CORONERS COURT OF
NEW SOUTH WALES 44-46 Parramatta Road GLEBE

Jurisdiction:	Coronial
Name of Deceased:	Charmaine Margaret Dragun
File number:	2000/07
Hearing dates:	8,9,10,11,12,16,17,18,19.22 and 26 March 2010
Date of Decision:	15 October 2010
Coroner:	M.MacPherson
Representation:	Mr. David Hirsch of counsel Assisting with Ms. Ngaire Watson; Mr. Michael Windsor SC for Dr. Cugadasan, Dr. Clowes and Dr. Tang: Mr. Michael Fordham for Dr. Khong Mr. Phillip Biggins for New South Wales Police Commissioner, Police Service and Police Officers Mr. A. Zahra for Wyeth Australia Pty Limited

REASONS FOR DECISION

INTRODUCTION

1 Charmaine Dragun was 29 years old when she jumped to her death from The Gap at Watson's Bay in Sydney just before 4:00pm on Friday 2 November 2007. The Gap is a notorious suicide spot. This inquest examines the possible reasons why Charmaine took her own life and considers what lessons might be learned and what recommendations might be made to try to prevent similar tragedies in the future.

2 The inquest heard evidence from 23 witnesses and 4 experts over 10 days. There were a further 14 statements or reports from others who were not required to give evidence at the inquest. In addition to statements and oral evidence from the witnesses called, there was considerable documentary evidence. This included extracts from Charmaine's personal diaries, her telephone records and her personal emails. Medical records from treating health care professionals were reviewed as were records from the Health Insurance Commission. There was also extensive literature dealing with suicide generally, the effects of antidepressant medication on suicide and product literature from the manufacturers of two antidepressant drugs that Charmaine had been taking before she died. A video of a television program on Charmaine's life and death prepared by the ABC's *Australian Story* series was viewed. This provided valuable background and many of the people who appeared in the program gave evidence at the inquest. A video of Charmaine's last news broadcast as a newsreader on the Channel 10 Network was viewed as well. The inquest also received evidence about suicides at The Gap and measures that have been taken already to address this problem.

3 In addition to the extensive evidence noted above, there was a full day of oral submissions by counsel assisting and counsel on behalf of the interested parties. Some written submissions were received as well.

4 Counsel assisting posed the key question for the inquest in these terms: *Why is it that Charmaine went to The Gap on that Friday afternoon and there took one step forward instead of one step back from the cliff edge?* We cannot be certain of the answer because it is impossible to know exactly what Charmaine was thinking at that moment. The best that we can to is to try to piece together from the available evidence a reasonable and plausible narrative that might illuminate the many forces that conspired to bring Charmaine to that cliff edge and to take that fateful step. The extensive evidence noted above was presented in an effort to achieve this end.

5 Much of the evidence was not contentious because it involved witnesses who gave accounts of their own recollections of Charmaine's character and her behaviour at the relevant times. Some of the evidence from her treating health professionals was contentious and findings on credibility need to be made having regard to other evidence, to the contemporaneous records and to the demeanour of those witnesses.

6 One matter that was not contentious is the magnitude of the problem of suicide in Australia. In his opening counsel assisting referred to statistics given in a television program by Professor Patrick McGorry, a psychiatrist who was this year awarded the honour of Australian of the Year in 2010. According to those statistics somebody commits suicide roughly every four hours in this country. For every successful act there are approximately 30 unsuccessful attempts.

7 It follows from these statistics that it is virtually impossible to predict any particular suicide because for every suicide there are some 30 failed attempts. Also, some people change their minds, others may be prevented from accessing the means to commit suicide and still others are stopped at the last minute by the intercession of others.

8 Even if it is not possible to predict any particular suicide, literature and expert evidence presented at the inquest support the view that there are indicators that point to increased risk of forming the intention to commit suicide. Three of these

indicators are perfectionism, negative thinking and hopelessness. As will be seen Charmaine was known to have perfectionist personality traits, she was beset by negative thinking especially during 2007 and in the months leading up to her death in November 2007 she perceived her situation as being increasingly hopeless. This understandably raises questions about whether Charmaine's treating health professionals, if not her friends and family, ought to have foreseen the magnitude of the suicide risk.

9 Aside from the personal factors that may have led to Charmaine making up her mind to commit suicide, a second factor that made possible the events on the day of her death was that Charmaine had virtually unimpeded access to the cliff at The Gap. A third factor was that nobody intervened to try to prevent her from jumping although, as will be discussed, both a concerned bystander and the police had wanted to.

10 A further matter that was not contentious is that there is a strong relationship between depression and suicide. Suicide is often seen as the end result of a person's battle with intractable depression. The product literature on the drugs that Charmaine was taking emphasises this point. This is important because Charmaine had struggled with periods of depression, especially in the last year of her life. Counsel assisting made the point that even if a person suffered from depression and even if that person ultimately committed suicide it does not follow that depression was *the cause* of the suicide. He said that whilst such a conclusion would be convenient, especially to the treating health professionals who might wish to blame the suicide on the patient's mental condition rather than any deficiencies in their management, it should not insulate those health professionals from an examination as to the correctness of the diagnosis and the treatment given. The expert evidence at the inquest does cast doubt on the correctness of the diagnosis of depression and on some of the treatment provided by several of Charmaine's treating practitioners.

11 It is appropriate at this stage to provide a cursory overview of the relevant facts before examining the issues and the evidence in greater detail.

OVERVIEW OF THE FACTS

12 Charmaine was born on 21 March 1978. She was the daughter of Michael and Estelle Dragun and she had a younger brother, Matthew. Charmaine was raised in Perth. Her maternal grandmother and her mother taught music and Charmaine was herself an accomplished pianist. Charmaine studied music at a tertiary level for a time, but she was attracted to journalism and eventually studied this at Edith Cowan University. After graduating from there in 1998 she had a number of jobs in the radio industry.

13 In 2001 Charmaine moved from radio to television and joined Channel 10 in Perth as a junior news and court reporter. There was considerable competition for the position of newsreader but Charmaine's talents were recognised and she eventually secured a position as the nightly newsreader of the Channel 10 Perth news. She sometimes presented the news with another newsreader and other times presented the news alone. She also presented Channel 10's national news broadcasts from time to time. This position as a newsreader required Charmaine to leave her family and friends in Perth and move to Sydney because although the news was broadcast live in Perth the program was produced and presented in Channel 10's Sydney studios. It was in July 2005 that Charmaine relocated to Sydney for this purpose.

14 Charmaine had met her lifelong partner, Simon Struthers, when both of them were teenagers. They eventually moved in together and bought a house in Perth. When Charmaine relocated to Sydney Simon stayed behind for a time but in February 2006 he moved to Sydney to join her. He obtained employment as a crime scene investigator with the New South Wales police force. They rented a house in Sydney's inner western suburbs.

15 Despite her move to Sydney and the fact that she met many people here, Charmaine missed Perth and was counting on moving back there, probably in 2008, where she and Simon were planning to start a family. Charmaine remained very close to her own family and she was in regular contact with them, and especially with her mother. She travelled back to Perth regularly for visits

with her family and friends and to attend various work-related functions, often related to charities and fundraising.

16 On the face of it Charmaine had an enviable life. She came from a secure and loving family and enjoyed a stable relationship with Simon. She had a good job, was highly respected by her employer and her peers, and enjoyed a significant public profile in Perth. But as counsel assisting pointed out in his opening, Charmaine was not a "vacuous celebrity". She was well read, well informed about history, national and international news and current events, and had exceptional writing skills. According to her friends she was self-effacing and completely lacking in the egotism often associated with television personalities. She would go out of her way to help others – some said even beyond what would be expected.

17 Despite all of the positives in her life Charmaine was emotionally troubled. Although she was always kind to others, Charmaine was very hard on herself. She felt inadequate in almost everything she did, despite the obvious evidence to the contrary. She developed anorexia in her teens and this interfered with her studies for a time. She was diagnosed with depression around this time and was prescribed the antidepressant Zoloft by a psychiatrist in Perth in 1996. Charmaine was not happy about being on this drug because she felt that it prevented her from experiencing her true emotions. She consulted a naturopath and was encouraged to stop the Zoloft completely. This she did for some time in 2004 and for a while felt very much better. But her mood worsened and a doctor recommended she start taking a new antidepressant, Efexor[1].

18 Charmaine continued to take Efexor when she moved to Sydney in July 2005. When Simon came to join her in early 2006 she had tried to stop taking Efexor. She felt well at this point but soon afterward her mood deteriorated and she resumed taking the drug.

19 In November 2006 Charmaine consulted Dr Cugadasan, a general practitioner at the Wetherill Street Practice in Leichhardt. She complained of increased

[1] Also known as *Effexor* or *Efexor-XR*. This is the trade name of the drug *Venlafaxine*.

moodiness and other issues. Dr Cugadasan felt that Charmaine had anxiety and depressive symptoms. Under Dr Cugadasan's direction the Efexor dose was increased from 75mg per day to 112.5 mg per day.

20 In February 2007 Charmaine began seeing a psychologist, Dr Belinda Khong (who was not a medical practitioner but had a PhD in psychology). She had read about Dr Khong in a newspaper article and was attracted to her treatment philosophy, which centred on meditation, Buddhist teachings and a technique described as "mindfulness". In addition Dr Khong employed other recognized psychological approaches. Charmaine consulted Dr Khong 16 times between 18 January and 24 October 2007. She had a good relationship with Dr Khong and obviously held her in high regard. But despite the extensive treatment her moods remained unstable and her overall emotional state worsened.

21 Toward the end of May 2007 Charmaine raised a concern with Dr Khong about her mood swings and specifically asked Dr Khong if she might have a bipolar condition. Dr Khong consulted a book, asked some questions, and Charmaine was relieved when Dr Khong told her that she did not meet the criteria for a bipolar condition.

22 During the month of June 2007 Charmaine and Simon travelled to Europe for a holiday. Charmaine wanted to investigate her family history and they went to Croatia for this purpose. Charmaine wrote an article on her family that was eventually published in a Perth newspaper around the end of July. She received plenty of positive feedback about the article.

23 The trip to Europe was a great success and Charmaine returned happier than ever. But it did not last long. Her diaries reveal that toward the end of July 2007 she was writing about feeling negative and hopeless and was contemplating suicide.

24 Dr Cugadasan had left the Wetherill Street practice early in 2007 and Charmaine consulted another general practitioner there, Dr Clowes. Dr Clowes saw her both before and after the trip to Europe. She knew that Dr Cugadasan had increased the Efexor dose back in November 2006. She also knew that in late

July Charmaine was struggling with depression and had thoughts of death. Although Charmaine was reluctant to increase the Efexor (indeed she wanted to get off antidepressants entirely) Dr Clowes encouraged her to persist and the Efexor dose was increased from 112.5 mg per day to 150mg per day. About three weeks after the increase in the Efexor Charmaine complained that she was not much better and was impatient for some effect. Dr Clowes encouraged her to give it more time and to continue seeing Dr Khong.

25 Charmaine's treatment sessions with Dr Khong covered a wide variety of issues but certain themes came up again and again. Charmaine complained that she had difficulty being "mindful" because she could not stop the endless mental chatter and negative ruminations in her head. Although she was encouraged to meditate Charmaine found meditation difficult. She was given strategies to help recognise when waves of negativity began in order to "short circuit" these thoughts and allow them to dissipate. She was encouraged by Dr Khong *"Don't change the thoughts – change your relationship to your thoughts"* and Dr Khong recommended books to read including one called The Mindful Brain. The time difference between Sydney and Perth meant that Charmaine's work day went from around 4pm to 9pm leaving her at loose ends for most of the day. With so much time on her hands and not much to do Dr Khong recommended that Charmaine fill the void with activity that she enjoyed, including volunteer work, in the hope that this would distract her from falling into repetitive cycles of negative rumination.

26 One project that Charmaine undertook was to prepare a video as a 30th birthday gift for her friend Brad Hodson. She managed to assemble video clips from Brad's friends, many of whom were overseas, and edit these into a 20 minute video which was, by all accounts (except of course her own), a masterpiece. The video project consumed much of September and October 2007. It was the source of considerable stress but Charmaine insisted on completing the job, not just for her friend but also because she felt it would assist in her "upskilling".

27 It was during this time that Dr Khong first mentioned the idea of seeing a psychiatrist but Charmaine was resistant to this. This was probably due in part to a bad experience she had with a psychiatrist in Perth. She had also been told

by Dr Clowes to give the increased Efexor dose more time to work and a psychiatric review of her medications did not seem necessary at that stage. Dr Khong continued to encourage Charmaine to readjust her attitude toward her thoughts rather than be caught up in them. Dr Khong was an assiduous record keeper and one of her entries during this time was *"Thoughts create the depression and the depression creates the thoughts"*.

28 In September 2007 Charmaine's emotional condition worsened and for the first time she told her mother of her thoughts about suicide. Her alarmed response was *"Don't even go there."* It was around this time that Charmaine became worried that she might lose her job to another newsreader but these worries were unfounded. Towards the end of September Dr Khong noted that Charmaine was "*Wallowing in self-absorption. Quite suicidal*". Dr Khong again raised the prospect of seeing a psychiatrist and this time Charmaine agreed. She was given the name of psychiatrist Dr Tang and told to arrange a referral through her general practitioner. Unfortunately, Dr Tang was not available to see Charmaine until 16 October. Dr Khong knew this but no alternative arrangements for an earlier consultation were made.

29 In the interim, on 29 September, Charmaine attended the Wetherill Street Clinic to see Dr Clowes about a referral to Dr Tang. She then learned that Dr Clowes was no longer working there. Instead another general practitioner, Dr Helena Berenson, saw her. Dr Berenson had read Charmaine's file and in a consultation that lasted around 30 minutes asked some probing questions about her emotional condition. Dr Berenson quickly formed the view that Charmaine did not fit the picture of a person with depression; she thought that Charmaine probably had a bipolar disorder. Dr Berenson wrote out a referral for Dr Tang, as Charmaine had requested, but she also wrote out a referral to Professor Gordon Parker, a psychiatrist with a special in interest in bipolar disorder.

30 It was also around this time that Charmaine wrote more about suicide in her diary. She travelled to Perth in early October for a fund raising event and there spoke with a lady, Ros Worthington, whose husband had committed suicide following a long battle with depression. Ros Worthington wanted to do something to raise awareness about depression and suicide and Charmaine told

her of her own problems and that she wanted to help if she could. After returning to Sydney she spent a few days with her mother and grandfather, who were there for a visit. They left on 10 October. It was clear that Charmaine's emotional state was worsening

31 On 12 October Charmaine consulted Dr Khong. She rated her depression as 9/10 and there was talk about suicide although Charmaine denied any plan but offered that she was thinking of a method that was *quick and easy*. Dr Khong took Charmaine for a walk in Bobbin Head National Park. There is some uncertainty about what happened during this walk. According to Dr Khong it was a basically silent meditation with not much said. According to Charmaine's diaries deep issues were considered, including the impermanence of life – a central theme of Buddhist philosophy. At any rate the Bobbin Head walk assumed a great significance to Charmaine who wrote about this and reported it to Simon and her mother in very positive terms.

32 It was shortly after the Bobbin Head walk, when Charmaine's mood had improved, that she was able to complete the Brad Hodson video. She was understandably relieved about this and saw the psychiatrist Dr Tang soon after on 16 October. There is considerable conflict over certain details of this consultation – the first and only consultation with Dr Tang. But some things are clear. First, Dr Tang was not made aware of the Bobbin Head walk and how this lifted Charmaine from deep despondency four days earlier. Second, she obtained a history from Charmaine that she had had one episode of acute suicidal ideation two weeks earlier but this had passed. Third, Dr Tang noted that Charmaine's mind was "*churning +++"* and she had "*negative cogitations +++ verging on irrational*". Finally, she formed the view that there was a "*clear biological component*" to Charmaine's problems because the psychosocial elements in the history did not warrant the extent of her symptoms. She considered that Charmaine's condition had been under treated from a medical point of view.

33 Dr Tang recommended that Charmaine stop taking the Efexor and start taking another antidepressant, Lexapro[2]. The plan was to reduce the Efexor and at some point introduce the Lexapro even though for a time Charmaine would be taking both drugs together. She would also be taking increasing doses of fish oil. Dr Tang's treatment plan was the subject of considerable expert evidence and, at least on its face, the plan was not consistent with the treatment guidelines of the manufacturer of Lexapro. The inquest heard that these guidelines were only this, and that giving reducing doses of Efexor whilst introducing Lexapro was permissible in the exercise of clinical judgment; but very careful monitoring was needed because of the many side effects associated with the reduction and/or introduction of these drugs.

34 What monitoring there was took place by telephone and text message because soon after the consultation Charmaine travelled to Perth for another charity fundraiser and to attend a friend's wedding. There is evidence that Charmaine was very enthusiastic about Dr Tang's treatment and about finally getting off Efexor. Her friends thought that she appeared happier than usual, although they had no idea why. According to Charmaine's mother and Simon, Charmaine said that Dr Tang's treatment was "*revolutionary*" and offered her "*a light at the end of the tunnel*". Dr Tang said that she could not understand how Charmaine formed this view but, whatever was said, it is clear that Charmaine made a huge emotional investment in Dr Tang's treatment.

35 Charmaine started to reduce the Efexor on 17 October. Soon after this she also went out with friends who gave evidence about her being unusually upbeat. Dr Tang had a conversation with Dr Khong on 18 October at which time the treatment plan was discussed. Among other things it was noted that Charmaine was very happy with Dr Tang and would not be seeing Professor Parker, the psychiatrist specialising in bipolar disorder that Dr Berenson had recommended Charmaine see.

36 Through this time Dr Tang's intermittent telephone and text message monitoring continued and Charmaine reported that all was well.

[2] *Lexapro* is the trade name for the drug *Escitalopram*

37 But this did not last long.

38 The Efexor dose was decreased after 17 October and on 26 October Charmaine spoke to Dr Tang who recorded that her mood was *slightly flattened*. By this time Charmaine was back in Sydney. The Efexor dose had been reduced to 75mg and on 27 October Charmaine started taking the Lexapro at a dose of 5mg per day. After this there were three important events. First, on the evening of 27 October Charmaine went to a concert with her friend Emma Ritchie. Ms Ritchie gave evidence as to Charmaine's erratic behaviour describing her as anxious and panicky. Second, the following day, 28 October, Charmaine declined an invitation to join Emma Ritchie and other friends on a walk. She decided instead to drive to Watson's Bay (the location of The Gap) and spend some time there alone. Finally, later on 28 October Charmaine went for dinner and a "Scrabble challenge" with another friend, Selina Day. Ms Day described the ordinarily effervescent Charmaine as confused, distracted and disinterested. These are all important events because of the possibility that Charmaine was affected by the reduction in Efexor and the introduction of Lexapro.

39 Simon had been in Perth during that week and returned on the evening of 28 October. He said that Charmaine was happy to see him but some of her behaviours were a little out of character.

40 There was then telephone contact with Dr Tang who wrote in a retrospective note dated 29 October (that is, the note was written after she had learned of Charmaine's death on 2 November) that Charmaine was not complaining of side effects, but that there had been no therapeutic effect yet. Her mood was recorded as "*flat – but not unusually*" and she was "*not agitated*". According to her mother and to her friend Sarah Bamford, Charmaine could not understand why the new drug program was not working yet because she expected to be feeling better by then. Mrs Dragun encouraged Charmaine to speak with Dr Tang, which she did later that day. No appointment was arranged and according to her mother Charmaine was encouraged by Dr Tang over the telephone to "*give it a few more days to kick in*". According to Mrs Dragun Charmaine's mood

continued to be flat and she sounded unwell when they spoke during the evening of 31 October.

41 On Thursday 1 November Dr Tang called Charmaine around lunch time and her retrospective note says: "*Mood still flat but no change from Monday [30 October]. No side effects on medication, not agitated but no lift in mood. Not suicidal."*

42 There are emails during these last few days that gave the impression that all was well. For example Charmaine had agreed to host another fundraising event in Perth in March 2008. She had also completed her CV for a volunteer position reading for the blind. Charmaine made plans to visit a gallery with Sarah Bamford. Charmaine's mother spoke with her around lunch time on 1 November when she was doing some volunteer work at the Cancer Council. According to her mother Charmaine "*sounded like she was still struggling with things but put on a brave front."*

43 In the evening of 1 November Charmaine presented her last news broadcast. This was viewed at the inquest. It was virtually flawless except for some barely perceptible stumbles over a couple of words. Charmaine was distraught and needed to be comforted and reassured by her co-newsreader Timothy Webster. That night she told Simon that she presented her worst news bulletin ever and was sure that she would be sacked. It was not the first time she had complained unnecessarily about her performance on the television but this was the first time she ever said she was worried about losing her job. Simon said that he talked with Charmaine for 45 minutes before he was able to calm her down.

44 On Friday 2 November, the day of her death, Charmaine drove Simon to work at around 7am. She said she was worried about being able to complete a massage course that she had been taking. Simon reassured her there was nothing to worry about. Later that morning her father sent two text messages saying that he hoped she was "*feeling a little better today".* Also that morning she arranged to buy concert tickets with another friend, Paul Lamond, to see the singer Bjork who was to play at the Sydney Opera House on 26 January 2008. Charmaine then took their car in to be serviced and picked this up in the early afternoon.

45 Later that afternoon Charmaine drove to Watson's Bay. She was dressed in black. She was seen by a number of people at the cliff edge near an area of The Gap known as Jacob's Ladder. One of these people, Anthony Sklavos, called Triple O and spoke with an operator who coordinated the police who were despatched to the scene. There is evidence from Mr Sklavos that Charmaine was rehearsing to jump and he told the operator several times that he wanted to speak to her. The operator told him not to. Mr Sklavos followed the operator's directive and did not approach.

46 The police were nearly at the scene but events were unfolding quickly. At 3:52pm Simon received a text message from Charmaine. It said *"Sime, I'm so sorry for what I'm about to do. I can't conquer my thoughts. Please know this is no one's fault but mine."* At 3:53pm a very distraught Mr Sklavos told the operator "*She just jumped!"* At 3:54pm Charmaine's mobile telephone, which was sitting atop a black handbag at the cliff edge, began to ring. It was Simon. By the time the police made it to the cliff edge Charmaine was already gone.

JURISDICTION AND PURPOSE OF THE INQUEST

47 Many cases of suicide, or presumed suicide, are referred to the coroner for investigation. Rarely is a full inquest held. In this case, however, sections 23 and 27 of the Coroners Act 2009 ("the Act") require that an inquest be held into any death that occurs "in the course of a police operation". Because Anthony Sklavos called "Triple 0" and the police were on the way when Charmaine jumped to her death, by definition, her death occurred in the course of a police operation and so an inquest is required.

48 Section 81 of the Act directs a coroner to inquire into the identity, time and place of a person's death. None of these matters are contentious. That section also requires a coroner to explore the manner and cause of a person's death. The term "manner and cause of death" is given a wide interpretation. In the present case the manner and cause of Charmaine's death include the question of whether her death was a suicide and what factors, including her management by health professionals and the possible effect of the drugs she was taking, may have contributed to any decision to take her own life. The manner and cause of

death also involves an examination of what other factors, including personal, social and professional pressures, may have contributed to her actions.

49 Proof of facts in a coronial inquest is established on the balance of probabilities. That is, in order to find a fact to be true the coroner must be satisfied that what is asserted is probably true. This is a lower standard of proof than the criminal standard of proof beyond a reasonable doubt. When suicide is in issue (in the sense that a finding of suicide needs to be made) the standard of proof is higher than just the balance of probabilities, but less than proof beyond a reasonable doubt.

50 Once the matters under section 81 of the Act have been determined a coroner has the power under section 82 of the act to make any recommendations considered to be necessary or desirable to make in relation to any matter connected with the death.

