The submissions set out in relation to Issue 6 above are also relevant to Issue 11.

419. In relation to Issue 11, counsel assisting submitted:[276]

> *…the first of the issues is whether there [were] adequate systems in place to prevent access to items that could be used for self-harm, including ligatures such as bed linen. Overall, my submission is there were adequate systems in place, but they weren't sufficient to prevent any of these women getting access to ligatures. But the context of my submission is that it is drawing on Dr Sullivan's evidence and Dr McDonald's. It's an impossible task to remove all ligatures. What you can hope for is a system which removes the obvious risks*

[272] Tab 110B, Further supplementary statement of Dr Andrew McDonald, [22]-[23].
[273] T153.30-35; T232.21-25; T233.1-2.
[274] T232.40-T233.6.
[275] Tab 110B, Further supplementary statement of Dr Andrew McDonald, [24]-[25].
[276] T285.14-38.

and in particular removes ligatures from people who present particularly heightened risk. There was, and this is in the policy about searching, environmental searching and personal searching that existed back at the time of these deaths. There was a reasonable system in place to remove ligatures from patients and the environment.

It wasn't sufficient to remove ligatures from these three women, but that is because there's that balance that I've already addressed your Honour about between providing people amenity and restricting any access to things that could cause harm. Positively, those policies and those processes have been enhanced since the time of these three deaths, and your Honour has in mind the evidence of Dr McDonald, including the policy that was introduced just this year, which represents an enhancement. Dr Sullivan's view of it was it's comprehensive and appropriate. It's also, as [your] Honour will see, something which Dr McDonald says they're going to audit at a stage later this year, that's the plan, to ensure that the process is being applied as they should be…

420. Senior Counsel for the SLHD orally submitted that:[277]

…Given the evidence that was given by Dr McDonald today about the fact that an audit process, not just that they are occurring, but it's the quality of them, is to be considered for introduction as part of the audit process later in this year, and Dr Sullivan's endorsement of that, I would submit that there's actually not a necessary basis, or there's not a necessity for that recommendation [to consider introducing a system for auditing or monitoring searches that are required under the LHD's policy] to be made. It's something that is already under consideration with a view to addressing the very issue that has been identified on the evidence, that is, it's all well and good to have a policy and to train people about searches, but it's also appropriate to undertake some form of checking that they're actually being done and done properly.

Your Honour heard the evidence, and again endorsed by Dr Sullivan, but the evidence from Dr McDonald about the fact that the training is done in a way where people are actually given this PowerPoint presentation, but there's then real-life type scenario-based review of staff so that the CNC that will provide the training will then observe people and give feedback in real time about how they're undertaking searches. So in that respect, my submission would be that

[277] T293.41-T294.10.

having heard all of the evidence, including that from Dr McDonald and Dr Sullivan today, that recommendation 3 is no longer necessary.

Findings

421. I accept counsel assisting's submissions that there were adequate systems in place to prevent access to items that could be used for self-harm, including ligatures such as bed linen, however, they were not sufficient to prevent the deaths of LF, Merryn and Shao.

422. As Dr Sullivan stated, it would be virtually impossible to remove all ligatures. There is an expectation, however, that all obvious risks will be removed, and any ligatures will be removed from people who present particularly heightened risk. There was environmental searching and personal searching that existed back at the time of these deaths. There was a reasonable system in place to remove ligatures from patients and the environment.

423. I am mindful of the evidence I have heard regarding the balance that needs to be considered, between providing people amenity and a therapeutic environment against restricting access to things that could cause them harm. Dr McDonald has provided evidence that the policies and processes have been enhanced since the time of these three deaths, including the policy regarding searches, to take into account the individual patient; the training provided in relation to searching; and the rolling out of audits for such searches. These are all positive steps and Dr Sullivan's view is that these enhancements are comprehensive and appropriate.

Issue 12: Were adequate systems in place to prevent access to locations that could conceal acts of self-harm, including bathrooms?

424. As set out above, Merryn's self-harm occurred in the ensuite bathroom within her room at the PMBC. As such, an issue considered in the inquest was the adequacy of systems in place to prevent access to locations that could conceal acts of self-harm, including bathrooms.

425. There was a system in place to prevent access to locations that could conceal acts of self-harm (including bathrooms) for patients with specific risk, such as Merryn, and this was noted within her Care Plan.

426. Throughout the inquest, a number of changes and improvements made to the PMBC since each of LF, Merryn and Shao's deaths were explored, including the works completed on the bathroom doors as at 12 August 2024. The bathroom doors are addressed in relation to Issue 13 below. Dr McDonald gave evidence that due to the

changes made to bathroom doors, ensuite bathroom doors now remain unlocked for high-risk patients, and other means are utilised to mitigate the risk that the enclosed ensuite bathroom poses.[278]

427. Counsel assisting noted that there have been changes, as provided by Dr McDonald, such as the new Zero Suicides in Care initiative and the intention of the SLHD to not stratify the risk of patients (for example: low, medium and high- risk), but rather to assess the risk of the environment and incorporate this into specific interventions and management plans for an individual patient.

428. Accordingly, counsel assisting submitted that if Merryn were to present to the PMBC as at the time of the hearing, the issue of keeping her bathroom door locked may no longer be relevant.

429. It was submitted on behalf of the SLHD that:[279]

> *As far as the common issues, I wanted to make one comment on counsel assisting's very thoughtful submissions as well, and that dealt with the issue about bathroom access. Your Honour's heard the evidence that now bathrooms are not typically locked, so that there's been a change after the physical changes were made, the doors were cut down and the changes made in the locking mechanism so that now it can't support a ligature. The practice is that they are not locked. The consequence is that there is the opportunity for them to be closed and for patients to be out of line of sight at various points in time.*
>
> *Counsel assisting made reference to the fact that what is now done because of that fact is that there is an increased emphasis on the observation levels, and that where a risk of self-harm is identified with a particular patient, that one way of dealing with that is that you can either increase the observation levels or lock them out of their room entirely. Can I just note that that again highlights one of the issues of tension between, on the one hand, austerity and amenity and having a therapeutic environment that came up in the evidence of Dr McDonald and Dr Sullivan.*
>
> *… I just highlight that on the basis that important changes have been made now so that the bathrooms are no longer locked. There are alternatives that can be made, but even with every alternative that's put in place, there's always*

[278] T220.24-31; 41-46.
[279] T292.31-T293.32.

the need to consider that balancing between amenity and austerity, or amenity and therapeutic effect and austerity.

430. I accept there were adequate systems in place to prevent access to locations that could conceal acts of self-harm, including bathrooms, although there was room for improvement and work has been done, and continues to be done to improve the policies and procedures. However, in Merryn's case, the incident appears to be due to a misunderstanding.

431. I am satisfied that there has been significant work done regarding the policies and training of staff. Again, I note the need to balance providing a therapeutic environment for patients with one that is restrictive and austere to minimise risks is challenging.

Issue 13: Were adequate steps taken to prevent patient access to hanging points?

432. LF used the bathroom door as a hanging point, and Shao used the bathroom door hinge as a hanging point. In both instances, the bathroom was an ensuite located within their room at the PMBC. Merryn did not use a hanging point.

433. Dr McDonald gave evidence that the ensuite bathroom doors at the PMBC have been modified to eliminate ligature points. In late 2022, the SLHD MHS reviewed the installation of anti-ligature bathroom fixtures across the service. In 2023, following a review of bathroom doors and a trial of alternative ensuite doors, a sloped top door design was adopted across all PMBC ensuite doors. These works were completed in August 2024.

434. In addition, the previous "lock latches" on all PMBC bathroom doors have been replaced with "roller latches". This was completed in August 2024. Ensuite bathroom doors now remain unlocked for high-risk patients (and other means are utilised to mitigate the risk that the enclosed ensuite bathroom poses).[280]

435. Dr Sullivan noted that having reviewed the photographs of rooms in the PMBC, it is clear that they have been designed to reduce ligature points, and Dr Sullivan had no further suggestions for the reduction of ligature points. Dr Sullivan noted that design specifications for ligature-free environments is a specific field of expertise and is routinely sought during planning, construction and refurbishment of inpatient settings, and that the SLHD appeared to have undertaken such an exercise.[281]

[280] T220.24-31; 41-46.
[281] Tab 111, Expert report of Dr Danny Sullivan, [231].