51 The purpose of an inquest is to find the truth, as far as this is possible, after considering all of the evidence presented. It is not the function of a coroner to lay blame for a person's death at the feet of any individual and it is not for the coroner to determine whether there was any negligence involved. Having said this a coroner is entitled to say whether he or she finds that mistakes were made because without such a finding it is difficult to understand the need for recommendations, which are aimed at identifying deficiencies and finding ways to prevent similar deaths in the future.

52 It is necessary in an inquest of this kind to look into deeply personal issues in Charmaine's life. From what emerged in the inquest Charmaine was a very private person and would not have wanted her life and death to become a public spectacle. Her family is, however, supportive of the inquest because they believe that Charmaine would have wanted to assist others struggling with mental illness. In his opening remarks counsel assisting put it this way:

> Charmaine would have wanted, and the parents do want this inquest to have one over arching purpose and that is to learn something to help others, to help other people who are suffering from depressive illnesses, to help families, partners, friends, carers of persons suffering with depression. To help health professionals, the general practitioners, the psychologists and the psychiatrists to better treat people with depressive illnesses. To encourage the drug companies who profit

> from the ever increasing use of antidepressants in this country to properly warn doctors and patients of the possible detrimental effects of antidepressants and they would want to encourage public officials who take control over notorious suicide spots like the gap to take measures to deter people from taking that final step forward off the cliff.

53 There are two other matters that bear on the private and personal aspects of this inquest.

54 On the private side Charmaine's mother and Simon expressed a concern that this inquest might create the impression that Charmaine was a chronically depressed and fundamentally unhappy person. They stressed that Charmaine was, for the most part, a happy person who was aware of and thankful for the many good things in her life. They acknowledge that Charmaine was struggling to cope with a mental illness especially in the latter half of 2007, but were concerned that this not overshadow the many positive things in her life that Charmaine enjoyed.

55 On the public side it was inevitable that because Charmaine was a journalist with a significant public profile her story would attract considerable interest from her colleagues in the media.

56 I made a request on the opening day of this Inquest that the media report this case responsibly and not sensationally and it should be acknowledged that they have done so.

ISSUES

57 There is no need to consider in detail the evidence in support of a finding that Charmaine's death occurred during the course of police operation. There was evidence from Constable Nathan Buxton (who was also the officer in charge of much of the investigation) and Detective Senior Sergeant Despa Fitzgerald. DSS Fitzgerald was a highly trained crisis intervention negotiator with extensive experience in dealing with situations where a person is threatening to commit suicide.

58 Both Constable Buxton and DSS Fitzgerald were part of the response team despatched after the "Triple 0" call by Anthony Sklavos. There was evidence to

the effect that both had learned that Charmaine had jumped shortly before they arrived at the scene at The Gap.

59 The following issues arose because they were relevant to the manner and cause of death and to the question of recommendations.

1. Whether Charmaine did commit suicide

2. The correct diagnosis of Charmaine's mental illness

3. The management by general practitioners Dr Cugadasan, Dr Clowes and Dr Berenson

4. The management by psychologist Dr Khong

5. The management by psychiatrist Dr Tang

6. Risks, side effects and warnings associated with the antidepressant drugs Efexor and Lexapro.

7. Whether Charmaine's death was preventable

8. The effect of Charmaine's death on others, and

9. Suicide prevention strategies at The Gap.

60 The relevant evidence touching on each of these issues will be considered in detail below.

THE EVENTS AT THE GAP

ANTHONY SKALVOS

61 Mr Sklavos prepared a statement and gave evidence at the inquest.

62 Mr Sklavos was a resident of Vaucluse in the Watson's Bay area. Shortly after 3:30pm on Friday 2 November he and some other neighbours spotted a woman on the wrong side of the fence by the cliff edge along The Gap. Mr Sklavos said that he wanted to speak with her but one his neighbours said he should call the police, which he did. The records from the "Triple 0" call reveal that the call was

made at 3:41pm. The operator asked many questions aimed at obtaining a description and determining the exact location of the woman and what she was doing. A recording of the "Triple 0" call was played at the inquest. On several occasions Mr Sklavos told the operator that he wanted to approach the woman and talk with her but on each occasion the operator told him not to approach and said that the police did not want him to – and that they were on their way.

63 Mr Sklavos said in evidence that he saw the woman rehearsing to jump. He said *"I saw a person in great torment – a lot of anxiety"*. He said that he deeply regretted not having intervened and felt that he should not have listened to the operator who told him not to approach. He added "*I firmly believe that even at that point, if there was a possibility of intervention that this lovely young lady's life could have been turned around. I saw her jump."*

64 Mr Sklavos listened to a recording of his "Triple 0" call and was understandably upset by this. He explained that he was "*a wreck for about a week*" afterwards. He went and stayed in a monastery. He obviously felt guilty about not intervening and said that if the same situation occurred again he would not be deterred in approaching a person in distress. He said "*I'm going to be approaching whoever needs my help because living with the fact that they did nothing is so much more worse knowing that you are at least giving something a go."*

DETECTIVE CHIEF INSPECTOR GRAHAM ABEL

65 Detective Chief Inspector Graham Abel was the commander of a negotiation unit and had extensive experience in the management of crises of the kind seen here.

66 There was a suppression order made in relation to the whole of his evidence because there is a public interest in police methodology and reasons for negotiators behaving the way they do not being made public. However, one thing he did say that would not impact on that work but is relevant for recommendations is that The Gap is not only well known in Australia as a place where people like Charmaine go to but also Internationally.

THE EVIDENCE OF CHARMAINE'S FAMILY, FRIENDS AND WORK COLLEAGUES

ESTELLE DRAGUN

67 Estelle Dragun provided a statement to the inquest.

68 Mrs Dragun described Charmaine as *"a perfectionist"* and said she was *"demanding on herself and self-critical."* Charmaine developed anorexia nervosa when she was 17 years old and finishing year 12 at school. Her weight had fallen to 37 kilograms. She was seen by doctors and told that if she lost any more weight she would be hospitalised. This seemed to have had some effect and she began eating, albeit her recovery was very slow.

69 After this Charmaine went to university where she studied music, psychology and English. She was unhappy there, especially about pursuing music. She told her mother that she was pursuing music because her mother wanted her to. Her mother said she should follow her own interests and she encouraged Charmaine to defer her studies for a while. She did. When she re-enrolled at another university she pursued media studies.

70 It was around this time that Charmaine was prescribed Zoloft by a psychiatrist. She seemed happy. She remained on this drug between the ages of 18 and 26.

71 It was during this time that her relationship with Simon developed.

72 In 2004, when she was 26, Charmaine saw a person that Mrs Dragun believed was a naturopath. That person encouraged Charmaine to stop the Zoloft, which she did. The reason given for wanting to stop taking the Zoloft is that she felt it blunted her true feelings. But about six weeks after stopping this drug she said Charmaine started crying a lot and she described her as *"extremely depressed"*. This led to Charmaine seeing a doctor who prescribed a new antidepressant, Efexor.

73 During the summer of 2004/05 Charmaine went to Sydney to read the Channel 10 Perth nightly news. The regular newsreader eventually resigned and Charmaine was offered a permanent position. She moved to Sydney in July 2005.

74 According to Mrs Dragun Charmaine expected to do more than just read the news. She said that Charmaine wanted to do reporting as well. The basis of this expectation was not clear but for a number of practical reasons Charmaine's job was limited to reading the news. Charmaine was not happy about this, but she accepted it.

75 In October 2005 Charmaine's grandmother (Mrs Dragun's mother) died suddenly. Charmaine was very upset as she was very close with her grandmother. But she appeared to get over this and by January 2006 was said to be happy in Sydney and looking forward to Simon joining her, which he did in February.

76 Mrs Dragun described regular contact with Charmaine. She would return home to visit every six weeks or so and they had telephone or SMS contact almost daily. Around September 2006 Charmaine expressed feelings of anxiety and depression and said she was going to seek help. According to Mrs Dragun Charmaine *"felt her medication was not working and again she felt artificial".* She was back in Perth for Christmas and Mrs Dragun described her as "*experiencing mood swings*". She added that Charmaine was frustrated at work because she could not do any reporting but only newsreading.

77 She said that Charmaine told her that her GP had referred her to Dr Khong and added that Charmaine had "*real confidence"* in her.

78 Mrs Dragun described how Charmaine and Simon's trip to Croatia was a great success and that *"she returned to Sydney after her trip very positive and excited".* But then *"only two weeks after returning to Sydney her spirits dropped considerably and she was really struggling with depression."* She said in her statement that Charmaine reported to her *"I am feeling very unhappy and I have no control over it"* and *"Mum I don't even have the energy to do the housework"*. Charmaine also reported lack of motivation and that she was forgetting things.

79 According to Mrs Dragun it was in July 2007 that she spoke with Charmaine about the possibility of a bipolar condition. She wrote in her statement

> *I had a friend at the time whose husband was Bi-Polar and I thought she should investigate this. In the context of treatment by Dr Khong, I said 'Do you think*

> *that you need to investigate Bi-Polar condition and does it reflect your condition?' She seemed to know what I was talking about. Her ears pricked up because she had times of great joy, but then descend into a depressed state quickly. I remember she replied: 'Yes Mum, I'll think about that. I've already been through tests and they don't think I've got Bi-Polar. I don't know who conducted those tests and she did not say who did it. This was the only time that I discussed Bi-Polar with her.*

80 She described how in August Charmaine had some family members visiting her in Sydney one weekend. She was very excited and thoroughly enjoyed their visit but *"as soon as they were gone she went back into a low mood and was very distressed by this".*

81 On 11 September there was a long phone conversation in which Charmaine was upset and crying. She said that she was having thoughts of suicide to which Mrs Dragun replied "*Don't even go there*". She spoke with Simon and said, "*Please persuade Charmaine to seek medical assistance*". Simon said he would.

82 On 22 September Charmaine was in Perth to attend a charity function, the Pink Ribbon Ball. Mrs Dragun relates that a friend, Sharlyn Sarac (now Sharlyn Vermey) had called Charmaine and had discussions about a new newsreader moving to Channel 10. Charmaine apparently assumed that *"her job was on the line".* This made for a difficult weekend with her family. Charmaine called one of the managers at Channel 10 who apparently reassured her that her job was not in jeopardy, but *"despite the reassurance Charmaine still remained in a low mood, feeling very unsure of herself."*

83 In early October Mrs Dragun and her father (Charmaine's grandfather) were visiting friends in Canberra. Charmaine was at this time in Perth at another charity function: the Purple Twilight Walk for breast cancer. It was at this time that she discussed her depression with Ros Worthington whose husband had committed suicide after battling depression (this is something Mrs Dragun only learned about from Ros Worthington after Charmaine had died). On 7 October Mrs Dragun and her father went to Sydney. Charmaine had just returned from Perth. They spent a few days together. She described Charmaine as "*very unsettled and very unhappy*". Charmaine told her "*Mum, I can't get out of this*

headspace, I feel totally consumed by it". She encouraged her to seek help saying that she could not do this alone.

84 On 9 October Mrs Dragun took a long walk with Charmaine who complained that "*it's all about her*" and "*she needed to get out of herself*". She mentioned that she had two referrals to psychiatrists, one for Dr Tang and the other for Dr Parker. When they parted on 10 October to return to Perth Mrs Dragun said that Charmaine was "*in tears*".

85 Mrs Dragun wrote in her statement that Charmaine told her that Dr Khong had "*pulled me back from the brink*". She thought this was on 12 September but it was more likely to be 12 October, the day of the walk at Bobbin Head National Park.

86 Mrs Dragun went on to describe Charmaine's reaction after having seen Dr Tang on 16 October:

> *Charmaine phoned me and was very excited saying there was "A light at the end of the tunnel". She described Dr Tang's treatment as "revolutionary". Dr Tang said she had success with a music teacher with longstanding depression and now that person had "turned his life around". Dr Tang's treatment included fish oil 4 per day increasing to 12 per day combined with a new drug, Lexapro. Charmaine was also directed to reduce the Efexor.*

87 On 19 October Charmaine was back in Perth hosting a quiz night to raise money for Princess Margaret Hospital. On 20 October she attended a friend's wedding. She described Charmaine as *"particularly happy".* She said that she had been in contact with Dr Khong and Dr Tang. On 21 October she said Charmaine was *"very 'up'"* and *"Charmaine flew back to Sydney feeling well and very positive".*

88 Charmaine's mood deteriorated when she got back to Sydney. In a phone call with her on Monday 29 October Charmaine said that she had been to dinner with friend on 27 October and "*They won't put up with me. I'm not much company*". She added *"Simon is not going to put up with this much longer".* At this point Charmaine had reduced her Efexor dose and had begun taking the Lexapro. Mrs Dragun relates "*Charmaine said she did not understand why the new medication was not working and making her feel better. She said she would speak with the doctor."* On 30 October she spoke with Charmaine again who

told her that she had spoken with Dr Tang and she "*wants me to give it a few more days to kick in".*

89 On 31 October the Dragun family met for dinner in Perth on the occasion of the second anniversary of Charmaine's grandmother's death. Charmaine spoke to her family by telephone. According to her mother Charmaine "*sounded flat and still not well*". The next day, 1 November, was the last time Mrs Dragun had any contact with Charmaine. She described a phone call when Charmaine was doing some work at the Cancer Council. "*She sounded as if she was still struggling with things but put on a brave front".*

90 Mrs Dragun says that her husband had received a text message from Charmaine during the morning of 2 November. He had asked her for a tip on the Melbourne Cup "*and wanted an opportunity to give her a boost*". Charmaine replied "*Thanks Dad, I hope you have a good day x C*". She called Charmaine twice during the day but there was no answer.

91 It was later that afternoon that she was contacted by her son Matthew and told of Charmaine's death.

92 Mrs Dragun gave oral evidence at the inquest.

93 She said the Charmaine's perfectionism emerged more during her high school years. When in university "*she was keen to get outstanding results*". She said that Charmaine had a desire to please others. When describing her anorexia nervosa she said that Charmaine would say to her, "*Mum, my mind is very powerful, I want to eat but it won't let me."*

94 She said that when working in Sydney Charmaine was very keen to get feedback on her performance as a newsreader and that she and others regularly complimented her. Sometimes Charmaine would complain about having made small mistakes. She said that this was "*where the perfectionism come in, that if she slipped up on a word or pronunciation wasn't correct, she found that difficult to deal with because to her it should be perfect."* She added "*Sometimes it was very difficult to convince her that she'd actually done a good job".*

95 Mrs Dragun explained that one of the reasons given for Charmaine's mood swings toward the end of 2006 was homesickness.

96 She was asked about Charmaine's relationship with Dr Khong. She said that Charmaine had full confidence in Dr Khong. She said that it was her impression that what started as a doctor/patient relationship "*became a very close relationship, maybe not as doctor/patient, more as friend/girlfriend*".

97 Regarding the Buddhist meditation aspect of Dr Khong's approach she said she was aware of this and added that Charmaine was receptive to this. She said that Charmaine's brother Matthew studied yoga, philosophy and meditation and often talked to Charmaine about the value of this. Although receptive "*she didn't actually get around to it in actually practising at all*".

98 She explained that one of the things that Charmaine complained about was that because of the time difference between Sydney and Perth Charmaine's work day began around 4:00pm. She said "*basically every day was like a holiday until 4 o'clock in the afternoon and Charmaine did not take too well. Some of us might like that lifestyle, but she didn't, she wanted to be busy and doing things*". She said that Charmaine wanted to be intellectually challenged at her work and she found reading another person's words off a monitor "*rather banal*". The prospect of doing some writing was one of the things that excited Charmaine about the trip to Croatia with Simon because she had already arranged to write an article about the trip for publication in a local newspaper, The Sunday Times. She received positive feedback from this article. Mrs Dragun believed it was published around the end of July.

99 Despite the obviously close contact Charmaine had with her mother, and even though her diaries from the end of July contained entries about suicide (to be discussed below) Mrs Dragun said that Charmaine never mentioned anything about suicide to her at this time.

100 Mrs Dragun confirmed that the first time Charmaine had discussed suicide with her was around 11 September. She recalled a phone call when Charmaine described herself as "*pretty worthless*", she complained about her inability to do

the housework, that she was having panic attacks and "*didn't seem to see any light at the end of the tunnel for her at that point".* It was during this call that Charmaine told her mother about thoughts of suicide and Mrs Dragun said "*Don't even go there*". She encouraged Charmaine that somehow they would find a way through this.

101 Regarding the discussions she had with Charmaine when she and her father visited Charmaine in Sydney around 8 October she said

> *Charmaine again was experiencing the head space of low in spirit, feeling worthless, she was totally negative about everything and she put it this way that, "I know there's good things happening around me and for me but I can't see it at all, all I can see is the negative side" and she likened it to be in a closed vacuum and not able to get out".*

102 She remembered being told by Charmaine that Dr Khong had taken her for a walk to the riverbank and that Dr Khong had brought her "*back from the brink*". Asked about how Charmaine was after this she said she felt better after the walk and said to her "*I now have some purpose again*".

103 Regarding the consultation with Dr Tang when she recommended stopping Efexor and introducing Lexapro with increasing doses of fish oil Mrs Dragun said

> *Charmaine seemed elated and excited that there seemed to be a light at the end of the tunnel that Dr Tang was offering her revolutionary style treatment that would really help her overcome her condition.*

104 She added that Dr Tang had told her about a patient who was a music teacher who "*had longstanding problems with depression and now that person had turned their life around and were free of drugs".* It was Mrs Dragun's impression that this information gave Charmaine *"a very positive feel that there was a chance that she would eventually be drug free and that she would once again be in control of her mind and the mood swings would not be an issue".* She confirmed that Charmaine wanted to be off all antidepressant medication.

105 Mrs Dragun said that when Charmaine came to Perth for the Red Kite Quiz Night fundraiser on 19 October they spoke at greater length about Dr Tang's treatment. She said that nothing was said about side effects. "*Nothing, no, it was all – it was going to be positive*".

106 She confirmed that Charmaine was feeling very positive when she left Perth to return to Sydney but that when they spoke on the phone on 29 October "*she at that point felt she was going back into her head space again and she was feeling unwell and that she couldn't understand why she wasn't feeling better with the new medication…".* She asked Charmaine to speak to her doctor about this and was later told the doctor (Dr Tang) wanted her to "*give it a few more days to kick in*". At that point she said Charmaine's voice was very flat "*and yes, very unhappy*".

SIMON STRUTHERS

107 Simon Struthers provided a statement to the inquest.

108 Simon met Charmaine in 1994 and was in a continuous relationship with her since 1999. This was after Charmaine's troubles with anorexia nervosa and after she had completed her journalism studies and had started working in media.

109 In 2003 Charmaine had participated in a self help course called "The Landmark Forum". This forced her to confront certain issues in her life. It was after this course that Charmaine told him of the anorexia nervosa and that she had been taking antidepressants. He recalled the time in 2004 when Charmaine had stopped taking the Zoloft. He said that "*during this time I saw her creativity return and her emotions and feelings about life were heightened at that time*". After this there were problems in their relationship and they broke up. Charmaine returned to her parents' home but she and Simon continued to have daily contact. He said that "*she was questioning everything and she felt that she had lost the last six years of her life due to the medication that she was taking*".

110 Simon said that he and Charmaine got back together in February 2005 after Charmaine had been in Sydney during the summer months reading the Channel 10 Perth news from there. This led to the offer of the permanent position in Sydney, which Charmaine took up in July 2005. They had bought a house together in Perth in March and moved in together in May. After Charmaine

moved to Sydney he stayed in the Perth house until this was eventually rented and he moved to Sydney in February 2006 to join her.

111 He knew when they got back together in early 2005 that Charmaine had started taking a new drug, Efexor. He said that Charmaine accepted that she needed to be on some kind of antidepressant and was looking for one that allowed her to be motivated and creative.

112 Like Charmaine, Simon was somewhat frustrated being in Sydney because he also missed his family and friends from Perth. He said that there was a possibility of moving back to Perth in early 2008 if plans by Channel 10 to return the newsreading from Sydney eventuated.

113 Simon said that Charmaine had started seeing Dr Belinda Khong who was "*helping her with meditation and mindfulness*". He added "*Charmaine loved her sessions with Belinda*".

114 About the trip to Croatia in June 2007 Simon described Charmaine as "*the happiest time*" that he had seen her and that they returned to Sydney "*feeling great*". His statement does not address the serious emotional collapse that Charmaine suffered towards the end of July when she was writing in her diary about suicide.

115 Simon recounted a successful ski holiday in late August and early September and also that Charmaine had taken on the project to do a birthday video for her friend Brad Hodson. This project "*gave her a lot of focus and gave her something to do*".

116 He remembered the time in early October when her mother and grandfather came to visit:

> *It was early October 2007; it all got too overwhelming for her. She couldn't finish the video. She said that she had taken on too much. At this time this was the lowest that I had ever seen her… I think her mum realised that Char was at her lowest with her depression. Her mum was crying on the phone. I spent more time with her. There were three of four nights that I would pick her up from work and she would be crying. I helped her with the video by taking over the sound and we broke up the video into sections so we could finish it. As soon as we were*

making progress with the video her mood bounced back and she felt that she could do it.

117 It was after her mother and grandfather left (on 10 October) that she first told Simon about her thoughts of self-harm. She said at that time "*I can't believe I ever had thoughts that I wanted to kill myself*". They spoke about a friend that had committed suicide and Charmaine "*mentioned the effects that this had on his family and friends and she couldn't believe that she had these thoughts*".

118 Simon knew that Charmaine had seen Dr Tang about getting her medications changed but was unclear about whether he knew when this had started. He related that Charmaine was happy when they were together in Perth from 19 October. This was when Charmaine was hosting the Red Kite Quiz Night fundraiser and they attended the friend's wedding. He was not aware of the problems that Mrs Dragun related that were discussed with Charmaine in her phone call on Monday 29 October. This was when Charmaine had told her that her friends *"won't put up with me. I'm not much company*" and added *"Simon is not going to put up with this much longer".* Simon says that when he returned from Perth on the night of 28 October "*she seemed fine and happy to see me. Everything was good.*"

119 In his statement Simon does not mention any problems earlier in the week of 29 October but he confirms that Charmaine was upset following the news broadcast on the night of 1 November. "*On that night she told me that she had the worst news bulletin that she ever had….I remember telling her that it was okay and things were only worse in her mind.*" That night (the night before she died) Charmaine went to bed early, something that "*seemed a little bit out of character*".

120 Simon's statement refers to his understanding of Dr Tang's treatment plan for Charmaine. He said:

> *She told me that psychiatrists reduce medication over a period of time coming off one completely before starting a new medication. The Doctor she was seeing (Doctor Tang) was going to do this over two weeks and supplementing her dosage with fish oil tablets. It was my understanding that she was initially reducing the Efexor 150 mg per day and a couple of days in to it starting to take the new medication gradually. Charmaine told me that she was supposed to have*

daily contact with the Doctor whist she was going through this. Charmaine wanted to see the change and the potential decrease in side effects going onto the new medication. She implies that she wanted to do this quickly rather than a gradual process.

121 Charmaine drove Simon to work at 7:00am on Friday 2 November. He noted that Charmaine would have picked up their car from being serviced at around 1:40 pm and then drove home. He noted that Charmaine had purchased tickets to the Bjork concert with Paul Lamond, a friend from her work.

122 Simon said that at 3:52pm he received a test message from Charmaine. This was the text message in which Charmaine wrote: *"Sime, I'm so sorry for what I'm about to do. I can't conquer my thoughts. Please know this is no one's fault but mine."* His statement continues, "*I tried to phone Charmaine straight away. It went to voicemail*".

123 Simon called some friends and also Charmaine's brother Matthew who would call her parents. Later that night he identified Charmaine at the Glebe Morgue.

124 Simon gave oral evidence at the inquest.

125 He said that when Charmaine told him about her history of anorexia and antidepressants after she had taken the Landmark Forum course "*It was a huge weight off her shoulders*". He said that after she had stopped taking the Zoloft, and before her emotional state subsequently worsened, "*It was almost like she was on a high… I think she started playing piano again, I don't think she'd done that since she was 19…"*.