436. Further, Dr McDonald and Dr Sullivan agreed that it is virtually impossible to remove all potential ligature points. Removing or locking away potential ligature points may be necessary to contain risk in acute situations, however in the longer-term it is important that patients develop the skills and strategies necessary to maintain their independence. Dr Sullivan agreed with Dr McDonald that "clinical risk assessment and other strategies, such as observations" were more important to manage risk.[282]

437. In terms of preventing patient access to hanging points, Dr McDonald noted that the SLHD MHS was assessed and re-accredited by the National Safety and Quality Health Service in February 2023, with no recommendations as to patient searches or the clinical environment being made.

438. As has been a recurrent theme throughout this hearing, the evidence indicated that it is challenging for inpatient settings to find a balance between managing risk and providing therapeutic care. A sterile and 'safe' environment may limit risk, but it does not foster therapeutic care or help to prepare people for life in the community.[283] This sentiment, expressed by Dr McDonald, was echoed by Dr Sullivan.

439. In relation to Issue 13, counsel assisting submitted:[284]

> *The 13th issue, were adequate steps were taken to prevent patient access to hanging points? Again, the context is it's not possible to eliminate them completely. Two of the women who we've been looking at did use hanging points that were then present in PMBC. So [Shao] used a door jam or a hinge. [LF] used the door itself. There is now, of course, a much reduced ability to use hanging points. There's been the review that your Honour knows about in 2022, a redesigned door, and extensive steps have been taken following these deaths to eliminate the hanging points within the bathroom and replace bathroom fittings.*

440. Senior Counsel for the SLHD did not specifically submit in relation to Issue 13.

441. I find that although Dr McDonald and Dr Sullivan pointed out that it is virtually impossible to remove all potential ligature points, it is clear that significant work has been done to reduce the ability to use hanging points. In 2023 the review of the ensuite doors to eliminate the hanging points within the bathroom was carried out. As at August 2024, changes were made by the SLHD to all PMBC ensuite doors

[282] Tab 111, Expert report of Dr Danny Sullivan, [219].
[283] Tab 110, Statement of Dr Andrew McDonald, [76].
[284] T256.20-28.

including a sloped top door design to address hanging points. I am satisfied that adequate steps have been taken to prevent patient access to hanging points.

Issue 14: Could further practical steps be taken to ensure evidence is preserved, following a self-harm incident which does not immediately result in a person's death?

442. After Merryn and Shao were found unresponsive, CPR was commenced, and both had return of spontaneous circulation. They were transported to RPAH for further treatment, where they were subsequently pronounced deceased. Accordingly, their matters were not considered as coronial matters at the time they self-harmed at the PMBC, and police were not called until after they were declared deceased. This issue was not relevant to LF as police attended PMBC on the evening of her death and were able to undertake their investigations.

443. After Merryn and Shao were transported to the RPAH, their rooms at the PMBC were cleaned.

444. In relation to Merryn, NM Tenille Pouw attended PMBC to support the staff on 3 December 2021. She states she contacted the Director of Clinical Governance about cleaning Merryn's room and was advised that it was okay to clean the room, as it was not a crime scene. NM Pouw states she therefore arranged for the bathroom to be cleaned and removed Merryn's belongings. She did not observe any hanging points in the bathroom to be broken, noting there were hooks which are designed to fail if weight is placed on them.[285] NM Pouw took the ligature to her office in Concord Hospital and locked it in a cupboard. It was handed over to police upon request days later. The remaining material of the ligature Merryn used was unable to be recovered during the coronial investigation.

445. In relation to Shao, on 20 July 2022, after she had been transferred to the RPAH, staff at the PMBC cleaned her room. The ligature was placed in a plastic pathology bag. NM Pouw attended PMBC and again took the ligature to her office at Concord Hospital. It was seized by police three days later.[286]

446. Whilst cleaning Shao's room, a nurse observed there was a small piece of glass missing from the bathroom mirror, and a clean cutlery knife in the sink. That was reported to the after-hours manager.[287] These items were not recovered during the coronial investigation.

[285] Tab 57, Statement of NM Tenille Pouw, [7].
[286] Tab 88, Statement of Leading Senior Constable Lachlan Coles, [3]; Tab 100, Statement of NM Tenille Pouw, [6]-[11].
[287] Tab 106B, RPAH and PMBC medical records, p 366.

447. The police officers in charge of both matters noted difficulties in obtaining evidence and recovering the ligatures. Senior Constable Tanya Bietresato was the officer in charge of Merryn's case. She noted that she would have preferred police to have been contacted at the time of Merryn's self-harm so that investigations could have been made to confirm whether the matter was suspicious or not and images taken of the scene with items in situ, as well as seizing the ligature at that stage. Senior Constable Bietresato indicated this is to ensure the scene is not tampered with and also to ensure contemporary witness accounts were obtained from those involved in resuscitation efforts. Constable Carla Rizk was the officer in charge of Shao's matter. Constable Rizk noted that investigative steps taken by detectives immediately following Shao's death had initially been somewhat hindered by the fact the room Shao was residing in had been cleared, removing all evidence. Photographs taken of the room on 25 July 2022 showed another person's personal belongings. Constable Rizk indicated that the ligature used by Shao was obtained on 23 July 2022 by another investigating police officer.[288]

448. Dr McDonald outlined relevant policies and procedures in place at the PMBC in relation to incident management, as follows:

    i. In July 2019, NSW Health published the Policy Directive: *Incident Management Policy* (PD2019_034). This Policy Directive applied as at September 2019 (being the time of LF's death).

       In December 2020, NSW Health published the Policy Directive: *Incident Management* (PD2020_047). This Policy Directive applied as at December 2021 and July 2022 (that is, at the time of Merryn and Shao's deaths), and it remains active.

    ii. In March 2021, the SLHD Policy Compliance Procedure: *Serious Incident Management* (SLHD_PCP2021_024) was published. This Policy Compliance Procedure was introduced after LF's death, however applied as at the time of Merryn and Shao's deaths, and remains active.

    iii. Prior to March 2021, there was no SLHD specific policy relating to incident management, and accordingly, staff were referred to the NSW Health Policy Directives which were in place.

[288] T180.7-12; 33-42.

iv. In August 2024 (subsequent to LF, Merryn and Shao's deaths), the SLHD Policy Directive *On-call Escalation Process* (SLHD_PD_2024_044) was introduced.

v. In September 2010 (prior to LF, Merryn and Shao's deaths), the NSW Health Policy Directive: *Coroners Cases and the Coroners Act 2009* (PD2010_054) was published.

449. In relation to Issue 14, counsel assisting further submitted:[289]

> *The penultimate issue that I'll refer to in detail is whether practical further steps can be taken to ensure evidence is preserved following a self-harm incident, which does not immediately result in a person's death. Your Honour knows this is the issue about the hiatus between the self-harm that Merryn and [Shao] committed and their tragic deaths in the days that followed. It means the police didn't attend and it means that this inquest didn't have the benefit of that initial investigation.*
>
> *To remind your Honour what Constable Bietresato said, if she had attended, and assuming she had power to do so, which is a rather big if, she would like to have spoken to people who had located therein, seen the room where the self-harm had been committed, looked at the positioning, looked at what method had been used, any first aid, identified who had been involved, and possibly take still photographs or even a video of the relevant points in the room, the location of the self-harm, the hanging points, and so on. And also would have seized the ligature and treated it as an exhibit.*
>
> *Your Honour knows the approach of the [SLHD] on Dr McDonald's evidence is that there is an investigation process, it's set out in policy. We'll see in due course because there is specific policy, we're told, which identifies the senior staff member who is tasked with undertaking an investigation. And of course, in this particular case, in both Merryn's and [Shao's] cases, the senior staff member, Ms [Pouw], did in fact seize the ligature and keep it securely until police themselves obtained it. Nonetheless, the advantage of having at least some guidance on the steps that could be undertaken if serious self-harm occurs, so that that type of evidence is preserved, both for this sort of inquest and of course, for the benefit of the [S]LHD, when considering whether*

[289] T286.20-T287.8.

opportunities for improvement, is in my submission something that would be worthwhile for the [S]LHD to consider.