126 When Simon moved to Sydney in February 2006 he said that Charmaine was very happy. It was during this time that she told him that she had stopped taking the Efexor. Not long after this her emotional state worsened and she became very negative.

127 Simon mentioned that he considered Charmaine to be a safe driver. "*Her driving was fine…I've, you know, never ever worried … about her driving at all".* (The relevance of this comment will be become clear later in these reasons.).

128 Regarding Charmaine's consultations with Dr Khong Simon said that he understood that she was learning meditation and mindfulness techniques. "*I actually didn't know that it was more formal counselling."* It was his impression that Charmaine's relationship with Dr Khong was not a doctor/patient relationship but "*it was like they were more friends, that's how she spoke of it*". He was aware that Charmaine kept diaries and believed that this was part of the techniques given by Dr Khong for her to work on to develop "*circuit breakers*". He said "*Charmaine explained to me about circuit breakers, about moods and mood changes, you look for a circuit breaker to change your way of thinking…*"

129 Simon mentioned that Charmaine had been taking a massage course "*as something to fill her time and her days*". She had completed 6 weeks of this at the time of her death. She had been taking this through October, at the same time as she was doing the video for Brad Hodson. He agreed that she was extremely stressed about the video project. He said that Charmaine often relied on him to solve problems. "*I think she always saw them bigger than really what they were. Yeah, usually once we spoke through them and were able to break them down into smaller sections it was you know, easier for her to sort of see how it get through it I think*".

130 Simon described their trip to Croatia as "*amazing…we really just had an absolute ball on that trip*". Regarding Charmaine's serious emotional collapse at the end of July when she was writing about suicide in her diary, Simon said he could not recall any change in Charmaine's behaviour. He recalled talking about homesickness and how Charmaine was wanting to get back to Perth and hoping that the Channel 10 news would be broadcast from there rather than from Sydney. He confirmed that Charmaine had said nothing to him about suicide at this time. He also said that the ski trip in August with a group of friends was a success and he and Charmaine had fun.

131 Around the end of September and the beginning of October Charmaine was working on the video project and Simon said, "*she was really really struggling with it*". Regarding the very emotional time that Charmaine spent with her mother during her visit with Charmaine's grandfather from 7 to 10 October he recalled that she really enjoyed that visit and was not aware of any particular

emotional distresses. It was only after this time that Charmaine first told Simon that she had thought about suicide. This was in the context of discussions about a friend who had committed suicide in 2003. He confirmed that Charmaine had never discussed suicide with him before that time around the middle of October.

132 Simon gave evidence about the walk that Charmaine took with Dr Khong in Bobbin Head National Park on 12 October:

> *She would have told me that afternoon, or probably the night when I picked her up from work. She had a really positive amazing session with her and she told me that she went there and Belinda said 'Look we, let's just go for a walk, let's get out'. And they went for this walk and she said it was exactly what she needed, it was a really positive thing.*

133 Simon was aware that Charmaine had seen Dr Tang on 16 October. He recalled Charmaine discussing that consultation when they were driving after he had picked her up from work.

> *She yeah, brought up that it was like, to her it was an amazing kind of new treatment for her and this was an answer for her. She was actually really really excited going into that… It seemed like a really positive quick answer to her at that time to change.*

134 This was followed by an exchange with counsel assisting:

> Q. You say positive and quick answer, did Charmaine have any views about whether she wanted to have a quick answer versus waiting the usual few months?
>
> A. Yea I don't think she wanted to go through a slow withdrawal. She said to me there was only two doctors in Australia that would do this and she was just really excited about doing that. She was really happy.
>
> Q. So when she said there were only two doctors in Australia who would do this, what do you mean by "this"?
>
> A. This fast treatment I guess.
>
> Q. So how would you describe Charmaine's attitude to the prospect of this quick treatment by Dr Tang?
>
> A. She was excited by it. It was a really positive thing for her at that time.

135 Simon confirmed that there had been no discussion with him about possible side effects but added that Charmaine had told him that she was going to have daily

contact with the doctor. He said he was given no indication about any particular things to look for during the course of the treatment.

136 He said that he was not aware that Charmaine had actually started on Dr Tang's treatment regime before they had got to Perth on 19 October where she attended a fundraiser and they both attended a friend's wedding. He said "*I don't think she would have done that without having a stable routine. I don't, we were all over the place, we were flying back and forth around that time so I didn't know that she'd started it*." He said that he did not learn that Charmaine had already started reducing the Efexor from 17 October until after she had died.

137 Simon confirmed that Charmaine had picked him up from the airport around 11:00pm on Sunday 28 October. He did not recall anything unusual about Charmaine's behaviour during that week until Thursday 1 November other than that she was going to bed earlier than she usually did.

138 On Thursday evening Simon picked Charmaine up from work and she was very upset. "*She told me that she had the worst bulletin ever and she couldn't speak and she was stumbling and then she was really worried, she thought they were going to fire her over it and she thought she was losing her job*." He confirmed that she had expressed similar concerns in the past when she made a mistake in a broadcast "*but she never sort of spoke about feeling like she was going to get fired before, that was different*".

139 The next morning Charmaine drove Simon to work. She was upset once again, this time about not being able to finish the massage course she was taking because she did not have time to complete the clinical training component. Once again Simon broke the problem down into smaller parts and explained that there was nothing to worry about. He said that Charmaine appeared fine when she dropped him off at work.

140 He then confirmed receipt of the text message from Charmaine sent at 3:52pm just moments before she jumped.

PAMELA McGILL

141 Pamela McGill prepared a statement and gave evidence at the inquest.

142 Ms McGill was one of Charmaine's co-workers at Channel 10. They had met in Perth when Charmaine was doing court reporting and she was working at the general news desk. She and her husband moved to Sydney in 2007. Charmaine "*went out of her way*" to make them feel welcome in Sydney inviting them out and taking them places. She described Charmaine as "*a big organiser*" who would not go out on her own and "*needed people around her all the time to fill the void*". She saw her most days at work in Sydney.

143 She and Charmaine were friendly but she did not consider herself a close friend or confidant. She said "*I don't know if Charmaine confided really truly in anyone*".

144 Ms McGill said of Charmaine that "*outwardly she was a very happy person, with hindsight she was always talking about you and not herself*". She said that Charmaine "*always made you feel good about yourself*." She described Charmaine as "*a perfectionist*" and "*self critical*". She said that Charmaine found her job not to be as fulfilling as she had hoped. "*While it's glamorous, the news was just reading lines off an autocue".*

145 She knew of Dr Khong, but only that she was "*a Buddhist woman and was learning about teaching and meditation from her… I was actually surprised to be told that the Buddhist woman was actually a psychologist*".

146 She confirmed that Charmaine was not happy just reading the news and wanted to report on stories. She was unhappy when she was told that she could not do this.

147 She was present on 22 October when a group of friends, including Charmaine, went for dinner to celebrate Brad Hodson's birthday. She recalled that "*Charmaine was not herself that evening … she didn't finish dinner and seemed unhappy…. Normally she is bubbly but she was not that night*."

BRADLEY HODSON

148 Bradley Hodson prepared a statement and gave evidence at the inquest.

149 Mr Hodson was a producer with Channel 10. He said that in 2007 he lived in Canberra where he worked as a political reporter. He met Charmaine in 1998 when they were both students in Perth. He described her as being eager to start her career in the media and "*she was single minded about being successful*". They became friends in 2004 when they were both working for Channel 10 in Perth. He said a close friendship developed after he moved to Canberra in January 2007. He would stay over at Charmaine and Simon's house when visiting Sydney. He and Charmaine would speak with each other over the phone most days. Their friendship was "*in the middle of having depth and being both superficial and fun"*. He said that "*she would not confide everything in me*".

150 Mr Hodson said that Charmaine saw herself more as a journalist than as a presenter. She considered Channel 10 to be a good place to work because it provided opportunities to move forward in her career. Regarding her work as a newsreader he said "*Charmaine knew she was good but she wanted to be perfect. She was very nervous about making mistakes*". He said she would have DVDs of her performances at home in order to monitor how she was doing. He said that she would worry about any problems with her bulletins "*more than probably was warranted*".

151 He described Charmaine as "*keen to learn and be well informed*" and said "*she would listen to ABC Radio National and she was always reading books*". He said that Charmaine was bored at work and being limited to reading the news left her "*frustrated as a journalist*". He was aware that she had started a massage course, but this was just something to do "*because she had time on her hands and always wanted to keep busy*". He said "*she seemed to always have something new on the go".*

152 He said that Charmaine had "*the standard newsreader insecurities that at any moment she could be replaced and that at any time her job wasn't for a long time*". But she was not otherwise a nervous person. She was not one to fish for

compliments. She was a good team player and was very appreciative of those around her. He mentioned the wardrobe and makeup people.

153 He knew that Charmaine always wanted to return to Perth to start a family there. He knew that there were plans to return the Perth news broadcasts to Perth some time in 2008. He was aware that in October 2007 there were some further discussions about this move. He said the Charmaine was "*excited and eager for it to happen*".

154 He formed the impression that Charmaine was not a weak person, indeed she was very driven, but she was very concerned about the reactions of others towards her and "*always wanted to please them"*. He described her as a "*very social person, she enjoyed the company of others*." He said she was very committed to her relationship with Simon and was not flirtatious. He described her emotional changes this way:

> *Charmaine's "ups" were very up and all encompassing and you got caught up in her ups as well. I never saw her behave in a "depressed" way; I would say that her "downs" were more like being "less up". I think in hindsight, she would always turn conversations back to the other person when she was "less up". She would deflect conversations away from herself and talk about other people.*

155 In his oral evidence Mr Hodson developed the idea of Charmaine's "all encompassing ups" further.

> *It was infectious, it was, the amount of joy that she radiated to see you for the first time was amazing. There was always an interest and intensity in, in having a good time and enjoying the time that you had together, that's kind of what I mean by that.*

156 Despite the closeness in their relationship Mr Hodson said that he was not aware that Charmaine was seeing a therapist. "*The whole issue of her mental health was never discussed between us…. I was not aware of any signs that she was suffering depression. She was always so enthusiastic, vibrant and happy".* He did not consider these traits to be signs of depression. He said that Charmaine never appeared "*glum*". He had vague knowledge that Charmaine was learning meditation but thought of this as just "*one of the projects that she was involved in*".

157 During October 2007 Mr Hodson was travelling with the Kevin Rudd election campaign and so had less frequent contact with Charmaine. He was not aware the Charmaine had been working on a video for his 30th birthday, which was on 22 October. "*Charmaine had made a 20 minute DVD for me. It was a total shock and the most amazing gift I'd received*". He recalled having a birthday dinner with Charmaine and others but did not recall many details.

158 He said that he did speak with Charmaine in the week or so before she died. When asked how she was going Charmaine was not very forthcoming. He said she was "*very guarded*". He did not see this as worrying at the time. He was not sure if this was in the week before she died or the week before his birthday when she was preparing the video.

159 He described Charmaine as "*a presenter*" and added that, in hindsight he did not really know her as well as he had thought he did.

SHARLYN VERMEY

160 Sharlyn Vermey prepared a statement and gave evidence at the inquest.

161 Ms Vermey was a weekend newsreader with Channel 9 in Perth. She first met Charmaine in 1998 and they became close friends in 2002 when she was working as a reporter for Channel 10.

162 Ms Vermey described Charmaine as "*The happiest person in the room. She would bounce into the room, jumping up and down. She wouldn't just hug you she would squeeze you. She loved her friends and family, loved her life".*

163 She was aware the Charmaine had done the Landmark Forum course and even went to an information evening with her when Charmaine encouraged her to get involved. She said that it allowed her to address some issues from her childhood, including her eating disorder, and disclose this to her boyfriend, Simon.

164 She said that Charmaine was "*extremely confident but very shy at the same time*". She was gifted and did not like attention. She avoided the spotlight. "*She was very humble*". "*She always dressed beautifully, like a lady and never*

showey offey about herself or how beautiful she was, she was very modest about the fact that she was absolutely stunning". She added *"…she did not think there was anything special about her at all…*"

165 Ms Vermey said that while Charmaine was easy to get close to "*not many people knew the full picture, she had lots of close friends but not many people knew everything*".

166 She and Charmaine often discussed parenthood. She said that Charmaine was "*the 'cluckiest' person I knew apart from myself*". She said that toward the end of September and beginning of October 2007 Charmaine's thoughts about parenthood changed. "*We were discussing how unhappy and unstimulated she was at work. I jokingly suggested she have a baby to keep herself busy. Her reply was, "Oh I've thought about that and there's no way I could look after a baby*". She found this change of attitude "*really strange*" and added "*In retrospect she was withholding something from me. I didn't ask her to elaborate on why she felt that way*".

167 She said that Charmaine never gave her any indication that she was depressed. Despite their apparent closeness Ms Vermey "*had no idea*" that Charmaine had been taking antidepressants for ten years. She also did not know the full story behind Charmaine's treatment with Dr Khong. She was aware that she was doing some Buddhist meditation, "*but I just put all of that in the same box as cake decorating and massage, I thought it was just another activity that she was doing*".

168 She was aware of the Brad Hodson video project and understood from Charmaine that this was "*a mini project*" and she was doing this "*as a way of teaching herself a new skill*".

169 She said that there was always stress in the newsreading job, but she felt that Charmaine "*was good at coping with the stress".* She said that often Charmaine would call her to complain that her newsreading was poor and that she made mistakes but Ms Vermey herself claimed that she could not see what Charmaine

was troubled about. But these episodes would pass. She said "*I just assumed she was rational enough to have faith in her abilities*".

170 Ms Vermey was aware of the plans to have the Channel 10 news returned to Perth and would tell Charmaine what she had heard. But Charmaine was apparently not informed of these rumours (which are what Ms Vermey called them) and because she felt left out she became concerned that plans were being made that excluded her. "*She had an irrational lack of confidence in her job security and her job*".

HEIDI COUCH

171 Heidi Couch prepared a statement and gave evidence at the inquest.

172 Ms Couch first met Charmaine in late 2003. They were both in the broadcasting industry in Perth. She had moved to Sydney before Charmaine did in July 2005 and once in Sydney they became good friends. She described Charmaine as "*an amazing friend to me all the time, really caring and enthusiastic*". "*She would go above and beyond what you would expect from any friend*". They would see each other once or twice a week.

173 She said that Charmaine wanted to be regarded as "*an intelligent journalist*" and felt that reading an autocue "*undervalued*" her. She said that Charmaine was "*very hard on herself*" and "*she did not value herself enough*". "*She never liked confrontation in any way, shape or form*". She would wear a jacket given to her by the wardrobe staff at Channel 10 even if she did not like it – because she could not bring herself to say "*I don't like this jacket*". Ms Couch described Charmaine as "*a shrinking violet … always worried about upsetting someone else*".

174 She described her as "*the most well informed that I've seen of any news anchor that I've ever worked with. She cared about the stories, they weren't just words on a page to her."*

175 She described one incident at the end of September or beginning of October when Charmaine was reporting a breaking story about the death of footballer Chris Mainwaring. It was a very big story in Perth but there were technical

problems and Charmaine was left on screen with no story to read she had lost contact with the producer in the Perth studio. Ms Couch said it took close to two hours to calm her down because Charmaine felt "*humiliated*" and "*exposed*". "*I don't know how she managed to compose herself to read the news the next night".*

176 Like Ms Vermey, Ms Couch would talk with Charmaine about motherhood and they spoke about returning to Perth to raise their families.

177 She remembered a time around the middle of October 2007 when Charmaine was "*more excited than normal*". She had stayed with Charmaine for three nights just before leaving to go overseas for two weeks. She had gone out for dinner with Charmaine and other friends, including Paul Lamond. She recalled that Charmaine was "*sort of happier than normal*". In retrospect this would have been the time after Charmaine had consulted Dr Tang on 16 October and before Charmaine left to go to Perth for the Red Kite Quiz Night on 19 October.

178 Although she described a very close friendship with Charmaine for a number of years, Ms Couch "*had no idea that she was on antidepressants*".

179 In what became a recurring theme in the inquest Ms Couch said Charmaine's diagnosis of depression and suicide was totally unexpected:

> *I had no idea, if someone said to me write a list of 10 people I thought may have had depression, or would harm themselves, she wouldn't have even been on the list. I suspected that she didn't want to be perceived as the newsreader that couldn't cope and was on antidepressants I think she was embarrassed about it, and I think maybe as well, she would think that would be seen as a sign of weakness.*

180 Ms Couch explained that there was a lot of competition for the position as newsreader and "*there's probably ten other pretty girls that are you know, have their claws out trying to get the job, so, she certainly would be aware of that and wouldn't want to show any kind of weakness…"* She considered that Charmaine would have thought that if word got out that she was on antidepressants and having counselling it would be a sign of weakness; "*it would make her look like she was in the Prima Donna category… it wasn't what she would like at all".*

181 Ms Couch returned from overseas on 2 November, the day that Charmaine died.

TIMOTHY WEBSTER

182 Timothy Webster prepared a statement and gave evidence at the inquest.

183 Mr Webster works as a radio broadcaster but had been employed with Channel 10 for 28 years. He had been reading the Perth news from Sydney with another newsreader, Celina Edmonds, before Charmaine took over her position in 2005. He read the news with Charmaine from that time up to the time of her death.

184 He said that the competition for the newsreading job for Perth was "*fierce*" but Charmaine "*was a terrific reader*", a "*superb newsreader*". He described her behaviour with others as being like "*the Energiser Bunny*". He said the she was hard on herself if she made a mistake. "*She liked every bulletin to be absolutely perfect*".

185 She was "*enthusiastic about advancing her career*" and "*got a real buzz out of reading the National Bulletin*". He thought there was nothing unusual about taking home DVDs of her broadcasts to watch her performance; it was part of her professionalism. He did acknowledge that the industry was competitive. He said that once management had decided to offer a newsreader position they backed that person and it would take a lot to lose that position. Even if Charmaine did make the occasional mistake (as everyone did) there was no reason for believing that her job would be at risk just because of this.

186 Mr Webster did not mix with Charmaine socially. This may explain why he saw her during her low periods whereas many of her social friends claim that this was seen only very rarely, if at all.

> *When Charmaine was on a high she was fun and funny … When she was on a low which I assumed may have been from a bad read she was very low. She would walk off the set in a very bad mood. At times when she was down on herself she would have a very faraway look in her face and she was difficult to engage.*

187 Mr Webster was shown a photograph of Charmaine that was taken by her friend, Selena Day, on Sunday 28 October. There followed this exchange with counsel assisting:

Q. How does that look of Charmaine compare to what you've just described?

A. Yeah that's – that's pretty much it. That's pretty similar, yeah.

Q. So that's what she would look like if she was feeling low?

A. Yeah, and hard to connect with. Almost, you know, like she was with her own thoughts and it was hard to get back from those thoughts.

PAUL LAMOND

188 Paul Lamond prepared a statement and gave evidence at the inquest.

189 Mr Lamond was the senior producer of the 5 o'clock Sydney news at Channel 10. He had contact with Charmaine every day she worked after she moved to Sydney to read the Perth news in July 2005. He had no involvement in the Perth news. He had never seen Charmaine's news broadcasts.

190 He described Charmaine as "*infectiously happy…always smiling and always very sociable*". "*Charmaine's probably one of the friendliest people you'd ever want to meet. She would bounce into the room, bubbly; put a big smile on your face…"* Over time he developed a good friendship with Charmaine and her partner Simon. Heidi Couch and Pamela McGill were in that circle of friends.

191

192 He recalled an evening at the North Annandale Hotel when he went out for dinner with Charmaine, Heidi Couch and Pamela McGill. He described her as "*more happy than she normally would be*". He did not know why. We now know that this was between 16 October when Charmaine first consulted Dr Tang and her leaving for Perth on 19 October.

193 He said

> *In the time I knew Charmaine I had no idea that she was depressed. I also had no idea she was taking medication. Charmaine never appeared to me to be anything other than happy. I never saw Charmaine upset or angry at work. I never saw her argue with anyone or talk badly about anyone; she always spoke nicely of everyone.*

194 Mr Lamond was the last witness at the inquest who is known to have spoken to Charmaine. He called her on the morning of 2 November and arranged to buy two tickets to the Bjork concert for her and Simon. Charmaine gave Mr Lamond her credit card details so he could set up an account to buy those tickets over the internet. He did not consider this unusual; "*She was a very trusting person…"* He did not get the impression from Charmaine that there was anything the matter. This would have been at around 10:00am.

LINDSAY DAY

195 Lindsay Day prepared a statement and gave evidence at the inquest.

196 Mr Day had been a camera operator with Channel 10 but left shortly after Charmaine started working there in July 2005. He was the partner of Heidi Couch and a friend of Charmaine and Simon and got to know her through that association. He was 15 years older than Charmaine. He said that he felt an affinity with Charmaine. "*I think she saw a bit of me in her and I saw a bit of her in me. She made me feel really welcome in the world*". He described himself as a bit of a perfectionist and agreed that Charmaine had perfectionist tendencies too.

197 He said that when he went to visit Charmaine at home "*she was like a dog wagging her tail, at the security grill happy to see you*".

198 Mr Day was one of the people who went on the ski trip with Charmaine and Simon at the end of August 2007. He recalls Charmaine saying she was "*On top of the world! … but she was on top of a mountain called "Friday Flats" in Thredbo".*

199 He was aware that Charmaine was doing meditation, but assumed that this was, like flower decoration, just one of a host of activities that Charmaine was involved with.

200 Because of his technical experience as a camera operator he helped Charmaine to make the video for Brad Hodson's 30th birthday present. He said she was reluctant to accept help because "*she didn't want to be a burden*" but eventually accepted his offer of assistance. She "*needlessly purchased a case of Stella beer"* to thank him. He described the video project as giving Charmaine "*a much needed sense of purpose and fulfilment*". He said he knew that Charmaine had felt isolated and unfulfilled at Channel 10 and needed a challenge. He knew that when the October 22 deadline (Mr Hodson's birthday) for the video was approaching Charmaine was "*quite stressed*".

201 Mr Day had split up with Heidi Couch in October 2007. He produced copies of some email exchanges he had with Charmaine at this time. One was dated 11 October and read "*Hey Lindsay just wanted to check in to see if you're okay. Xc*". To put this in context it was a day before Charmaine, who was then severely depressed, went on the walk at Bobbin Head with Dr Khong.

202 Mr Day said that "*Because Charmaine seemed like a sensitive, yet sometimes over-joyous person I sometimes wondered whether she was masking depression*". He added "*I felt like I was a millimetre away from guessing that she was suffering depression*". Asked in evidence to expand on this entry in his written statement Mr Day said:

> *I – I guess I wrote that because she – I just – I felt that she was quite lonely. I mean she had great support, you know. Simon is a great partner and family and certainly her friends but, you know, she did like to be surrounded by good friends and – I think just that space between I felt, you know, there was something maybe missing.*

203 Regarding the "*over-joyous*" behaviour that he said Charmaine sometimes showed, he thought that Charmaine might be trying to overcompensate for her inner sadness: "*Overcompensate by – by taking the, you know, the feeling the other way, or the exterior".*

EMMA RITCHIE

204 Emma Ritchie prepared a statement and gave evidence at the inquest.

205 Ms Ritchie worked as an executive production supervisor at Channel 10. She started in that position in April 2007 and this is when she met Charmaine. It was her job, among other things, to coordinate the rosters for the newsreaders. She described Charmaine as "*adorable*". "*She was lovely…she's the easiest one out of all of them in terms of if ever there's any changes, she made my life, my job, very, very easy*".

206 Ms Ritchie said that she really only began to see Charmaine socially around September 2007. They would see each other at work functions and speak there. She said that Charmaine was always interested in how others were feeling. "*She was just a quite caring person*". She never talked much about herself, though.

207 Charmaine went out with Ms Ritchie twice about a week before she died. On Friday 26 October she met Ms Ritchie and other friends in Newtown where they saw a band playing. She arrived after doing the Friday evening news bulletin. She described Charmaine as "*just her usual bubbly self*".