450. Senior Counsel for the SLHD submitted:[290]

The LHD's primary position is that while the evidence before the Court indicates that there was a period of time between Ms Ward's and [Shao]'s acts of self-harm and their deaths, which meant that Police were not notified at a time when they could access their respective rooms at PMBC in the condition they were at the time of the act of self-harm, that did not ultimately affect the quality of the evidence which was available at inquest. Each of the ligatures was preserved and statements were taken from all staff involved in the lead up to and aftermath of each act of self-harm. As Senior Constable Bietresato (the OIC in respect of Ms Ward) and Constable Rizk (the OIC in respect of [Shao]) acknowledged in their oral evidence, the investigations they would have pursued, other than taking photos with the scene in situ, were all undertaken.

In the circumstances, the evidence in this matter does not suggest that the fact of the Police not being called in immediately after Ms Ward and [Shao]'s acts of self-harm made any practical difference to the ability of the Court to conduct a coronial investigation and make appropriate findings.

…

In his oral evidence, Dr McDonald explained that there is an existing process for responding to and investigating serious incidents, which would include instances of self-harm/serious self-harm. That is under the LHD's Policy Compliance Procedure for Serious Incident Management (SLHD_PCP2021_024) and the associated Policy Directive in respect of the on-call escalation process (SLHD_PD_2024_044).

On the face of those documents and as Dr McDonald indicated in his oral evidence, the existing policies for serious incident management and the on-call escalation process, a system has been established whereby serious incidents, including instances of self-harm/serious self-harm, are reported to site management (typically a Nurse Manager) who becomes responsible for taking the lead role in incident management and escalating to the LHD executive. In addition, under SLHD_PCP2021_024, there is a process of preparing a Reportable Incident Brief, a Preliminary Risk Assessment… with the

[290] Written submissions for the SLHD in response to counsel assisting's proposed recommendations, [19]-[24].

Reportable Incident Brief beginning on the day of the serious incident being notified and a preliminary risk assessment taking place within 72 hours.

In his oral evidence, Dr McDonald indicated his understanding that as part of the preliminary risk assessment process, interviews with key staff typically take place (in addition to review of the relevant medical records) as part of fact finding to determine what occurred. That evidence is consistent with the part of SLHD_PCP2021_024 that sets out the role of the preliminary risk assessment, which includes assessing the immediate situation and clarifying the facts and ensuring immediate risks are managed…

451. I find that the policy appears to be mostly adequate however, there are some changes that could be made to the policy to better deal with the issues that arose in this inquest in relation to the preservation of evidence. This is dealt with further below regarding proposed recommendation 1.

Issue 15: What changes or improvements have been made at the PMBC since these deaths?

452. Dr McDonald provided an overview of changes implemented at the PMBC since the deaths of LF, Merryn and Shao. Broadly, those relate to the following:

i. The introduction of the Zero Suicides in Care initiative and associated training (also considered at Issue 2):

a. Dr McDonald noted that the implementation of the Zero Suicides in Care Initiative involves a systems change approach to improving care within the MHS in both inpatient and community settings. This includes a focus on empowering a confident, competent and caring workforce through the provision of consistent, evidence-based training across the MHS workforce.

b. Dr McDonald further noted that through this initiative, the SLHD's intended approach is not to stratify risk of patients into categories (such as low, medium and high-risk), but rather staff to have competence to recognise and synthesise information in such a way that they can make on the basis of a comprehensive assessment of the individual in front of them, a judgement about what is the appropriate means of support or treatment for that individual.

c. Dr McDonald confirmed in oral evidence that training about suicide prevention had been introduced since 2019 as a result of the Zero

Suicides In Care Initiative. This training includes addressing situations where a staff member receives information from family or carers and how to escalate that when the staff member feels that the risk to the patient may be changed. The training consists of a two-day course that all transitioning and new mental health nurses complete, as well as a one-day refresher course for nurses who have previously completed suicide prevention training.

ii. Changes made to policy relating to working with families and carers, and the REACH initiative (as considered at Issue 2);

iii. Changes made to policy and procedure with respect to searching patients and their environments and access to bed linen (as considered at Issue 11);

iv. Changes made to PMBC ensuite bathroom doors and locks (as considered at Issue 13); and

v. Changes made to policy and procedure regarding responding to a self-harm incident that does not immediately result in a person's death (as considered at Issue 14).

453. Overall, Dr Sullivan opined that:[291]

There is no gold standard model for suicide prevention but Dr McDonald's statement sets out a service system change aligned to New South Wales Health policy, and a process for implementation of a framework accompanied by appropriate training and orientation for staff.

Improvements at the Professor Marie Bashir Centre referred to by Dr McDonald reflect shifts in policy and associated efforts to improve health care systems by implementing systematic programs of improvement focused upon specific outcomes such as suicide prevention. I consider this worthwhile but reflect that whether in the community or on inpatient units, suicidal people who are determined will continue to find … methods to harm themselves.

Given that prediction of suicide risk using risk assessment tools remains challenging and of no predictive utility, good clinical care remains the critical factor, rather than stratification of risk. Without claiming primacy of any specific framework or model, it is likely that a policy framework and investment in service development, staff training, and consistent implementation of good

[291] Tab 111, Expert report of Dr Danny Sullivan, [226]-[228].

practices is unlikely to do harm and may be associated with at least a small reduction in suicide rates. As with many clinical practice changes, the intention is to define and resource minimum standards of care, consistency in practice, and enable clinical staff to provide effective treatments.

454. Having regard to the relevant issues and evidence, counsel assisting submitted that there have been significant changes undertaken at SLHD following the deaths of LF, Merryn and Shao, such as the overhaul of the room design (and in particular doors), the introduction of a new search policy and the systems change represented by Zero Suicides in Care.[292]

455. Senior Counsel for the SLHD did not specifically submit in relation to Issue 15.

456. I find that overall the improvements at the PMBC reflect a responsiveness to issues that have arisen as a result of these three deaths. As Dr Sullivan stated in evidence, the shifts in policy and associated efforts to improve care are focused on suicide prevention, noting that there is no gold standard or model for suicide prevention using risk assessment tools.

457. This of course, remains a challenging goal. In Dr Sullivan's view, good clinical care remains the critical factor, rather than stratification of risk.

458. I am satisfied that the policy frameworks and investment in service development, and staff training, since the three deaths are appropriate responses.

Issue 16: Is it necessary or desirable to make any recommendations in relation to any matter connected with these deaths?

459. Counsel assisting proposed three potential recommendations connected with the deaths of LF, Merryn and Shao, directed to the SLHD, which will be considered below.

Proposed recommendation 1

460. Counsel assisting proposed recommendation 1 be made to the SLHD as follows:

Consider introducing guidance on action to be taken by staff following an incident where a patient has sustained serious self-harm, to preserve evidence for any future investigation or inquest, and to ensure details about the incident are provided promptly to the Clinical Governance Unit, to include:

[292] T287.15-20.

a. *instructions on where and how to keep the ligature or other item that is suspected to have been used to cause self-harm,*

b. *early consideration of how the patient obtained the item,*

c. *photographs of the location where the self-harm occurred and the item used to cause self-harm, and*

d. *a list of staff who witnessed or have knowledge of the incident.*

461. The circumstances giving rise to proposed recommendation 1 are detailed with respect to Issue 14 above.

462. Counsel assisting submitted that there was a delay in police becoming involved in the investigation of Merryn and Shao's deaths, due to the fact they died 'off-site' of the PMBC.

463. Senior Counsel for the SLHD, Mr Downing SC, submitted that the evidence does not warrant the making of proposed recommendation 1; however, if the Court was minded to make a recommendation in respect of the subject matter covered by proposed recommendation 1, the SLHD submitted that it would be best framed as follows:

> *That the LHD review and consider updating SLHD_PCP2021_024 in respect of serious incident management to provide guidance as to steps the person who initially takes the lead role in incident management might take or organise to be taken so as to:-*
>
> *i locate and preserve items or equipment used in the incident; and*
> *ii identify staff who witnessed or have knowledge of the incident, and gather other information in respect of the incident.*

464. As noted above, I find that the policy appears to be mostly adequate however, there are some changes that could be made to the policy to better deal with the issues that arose in this inquest in relation to the preservation of evidence.

465. Having regard to the submissions of Senior Counsel for the SLHD, I agree with the amendments to proposed recommendation 1 as suggested by the SLHD and I intend to make that recommendation.

Proposed recommendation 2

466. Counsel assisting proposed recommendation 2 to the SLHD as follows:

> *Consider amending observation forms to prompt staff to undertake specific action required for high-risk patients (such as checking doors are locked or*

searches have been undertaken) in accordance with the patient's management plan.