208 On Saturday 27 October Ms Ritchie and Charmaine went to the Josh Pyke concert at the Enmore Theatre. Charmaine picked Ms Ritchie up from her home in Glebe and they drove together to the theatre. On the way there Charmaine appeared to Ms Ritchie to be "*hyperactive and nervous*". "*She seemed just really sort of tense, like quite tense*". She would cut Ms Ritchie off when she was speaking and this was quite out of character because she always knew Charmaine to be a good listener. She wrote in her statement that Charmaine appeared "*agitated and panicky*" as if they were running late – but they were not running late. She said she had never seen that kind of behaviour from Charmaine before.

209 Ms Ritchie went on to say that during the drive Charmaine had two minor car accidents. She said that Charmaine bumped the car into a concrete barrier – twice. At that point Charmaine said something like "*I just don't know what's wrong with me, I'm really sorry, I just don't know what's wrong with me at the moment*".

210 The concert was otherwise uneventful. Ms Ritchie invited Charmaine to join her on the Seven Bridges Walk the next day (Sunday). Charmaine did not commit to going and said she would let Ms Ritchie know the next day.

211 The next day Ms Ritchie heard from Charmaine that she had other things to do and would not join her. She sent a text message to Ms Ritchie on Monday 29 October saying that she went to Watson's Bay and then to a friend's house to play Scrabble – "*Very relaxing*".

212 To put these events in context Charmaine had been reducing her dose of Efexor from 17 October. On 27 October she had started to introduce the new drug, Lexapro. The events during the drive to the Enmore Theatre occurred on the first day that Charmaine was taking the new drug.

213 Ms Ritchie added that some weeks after Charmaine's death she spoke with a person in the Channel 10 wardrobe department who related an incident that she recalled happened a few weeks earlier (in other words shortly before Charmaine died). This person told her that she had entered the darkened wardrobe room, turned on the light and saw Charmaine sitting in a corner by herself eating lollies.

SELINA DAY

214 Selina Day prepared a statement and gave evidence at the inquest.

215 Ms Day first met Charmaine toward the end of 2006. She estimated that she had seen Charmaine socially about half a dozen times through 2007. She described Charmaine as "*a very friendly, affectionate person*". "*When she met you she would give you such a hug it was like a vice!"*

216 On Sunday 28 October 2007 Charmaine went to Ms Day's house to play Scrabble (which Charmaine had described in an email on 6 October as a planned "*Scrabble challenge*"). This was the day that Charmaine went to Watson's Bay rather than do the Seven Bridges walk with Emma Ritchie. She arrived around 3:00 pm.

217 She said in her statement

> *I recall Charmaine had great difficulty trying to play Scrabble. She appeared to have difficulty concentrating on the game, looked confused, and would sit and stare for long periods. She looked distracted and disinterested.*

218 She said that in hindsight this behaviour was out of character.

219 Ms Day took a photograph of Charmaine playing Scrabble. She said "*that's pretty much how she was while we were playing*". It was this photograph that Timothy Webster said depicted what Charmaine looked like when she was feeling low, "*Almost, you know, like she was with her own thoughts and it was hard to get back from those thoughts".*

220 She recalled that Charmaine perked up at the suggestion of food ("*She was a foodie*") but ate very little. Afterwards she left to pick up Simon from the airport.

221 Ms Day said that she had no idea that Charmaine had been suffering from depression, seeing a doctor or was taking medication.

SARAH BAMFORD

222 Sarah Bamford did not prepare a statement but gave evidence at the inquest.

223 Ms Bamford was unique among all of Charmaine's friends (many of whom considered themselves good and close friends) in that she had been told by Charmaine about her depression, medical treatment, antidepressants and thoughts of suicide.

224 Ms Bamford first met Charmaine in 2005 before Simon had come from Perth to join her. From the outset she was struck by Charmaine's energy. "*She was always talking to people, buzzing, looked a little bit anxious. Very effervescent and it struck me as a little bit unusual*". It was her impression that this behaviour was unnatural and she thought that Charmaine "*looked like she was covering up for something*". She took this up with Charmaine who was "*pretty shocked*" by her insightfulness and eventually told Ms Bamford of her problems with depression. "*She couldn't understand why she wasn't feeling great because she had so many great things in her life*".

225 When asked by counsel assisting whether Charmaine felt there was something wrong with her job, her family or her friends Ms Bamford said "*No. There seemed to be nothing wrong with anything in her life. It was in her head*". Despite being on Efexor, which she told Ms Bamford was better than the previous drug she had been taking (Zoloft) "*She was still looking for other ways to make her feel better, to make her feel better about herself and to feel better in a health sense*".

226 Ms Bamford agreed that Charmaine was afraid that if people found out about her "*unwellness*" it could be damaging for her career and her friendships because "*people would see her differently*".

227 She was aware that Charmaine had been referred to Dr Khong for therapy through her general practitioner and Charmaine reported that she was very positive about this. "*I think the relationship with that person became more like a friendship and she certainly got a lot out of it…"*

228 Ms Bamford observed that Charmaine had her ups and downs and added "*sometimes within an hour she'd be very up and then sort of come down quite quickly*". She could not say whether there were particular triggers for these downward moods. She described Charmaine as "*very anxious in groups … very bubbly and trying to be very extrovert*." But she said that Charmaine was relaxed and not "*performing*" around her. On the subject of her "performance" around others Ms Bamford said Charmaine was "*quite convincing*".

229 Ms Bamford recalled that around the end of July 2007 after her return from Europe Charmaine was feeling more down than she had seen before. She asked Charmaine whether she should be "*concerned*" and offered to speak with her family but Charmaine insisted that she should not and assured Ms Bamford that she would be okay. The reference to "*concern*" was, she said, understood to be a reference to the risk of suicide. She added that Charmaine said that she would never do this because it would hurt her family and Simon. (This accords with the time that Charmaine was writing about suicide in her journal.). Ms Bamford added "*She couldn't comprehend why she felt so deeply unwell when she was doing everything that she could to get well*".

230 Ms Bamford recalled that September 2007 was a particularly bad time for Charmaine and "*she sounded much more flat than usual*". She was aware that Charmaine was feeling stressed about the Brad Hodson video and also that she had unspecified concerns at work.

231 She recalled having dinner with Charmaine and Simon on Saturday 13 October. She said that Charmaine was calm, as she usually was around her. But she said that her partner commented saying "*What was with Char tonight, she's so calm and so level and just being so natural?"* Ms Bamford said she was concerned by her partner's observations and said "*I was thinking I wonder if this is something I should be worried about given that she'd been quite depressed leading up to that night*". It should be noted that this was the day after Charmaine's Bobbin Head walk with Dr Khong.

232 Ms Bamford said that she took this up with Charmaine the next day but was assured that she was all right.

233 She and Charmaine went for dinner in Mosman on Thursday 25 October. She described Charmaine as being "*in a pretty good mood that night*". She was aware that Charmaine had been taking a lot of fish oil. They spoke briefly "*about a change in medication and how much she was looking forward to it…"* She said that Charmaine had often spoken about wanting to get off antidepressants and have "*a drug free life*". To put this in context, this dinner took place when Charmaine had been starting to reduce the Efexor dose and take fish oil tablets, but before the introduction of the Lexapro.

234 Ms Bamford then related a conversation she had with Charmaine on Monday 29 October. She said that Charmaine sounded "*really flat*". She said that Simon had just come back from Perth the night before and she was having a bad day but "*I've just got to persist*" and "*I expected to feel better by now.*" This conversation took place two days after Charmaine started to take Lexapro and the events with Emma Ritchie on the drive to the Enmore Theatre; it was one day after the "Scrabble challenge" at Selina Day's house; it was the same day when Charmaine spoke with her mother saying she could not understand why

she was not feeling better yet. It was also on that day that Charmaine decided to increase the Lexapro from 5mg to 10mg.

235 Ms Bamford could not recall speaking with Charmaine after Monday 29 October although she said she might have.

236 Counsel assisting asked Ms Bamford if she was surprised that Charmaine committed suicide when she did. She answered

> *I was surprised that it was that week and not three months before, or two months before. I didn't, I didn't think that would have happened that week.*

237 Ms Bamford recognised that in giving the evidence that she did she was presenting a very different picture of Charmaine than the one presented by her other friends and work colleagues. She said she had misgivings about giving her account of Charmaine:

> *She was very real, natural, much more calm than what you could probably imagine, but I also saw that she was very unwell and while she was very happy with aspects of her life, it was her mind that was tormenting her and I think that my memory of Charmaine and my perception of her doesn't, doesn't match any of those other images that I've heard people describe her as and I guess I feel as though I don't want to colour that image of her as this bubbly person…*

CHARMAINE'S DIARIES

238 The inquest received two notebooks containing Charmaine's handwritten personal diaries. They comprised some 111 pages. These were transcribed by the Crown Solicitor's Office for the purposes of the inquest. Most of the entries were dated but some were not. Nevertheless the context of most of the undated entries made it possible to determine approximate dates. The following excerpts were referred to during the inquest but are not meant to be exhaustive of all entries relevant to Charmaine's state of mind.

20 July 2007

239 This was written three weeks after Charmaine and Simon had returned from their trip to Europe, a time when Simon described Charmaine as "*the happiest time*".

> *For 5 days now I have been submerged under a torrent of raging thoughts and feelings, unable to break through to the surface where reality and reason lives.*

At the heart (core) has been fear and intense negativity my ability to live in this world and function as a normal person.

I see myself as utterly incompetent in nearly all aspects of life, from work, to friendships, to my relationship, as well as all the mundane things like chores and getting on top of business matters. To me this seems to be getting worse and spiralling out of control to the extent that I feel close to having a nervous breakdown and will be sentenced to a life as a hopeless basket case.

As you can see, my mind is drenched in negativity….

I'm obsessed with what people must think of me and whether they approve, which shatters my ability to converse normally and inject fun and my real personality into everyday encounters. Anxiety has been keeping me awake at night and preventing me from learning because it gets in the way of other thoughts. Thus, the situation spirals out even further. The rut deepens and I descend further into a trough.

I interpret every negative comment people say as how it relates to me, comparing my ineptitude to whatever they may be discussing. I can't think straight & panic locks me into a state of frozen fever.

For the first time I have actually contemplated ending my life because I am never going to get a grasp on it. This prompts me to fear that I am a danger to others on the road because my thoughts prevent me from concentrating. I could never understand why others would end their lives because of the effect this would have on the ones they love, but as the anxiety and fear build up, it clouded my ability to even let such thoughts in. Only glimpses of how devastated Simon and my Mum might be, along with the loneliness that would leave them override my own selfish motives.

Later in July

ENTRAPMENT: caught/stuck/rooted in a debilitating whirl of thoughts and incessant indecision. Every 10 secs another thought of what I could/should be doing pops into my head & that leads to guilt & worry about what I'm not doing & getting further behind - I can't do anything I'm so entrenched in this cycle - second guess everything I do - I take action then am plagued by new worries & doubts over what I've done & what that could mean….

Can't cope without parents - couldn't be a good parent myself - going to be wracked with fear/self-doubt/indecision/hopelessness. Good things happen but I forget & dwell on what's not happening.

Need to fill life w activities, cabin fever in the house that leads to worse thought & inaction. Need a firm direction - someone to tell me what to do each day so I achieve each day.

Can't see good things, can't find laughter/humour.

What I found on holiday - humour/laughter…

7 August 2007

240 Charmaine was asked by Dr Khong to prepare a dialogue between "*C1 and C2".* She described these are her two "tracks":

***C1**: my auto pilot way of thinking (negative) bad cop and*

***C2**: my voice of reason (positive mind training) good cop*

***C1**: I feel like I'm stuck in glue, doubting myself as a person, as a friend, and my career path despite some good signs that came through this week.*

***C2**: So what are your fears? What's the worst that could happen?*

***C1**: I'd remain like this for the rest of my days, unsure of every step, second guessing myself and so obsessed with this crazy shit that no one would want to know me anymore. Also it's affecting my relationship with Simon, I can't see past myself. I don't feel anything is fun anymore, like I'm searching for a saviour, but there is none.*

***C2**: You are the saviour silly. Be kind to yourself. You know everyone is in the same boat. You need to be strong and get on top of this for Simon too. Now cut the bullshit C1, you're just using anxiety as an excuse to be lazy, get on with it...*

***C1**: (breaths) ok. I know I'm sweating the small stuff and that makes me feel even worse.*

***C2**: Why? At least you are aware of it. What happened to the most crucial aspect - being kind to yourself?*

***C1**: I just feel hopeless.*

9 August 2007

241 Charmaine has just had her 11th appointment with Dr Khong at which time the dialogue above was discussed. Later that day she wrote in her diary:

There is no magic bullet, but there is a change of thinking & attitude that you have to make.

...

Happy people don't just accept change, they embrace it. They say "why should I want my next five years to be like my last"? If you accept and embrace the

change, no matter how hard it is - nobody says it is not hard. Your way of thinking says it should be easy and it is for everyone else - it's not…

13 September 2007

242 This was two weeks after the successful and fun ski trip to Thredbo. She was just starting to work on Brad Hodson's 30th birthday video.

There is difference between nerves about a new project and nerves about the new project reinforcing the self-esteem. Of course it is [indecipherable] and I want to do my best and not disappoint people but at the end of the day…But I'm prepared to take the risk for it because the not doing is worse than the doing. The not knowing outweighs the fear of failure by doing nothing.

Fear vs excitement of doing it. There will be days you will regret taking it on, but at the end of the day doing is always better than not doing.

All of us are paralysed by fear, even Belinda, but she uses mindfulness to identify fears and diminish irrational thoughts. Tap into the right side of the brain to calm yourself.

Part of it is your default position it's a habit. The insights make you catch the anxiety much earlier in the piece. Being anxious about anxiety.

The anxiety will always be there, mindfulness helps you identify it quicker.

Belinda can guarantee it will get better.

October 2007

243 These entries were made after Dr Berenson wrote the referral letters for Dr Tang and Dr Parker. They were written before Charmaine went on the walk to Bobbin Head with Dr Khong on 12 October. They coincide with the time when Charmaine thought she was going to be replaced by another newsreader, and she told Sharlyn Vermey that should could not handle having a baby. They also coincide with the time that Mrs Dragun and her father were visiting Charmaine in Sydney from 7-10 October.

244 (The numbers in bold represent different pages of the handwritten diary)

(71)
Can't escape my own misery and self-absorption even when doing activities.

...
People are starting to know something's wrong with me, avoiding me, don't want

to know or don't know what to say. I'm starting to do things that are annoying and offending people. Losing the only people I have.

(72)

Lost memory & ability to comprehend and take in things. Losing brain function.

[indecipherable] what I say to people & not being able to see the impact my words have on people.

Being a danger on the road.

WHAT CAN I DO

Construct a routine

Seek help

If you don't stay, Simon, who gave up his life to be with you, will be stranded & stuck with a massive mortgage, dogs, all our stuff, moving, cleaning, organising &all-engulfing grief. Why do that to him. My Mum His Mum, Dad, my [indecipherable], Matt the few friends I have left. To have left. You can't do that to him - never got to be a Mum.

Plus the guilt on shoulders. And the anger & disgust people will be left feeling towards me. How I could have done this, to my loved ones. Funeral costs, loss of money & employment for Sime.

If I don't die but am left horribly injured - they will be stuck looking after me as well as all the rest. Massive burden & loss of life which they don't deserve.

Do I deserve to just bail? Because it seems too hard? Take the easy way out & leave an unending trail of destruction in my wake.

Word is going to start getting out about how unstable I am. Might get back to work & friends. End up w nothing & Simon still looking after me.

(75)

Please leave everything to Simon, all my savings that remain after the funeral & anything of value that can be sold so he can support himself. He'll be left with a terrible financial burden & will need every cent to cover the mortgage.

(77)
What can I do right now:

From a Buddhist perspective - not self-esteem, look at self compassion...

(82)

Need to change thinking.

(83)

I cannot live like this & I don't want to live like this.

Self-compassion is letting go.

12 October 2007

245 This was written shortly after Charmaine walked with Dr Khong at Bobbin Head

The National Park experience is a watershed event which must be remembered.

Interdependent and interconnectedness: learning lessons from nature and feeling like a part of the universe. Buddhism believes that once you are able to see yourself in the bigger community your concerns become reduced.

Going to the National Park made me feel calmer, if not instantly brighter - and that calmness changed the circuitry from the right to the left of the brain...Belinda asked me to focus on the river and the crabs and nature - all except my thoughts - to take me out of the black hole...

Going out into the world and focusing on elements of nature - raindrops, animals, clouds, trees with falling leaves (trees don't cry when they lose their leaves so why should I fear change and loss?) Let nature be your guide and teach you.

Chinese saying - A CRISIS IS NEVER JUST A CRISIS, BUT AN OPPORTUNITY TO LEARN.

THE ANTIDEPRESSANT DRUGS

246 Charmaine had been taking Efexor since 2004 for what her doctors in Perth diagnosed as depression. When she came to Sydney in 2005 she was still taking this drug. When she came under the care of the Sydney general practitioners Dr Cugadasan and Dr Clowes the dose of Efexor was increased from 75 mg/day to 112.5 mg/day and then to 150 mg/day. When she eventually came under the care of the psychiatrist Dr Tang the Efexor was reduced to

75mg/day and a new drug, Lexapro, was introduced. Charmaine died about two weeks after she started reducing the Efexor and one week after starting Lexapro.

247 The significance of the antidepressant drugs for the purposes of this inquest fell into three categories: First, whether these drugs "caused" (in any relevant sense) Charmaine to take her own life; second, whether the product literature appropriately drew attention to any increased risk of suicidality; and third, whether Dr Tang's management plan to reduce the Efexor and introduce Lexapro in the manner she did and with the monitoring that she did was consistent with the product literature and, if not, what if anything flowed from this.

248 Counsel assisting made the point in final submissions that the issue of the safety and efficacy of antidepressant drugs, especially in light of their widespread use in this country, were important matters to be investigated. But they were not properly matters for this inquest.

THE PRODUCT LITERATURE

249 Wyeth Australia Pty Ltd (Wyeth) is the manufacturer of Efexor. Lundbeck Australia Pty Ltd (Lundbeck) is the manufacturer of Lexapro. Wyeth and Lundbeck provided the product literature available at the relevant time for each of Efexor and Lexapro, respectively. A representative of each company also gave evidence.

250 The product literature was available from a number of sources (prescribing handbooks, detailed and abbreviated product literature and product inserts). There were slight differences in the product literature of each and there were some changes in the literature specific to each drug over time. These slight differences and changes were not relevant to the issues in this inquest although they might be in an investigation of what each of the drug companies knew at a given point in time and what their product literature actually disclosed. Most of the relevant entries in the product literature were "generic" for antidepressant drugs and were included at the instigation of the Australian drug regulator, the Therapeutic Goods Administration (TGA). These inclusions followed similar

recommendations by the US drug regulator, the Food and Drug Administration (FDA).

251 For present purposes it is sufficient to note the following from the product literature and prescribing information.

1. Suicidality was strongly linked to depression and was present whether or not a person was taking antidepressants. The risk of worsening depression and suicidality was, however, increased when antidepressants were being introduced for the first time, when the drug was being withdrawn, and at any time that there were dosage changes, either increases or decreases.

2. The side effects from the introduction, discontinuation or change in dose of antidepressants included (relevantly)

    - Headache
    - Nausea
    - Agitation
    - Anxiety
    - Confusion
    - Nervousness
    - Panic attacks
    - Impaired driving
    - Psychomotor restlessness
    - Other unusual changes in behaviour
    - Hypomania
    - Serotonin syndrome

252 Although a causal link between the emergence of any or all of the above symptoms and either worsening of depression and/or emergence of suicidal impulses has not been established there is a concern that such symptoms may be precursors of emerging suicidality. The lack of an *established causal link* between drug effects and worsening depression and suicidality has to do with the impossibility of conducting ethical clinical trials. The fact is that concerns about a causal link exist.

253 Patients taking antidepressants need to be informed of the drug effects that could lead to worsening depression and suicidality. Families including parents, partners and caregivers, should also be informed about the side effects so that the patient can be properly monitored. Emergence of such symptoms should be reported to health care providers immediately.

254 Certain antidepressants (including Efexor and Lexapro) should be used with caution in patients with a bipolar disorder (mania/hypomania). There is a warning that a major depressive episode could be the initial presentation of a bipolar disorder and patients should be adequately screened for bipolar disorder.

255 Discontinuation of Efexor should be achieved slowly. The product literature only gives the following advice:

> *When Efexor-XR at a dose of 75 mg/day or greater has been administered for more than 1 week is stopped, it is generally recommended that the dose be tapered gradually to minimise the risk of discontinuation symptoms. Patients who have received Efexor-XR for 6 weeks or more should have their dose tapered gradually over at least a 2-week period.*

256 Wyeth was asked during the inquest to indicate what advice they would give to a doctor seeking assistance with the discontinuation of Efexor in circumstances here, namely the use of Efexor for some 3 years and at a dose of 150mg/day at the time of commencement of withdrawal. The written response provided stated:

> *Due to the complexity of patient care, we are unable to suggest individualised treatment approaches or provide advice or recommendations for the management of patients. Decisions regarding how to taper a patient off venlafaxine must be made by the treating health care professional. We are unable to make patient specific recommendations regarding individualisation of tapering*

257 In other words Wyeth left the proper regime for the discontinuation of Efexor to the discretion of the prescribing doctor.

258 The product literature for Lexapro included “switching guidelines” to be considered when changing from another drug to Lexapro. The information deals specifically with Efexor and says that when switching from Efexor to Lexapro there should be *1-2 drug free days* before commencing Lexapro. In other words, the giving of both Efexor (albeit at a decreasing dose) and Lexapro at the same

time (as occurred in this case) was contrary to the "switching guidelines" provided by the manufacturer of Lexapro.

259 Dr Tang's legal representatives presented evidence from other sources, including from the Bethlem and Maudsley prescribing guidelines from the UK. Those guidelines include "switching" from one drug to another and contemplate "cross-tapering" of Efexor and Lexapro (where Efexor is being reduced the Efexor introduced at the same time) but say that this must be done with caution.

KAREN JAMES

260 Wyeth provided written answers to questions put to it by the Crown Solicitor's Office attached to which was relevant product literature. An explanation of the genesis of the product literature was provided. It appears that Wyeth's product literature for Efexor took its cue from changes required by the US FDA and was prepared in compliance with any requirements from the Australian TGA and the Medicines Australia Code of Conduct.

261 Karen James provided a statement endorsing the written answers, above. She also gave evidence at the inquest to expand upon matters in the Efexor product literature.

262 Ms James was not a doctor but rather the regulatory affairs director for Wyeth. She had a degree in science. She said that as at 2009 some 280,000 people in Australia were obtaining prescriptions for Efexor every month. She said that in 75 mg packages of Efexor Wyeth includes a booklet "*Back on Track, Your Guide to Managing Depression and Anxiety*" (tendered in evidence) which aims to provide general information about these conditions and directs the reader to a website where more detailed information about Efexor can be obtained.

263 It was clear that this booklet did not provide much information about Efexor. She added "what's important is that the primary source of information for patient is the consultation with their doctor". She described the doctor as "the learned intermediary and the relationship is between the doctor and the patient." She explained that if Wyeth became aware of reports of adverse reactions to Efexor it is obliged to notify the TGA but no such obligation rests on doctors to report

adverse events. She accepted that it was reasonable to assume that there was an underreporting of adverse effects of drugs generally to the TGA.

264 Ms James confirmed that the Wyeth product literature noted the importance of careful monitoring of the patient during the time of dose changes both up and down because this was a danger period for worsening depression or suicidality. She confirmed that Efexor was not approved for use in bipolar disorders and that the literature specifically directs doctors to carefully screen patients for this condition. She agreed that patients need to be aware of side effects that might lead to worsening depression and increased risk of suicidality. The source of that information was either consumer medical information provided by a chemist, review of the product literature on the internet (as directed by the booklet referred to above) or by the prescribing doctor.