467. Dr McDonald gave evidence that due to the significant works to the bathroom doors at the PMBC, it is no longer common practice to lock bathroom doors as a means to protect patients from harming themselves in the bathroom.

468. Senior Counsel for the SLHD, submitted that proposed recommendation 2 was not necessary for the reasons described by Dr McDonald in relation to the current practices for access to bathrooms and that the bathroom doors are no longer locked, and that there is not a systemic problem that would warrant a recommendation of this type being appropriate. Mr Downing SC further submitted that introducing an obligation to create an observation or checklist record of doors being locked or searches being performed would increase the administrative burden on staff without there being evidence to demonstrate a likely benefit in terms of reducing the risk level for high-risk patients.

469. Having regard to the submissions of Senior Counsel for the SLHD, noting that bathroom doors are no longer locked and high-risk patients have individual management plans in place, I do not consider it necessary or desirable to make the recommendation.

Proposed recommendation 3

470. Counsel assisting proposed recommendation 3 to the SLHD as follows:

> *Consider introducing a system for auditing or monitoring searches that are required under the LHD's policy, "Searching Consumers and Their Property in Mental Health Environments", including whether personal searches are being conducted effectively and at the points identified at paragraph [9.1].*

471. The points identified in [9.1] of the abovementioned policy are as follows:[293]

> *…*
>
> - *Searches of individuals must consider the unique needs of each consumer and be trauma-informed, but can occur at:*
> - *Admission*
> - *Transfer between inpatient units within the MHS (can occur before and after)*
> - *Transfer to other facilities or services*

[293] Tab 110B, Further Supplementary Statement of Dr Andrew McDonald, Annexure A, p 14.

    - *Return from episodes of leave*
    - *Following an incident (e.g. that created concerns for safety and if contraband was identified)*
    - *Entry into seclusion*
    - *When there is a reasonable suspicion that the consumer is in possession of, for example illicit substances, weapons, non-prescribed medication, alcohol, cigarettes and/or lighters*
    - *Upon clinical risk assessment.*
- *Search types include:*
    - *Consumer clothing search*
    - *Consumer personal external body search*
    - *Personal property search*
    - *Environmental search.*

472. This proposed recommendation by counsel assisting seeks to introduce a system for auditing or monitoring searches conducted on patients, their property and their environment. This recommendation was proposed given LF, Merryn and Shao all had items in their possession which they used to self-harm.

473. As set out earlier in these findings, the PMBC had policies in place relating to searches of the patient and their environment at the time of each of the deaths.

474. Dr Sullivan opined in his first report that the policies at the PMBC on searching were robust, however, if the training is not mandatory, searches should be undertaken by staff who are verified as having completed training. Rather than refresher training, Dr Sullivan opined it is better to have a program of audit by an observer, or random search exercises.[294]

475. There was evidence that staff are trained in performing searches, however, this training was not mandatory.

476. Further, as explored above in Issue 11, Dr McDonald stated that the current education provided as part of the monthly in-service education program relating to searches is in the process of being revised.

477. A question arose as to whether the taking of photographs of ligatures used by patients to self-harm would assist staff in identifying items which could be considered harmful, or contraband, and should be removed from the patient. Dr McDonald gave evidence that the view has been formed that including photographs of ligatures that have been

[294] Tab 111, Expert report of Dr Danny Sullivan, [230].

used or discovered in any training may be traumatic for staff, some of whom may have been involved in a ligature incident previously. Therefore, the PMBC was considering including a 'lessons learnt' section in the training.

478. There was also evidence that random searches of patients, their property and the clinical environment are conducted on a daily basis within the inpatient units. Daily screening of any incidents occurs, with any issues identified discussed at local team meetings. There was evidence that there are no other audits per se of the outcomes of planned or random searches. However, Dr McDonald indicated in evidence that searches would commence being audited later in 2025.

479. Mr Downing SC, on behalf of the SLHD, submitted that the proposed recommendation 3 was not necessary or desirable as Dr McDonald indicated that the SLHD has already determined to conduct audits as to the occurrence of searches as required under the Policy Directive and as to their quality (which were scheduled to commence in October 2025), and Dr Sullivan endorsed the proposal of auditing searches in accordance with the policy directive.