265 In answer to question posed by counsel for Dr Khong Ms James agreed that in the booklet there was no reference to increased risk of suicidal ideation with the slow withdrawal of Efexor; only a warning not to stop taking the drug abruptly – but even then the booklet does not refer to any increased risk of suicidality. Ms James emphasised that the booklet was not intended to be comprehensive and it was for the prescribing doctor to ensure that more complete information about risks was given to the patient.

266 In answer to questions posed by counsel for Dr Tang Ms James said that it was not her role to review the medical literature on the drugs that Wyeth manufactures; but she would obtain such information from time to time if provided by the head office of the company if relevant to regulatory issues.

267 Ms James said that for the purposes of preparing documentation for the inquest she did not undertake any research or investigations into the current literature regarding the safety or efficacy of Efexor but relied on Wyeth's solicitors to provide the information. She accepted that she was "*not the person to be answering questions in terms of prescribing guidelines."* She agreed that she was not familiar with any of the prescribing guidelines of the Maudsley Hospital in the UK and in particular the "switching guidelines" referred to by Dr Tang's counsel. She could provide no assistance on the issue of switching from Efexor

to another drug as this was not her area of special knowledge. She said that she was not apprised of the specific issues that the Crown Solicitor's office, on behalf of the coroner, wanted addressed in evidence. She left the agenda for what she was to give evidence on in the hands of Wyeth's legal department.

268 In answer to questions put by her own solicitor it was clear that the Efexor product information was not silent on the risk of suicide and the need to inform a health professional if suicidal feelings emerged. But this information could only be obtained with effort over the Internet, or if a consumer product information sheet was given by a chemist, or if the information was conveyed by the prescribing doctor. It was clear from Ms James evidence that Wyeth considered the prescribing doctor to bear the principal responsibility for ensuring that the relevant warnings and other information in the product information were given to the patient.

DEBORAH PELSER

269 Dr Deborah Pelser provided a statement and gave evidence at the inquest.

270 Dr Pelser is a medical doctor who had special training in psychiatry. She was since 2008 the Manager of Scientific Affairs at Lundbeck. From 2001 until 2008 she held the position of Manager of Medical Affairs. She was familiar with the product literature but (unlike Ms James of Wyeth) was also familiar with medical issues surrounding antidepressant drugs in general and Lexapro in particular.

271 She explained how product information was disseminated to the TGA, to prescriber handbooks like MIMS, to the National Prescribing Service (NPS). She said that the most doctors inform themselves about Lexapro through accessing the product information through MIMS, the NPS, and discussions with peers, review of medical journals and from Lundbeck's sales representatives.

272 Dr Pelser emphasised that the Lexapro product literature acknowledged an increased risk of suicide at the commencement of use or during any dose changes and that "*patients should be closely monitored for clinical worsening and suicidality*" at these times. There was evidence that Lundbeck did receive, from time to time, queries about Lexapro and suicidality. Dr Pelser's statement exhibited a document with such queries and answers

and these demonstrated that Lundbeck's response was in each case to quote from the Lexapro product literature (already in evidence) but also to refer the inquirer to an article published in 2005: Pedersen, *Escitalopram and suicidality in adult depression and anxiety*, International Clinical Psychopharmacology 2005 Vol 20 No 3 139-143.

273 This article commences this way

> *The relationship between antidepressants, particularly the selective serotonin reuptake inhibitor (SSRIs), and suicidal ideation and behaviour has caused considerable debate and public attention. There is concern that there might be paradoxical increase in suicidality in patients treated with antidepressants, particularly SSRIs[3] and especially during the first weeks of treatment.[4]*

274 The article reviews published literature on clinical trials and concludes that there is no indication that Lexapro provokes suicidal behaviour compared to placebo in patients with major depressive disorders or anxiety disorders. Importantly, the study had a significant limitation recognised by the author:

> *The patients in the clinical trials represent a privileged subset of patients because those patients with a significant risk of suicide were excluded at trial onset. Although this is clearly necessary for ethical and patient safety reasons in out-patient trials, it does introduce a caveat because it reduces the possibility of detecting treatment differences in the rate of active suicidal behaviour, and provides patients with a limited change of improving on this parameter. Conversely, such a selected patient population could obviously deteriorate.[5]*

275 The article continues that efficacy and safety data do not provide evidence that active treatment induces such deterioration, but this conclusion is obviously not something that could be tested for. This clear limitation is important in this case because clearly Charmaine was at significant risk of suicide when she was prescribed Lexapro by Dr Tang on 16 October – albeit a risk not fully appreciated by Dr Tang as discussed further in these reasons.

276 In her oral evidence Dr Pelser said that Lexapro was a short acting SSRI with a half life of 30 hours. She explained this.

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[3] This refers to Selective Serotonin Reuptake Inhibitors, a class of antidepressants that includes Lexapro

[4] *Pederson* p 139

[5] *Pedersen* p 142

> *The half life is the time that it takes for half of the dose of the drug that you've taken to be cleared by the body. So if you take a drug, if you take Lexapro, you take 10 milligrams, within 30 hours there will be 5 milligrams left in your body, in another 30 hours there will be 2.5 milligrams and so on and so on and so on.*

277 Dr Pelser agreed that one can have a reaction to Lexapro on the first day that it is given. She agreed that where a patient is first starting Lexapro (which Charmaine did on 27 October at 5mg) and also when increasing the dose (which Charmaine did to 10 mg on 29 October) the patient should be closely monitored for clinical worsening and suicide risk. She agreed that families and caregivers had a role in monitoring a patient taking Lexapro and that this included adult patients and not just children.

278 Dr Pelser explained why antidepressants like Lexapro (and Efexor) could be dangerous if given to a patient with a bipolar disorder:

> *…the danger with antidepressants is that they can release a manic episode in someone who is being treated with them, so for instance, if a doctor sees someone suffering from depression and their full history is not known an antidepressant – any antidepressant in that particular patient could uncover a manic episode.*

279 Self-evidently, it is incumbent on a doctor to consider whether a patient may have a bipolar condition before prescribing antidepressants. Dr Pelser said that Lexapro may still be given to patients with a bipolar disorder, but the doctor (and patient) needed to be aware of the risk of provoking a manic episode.

280 Dr Pelser recognised potential problems with depressed patients self-monitoring their condition because they might not have sufficient insight to recognise that they were unwell. This was a good argument for monitoring by others (eg family or caregivers). She agreed that one reason why patients needed to be told of side effects was to know what to expect. There was a risk that if the patient was not expecting a certain side effect the drug might be stopped, to the patient's detriment. Equally, she said that if a patient was not told of a potentially distressing side effect, experienced this and questioned what was happening, "*it would be perplexing and distressing for that patient*".

281 Dr Pelser confirmed that the Lexapro "switching guidelines" called for 1-2 drug free days between stopping Efexor and starting Lexapro. She explained that this

was recommended first, to know what symptoms are due to discontinuation of the drug just stopped; second, to avoid serotonin syndrome; and third to comply with the Medicines Australia Code of Conduct which cautions against concomitant use of drugs. She explained that serotonin syndrome can cause a number of problems that range from being quite mild to necessitating hospitalisation.

282 Counsel assisting put to Dr Pelser a list of signs and symptoms that, according to other evidence at the inquest, Charmaine appeared to be experiencing from 27 October, the day she started taking Lexapro (and was reducing her dose of Efexor). This list included:

- Agitation
- Panic attacks
- Psychomotor restlessness
- Impaired driving ability
- Other unusual changes in behaviour

283 Dr Pelser had previously agreed that these were all associated with the introduction of Lexapro and that side effects could be seen from the first day of treatment. She agreed that these signs and symptoms could possibly have been due to Lexapro. She agreed that these signs and symptoms can be the precursors to emerging suicidality.

284 Counsel for Dr Tang asked Dr Pelser about the "switching guidelines" prepared by Lundbeck that recommend 1-2 drug free days when switching from Efexor to Lexapro. She agreed that the Lexapro switching guidelines were not consistent with those of the Maudsley Hospital in the UK, but she did not take these into consideration. She said that the "switching guidelines" were prepared by Lundbeck's marketing department based on information obtained by others. She agreed that there were "*no set guidelines for switching among antidepressants*" and that "cross-tapering" (that is, reducing one drug whilst slowing introducing another) was a recognised method of switching drugs – albeit not a method recommended by Lundbeck.

GENERAL PRACTICE ISSUES

285 To provide some background as to the proper management by general practitioners of patients with mood disorders including depression the inquest considered extracts from a leading textbook, General Practice by Dr John Murtagh. The general practitioners who gave evidence confirmed that this was an authoritative text, one even describing it as "*the Bible of general practice*".

286 The textbook made the following points relevant to the matters in issue in the inquest:

- Depression is an illness that affects the entire mind and body
- No one is to blame
- There is a distinction between depressive disorders and bipolar disorders, but the text did not address the diagnosis of bipolar disorders focusing instead on depression
- Depression responds well to treatment but can be lethal if untreated
- Improvement with antidepressants can be expected (if at all) after about 2 weeks of treatment
- Referral to a psychiatrist is needed when there is
    - Uncertainty about the diagnosis
    - Severe depression
    - Substantial suicide risk
    - Failure to respond to routine antidepressant therapy

CHARMAINE'S TREATING DOCTORS

GENERAL PRACTITIONERS

DR THUSYANTHIE CUGADASAN

287 Dr Cugadasan provided a statement and gave evidence at the inquest. She was a general practitioner at the Wetherill Street Clinic and the records from her management of Charmaine were reviewed.

288 Charmaine first consulted Dr Cugadasan on 28 November 2006. The notes say, in summary:

- Charmaine had moved from Perth two years before and was living with her defacto partner
- She had a *longstanding depressive and anxiety symptoms*
- She was *worse in last few weeks - increased moodiness - can feel happy one minute then really down the next, teary, anxious - heart racing/abdo.*
- *Reduced self-esteem/lack of interest in planning things/amotivation*
- *Job dissatisfaction in Sydney - busier/more fulfilling in Perth - too much time on her hands/just reading the news*
- *No other obvious precipitators*
- *Supportive partner, some friends here but all her family in Perth*
- *Been on Efexor XR 2 years - 75mg. Worried about being pregnant in the future and taking Efexor - not planning to have a baby for 2 years.*

289 Dr Cugadasan increased the Efexor dose from 75mg to 112.5 mg and arranged a review in one week. She also prepared a referral to a psychologist, Lyn Anthony. For the purposes of the referral she had to prepare a document entitled "GP Mental Health Care Plan".

290 This plan included patient details and the goals of treatment and also the following:

- The past medical history stated Anorexia Nervosa (1996) and Depression (1996)
- The DASS Score (Depression Anxiety Stress Scales) was left blank
- The use of Efexor and the planned increase in dose was noted
- There was a discussion about *cognitive behaviour therapy / negative thinking*
- There was a discussion about crisis and relapse management
- The patient was to comply with the increased medication, report any side effects and see the psychologist and Dr Cugadasan for ongoing counselling.

291 The reason the section on the DASS was left blank was because a DASS questionnaire was not filled in at the time the GP Mental Health Care Plan was made. But Charmaine was given this questionnaire to complete and she brought it with her at the next appointment, which was on 5 December 2006. The

completed questionnaire was dated 29 November but was apparently scored by Dr Cugadasan at the consultation on 5 December.

292 The results of this self-reporting questionnaire showed that Charmaine's scores for Depression, Anxiety and Stress were all in the "Extremely Severe" range. It is not known whether the results of the DASS score were sent to the psychologist, Lyn Anthony, although they might have been. Unfortunately Lyn Anthony could not be located despite extensive efforts by the Crown Solicitor's Office, and with the assistance of the Wetherill Street Clinic. But Charmaine only saw Lyn Anthony once.

293 Dr Cugadasan's notes from the consultation on 5 December confirm that the DASS form was filled in and was eventually saved on the clinic's computer. The notes say that Charmaine was "*feeling really good – doing few more projects at work*". It will be observed that this was just one week after Charmaine's self assessment showing depression, anxiety and stress in the "extremely severe" range according to the DASS criteria; it was only one week after the dose of Efexor had been increased from 75 mg to 112.5 mg.

294 After this consultation Charmaine had made arrangements to see Dr Khong. She returned to Dr Cugadasan on 31 January 2007 seeking a formal referral to see Dr Khong. Her notes confirm that this was done and also say "*feels doing fairly well especially with increased medication*". Dr Cugadasan's referral letter to Dr Khong confirms the history of anorexia nervosa and depression and the treatment with Efexor. It says

> Thank you for seeing Ms Charmaine Dragun, age 28 yrs. She has had anxiety, depressive symptoms and is on Efexor 75 mg 1.5 tablets daily. She would like your help with counselling and further treatment.

295 Dr Cugadasan did not advise Dr Khong of Charmaine's DASS scores indicating depression, anxiety and stress in the "extremely severe" range.

296 Dr Khong wrote to Dr Cugadasan on 12 February 2007 thanking her for the referral and indicating of Charmaine that "*Her prognosis is good*".

297 There was a further consultation with Dr Cugadasan on 12 February 2007 but nothing was discussed about her mental health. After this Dr Cugadasan left the Wetherill Street Clinic on maternity leave and Charmaine started to see another GP there, Dr Kate Clowes.

298 Dr Cugadasan said in evidence that she had no real recollection of her consultations with Charmaine and was relying on her notes. She had reviewed the relevant sections of the textbook by Murtagh and said "*It's regarded as the Bible of general practice*". She said that if she thought a patient had a bipolar disorder she would refer on to a psychiatrist. She agreed that depression was not the kind of illness that responded to exhortations to "*Get a life!"* or "*Pull yourself together!"* She accepted that there could be a biological or chemical component to depression. She agreed that a diagnosis of major depression or the failure to respond to treatment within a reasonable time would be a reason to refer to a psychiatrist. She agreed that "*general practitioners need to be astute enough to know*" when to send a patient to a psychiatrist.

299 Dr Cugadasan explained that in the management of depression there may be a role for both antidepressants and counselling by a psychologist. She said that a psychologist would give a patient "tools" in the sense of strategies and skills to identify and change troubling behaviours. There followed this exchange with counsel assisting:

> *Q. The point is that if you just give somebody drugs with no counselling you may be getting them thinking straight?*
>
> *A. Yes.*
>
> *Q. But they have no tools to employ?*
>
> *A. Yes, yes.*
>
> *Q. But if you only give them tools to employ but they are not thinking straight, then you're kind of wasting your time?*
>
> *A. That's right but if someone had minor depression you may just give them counselling without necessarily needing to resort to drugs.*
>
> *Q. And you would think that the tools that you're giving the person in counselling, the message must be getting through?*

A. Yes.

Q. If the message wasn't getting through you might be thinking to yourself maybe we should take a look at some medication to make sure that they are thinking straight?

A. Yes.

300 Dr Cugadasan explained what she would be looking for if she thought a patient might have a bipolar disorder. She described "mania" and "hypomania" as "*an upswing as well as a downswing and it's quite a pronounced upswing as well as a pronounced downswing and so I would be looking for whether they were having those mood swings…*".

301 Counsel assisting took Dr Cugadasan to the statement she prepared for the inquest. The statement was, for all intents and purposes, a verbatim repetition of what was written in her notes. But the statement omitted the reference in the notes to: "*can feel happy one minute then really down the next".* She was asked why she omitted this and whether it was a sign of the kind of swinging moods that characterised a bipolar disorder. Dr Cugadasan said that she excluded this from her statement because "*it was consistent with her depressive symptoms*". She did not believe that if a patient can feel happy one minute then really down the next it could be a sign of a bipolar disorder. There followed this exchange with counsel assisting:

Q. So that reference to feeling happy one minute, really down the next is really a non-starter for you, is that right?

A. That would not indicate bipolar, no.

Q. Didn't make you think that there was a potential problem with mood swings?

A. No, it is my usual practice when I am assessing someone that particularly because I have written this down I would have said to her, have you had a period where you were having sustained elevated period – elevated mood and I would have noted any – any positive symptoms but I have written it down this way because I have – that tells me that it was happening all within minutes of each other and that was more consistent with depression, that was my analysis.

Q. Are you quite sure that you asked Charmaine Dragun if she ever had sustained periods of elevated mood?

A. I cannot recall exactly what happened during the consultation but that is my usual doctor practice.

302 Dr Cugadasan was asked whether she was familiar with the term "rapid cycling bipolar" and she said she was. She said that she understood this to be "*cycling in and out quickly but that would still be occurring over a period of – of some months, of some months*." When pressed on this she accepted that she had not excluded a bipolar disorder at the time of her original assessment.

Q. So if a person says to you, look I am feeling pretty moody for the last few weeks, I can be really happy one minute and then really down the next, you would not consider that as holding up any kind of flag for bipolar?

A. No, I find that people often use the word moody when they describe things and you need to sort of go into it a little bit further and if – if they said to me that it was, I would need to sort of go into it a little bit further but often I find that people say they are moody when they – when they feel depressed but they don't say I feel depressed.

Q. But you said that hadn't excluded bipolar at that point, had you?

A. In my mind she had symptoms that were consistent with a depression and anxiety but – and – and I was happy to initiate treatment and monitor her carefully and see what was going on and if she had shown that she was not responding to treatment then I would have referred her to a psychiatrist to look at other possibilities.

303 Dr Cugadasan was then taken to the GP Mental Health Care Plan. She said this had to be completed in order to claim a Medicare rebate for seeing a psychologist, in this case Lyn Anthony.

304 Dr Cugadasan had noted that other than job dissatisfaction there were "*no other obvious precipitators*" to Charmaine's depression which was, according to her, *worse in last few weeks - increased moodiness - can feel happy one minute then really down the next, teary, anxious - heart racing/abdo.* She said, in evidence, that the move to Sydney and feeling unsupported could be precipitators as well, but it was put to her that she had moved two years before and that her partner was noted as being supportive.

305 She agreed there were questionnaires that could be used to help detect bipolar disorders but that these were not the kinds of things that general practitioners would employ. She agreed that the DASS questionnaire was designed to provide an objective measure of the severity of depression, anxiety and stress. She confirmed that her handwriting appeared on the scoring sheet showing scores in the "extremely severe" range for depression, anxiety and stress. But she said that these scores would not have been a reason to refer Charmaine to a psychiatrist, even though the textbook (that she described as "*the Bible of general practice*") said that such a referral should be made in the case of severe depression.

306 By 5 December, seven days later, Charmaine reported that she was "*feeling really good*" and had already been to see the psychologist Lyn Anthony. Dr Cugadasan was asked whether this improvement from "*extremely severe depression*" to "*feeling really good*" one week later caused her to have any concerns about mood swings and bipolar disorder, especially given that one would usually expect benefit from increased medication to be seen in about two weeks. She said that this change would not have led her to consider a diagnosis of a bipolar condition which, she had said previously, would have necessitated referral to a psychiatrist.

307 Dr Cugadasan explained that she used the DASS to assess a patient's progress so the scores from 29 November would be a baseline from which to measure improvement. She noted that the DASS questionnaire did not include any questions addressing suicide risk, unlike other questionnaires used by general practitioners. She also confirmed that the DASS was not used in order to classify a patient's depression using DSM IV criteria (which defines psychological disorders including "major depression"). It was clear from this that the utility of the DASS questionnaire in clinical practice was very limited.

308 She agreed that when she referred Charmaine to Dr Khong on 31 January (at her request) she did not provide her with a copy of the DASS results. She also did not provide her with copies of her clinical notes that included that Charmaine had reported *longstanding depressive with anxiety symptoms worse in last few*

weeks - increased moodiness - can feel happy one minute then really down the next, teary, anxious - heart racing/abdo. Dr Khong was not made aware of the improvement from "*extremely severe*" DASS scores for depression, anxiety and stress and the change to "*feeling really good*" one week later. She said it was not usual practice to provide the specialist to whom a patient was referred (in this case the psychologist Dr Khong) with the clinical records; only a referral letter. She agreed that the referral letter sent did not provide all of the relevant information available to her. She thought that providing complete information was important and would endorse any recommendations in this regard.

309 Counsel assisting made certain submissions in regard to Dr Cugadasan. He said that she failed to recognise that Charmaine had a severe depression when she was first seen on 28 November. She knew on 5 December that Charmaine's DASS score put her into the "extremely severe" range for depression, anxiety and stress when this was completed on 29 November and should have known that for her to have improved so dramatically by 5 December after the increase in Efexor from 75 to 112.5mg was unusual. He said that she should have considered the history of mood swings ("*… can feel happy one minute then really down the next…"*) together with this unexpected change to be a sign of a rapid cycling bipolar condition. He submitted that Charmaine should have been referred to a psychiatrist at that stage. He also said that Dr Cugadasan could be criticised for not providing the DASS score to Dr Khong or her notes which contained a more comprehensive history than the very cursory note written when she referred Charmaine to Dr Khong.

310 Counsel for Dr Cugadasan in written submissions said that all that Dr Cugadasan did was reasonable. In oral submissions, after hearing those of counsel assisting, he said that the diagnosis of a generalised anxiety disorder with depressive symptoms was a reasonable diagnosis to make and indeed was consistent with what Dr Phillips, one of the psychiatric experts at the inquest, concluded as well from the evidence available to him at the time he wrote his report.

311 Her counsel said the increase in Efexor was appropriate and consistent with what another expert, Dr Dudley, said was an undertreated depressive condition.

He said that I "*should not approach the conduct of Dr Cugadasan as if she also had the information and history available to Dr Berenson".*

312 However, even if Dr Cugadasan's preliminary diagnosis of an anxiety disorder with depressive symptoms was understandable, there was no exploration of any mood swings despite the information that Charmaine *can feel happy one minute then really down the next.*

313 This was a relevant consideration for the very experienced GP Dr Berenson who considered the lack of response to treatment with increasing Efexor and months of treatment by Dr Khong, to be reasons to suspect a bipolar condition.

314 The DASS score appeared to be an assessment tool that was not taken very seriously and was only filled out to satisfy requirements for Medicare rebate for psychological treatment.

315 Whilst I do not make any serious criticism of Dr. Cugadasan, apart from the fact that like many others she did not consider the possibility of a bipolar condition in a patient who presented with depressive symptoms, she should have better informed Dr Khong by providing a more complete summary of her notes and the DASS score just as a matter of good practice.

DR KATE CLOWES

316 Dr Kate Clowes prepared a statement and gave evidence at the inquest.

317 Dr Clowes took over Charmaine's care after Dr Cugadasan left the Wetherill Street Clinic on maternity leave. She saw Charmaine on four occasions: 5 March, 2 April, 25 July and 13 August 2007.

318 The clinical notes confirm that on 5 March 2007 she reviewed Charmaine's history and noted that she had been taking antidepressants and that there were two relapses with withdrawal in the past. (This would have been the withdrawal from Zoloft when in Perth and then when she stopped taking Efexor around the time Simon arrived to join her in Sydney in early 2006.). There was a discussion about the safety of antidepressants in pregnancy and Dr Clowes suggested a

psychiatrist's opinion on this issue. This does not appear to have been followed up.

319 The second consultation on 2 April did not involve any management of Charmaine's emotional issues.

320 On 25 July Charmaine saw Dr Clowes for the third time. This was after her return from Europe with Simon and when she was suffering severe depression and writing thoughts of suicide in her diary. The notes say, in summary:

- *Dr Clowes learned that Charmaine had been on antidepressants for more than 10 years and had a history of an eating disorder at age 18. When she tried to wean herself off the antidepressants there was increased anxiety. She also expressed a concern about child bearing and noted Charmaine may want to speak with someone at the Royal Hospital for Women about this.*
- *Struggling with depression again the last few months; low self confidence, teariness, lack of enjoyment of things especially socially, low motivation, low energy, has actually had thoughts of death, never before this*
- *feels main problem is change 2 years ago to newsreader position with glamour and money but no satisfaction*
- *increasingly doubting whether has made the right choice tho was her 'dream job'*
- *tried to do some freelance work recently but lacks motivation and ability to see things thru completion.*
- *Presents nightly news to Perth. Originally from Perth, some talk may be transferred back there in same role. Would love that as closer to family and support network.*
- *Partner supportive*
- *Seeing a psychologist for about 6 months, likes her a lot.*
- *Feels torn about increasing Efexor. Long chat.*

321 Dr Clowes recommended that Charmaine increase her Efexor dose from 112.5 mg to 150 mg and directed her to come for a review in 2 to 3 weeks. She noted that there would be ongoing review by a psychologist (Dr Khong) and she noted

that she may need to reconsider her job prospects. She said in her statement that the reason for the review in 2 to 3 weeks was "*to give the higher dose of Efexor-XR time to work*".

322 Charmaine saw Dr Clowes for the last time on 13 August 2007. This was nearly three weeks after she had increased the Efexor dose to 150 mg. (This was soon after Charmaine wrote about the C1-C2 dialogue that ended with "*C1 I just feel hopeless*", referred to above.) The notes say:

- *says not much better but objectively less tense and more spontaneous*
- *increased Efexor just under 3 weeks ago, impatient for effect*
- *felt very low last week; psychologist has suggested volunteer work as a way of making her busier and focused less on herself and dilemmas, encouraged to consider this*
- *encouraged to continue with Efexor at this stage, time to full effect discussed*
- *chat about making the transition to adulthood and being self-determining*

323 There was a plan to review Charmaine again in three weeks, but no such review actually took place.

324 Dr Clowes said in her statement that Charmaine "was unhappy about needing antidepressant medication at all and that the further dosage increase I suggested because of the recent worsening of her depressive symptoms would represent movement of the status quo further from where she wished to be".

325 In oral evidence Dr Clowes said that she would refer a patient to a psychiatrist if there was an issue about diagnosis or when she was "*feeling that things are not going according to plan…"* She was taken to the textbook by Dr Murtagh and confirmed that this was an authoritative text. She said that if there was no improvement on a course of treatment it would be a reason to refer, and this included no improvement with treatment given by previous general practitioners as well as treatment initiated by her.

326 She said that she had some exposure and experience with patients with bipolar disorder as part of her education and training. She added "*I would always involve a psychiatrist if I had a suspicion that the patient had bipolar disorder*".

327 Dr Clowes would have read Dr Cugadasan's notes that included "*Can feel really happy one minute then really down the next"*. She did not recall reviewing the DASS results that were available on the clinic's computer system. She said that at the first consultation on 5 March she had no concerns about a bipolar disorder and was comfortable with the diagnosis of depression. She agreed that Charmaine's condition by the end of July 2007 was not much different to what Dr Cugadasan had written at the end of November 2006. If there had been some improvement, it had deteriorated again. She did not reassess Charmaine using the DASS because it was not a tool that she used other than for the purposes of filling out a GP Mental Health Care Plan.

328 Dr Clowes was taken to the entries in Charmaine's diary written on 20 July (see above), which was five days prior to the consultation with her on 25 July. She said that what Charmaine related to her at the consultation was not "*as dramatic and awful*" as what was written in the diary. She said that if Charmaine had conveyed the level of feelings to her that she wrote in her diary then this would have been a reason to refer her to a psychiatrist.

329 Dr Clowes said that on 25 July "she was certainly suffering from recurrent depression, depression which was perhaps inadequately treated with the treatment so far". But she repeated that she did not consider a bipolar disorder as the reason for the recurrence of the depressive symptoms.

330 She said that she would have asked Charmaine on 25 July whether she was considering suicide and the answer would have been in the negative, or else Dr Clowes would have referred her to a psychiatrist.

331 Dr Clowes agreed that when she increased Charmaine's dose of Efexor to 150 mg (an increase that Charmaine was not happy about) she would have explained that she expected an effect in 2 to 3 weeks and the reason why there was an appointment on 13 August was to check for the expected effect. She

also agreed, and noted, that Charmaine said she was "*not much better*" and "*impatient for effect*". Clearly the expected improvement had not occurred.

332 Dr Clowes decided at that point to give the increased Efexor dose another 3 weeks. This is despite the fact that the Murtagh text says that one expects an effect after about 2 weeks and 3 weeks had been given already and Charmaine was "*not much better*" and (Dr Clowes agreed understandably) "*impatient for effect*". She explained in evidence

> *It can take 2 to 3 weeks to notice some improvement and after 4 to 6 weeks to have its full effect, that is my standard advice when I'm starting or increasing a dose of an antidepressant.*

333 Dr Clowes had written in the records on 13 August, when she wanted to give the increased Efexor a further 3 weeks to achieve its "*full effect*" that they had a chat about "*making the transition to adulthood*". Counsel assisting put it to Dr Clowes that she considered Charmaine's problems to be 'existential' rather than 'biological' but Dr Clowes said that both were involved. She agreed, though, that "*the unwellness is something that we have to contrast from the existential dramas of growing up … the unwellness is the biological issue*…" She agreed that if there were a biological problem (the unwellness in the brain) then the recommendations to address her existential issues (the transition to adulthood) would not be able to get through. She said that if she had continued to work at Wetherill Street Clinic and had seen Charmaine again, and if there had been no improvement, then she would have referred her to a psychiatrist.

334 Dr Clowes acknowledged that there were problems with continuity of care in general practice.

335 Counsel assisting made submissions regarding the management by Dr Clowes. He said that by 25 July when she became aware of Charmaine's suicidal thoughts she should have referred her to see a psychiatrist, especially against the background of a previous increase in Efexor and the treatment from Dr Khong since February. He said that even if it was reasonable to increase the Efexor dose to from 112.5mg to 150mg and to wait for 3 weeks for improvement, when this time had passed and the expected improvement had not come, she should have arranged for psychiatric review then rather than give the Efexor a

further 3 weeks to work. He said that Dr Clowes failed to recognise the significant biological component to Charmaine's illness (to be discussed later) and continued to treat her as if her problems were fundamentally psychological and she encouraged Charmaine to take more control of her life. This he said was the same approach that had been pursued by Dr Khong, with little to show for it so far.

336 Counsel for Dr Clowes said that the fact that Dr Clowes increased the Efexor dose meant that she believed there was a biological component to Charmaine's illness and that it was not all psychological. He said that it was reasonable to tell Charmaine to continue to give the Efexor more time to work when there was no real improvement after three weeks because "*you wouldn't expect to get a positive or significantly beneficial effect in that length of time"*.

337 Dr. Clowes should have concluded by 13 August consultation that the treatment was not going according to plan and that according to the Murtagh text, and her own evidence, this was a reason to arrange a psychiatric review. There was no real explanation given by her why she did not do this, because the evidence was that Dr Clowes expected a benefit from the increased Efexor dose within three weeks and the Murtagh text says that a benefit should be seen in even less time than that.

DR HELENA BERENSON

338 Dr Helena Berenson prepared a statement and gave evidence at the inquest.

339 Dr Berenson was a very experienced general practitioner at the Wetherill Street Clinic. She graduated medical school in 1972 and had 38 years experience in general practice.

340 Dr Berenson had only one consultation with Charmaine. This was on 29 September 2007. Charmaine attended the practice intending to see Dr Clowes in order to get a referral to the psychiatrist, Dr Tang, as Dr Khong had recommended. But she learned on arrival that Dr Clowes was no longer working there.

341 Dr Berenson said that the consultation "*began in a very awkward, strained manner*" because she had to explain that not only had Dr Clowes left but that she would not be able to consult with her for one year due to contractual clauses in her contract with the Wetherill Street Clinic.

342 Despite the poor start Dr Berenson had a "*full and frank*" discussion with Charmaine. She had reviewed Charmaine's clinical records before seeing her and went over the history with her.

> *It seemed to me that there had been several significant episodes of mood swings. I asked her if the diagnosis of bipolar disorder had ever been considered as I thought this was high on the differential diagnosis list.*

343 She said that the reference in Dr Cugadasan's notes, *can feel happy one minute then really down the next*, was significant.

> *One of the symptoms that we have to be on the alert for in case you are not just dealing with a pure depressive, so yes that is one of the statements the cyclic swings, I thought was significant from the history.*

344 She added that such mood swings without any obvious precipitators could be a sign of cyclic swings. When asked to consider Charmaine's apparent improvement from depression, anxiety and stress in the "extremely severe" range on the DASS to "feeling really good" one week later she said

> *That's quite significant to go from that degree of anxiety, stress and depression to feeling good, is quite out of character for major depressive illnesses.*

345 Dr Berenson explained that in a major depressive illness

3. *…it takes a number of weeks of fairly intense either CBT or therapy, chemical treatments to bring them out of it, it doesn't happen within a week and if it does it is another red flag that makes us, if the medication causes an elevation of mood then perhaps the original diagnosis should be reviewed.*

346 She agreed that the history provided her with "*some red flags*" that required further discussion and clarification. Included in this was the fact that Charmaine was not getting better despite the increase in Efexor from 75 mg to 112.5 mg (by Dr Cugadasan) and then from 112.5 mg to 150 mg (by Dr Clowes). She said of this:

We should be able to control it with medication to a reasonable degree and if we are just pushing the dose up and up then we are missing something, well that's the way I think that you have to look outside the circle, and see if there is anything we are missing.

347 She considered the history of anorexia nervosa in her teens was significant as well because it was associated with bipolar disorders later in life.

4. She also considered it a concern that Charmaine was not getting better despite psychotherapy from Dr Khong for at least six months. She added:

I think if the rises and falls were noted by the psychologist then they would have be in contact with the GP and make comment about it and therefore then it is the GPs role to work out what to do in those cases, the psychologist usually alerts doctors to whether they think the counselling is doing is adequate or whether they need extra or not, extra treatment or assessment.

It depends on what is actually discussed in the consultation [with the psychologist] if those areas weren't touched on then it might not have arisen so depression may have been focused on exclusively and the good times were not considered important.

348 Dr Berenson said that a GP faced with a patient with significant depression should enquire about the "ups" and not just the "downs".

349 In giving her evidence Dr Berenson noted the following about Charmaine when she described feeling "up":

- *She said when she was happy she would be really firing on all cylinders*
- *Her brain felt as if it was working well*
- *She could make very funny jokes*
- *She was very alert and alive and happy and everything was going well*
- *She did not spend too much money which is something that classically bipolar people can do, but she felt very happy with herself and confident and secure and being able to conquer anything, she could conquer the world*
- *Overjoyous – almost like looking at herself from outside herself and saying, I was really funny, and really making jokes that even she thought were very clever on her own terms*

350 Dr Berenson noted the following when Charmaine described feeling "down"

- *Feeling of crashing and feeling she was not good enough for the job*

- *Extremely aware if she made a slip on television or got muddled up*
- *Her mental depression was getting in the way and she was not being able to cope*
- *Feeling worthless*

351 Dr Berenson said that she could not identify any specific triggers to these mood swings and that this was important.

352 When asked if she thought "depression" was the right diagnosis for Charmaine she said

> *I didn't think it was right – it didn't feel right at all to me, didn't have a good fit. Sometimes you feel you know the diagnosis is right, but this didn't feel right at all.*
>
> *The depression itself was similar to major depression but the mood swings…without triggers the feeling of being able to conquer the world, it is like people on speed you know, they give you the same sort of description. It is not normal happy I'm out of my depression I feel good, it was a much more of a pendulum swing to abnormal happiness than should have been. It just didn't fit.*

353 She said that Charmaine appeared to be frustrated by the treatment she was getting "because… she knew she shouldn't be as depressed as she was, things didn't add up for her otherwise she wouldn't have gone around asking for help." She said that Charmaine "seemed agitated about the length of time that she wasn't improving and so she wanted more to have a speedier result…"

354 Dr Berenson said she thought Charmaine was behaving as if her brain wasn't functioning properly. She then explained the difference between "mania" and "hypomania":

5. *…pure mania is quite obvious to every person, when someone is in full mania they sell their house, they do absolutely crazy things … but hypomania is not quite so severe so it is not quite as noticeable and might be misinterpreted as oh good they're out of their depression they're happy again.*

355 Dr Berenson wrote the referral to Dr Tang, as Charmaine had requested. She understood that the purpose of this was to have her medications checked. But she also wrote a referral to Dr Gordon Parker for the express purpose of having

Charmaine assessed for a bipolar disorder. She said that Charmaine told her that she had never had a bipolar assessment before and was happy to see Dr Parker for this purpose.

PSYCHOLOGIST

DR BELINDA KHONG

356 Dr Khong prepared a very brief statement for the inquest. In it she referred in very general terms to the type of therapeutic strategies she employed over the course of her consultations with Charmaine between 18 January and 24 October 2007. She wrote "*Ms Dragun did not indicate to me that she was suicidal*". This sentence in her statement could only have referred to the last consultation she had, nine days before Charmaine died. There is clear evidence that Dr Khong knew of Charmaine's suicidal thoughts at least from July.

357 Dr Khong's handwritten notes were reviewed and a transcript of those notes was prepared. The transcript alone comprised 284 pages. These contained an impressive amount of detail. Those notes can be relied on to provide a reasonably reliable account of what was and what was not said. This applies not only to Dr Khong's consultations with Charmaine but also what was said and not said in her record of contact she had with Dr Tang.

358 Dr Khong's qualifications in psychology include a BA (Honours) and a PhD from Macquarie University in Sydney. She does not hold a Master's degree and this is an important point as was explained by psychology expert Dr Seidler (see below) because it is in the Master's program that one obtains intensive clinical training. She said that at Macquarie University at that time "*if …you get a very good honours which I did, I got a first class honours, you are then waived from the masters qualifying degree for your PhD.*" She said that she did have some clinical training and referred to some courses she took with the organisation Relationships Australia.

359 Before studying psychology Dr Khong practised as a lawyer in Malaysia and Singapore where she was the senior partner of a law firm. She said that her legal training was probably responsible for her assiduous note-taking.

360 She gave evidence in court over three days. The main reason for her evidence taking three days was her approach to answering questions put to her by counsel assisting. Perhaps it was her previous experience as a lawyer but she hardly answered a question immediately. It seemed to me that what she was doing was first trying to determine *why* the question was asked before answering it. That gave the impression she was either evasive or defensive, or both, because had something to hide.

361 Dr Khong is a registered psychologist. Her website describes her integrating Eastern and Western approaches to psychology. Her academic interests explore this at a deep theoretical level and she has written on these two approaches to psychology – the Eastern approach focused on the teaching of the Buddha, the Western approach on the writings of the existentialist philosophers, especially German philosopher Martin Heidegger. One of these publications, a chapter in a book on psychology and Buddhism entitled "*Role of Responsibility in Daseinanalysis and Buddhism*", was referred to at some length at the inquest.

362 In her evidence Dr Khong explained that one of the principles she applied in her practice was to get patients to take responsibility for their actions. She also agreed that she would employ "mindfulness" techniques where she considered it appropriate. She described this technique as involving getting the patient to "**L**abel" a feeling, "**A**cknowledge" it, "**E**xperience it", focus on a neutral stimulus, namely the "**B**reath" and then "**L**et go". She said this technique can be referred to by the acronym **LAEBL**. But she added that mindfulness was more than just a technique, "*it is a whole attitude and approach"*. She said that mindfulness is

> *actually being aware of what is happening in your mind and in your body as it is happening, so it is a very real time awareness of what is taking place in your mind and body at that time.*

363 The consultations with Charmaine demonstrate that mindfulness techniques were used and that approach fostered. Charmaine was also encouraged to take responsibility for her emotional issues.

364 It is an important part of the mindfulness process that a patient is able to meditate and still the mind in order for emotions once labelled, acknowledged and experienced to be able to be let go. Dr Khong explained that "*the breath provides a neutral focus so it becomes a form of circuit breaker from the rumination."* There is clear evidence that Charmaine had difficulty meditating and was unsuccessful in arresting her ruminations.

365 Dr Khong agreed with counsel assisting that the thrust of Heidegger's philosophy of Dasein (translated as "being in the world") was the notion that human experience needs to be understood as a "lived experience" inextricable from what we call "the outside world". Hence the emphasis in mindfulness of recognising all emotions as lived experiences in the "here and now". Dr Khong explained that this promotes responsibility because it teaches us to avoid blaming our feelings in the present moment on past experiences and instead to see them as present events that affect both body and mind which will eventually pass. For example if one is angry instead of saying that the anger is caused by something someone else did or said, one learns to say to oneself "*I am angry and that's okay because that will pass*".

366 Further on the subject of responsibility Dr Khong explained that to live authentically (a term used by Heidegger) one needs to be aware of what one wants, then to take responsibility to choose a course of action, and then be accepting of that choice and its consequences.

367 Responsibility in Buddhist philosophy takes a somewhat different approach to that used by Heidegger. Dr Khong was taken to the chapter of the book where she wrote:

> *Responsibility in Buddhism is based on the view that human being are responsible for their sufferings as these are consequent upon their own actions and it is within their own power to overcome them. The Buddha maintains that suffering is psychological brought about by the human tendency to cling to experiences, beliefs and even to life all of which are, by their nature, impermanent.*

368 Both Heidegger's existentialist philosophy and Buddha's teachings make reference to death. Further in the book chapter Dr Khong referred to a psychiatrist who adopted Heidegger's views (Medard Boss) who said

> *Resolutely anticipating death…helps people live authentically since it inculcates them in the ability to look at their lives holistically and to evaluate future possibilities in the face of this eventuality. … The Buddha posits another way of helping people deal with change by showing that our inability to cope with it is part of our failure to come to terms with impermanence. In Buddhist psychology people are assisted in dealing with change not by seeing it as a possibility but by understanding change as ontological and inevitable i.e. it is in the nature of things.*

369 Dr Khong confirmed that her first contact with Charmaine was an email request by Charmaine seeking assistance in learning to meditate. After a first consultation on 18 January 2007 it was agreed that Dr Khong would provide counselling and that meditation would be part of this. Charmaine then obtained a referral letter from Dr Cugadasan on 31 January and this formally started the counselling treatment. It will be recalled that referral letter noted that Charmaine had anxiety and depressive symptoms and was taking Efexor. Dr Khong responded saying she would provide "*a broad range of therapeutic strategies including CBT* [cognitive behavioural therapy], *meditation and relaxation*" and added "*Her prognosis is good*".

370 Counsel assisting put to Dr Khong that other witnesses in the inquest described Charmaine as "*the happiest person in the room*" and "*over-joyous*" and "*the Energiser bunny*" (among other similar descriptors). Dr Khong accepted that she did not see these behaviours in evidence in her sessions. She accepted as accurate Dr Seidler's summary of her clinical notes (to be discussed later) that Charmaine's mood "*was persistently low throughout much of her work with Dr Khong and depression was an almost constant theme in their sessions*". Not only did Dr Khong not witness Charmaine when her mood was "up", she also did not obtain a history of her "ups" along these lines as Dr Berenson did.

371 Dr Khong said that whilst her approach to psychotherapy was informed by Buddhist practice, she did not consider her approach to be that of a "spiritualist". She said that she believed that the brain affected emotional states and that it would be too narrow to view these as being related to psychological causes only, which is an interpretation open on Buddhist teaching which sees all human suffering as grounded in psychological resistance to accepting the impermanence of life. She was interested in neuroplasticity, that is, the ability of

the brain to change through training. She said that mindfulness practices can lead to changes in the brain. She referred to a book entitled "The Mindful Brain" that discussed this idea. But she also agreed that there was a role for medication, which acts directly rather than (as mindfulness practice does) indirectly on the brain.

372 Dr Khong's records show that in the consultations from 18 January to 24 May she and Charmaine covered a range of issues including Charmaine's avoidance of confrontation, self blame, lack of self esteem, weight and body issues, perfectionism, fear of humiliation, need for acceptance by others, feelings of inferiority, homesickness and the need to take responsibility. The notes refer to Charmaine's negative ruminations and about meditation ("*Somehow can't do it*"; it was "*a chore*"; "*I try so hard. I want to*.") There was no evidence of a detailed mental state examination of the kind that psychology expert Dr Seidler said should have been done (see below).

373 The 24 May consultation was especially significant because it was at this time that Charmaine herself raised concerns about her highs and lows and specifically inquired about whether she might have a bipolar condition. Dr Khong accepted that she covered a number of issues on this day – seven were noted in evidence – in addition to the discussion about a bipolar condition.

374 According to her notes Dr Khong consulted a book that listed a number of criteria "A" through "E" that described the condition known as "mania". The notes refer to each of these and next to each appear the words "*No*" or "*Don't have*". Dr Khong eventually accepted that she conveyed to Charmaine what she believed to be the case, namely that she did not have a bipolar disorder. She maintained that she did not actually tell Charmaine that she did not have a bipolar condition, only that she did not meet the criteria). There is a note "*Happy don't have criteria*". The book also contains criteria "A" through "F" for another condition, "hypomania". In her evidence Dr Khong said she considered these, although her records say only that she considered the criteria "A" through "E" of "mania". She also said that she considered not only Charmaine's answers to the specific criteria but had regard to all of her sessions. Even if she did, Dr Khong never obtained the kind of history of highs and lows that Dr Berenson did. The

discussion about a bipolar condition on this day occupied only one part of a longer session in which seven other discrete issues were discussed. Dr Khong agreed it was not the major feature of the consultation.

375 Dr Khong eventually agreed that she never got a Berenson-like history from Charmaine at any time.

376 On any view of it the discussion about a bipolar disorder was cursory and focused on the criteria for "mania", which Charmaine did not have, and according to the notes which are a very reliable contemporary record, "hypomania" was not considered, although this is most probably what Charmaine had.

377 Charmaine saw Dr Khong for her ninth consultation on 27 July. This is when her emotional state worsened after the trip to Europe and she was writing of suicide in her diary on 20 July. The diary entries were discussed at the consultation. She agreed that Charmaine was presenting "*a fairly disturbing catalogue of troubles*" including a feeling of panic and being locked in, a fear of not being able to be a good parent because she would pass on her anxiety to her children, approaching sleep as an escape, and her suicidal thoughts. Dr Khong confirmed she was told of Charmaine's suicidal thoughts but added that she was also told that Charmaine did not have any plans to kill herself. She said that when the diary entries were written Charmaine reported her depression and anxiety as 10/10 but at the consultation it had reduced to about 6.5-7/10. She agreed that she did not refer Charmaine to a psychiatrist because her suicidal thoughts had subsided somewhat.

378 The plan of action for Charmaine was noted to be "Continue with counselling more regularly. Get as busy as possible and have a plan for each day." She also made a note: "Don't change the thoughts – change your relationship to your thoughts". She encouraged Charmaine to employ mindfulness techniques. She wrote in her notes: "Mindfulness – when you are low – use LAEBL. Differentiate between your mood and your thoughts. Experience feeling <u>I am negative</u>. Don't go to cognition."

379 Dr Khong said that she made a "contract" whereby she agreed with Charmaine to be "available to her to call any time that she would like to discuss anything". She noted Charmaine's reply: "Good, fantastic. Whatever it takes to continue the counselling. You are tough and good." Dr Khong then added a note "We will get through it". She explained that this was an example of the collaborative approach to counselling. It did not signal (or was not intended by her to signal) a movement in the therapist/client relationship towards a personal friendship. She considered her counselling with Charmaine to be "a shared journey through her problems".

380 The next session was on 2 August and Charmaine reported that she was feeling much better. The notes say that Charmaine described the C1-C2 exercise that Dr Khong had recommended as "*empowering, a thousand times better. Relief to feel normal and not biggest drama and to be crushed by drama*".