480. In June 2026, additional information was sought from the SLHD as to whether those audits had commenced. The SLHD advised that whilst the audits of search processes were intended to take place in late 2025, they were delayed and ultimately took place in February 2026. The SLHD also indicated that in February 2026, 53 sets of clinical records were audited, with a compliance result of 93%. The audit itself consists of 77 questions. For completeness, the submissions of counsel assisting and the SLHD as set out above regarding proposed Recommendation 3 were made prior to this additional evidence being obtained.

481. Based on the information provided by the SLHD, I am satisfied that it is not necessary or desirable to make this recommendation.

Findings

482. The findings I make under s 81(1) of the Act in relation to LF are:

Identity

The person who died was LF.

Date of death

LF died on 2 September 2019.

Place of death

LF died at the Royal Prince Alfred Hospital, 50 Missenden Road, Camperdown NSW 2050.

Cause of death

The cause of death was in keeping with hanging.

Manner of death

LF's death was intentionally self-inflicted at a time when she was voluntarily admitted to the Professor Marie Bashir Centre.

483. The findings I make under s 81(1) of the Act in relation to Merryn Ward are:

Identity

The person who died was Merryn Ward.

Date of death

Merryn died on 5 December 2021.

Place of death

Merryn died at the Royal Prince Alfred Hospital, 50 Missenden Road, Camperdown NSW 2050.

Cause of death

The cause of death was ligature strangulation.

Manner of death

Merryn's death was intentionally self-inflicted while detained on an involuntary basis at the Professor Marie Bashir Centre.

484. The findings I make under s 81(1) of the Act in relation to Shao are:

Identity

The person who died was Shao.

Date of death

Shao died on 22 July 2022.

Place of death

Shao died at the Royal Prince Alfred Hospital, 50 Missenden Road, Camperdown NSW 2050.

Cause of death

The cause of death was hanging.

Manner of death

Shao's death was intentionally self-inflicted while detained on an involuntary basis at the Professor Marie Bashir Centre.

Recommendations

485. I make the following recommendation pursuant to s 82 of the Act, which I consider necessary and desirable:

<u>To the Sydney Local Health District</u>

1. That the LHD review and consider updating SLHD_PCP2021_024 in respect of serious incident management to provide guidance as to steps the person who initially takes the lead role in incident management might take or organise to be taken so as to:
    a. locate and preserve items or equipment used in the incident; and
    b. identify staff who witnessed or have knowledge of the incident, and gather other information in respect of the incident.

Closing remarks

486. I thank the officers in charge of the coronial investigations, Detective Senior Constable Christopher Vea for LF, Senior Constables Tanya Bietresato and Joshua Yashenkoff for Merryn, and Constable Carla Rizk for Shao, for their assistance throughout the coronial investigations and inquest process.

487. I thank counsel assisting, Jake Harris and instructing solicitors, Ashliegh Heritage and Taylor Bird for the enormous amount of work they have put in to assisting me in preparation of and throughout the inquest.

488. On the final day of the hearing, I had the privilege of hearing from the families of LF, Merryn and Shao, through their family statements that I have referred to above.

489. LF's husband shared memories of LF, a curious and fierce spirit, who loved being in nature and was loved dearly. LF's husband shared LF's favourite poem, Valentine, by Carol Ann Duffy.

490. Merryn's sister shared beautiful memories and provided a glimpse into the vibrant, creative and talented life of Merryn. As Merryn's sister noted, "*her life was too short, but it was full*".

491. Shao's daughter also shared loving memories of her mother, and it was clear Shao cared very deeply about her loved ones, and always wanted the best for her family.

492. During the inquest, Merryn's family also shared that the "*staff at the PMBC gave the best care they could and tried to balance Merryn's dignity and freedom with her safety*".

493. LF's husband shared the following:

> *I have a plea to all mental health workers and that is to take heart, your work is vital, it alleviates suffering and saves lives. Don't be broken by those you couldn't save for without you there would be much less hope for families who face the ordeal of mental illness.*
>
> *Kia kaha, be strong.*

494. I am grateful for the generosity of each of the families in sharing their memories. It was clear just how loved LF, Merryn and Shao are. I am so sorry to their families and friends for their loss.

495. I close this inquest.

Judge Teresa O'Sullivan

State Coroner

30 June 2026

Coroners Court of New South Wales