381 The following session was on 9 August and Charmaine's condition had deteriorated again. The notes say that she reported the following:

> *Feel like losing it, out of control, are you ready to give up on me? Easier to give up. Found it too hard. Want to find pleasure in and (be) positive. Nothing happened. The rollercoaster.*

382 On this occasion Dr Khong suggested referral to a psychiatrist, most likely to review her medication because Dr Clowes had recently increased the Efexor dose and Charmaine said she expected to be feeling better by then. But Dr Khong said she was also interested in a second opinion on diagnosis. Charmaine was resistant to the idea of seeing a psychiatrist. Dr Khong knew of her poor experiences with a psychiatrist in Perth and assumed this could have been a reason for the resistance.

383 There was a further note in the records: "Depression could be your friend because if you don't feel well, given a rest your body feels better". She explained that "sometimes depression is just your body telling you, you need a rest". She said in evidence that she was trying to give Charmaine different perspectives on her depression. In the same vein she also encouraged Charmaine to "embrace change". She agreed with counsel assisting that Charmaine was not looking for strategies to deal with her depression, she

wanted the depression to go away and she could not understand why this was so difficult.

384 Later in that consultation there are notes that Charmaine considered herself to be self-focused and self-absorbed and that she saw herself as a victim. Dr Khong encouraged Charmaine to get involved with voluntary work, which was something that she did already in Perth and enjoyed.

385 The next session was on 17 August and Charmaine reported an improvement once again. There was a note that her general practitioner, Dr Clowes, recommended against the psychiatric review that Dr Khong had suggested earlier. This appears to have been because Dr Clowes had said that it could take six weeks for the increased Efexor dose to take effect (although she had earlier said that she expected benefit with three weeks – and this explains why Charmaine told Dr Khong on the previous occasion that she expected to be feeling better by then). There was a note that Dr Khong explained "*thoughts create the depression and the depression creates the thoughts – mood is low, thoughts are negative*". She recorded Charmaine's response: "*True. Think your way out of it and it spirals and feels worse*". She agreed that her proposed strategies involved doing things that made Charmaine feel good and then to maintain her mood from dropping (examples were doing the C1-C2 dialogue, baking pancakes, writing emails, engaging in social activities, interests and hobbies).

386 Dr Khong said that she felt the reason why Charmaine's depression kept coming back despite long term use of antidepressants and increasing dosages of these is that she needed to address developmental issue, transition, taking responsibility and grief work. She was asked by counsel assisting whether biological reasons could be the cause of the recurring depressive symptoms and she agreed that they could be, but this was not discussed at this session because she dealt with the issues that Charmaine herself "*brought to the table*". (It should be noted that Charmaine clearly brought her concerns about mood swings and bipolar "to the table" on 24 May and she was reassured to learn that she did not meet the criteria for this condition.).

387 The next consultation was on 13 September. Charmaine reported "*All positive and exciting. Renewed confidence in myself. Also had busy social life"*. There was another note that Charmaine did not do meditation and an encouragement by Dr Khong "*Try to do some*". There was a note that she had not read the books that Dr Khong had recommended but intended to do so. Dr Khong wrote that mindfulness practice would "*create new circuitry*" in her brain. She said that every time her mind wandered Charmaine should "*just escort it back*".

388 There was a discussion about going deeper into foundational feelings, especially about childhood experiences. Charmaine was encouraged to let the anxiety of her childhood experiences go. "*Leave them behind*" but "*don't reject those experiences*".

389 The next consultation was on 28 September. There had been a marked deterioration. The notes of that session begin with Charmaine reporting: "*Wallowing in self absorption. Quite suicidal*." Charmaine denied any triggers for this change. The notes continue: "*Can't pull myself out of it. Makes everything worse. Can't concentrate. No confidence in doing things. Nothing to say to people. Have been trying. Went through notes (C: cried) trying to practice MP (mindfulness practice) and what is the pattern. Interaction with people quite bad*".

390 Charmaine told Dr Khong that she had suicidal thoughts. She had no plan but was "*thinking of a way that is easy*". At this point Dr Khong again raised the prospect of review by a psychiatrist. Charmaine agreed to get a referral from her GP to see Dr Tang. At this same consultation Dr Khong discussed the book "The Mindful Brain" and how mindfulness practice could alter brain circuitry. There are diagrams in her notes explaining this process.

391 The notes indicate that Charmaine felt angry and frustrated about her condition, "Angry at how I got here and getting worse…. Anger at myself, can't see anything positive and differently. Self destructive. Take myself out of the equation – not a player". In her evidence Dr Khong insisted that these comments did not relate to suicide but rather to the technique of distancing her "self" from her problems, however, it is difficult to see how words like self

destructive and taking myself out of the equation relate to distancing oneself from one's problems.

392 At this point Dr Khong urged self-compassion and Charmaine's reply queried, "*Whether giving myself too much compassion and get on with it*".

393 There was a discussion about a "contract" for Charmaine to call Dr Khong and the notes say

Khong: *to call me*

Charmaine: *Don't like to bother people*

Khong: *I am happy for you to. Call if you feel a need to. How do you feel now*

Charmaine: *Good*

Khong: *How do I know that you not just kidding me. How do I know that?*

Charmaine: *You don't.*

Khong: *Is it true – feeling good?*

Charmaine: *Mostly. It isn't the dead end I thought it was previously.*

394 Dr Khong agreed that this "contract" was not one whereby Charmaine agreed not to harm herself, or to call her if she ever had thoughts of harming herself. Rather it was a reminder that she was available for Charmaine if she felt a need to talk.

395 Dr Khong was asked whether she agreed that giving hope was an important issue in preventing suicide in that it gave a person something to live for. She said she did agree with this. She also agreed that the referral to Dr Tang could fairly be interpreted as giving her hope.

396 Regarding the referral to see Dr Tang, there was a reference in Dr Khong's notes to an "urgent" appointment. Dr Khong called Dr Tang straight away to organise a consultation. Dr Tang explained that unfortunately she was not available to see Charmaine for another 18 days. Dr Khong did not arrange an

appointment with another psychiatrist. There was a lengthy exchange with counsel assisting about this "urgent" phone call for an appointment with Dr Tang, made in light of Charmaine's suicidal thoughts, that was not to take place for another 18 days. Dr Khong said that she responded to the urgency by making an urgent phone call to Dr Tang. When it was put to her that what Charmaine needed was not an urgent phone call but rather an urgent appointment, Dr Khong would not respond directly.

> *Q. And will you agree with me that the telephone arrangement for a referral 18 days hence at least is not an urgent referral for psychiatric review?*
>
> *A. Mr Hirsch, I do not have any more things to add to the description of urgent, I have explained it many, many times, it would be your interpretation I'm sorry I cannot elaborate further on that.*

397 In later evidence Dr Khong denied that Charmaine needed an urgent psychiatric review because of her emotional state on 28 September. As will be discussed below, the expert evidence was that Charmaine did require an urgent appointment with a psychiatrist at that stage and Dr Khong should have organised this. Not only did the experts say that an urgent appointment was necessary, so did Dr Tang when counsel assisting put to her the details of Charmaine's presentation to Dr Khong on that day.

398 Dr Khong made notes of her phone call to Dr Tang. The notes say: "Briefed Dr Tang that Charmaine has several episodes of depression and high anxiety relating to development issues of self-esteem". There was no note that she told Dr Tang that the reason for the appointment was because Charmaine had once again been feeling suicidal. Dr Tang said that she was not informed of this. Dr Khong said that she could not remember the phone call in detail.

399 I am satisfied that although Dr. Khong made an urgent phone call, she did not tell Dr Tang about Charmaine's renewed suicidality because if she did it would have been in her notes.

400 During the 18 days between Dr Khong's phone call to Dr Tang on 28 September and the consultation with the psychiatrist on 16 October there were a number of events. Charmaine saw Dr Berenson on 29 September and obtained the

referrals to Dr Tang and Professor Parker. She then went to Perth for the Purple Twilight walk for breast cancer when she met Ros Worthington and discussed her husband's battle with depression and suicide. There was also the visit from her mother and grandfather back in Sydney when Charmaine was deeply depressed, told her mother that she had to "*get out of herself*" and had been given two referrals to two psychiatrists. Mrs Dragun relates that when she and Charmaine's grandfather left her on 10 October Charmaine was in tears.

401 On 12 October Charmaine had her 15th appointment with Dr Khong. According to the notes Charmaine reported that things were not going well. Her mindfulness practice was not working. She felt overwhelmed by the Brad Hodson video project. She had bought The Mindful Brain but had not read it yet. She rated her depression as 9/10. She had suicidal thoughts but no plans – but was thinking of a method that was "*quick and easy for example step in front of a truck/bus*". When asked by Dr Khong if she would do that the notes say that Charmaine felt that this would be "*callous especially to Simon and family. Having so much support from Simon and family hard to (illegible). Makes no sense. No control over feelings. I'm thinking it out*."

402 At this point Dr Khong considered it was necessary to change Charmaine's mood and decided that a walk in nature would do her some good. A note in Dr Khong's records reads:

> *CD (Charmaine) was feeling depressed and thoughts are negative. Although doesn't have suicide plan do have negative thoughts. BK (Dr Khong) decided that more important to change her mood presently… Discussed with CD about change of mood by going to National Park. Explained the rationale. CD agreed. BK drove CD to Bobbin Head National Park and do mangrove walk – use it as meditation to reduce rumination and experience here and now. No 2 drops of water are the same – same as thoughts and feelings. Also watched crabs.*

403 The Bobbin Head walk made a profound impact on Charmaine. As she noted in her diary (referred to above):

> *The National Park experience is a watershed event which must be remembered.*
>
> *Interdependent and interconnectedness: learning lessons from nature and feeling like a part of the universe. Buddhism believes that once you are*

able to see yourself in the bigger community your concerns become reduced.

Going to the National Park made me feel calmer, if not instantly brighter - and that calmness changed the circuitry from the right to the left of the brain...Belinda asked me to focus on the river and the crabs and nature - all except my thoughts - to take me out of the black hole...

Going out into the world and focusing on elements of nature - raindrops, animals, clouds, trees with falling leaves (trees don't cry when they lose their leaves so why should I fear change and loss?) Let nature be your guide and teach you.

404 Dr Khong offered not to charge Charmaine for this consultation but Charmaine said that she would pay as this was part of mindfulness practice. Counsel assisting suggested that perhaps the reason to offer not to charge her was because the walk to Bobbin Head was intended as an act of friendship and compassion and not part of "commercial therapy". Dr Khong disagreed. She said there were "*several other times*" that she offered not to charge Charmaine for consultations because she knew the cost of therapy was a concern for her. There is no record of any such offers in the notes other than the one on 12 October. There is nothing in Charmaine's diaries about any other offers by Dr Khong to waive payment, much less "several" of these.

405 Clearly for treatment to be effective it is necessary to maintain a therapist/client relationship. There was disagreement among the experts as to whether the walk was "out of the ordinary" crossing that therapist/client relationship line and moving towards "friendship". It might be seen that offering to waive payments was evidence that the relationship with Charmaine was more "friend" than therapist, but to make findings in relation to that I would need evidence of whether her treatment of Charmaine differed in relation to her treatment of other patients.

406 What is clear, in my view, is that Charmaine treated Dr. Khong more as a friend than a therapist and that impacted on the effectiveness of her treatment.

407 Four days after the Bobbin Head walk Charmaine had her first and only consultation with Dr Tang. Dr Khong spoke with Dr Tang over the phone on 18 October and made detailed notes of what Dr Tang had said about the

consultation on 16 October. The relevant points from these notes are detailed below in the discussion on the evidence of Dr Tang. For present purposes it is sufficient to note that Dr Khong learned from Dr Tang that Charmaine appeared well on 16 October but had related that she had fleeting thoughts of throwing herself in front of a truck on the F3 freeway. These thoughts occurred on the way to the consultation on 28 September but Charmaine did not mention this to Dr Khong at the time.

408 Counsel assisting asked Dr Khong if she had told Dr Tang of Charmaine's further suicidal thoughts on 12 October and how she took her for a walk at Bobbin Head. This, he said, could explain why Charmaine seemed reasonably well when she saw Dr Tang on 16 October. Dr Khong's answers were evasive but ultimately she said "*I might have yes*".

409 I am satisfied that Dr. Khong did not tell Dr. Tang about the further suicidal thoughts on 12 October because if she had of it would have been in her comprehensive notes. Also, I accept Dr Tang's evidence that she was not told anything about this.

410 Dr Khong was not aware that Charmaine had thought about stepping in front of a truck. The first she heard of this was when Dr Tang mentioned this over the phone on 18 October. Counsel assisting referred to the "contract" between her and Charmaine that Dr Khong would, in effect, be there any time that Charmaine felt a need to call. (It was not a contract to call her if she ever felt suicidal or the urge to harm herself.) Evidently Charmaine did not feel a need to contact Dr Khong about this and did not even mention it at the consultation later that day.

411 Dr Khong did call Charmaine on 19 October. Charmaine was in Perth and feeling good. She had reduced her Efexor dose from 150mg to 112.5mg from 17 October. Dr Khong's notes record Charmaine saying that the Bobbin Head walk "*was a breakthrough*" and she was able to complete the Brad Hodson video afterwards (between 12 and 16 October). Dr Khong obviously considered that the walk might be responsible for her change in mood because she made a note to herself to see whether this mood change was the result of the new medication regime that Dr Tang had initiated or the result of the walk. This was never

followed up because Dr Khong did not speak with Dr Tang again after the phone call on 18 October.

412 The final consultation was on 24 October. Charmaine was feeling very good. The notes record her saying "Walk was so inspiring. Made a real difference. Able to get out negative thought and feelings. Surprise at how powerful the experience was." Dr Khong recorded her congratulations and Charmaine had completed the Brad Hodson video and also made a note that she was proud of Charmaine. Charmaine now reported that she was more mindful of her thoughts and feelings and was "doing meditation constantly".

413 They discussed Charmaine's consultation with Dr Tang and that she was feeling better when she saw her. "*I was feeling OK by then*". They discussed the Efexor reduction regime and the introduction of Lexapro. Charmaine said that she and Dr Tang would be in touch with each other by phone or text message to check on side effects. Dr Khong noted that Charmaine was "*grateful for all the support*" and that she now felt "*empowered and confident*". They discussed her volunteer work with the Cancer Council and her reading for the blind.

414 Dr Khong also raised the issue of the suicidal thoughts about stepping in front of a truck on the freeway (which Charmaine disclosed to Dr Tang but not to Dr Khong). Charmaine explained that the reason she did not mention it is that the thought was negative and fleeting. She added that she wouldn't have done it because "*it would upset her family and friends and everyone has given her a lot of support*." She was reminded of their "contract" but according to the notes this time the terms of the contract were not for her to call whenever she felt the need, but rather to call "*any time she has any negative or suicidal thoughts or thoughts about killing herself, hurting herself or to others*."

415 Counsel assisting then returned to the matter of the Bobbin Head walk and Dr Khong was asked what was discussed during the walk. She maintained that this was basically a silent meditation and there was not much discussion. She said that she could not recall anything in particular discussed during the walk. Counsel assisting pressed Dr Khong on this point because Charmaine's diary note ("*Going out into the world and focusing on elements of nature - raindrops, animals, clouds, trees with falling leaves (trees don't cry when they lose their*

leaves so why should I fear change and loss?)") contained imagery strikingly similar to something Dr Khong had written in the book chapter about Daseinanalysis and Buddhism. The relevant passage is as follows:

> *"In empowering clients to take responsibility we need to distinguish between the ability to see the problem and the ability to bear the problem that this insight brings. In addition to learning to see things realistically the Buddha also encourages people to accept them as they are. Acceptance does not imply becoming passive or fatalistic. It means learning to see the situation realistically and to come to terms with what the situation calls for. Take again the example of death. Dasein analysis believes that people cannot transcend existential anxiety concerning death. At best they can become aware of their fear of death. Adopting a different approach,* ***Buddhism maintains that people can learn to accept death without anxiety while they are still alive. Acceptance involves the insight that transitoriness or impermanence affects not only human beings but every phenomena in the world. As Dharma Nunda expresses poignantly, 'inevitably I'm going to die, so does every plant, every form, every living being, soon it will be autumn, the leaves will fall off the trees we do not cry, it is natural that is what leaves are supposed to do at the end of the season, human being experience the same thing'.*** *In other words if I understand and accept now that I am not exempt from what the Buddha refers to as possessing the nature to rise and pass away than anxiety concerning this happening to me can dissipate".*

416 The highlighted sentences bear a striking resemblance to what Charmaine wrote in her diary about the Bobbin Head walk. Dr Khong did not believe she had given this book chapter to Charmaine to read.

417 It seems to me to be too much of a co-incidence that shortly after the 'Bobbin Head' walk this note appears in Charmaine's diary

> *"trees with falling leaves (trees don't cry when they lose their leaves so why should I fear change and loss?)"*

418 The issue then is what should be made of the entry in Charmaine's diary, what did it mean for Charmaine?

419 There was then this exchange

> *HIS HONOUR*
>
> *Q. Just on that if it appears at least from the wording that she has got it from this particular passage about death and dying that somebody like Charmaine you see that there may be a risk, someone like Charmaine in*

a deep depression or anxiety or both that she may use this as a justification for taking her own life?

A. No your Honour because that's not the intent of this chapter.

420 I accept that it was not the intention of Dr Khong to "sensitise" Charmaine to the idea of dying and becoming accepting of this, but it may have had this effect. (See the concerns raised by Dr Seidler on this point.)

421 Dr Khong said that she kept an open mind about whether Charmaine's problems were biological in origin and not just psychological or, as counsel assisting put it, "existential". She did not consider Charmaine's problems with meditation being a sign of a biologically based problem; she said that many people have difficulty meditating. She said that even if Dr Cugadasan had sent her Charmaine's DASS scores showing anxiety, stress and depression in the "extremely severe" range, and even if she had sent her notes that refer to Charmaine "*feeling happy one minute really down the next*" it would not have changed her approach to Charmaine's management; she would have relied on her own assessment.

422 Dr Khong's approach to the management of Charmaine was so heavily focused on "mindfulness" that she failed to recognise the significance of the fact that this technique was simply not working.

423 I agree with counsel assisting that it was clear that Charmaine had difficulty meditating and Dr Khong should have seen this as a sign that there may be something wrong with Charmaine's thinking. Despite her stated interest in science, and in particular in "brain neuroplasticity" her approach was firmly rooted in getting Charmaine to develop "mindfulness". When mindfulness was not working and Charmaine was feeling suicidal, she considered that she should do something to lift her mood, hence the Bobbin Head walk, and also to have more self-compassion.

424 Counsel assisting submitted that Dr Khong's management could be criticised on a number of specific fronts.

425 First, he submitted that Dr Khong failed to take a proper history and perform a proper mental assessment of Charmaine at the outset. He referred to Dr

Seidler, the clinical psychologist who said that 1 in 10 people who consult a general psychologist like Dr Khong have an endogenous, biologically based mental illness. He said that Dr Khong failed to recognise that Charmaine was the 1 in 10 with such an illness and Dr Khong wrongly persisted in treating her as if she was in the 9 in 10 whose problems were more situational (in Charmaine's case, low self esteem, poor job satisfaction, fear of confrontation etc). This, he submitted, was due to Dr Khong's lack of clinical training and this was a consequence of her being able to obtain her credentials as a psychologist by going from a Bachelor's degree to a PhD bypassing the Master's Degree program where clinical training takes place.

426 The failure to recognise that Charmaine had a biologically-based mental illness continued past the initial assessment. Dr Khong failed to recognise that Charmaine's difficulties with meditation, and her worsening condition despite increasing Efexor, and her lack of any sustained improvement despite extensive psychotherapy from her all pointed to Charmaine having a much bigger problems than just *developmental issues relating to self esteem* (as she told Dr Tang) and she needed much more than *grief work* to *take more responsibility for her life*.

427 Second, he submitted that Dr Khong failed to properly address the issue of a bipolar condition even though Charmaine herself was worried about this and put it "*on the table*" at the consultation on 24 May. He said that Dr Khong's evidence that she considered a "hypomanic" condition should be rejected since her notes make it clear that only the criteria for a "manic" condition were referred to. He says that Dr Khong failed to explore Charmaine's mood swings properly because, if she did, she could have obtained the kind of history that the GP Dr Berenson did in a consultation that did not last much more than 30 minutes. He said that she failed to appreciate the clearly cyclical pattern of mood swings that did not have any apparent trigger.

428 Third, he submitted that it should be found as a fact that Dr Khong never told Dr Tang about Charmaine's suicidal thoughts when she made the "urgent" phone call to her on 28 September to arrange a consultation. All of the experts said that an urgent consultation was required. Dr Khong said she would have told

this to Dr Tang, but there is nothing about this in her records. Dr Tang said she did not know, and added that if she had been told of Charmaine's presentation on 28 September she would have told Dr Khong to make other arrangements because an appointment with her on 16 October would have been too late.

429 Counsel assisting said that the failure to tell Dr Tang about Charmaine's suicidality, and arrange an urgent alternate appointment, raised serious questions about Dr Khong's clinical judgment and knowledge.

430 Fourth, he submitted that it should be found as a fact that when Dr Khong took Charmaine on the Bobbin Head walk to lift her then suicidal mood, the walk was not an entirely silent meditation. He says it should be found that Dr Khong did encourage Charmaine to take a more accepting and Buddhist-like view of the impermanence of life and the necessity to accept change. This was calming, but it may well have had the unintended consequence of giving Charmaine the idea that it was alright to resign herself to dying. Both Dr Seidler and Dr Tang said that discussing impermanence with a person who was contemplating suicide was not wise.

431 Fifth, counsel assisting submitted that Dr Khong could be criticised for not alerting Dr Tang during the phone call on 18 October that just four days before the consultation on 16 October, when Charmaine was described as "*Energetic. Seems well*", she had been suicidal and rating her depression as 9/10. Her mood only lifted following the Bobbin Head walk. Dr Tang said that had she been aware of this she would have called Charmaine back for a further assessment when she would have explored the issue of a bipolar condition more deeply.

432 Finally, counsel assisting submitted that the therapeutic relationship between Dr Khong and Charmaine was troubling. He said that whilst Dr Khong should be accepted when she said that she never saw Charmaine as a "friend" the fact is the Charmaine appeared to consider Dr Khong this way. He said that the fact that the consultations were long (usually 1.5 hours or more whereas most therapists' sessions were 1 hour), comments like Dr Khong saying "I am proud of you" (regarding the completion of the Brad Hodson video) and the "contract" to

be available 24 hours a day, 7 days a week of Charmaine felt the need to talk were all matters that could compromise the therapeutic distance required in an effective therapist/client relationship. It may be relevant to this point that Charmaine did not disclose to Dr Khong that she had thoughts of throwing herself in front of a truck prior to one of their sessions, and that she resisted the offer of a "24/7 contract" by saying she did not want to be a burden.

433 Counsel for Dr Khong made submission on her behalf.

434 Dr Khong's counsel submitted that Dr Khong "went through the criteria" for both manic and hypomanic episodes when Charmaine raised concerns about a bipolar condition at the 24 May consultation. He said "*the history obtained did not fit the criteria*" even though "*the analysis took account of the entirety of the observations and history to (the then) date*". He added that the criteria for "mania" and "hypomania" are nearly the same, and patients do not complain about their mood when they are feeling good.

435 This submission ignores the fact it was Charmaine herself who raised the concerns about mood swings; it's not as if Dr Khong had to cleverly "spot" them. Also, a Berenson-like history was available if only Dr Khong knew to ask the right questions. Also, on this day the discussion about a bipolar condition was only one of seven issues covered in that consultation. Dr Khong accepted that she never saw Charmaine when she was "up" and never obtained any history of her being "up".

436 Her counsel submitted that even if Charmaine did have a bipolar condition the psychological treatment would be the same.

437 In my view this ignores the fact that if the bipolar condition is recognised and properly treated then it will be possible for psychological interventions to have some effect. In this case Charmaine was constantly troubled by the "white noise" of her mind and could not get the mental chatter and ruminations to stop

438 Her counsel submitted that Dr Khong's treatment was appropriate and included not only mindfulness but other behavioural coping strategies endorsed as

conventional by her peer, Dr Seidler. The C1-C2 dialogue, that Dr Phillips did not endorse, was considered conventional by Dr Seidler.

439 I agree, but they did not appear to be working in any sustained way because Charmaine would be feeling good for one or two sessions and then awful for the next one or two and then good again a constant theme in her battle against her illness.

440 Dr Khong's counsel submitted that there was nothing inappropriate about the Bobbin Head walk and that Dr Phillips and Dr Seidler both thought that a change of scenery can be a good thing.

441 Dr Seidler said she would not have done it because it did not fit her therapeutic "style" but it was consistent with Dr Khong's philosophy.

442 Her counsel further submitted that "any criticism in relation to the transfer of information as regards suicidal ideation is causally irrelevant in circumstances where all parties owe independent duties and the treating psychiatrist obtained a history of suicidal ideation. Basically, he was saying that Dr Tang should have obtained a more complete history of Charmaine's suicidal thoughts since she obtained at least some information about this.

443 With all due respect this ignores a key fact of this case and that is that these doctors/psychologists should be working TOGETHER. By the end of September Dr Khong had the benefit of 14 sessions with Charmaine and she was speaking about suicide at the end of July as well as the end of September. Dr Khong cannot escape criticism for not telling Dr Tang that the reason for the "urgent" phone call included that Charmaine was suicidal on the day by saying that Dr Tang could have discovered this herself two weeks later!

PSYCHIATRIST

DR WAI MUN TANG

444 Dr Tang prepared a statement and gave evidence at the inquest.

445 Dr Tang is a consultant psychiatrist. She obtained her Bachelor of Medicine degree in 1987. She began working in the field of psychiatry in 1989 and obtained a Fellowship of the Royal Australian and New Zealand College of Psychiatry in 1996. She describes her areas of interest as "*adult general psychiatry, with a specialty interest in the integrative use of orthodox, complementary and traditional medical perspectives and treatment modalities in mental illness.*"

446 Dr Tang saw Charmaine only once, on 16 October 2007. She had "telephone discussions" with her on 18, 22, 26 and 29 October and finally on 1 November 2007. Her clinical notes record details of the consultation and the phone calls. The notes of the phone calls on 26 and 29 October and on 1 November were written in retrospect after she had learned that Charmaine had died.

447 The evidence of the history obtained by Dr Tang, what her impressions were and what she told Charmaine, comes from several sources: Dr Tang's statement, her notes, the notes of Dr Khong who discussed the consultation with her, what Charmaine related to others, and Dr Tang's oral evidence.

448 According to her statement the history obtained included the following relevant matters:

- The consultation was arranged by Dr Berenson at the request of Dr Khong for review of her psychiatric condition and management specifically in regard to her medication.
- Charmaine told her that she suffered from recurrent major depression and an anxiety disorder associated with significant obsessional and perfectionistic traits, which were longstanding and chronic.
- She had suffered from anorexia nervosa in her teens but this was in remission.
- She expressed low self esteem and assessed herself and her work performance critically despite her career success and the positive social regard she was held in.
- She did not allow her depression and anxiety to impact on her work performance or public presentation.

- She described herself as a private person who was very close to and supported by her family and her fiancé (Simon) who were aware of her illness.
- She said that her symptomatology was fluctuating despite treatment with Efexor at 75 mg for a period of years.
- She said that she started to see Dr Khong in February 2007 and was being treated with mindfulness based cognitive therapy and also attempting a number of lifestyle changes.
- Despite the Efexor and the treatment by Dr Khong she reported limited improvement "*and as a result Ms Dragun independently increased her dose of Efexor to 150mg daily approximately 3 months early (July 2007) in a further attempt to improve her condition. Ms Dragun told me that she had increased the Efexor without medical advice and it was this event which prompted Dr Khong to recommend that she should be reviewed by a psychiatrist*".
- She said that the increased Efexor did not result in any improvement and she had "*possibly became more agitated following the increase*".
- She said that she had been on Zoloft from the age of 18 until 2004 when she stopped this on the advice of an iridologist and her condition deteriorated thereafter. In August 2004 she saw her general practitioner who commenced her on Efexor 75mg.
- She said that in January 2006 she attempted to stop taking Efexor but recommenced this in April when symptoms of depression and anxiety returned.
- Her Efexor was increased to 112.5mg in November 2006 and this resulted in a significant improvement over her condition in December 2006.
- Her condition deteriorated in February 2007 and this led to her seeing Dr Khong.
- "*Approximately 3 months before seeing me in October 2007 Ms Dragun independently increased her Efexor to 150mg a day*".
- On being asked about suicidality Charmaine told Dr Tang that "*her condition had deteriorated six weeks prior to seeing me on 16 October 2007…in the context of severe performance anxiety and self doubt in relation to*

undergoing a video project for a friend". This period of worsening depression and anxiety led to an episode approximately a week and a half prior to the consultation on the 16th at which time Charmaine reported "*a brief episode of feeling acutely suicidal with plans to throw herself in front of a truck on the F3 freeway*". Charmaine reported "*snapping out of it stating that she would never hurt herself for the sake of her family and fiancé. Ms Dragun told me that although this was the closest she had come to planning a suicide, yet, she considered it to be such a minor incident that she did not report it to her psychologist whom she saw shortly after*."

- She said that her mental state had improved since finishing the video project for a friend. She denied any ongoing suicidal ideation.

449 It is noteworthy that Dr Tang did not understand suicidal thoughts to be the reason for Dr Khong wishing Charmaine to see her; the reason was to review her psychiatric condition and management specifically in regard to her medication. Dr Tang's history was incorrect about the increase in Efexor because it was done on the advice of the general practitioner Dr Clowes, not on her own, and without medical advice. Charmaine was agitated because there was no improvement after three weeks, despite Dr Clowes telling her she could expect improvement by that time.

450 There is no note that Dr Tang was told that the improvement in Charmaine's mood shortly before seeing her on 16 October was precipitated not simply because Charmaine had finished the video project, but because of Dr Khong's Bobbin Head walk on 12 October which was taken because Charmaine assessed her depression as 9/10, had suicidal thoughts but no plans, but was thinking of a method that was "*quick and easy for example step in front of a truck/bus*". It was the Bobbin Head walk that led to the calmness that led to her being able to finish the Brad Hodson video.

451 According to the statement Dr Tang's impressions and treatment plan were as follows:

- Dr Tang considered there was "*a significant biological component underlying Ms Dragun's depression and that pharmacological treatment had been sub optimal to date".*
- She wanted to optimise Charmaine's condition pharmacologically in order to stabilise her so that the non-pharmacological treatment by Dr Khong could be

more effective. The non-pharmacological treatment included fish oil supplements, exercise and acupuncture.

- She wanted to change the antidepressant from Efexor to Lexapro because she thought that there was increasing agitation when the Efexor was increased from 75mg to 150mg. Lexapro was selected "*for its low side effect profile and efficacy*".
- She instituted a gradual reduction of Efexor and a gradual introduction of Lexapro and would monitor side effects with telephone contact every 2 to 3 days. The first reduction of Efexor was to be from 150mg to 75mg, which was commenced on 17 October (the next day).
- The withdrawal effects from the reduction of Efexor that she intended to monitor were "*in the form of headaches, nausea or agitation*". The adverse side effects of the introduction of Lexapro were "*particularly agitation, anxiety or suicidality*".
- She discussed her impressions and treatment plan with Dr Khong on 18 October.

452 Importantly there is no mention in the statement that Dr Tang ever considered that Charmaine might have a bipolar condition. There is nothing in the statement about wanting to inform Charmaine's family or Simon to watch for side effects, despite a note that Charmaine was close to both and they knew of her treatment.

453 According to the statement Dr Tang the follow up phone calls with Charmaine included the following:

- On 18 and 22 October Charmaine reported that she remained well and had not experienced any withdrawal effects or changes in her mental state from the reduction of Efexor from 150mg to 75mg. There are contemporaneous notes of these phone calls.
- On Friday 26 October Charmaine reported a flattening in her mood. Dr Tang considered this to be due to the reduction of Efexor for the last 8 days. She instructed Charmaine to start taking the Lexapro at 5mg increasing to 10mg if she did not have any side effects.
- On Monday 29 October Charmaine's mood remained flat but had not noted any adverse effects from the Lexapro. She was instructed to increase the

Lexapro to 10mg and keep the Efexor at 75mg "*while we waited for the therapeutic dose of Lexapro 10mg to take effect*".

- On Thursday 1 November Charmaine's mood continued to be flat as it had been all week. She denied any adverse effects and "*specifically she denied any increase in agitation or anxiety*" and also "*she did not report or exhibit any signs of suicidal ideation*". She discussed that there had been no improvement with Lexapro as yet but it was a fast acting drug and "*it was not uncommon for patient to experience improvement within the first week of treatment*". She recommended a further increase in the dose of Lexapro over the weekend if there had been no improvement yet.

454 The contemporaneous notes of the phone calls on 18 and 22 October are consistent with Charmaine's positive frame of mind when she was in Perth for a fundraiser event and her friend's wedding.

455 The notes on 26 and 29 October and on 1 November were not contemporaneous but written after Dr Tang learned that Charmaine had died. Charmaine may have reported a flattened mood on 26 October, but Emma Ritchie did not see this when Charmaine joined her and her friends at the Sandringham Hotel in Newtown that evening after work. Charmaine certainly was agitated on 27 October, the day she commenced the Lexapro, as Emma Ritchie described during the drive to the Josh Pyke concert at the Enmore Theatre. She was also distant and confused and had the troubled look identified by Tim Webster when she visited Selina Day for the "Scrabble challenge" on 28 October, after spending the afternoon at Watson's Bay.

456 If Dr Tang's retrospective notes were correct then Charmaine did not report any of this agitation or deterioration in her mental state when they spoke on 29 October. The reference on 29 October to wanting to wait for the therapeutic dose of Lexapro to take effect is consistent with Charmaine telling her mother and Sarah Bamford that she expected to feel better and could not understand why the treatment was not working, and also with Charmaine telling her mother that Dr Tang had wanted her to wait a few more days for the drugs "*to kick in*". Also, Charmaine had increased her Lexapro dose from 5mg to 10mg on 29 October off her own bat – even before she spoke with Dr Tang.

457 Dr Tang's handwritten notes were transcribed and typed by her solicitors and then reviewed by her.

458 By and large the notes mirror Dr Tang's statement but provide some further, accurate details including about Charmaine's family, when Simon moved to Sydney and about how she found her job as a newsreader unsatisfactory and boring. The notes include a reference of an acute worsening of the depression some two weeks before seeing her (this would have been at the time of Dr Khong's "urgent" phone call) and also notes about "*decreased concentration, decreased memory, increased anxiety, insomnia, mind churning+++… negative cogitations+++ verging on irrational*".

459 The notes say that Dr Tang's impression was that there was a "*seasonal component*" and "*no clear mania*".

460 There is a further note of Dr Tang's impression and this made reference to the 5 axes of the DSM IV (the Diagnostic and Statistical Manual used to make diagnoses in psychiatry) as follows:

> I Recurrent Major Depression – Anxiety disorder – AN (anorexia nervosa) in past with current remission
>
> II Obsessional – Perfectionist traits
>
> III -
>
> IV
>
> V GAF (Global Assessment of Functioning) 60-80/90

461 Dr Tang made notes of the findings on her mental state examination as follows:

> Energetic, well today
>
> But recent 6/52 of symptom
>
> ? BPD (bipolar disorder) – but little evidence at present
>
> Some SAD (Seasonal Affective Disorder) component
>
> Obsessive

To discuss full gammit of Rx next session

462 Dr Tang made some notes from her telephone conversation with Dr Khong on 18 October at which time she discussed her findings on 16 October, her impressions and her treatment plan. These notes say

D/C with Belinda Khong x 30 min re my impression.

Informed re episode of suicidal ideation. No risk now.

Clear biological component

Suboptimal Rx. Psychosocial precipitant does not warrant extent of symptom.

Plan → stabilise with meds then

Non pharmacological Rx including meditation /Omega 3 etc

+/- joint session with Belinda and myself

? SAD / bipolar → to observe

? mood stabilisers if necessary

Follow up with Belinda weekly

Myself 4/52 with stabilising on new meds monitored on phone

463 The transcribed notes provide further evidence of the detailed history that Dr Tang was able to obtain from Charmaine and the description of her most recent depressive episode that included *mind churning+++… negative cogitations+++ verging on irrational*.

464 The reference in Axis II of the DSM IV criteria is to personality traits and, as was explained in the expert evidence, if there was a borderline personality disorder it would be recorded here.

465 Dr Tang made three references relevant to the possibility of Charmaine having a bipolar disorder. The first is her note that there was a "*seasonal component*" and "*no clear mania*". The second is her note: *? BPD (bipolar disorder) – but little*

evidence at present - Some SAD (Seasonal Affective Disorder) component. The third is her note: *? SAD / bipolar → to observe - ? mood stabilisers if necessary.*

466 It is significant that there is an absence of any reference to a borderline personality disorder in Axis II of the DSM IV criteria, and the three references to a bipolar condition.

467 Dr Khong also made notes from her telephone conversation with Dr Tang on 18 October. Her notes included the following points:

- There could be a biological component to Charmaine's depression because there were no obvious social triggers
- The increase in Efexor from 75 mg to 150 mg appears to have caused some agitation
- Dr Tang would be phasing out Efexor and phasing in Lexapro to avoid elevated side effects with the two types of antidepressants
- The plan called for 10 days to get off Efexor with Lexapro to be introduced on day 9
- Dr Tang would be calling Charmaine to discuss side effects
- The side effects of getting off Efexor could be headaches and nausea, which could wear off in 2 to 4 weeks
- Charmaine would not be seeing Professor Parker because she was happy for Dr Tang to manage her treatment
- Bipolar and seasonal affective disorders were discussed
- There was a note that there was no sign of mania but there could be a Bipolar II disorder but currently no sign of this
- Charmaine had related that she considered stepping in front of a truck and Dr Tang thought that the Efexor might be causing some agitation
- Dr Tang recommended
- Adjustment of medication to stabilise her mood first
- Mood stabilisers – lithium, fish oil + anti-depressant – Lexapro
- Regular exercise – walk, massage, yoga and meditation
- Medication for a while – calm down brain neuroplasticity in order that she (Dr Khong) could help her on cognition
- Dr Tang believed there was a cognitive-biological component

468 Comparing the notes of Dr Tang's and those of Dr Khong it is clear on the face of these that Dr Tang had entertained the idea that Charmaine may have had a bipolar condition, but there was no evidence of "mania" at the consultation on 16 October.

469 Khong recorded that Dr Tang considered the possibility of a *Bipolar II disorder*. The reference to the use of lithium as a mood stabiliser is consistent with Dr Tang having considered the possibility of a bipolar condition.

470 Dr Khong also noted the side effects from Dr Tang's plan to gradually decrease the Efexor and introduce the Lexapro; these were *headaches and nausea, which could wear off in 2 to 4 weeks*. There is no mention of other drug effects like agitation, worsening depression or suicidality. There is also no mention of Dr Tang wishing to discuss side effects with Charmaine's family or with Simon in order to assist in monitoring during the proposed new drug treatment.

471 One would have thought that if Dr Tang had that in mind she would have spoken about it to Dr Khong particularly if she were having difficulty in getting Charmaine to involve her family and partner she could have enlisted the assistance of Dr Khong.

472 The evidence from Charmaine's mother and from Simon is also relevant to what Charmaine had understood from her consultation with Dr Tang on 16 October.

473 Charmaine's mother said that Charmaine seemed elated and excited that there seemed to be a light at the end of the tunnel that Dr Tang was offering her revolutionary style treatment that would really help her overcome her condition. When she was asked what, if anything, Charmaine had told her about side effects from the new drug treatment the answer was "Nothing, no, it was all – it was going to be positive".

474 Simon's evidence about what Charmaine had told him after seeing Dr Tang was this:

> *She told me that psychiatrists reduce medication over a period of time coming off one completely before starting a new medication. The Doctor she was seeing (Doctor Tang) was going to do this over two weeks and*

> *supplementing her dosage with fish oil tablets. It was my understanding that she was initially reducing the Efexor 150 mg per day and a couple of days in to it starting to take the new medication gradually. Charmaine told me that she was supposed to have daily contact with the Doctor whist she was going through this. Charmaine wanted to see the change and the potential decrease in side effects going onto the new medication. She implied that she wanted to do this quickly rather than a gradual process.*

475 The weight to be given to this evidence is limited insofar as it purports to be what Dr Tang actually told Charmaine, however, because of its hearsay nature.

476 It is against this background of evidence from Dr Tang's statement, her transcribed notes, the notes and Dr Khong and the evidence of Charmaine's mother and Simon that Dr Tang's oral evidence needs to be assessed.

477 Dr Tang was taken to the evidence of Charmaine's mental state on 28 September when she saw Dr Khong and Dr Khong's notes say that Charmaine was "*wallowing in self absorption"* and *"quite suicidal*", that there were no triggers and that whilst she denied any suicide plan was "*thinking of a way that is easy*". She said that if Dr Khong had told her over the phone during the "urgent" phone call to arrange a consultation then she would have told Dr Khong to organise a more urgent referral to a psychiatrist or even admission to hospital because she (Dr Tang) would not be able to see Charmaine before 16 October.

478 Dr Tang said she was not aware of the Bobbin Head walk on 12 October and how this lifted Charmaine's mood. She said that if Dr Khong had told her of the Bobbin Head walk and how this took place after Charmaine again reported severe depression and suicidal thoughts, then she would have reconsidered Charmaine's "energetic" presentation to her on 16 October. She said that she would have wanted to explore this more fully and would have brought Charmaine back to her for an assessment in light of this information. She said that if she had known about the events on 12 October she would have explored with Charmaine any triggers for her descent back into depression that led to the Bobbin Head walk (Dr Khong noted "*no triggers*") and would have been more alert to the prospect of a bipolar disorder.

479 Dr Tang said that she understood that Charmaine had increased her own dose of Efexor without medical supervision and that this came from both Dr Khong and from Charmaine. She recalled the conversation with Dr Khong on 28 September and said "*it was Dr Khong expressing a concern that she was managing her own medication and hadn't actually seen a psychiatrist in regards to it*". Dr. Tang was apparently unaware of the involvement of Dr Clowes in increasing the medication from 112.5mg to 150mg, however, I am not certain if having this knowledge would have made any difference to her treatment.

480 Dr Tang explained that she considered there was a significant biological (as opposed to psychological or social) component for a number of reasons. These included the history of anorexia nervosa at the age of 18, the chronic nature of the depression, although with fluctuations of major depression, there were neurophysiological components including sleep and appetite disturbance, weight loss and concentration problems and the fact that when she stopped the Zoloft and Efexor on previous occasions her depression worsened. There were also persistent thinking problems like churning and negativity that she could not be talked out of and did not alter with psychological techniques. She also said that in this case Charmaine's inability to meditate was another indicator of a significant biological component to her problems.

481 Dr Tang said that Charmaine did not want to be on antidepressants at all:

> *Her preference was not to be on antidepressants. She, she saw it very much as a sign of failure, that there was something flawed about her and being on antidepressants meant that she was flawed.*

482 Dr Tang said that she explained to Charmaine that since there was a significant biological component to her condition she would need to be on medication. She said that being told that she was responsible for how she felt (which was one of the themes of the treatment with Dr Khong) "*certainly could have been interpreted by her in an unhelpful way*".

483 Counsel assisting took Dr Tang to the typed transcript of her note in which there is an entry:

> *BPD (bipolar disorder) but little evidence at present*

484 Dr Tang said that the reference to BPD was not to "*bipolar disorder*" but rather to "*borderline personality disorder*". She said that what appeared in the transcript (the words *"(bipolar disorder)*") was typed by her legal advisers and was an error that she overlooked in her review of that transcript. She said that she did enquire of Charmaine whether she may, in the past, have had any manic or hypomanic episodes. She said that she obtained no evidence to support any such episodes.

485 Counsel assisting put to Dr Tang the history obtained by the general practitioner Dr Berenson which dealt with Charmaine's periods of being very "up" and not just her periods of being very "down". She accepted that she obtained no history of the kind obtained by Dr Berenson.

486 Dr Tang accepted that the issue of a bipolar condition was discussed with Dr Khong over the phone on 18 October, and this is corroborated in Dr Khong's detailed notes. But Dr Tang said that the issue was raised by Dr Khong herself, and not by her:

> *I remember Dr Khong also stating that she could glean no history in the time that she had known her, there was no evidence for her that she had bipolar. I said and I recall saying that, "although we could not confirm the diagnosis, it was something that we needed to look out for as a differential."*

487 Although Dr Khong's notes of Dr Tang's conversation with her on 18 October refer to the possibility of Charmaine being given lithium – a mood stabiliser commonly used in the treatment of a bipolar disorder – Dr Tang said that she was not thinking of a bipolar disorder when lithium was discussed. She said that she was thinking of other kinds of therapy for depression if there had not been an adequate response to her new treatment plan of removing the Efexor and treating with Lexapro.

488 The expert psychiatric evidence took the reference to lithium to mean that Dr Tang was actually contemplating that Charmaine could have a bipolar condition and that this needed to be watched. They considered this to have been a sign that Dr Tang was appropriately open minded about the bipolar issue (and the reason it was not more prominent in her thinking was that she had not been

given a more complete history from Dr Khong either at the time of the "urgent" phone call on 28 September or during the phone call on 18 October). But in her evidence Dr Tang maintained that the reference to lithium had nothing to do with the possible future treatment of a bipolar condition.

489 The evidence that she was thinking of a bipolar condition is overwhelming. And I can only surmise that the reason she is adamant that the reference to BPD was a reference to Borderline Personality Disorder is that she is trying to run from any potential criticism that having thought of it she should have explored it more fully at the consultation on 16 October.

490 Dr Tang explained that her plan to reduce the Efexor called for a reduction from 150mg to 112.5 for 5 days, and then a reduction to 75mg at which point the Lexapro would be introduced. She denied that her plan was to stop the Efexor at that stage. She said she intended to keep Charmaine on both Efexor 75mg and Lexapro and see how she went with this before reducing and ultimately removing the Efexor. This is not consistent with Dr Khong's notes which appear to suggest that the Efexor would be eliminated after about 10 days. It is also not consistent with the evidence of Simon who understood from Charmaine that she would be off the Efexor in about two weeks. It is also not consistent with Charmaine's daily diary which notes what her Efexor and Lexapro doses were supposed to be for each day, and the Efexor dose ended on 31 October (there was no notation to take any more Efexor after that date). Dr Tang said in evidence that she expected Charmaine would still be on Efexor for another one to two months, depending on how she responded to the Lexapro.

491 think the evidence is actually unclear about just how long Dr Tang wanted to keep Charmaine on the Efexor, but Charmaine's belief was that she would be off this quite soon.

492 Dr Tang explained that she had intended to see Charmaine again and an appointment was made for 13 November. She said

> *I'd actually asked her at the time to see her sooner and the reason is because my usual practice is to see a patient within two weeks of seeing them initially, so we could just follow up and touch base, but she had, she stated that she was too busy in term of her schedule, she told me she was*

going to see Dr Khong every week and so we booked her in on the 13th at 10'o'clock.

493 It is true that Charmaine was busy – but only in the first week of the new treatment because she was in Perth. She was back in Sydney on 22 October because she attended Brad Hodson's birthday dinner. She did see Dr Khong on 24 October and reported that all was well. But Dr Tang knew from the phone call on 26 and 29 October and again on 1 November that Charmaine was not well; her mood was flat and she was asking why she was not feeling better. Even with this change, which Dr Tang said she thought was due to the reduction of the Efexor dose, she did not organise a face to face consultation with Charmaine

494 Counsel assisting took Dr Tang to Dr Khong's notes of their telephone call on 18 October. The notes say that Dr Tang told her that the "*side effects of getting off Efexor could be headaches and nausea*" and that this could wear off "*in two to four weeks*". She said that she would have told Dr Khong of other side effects like "*agitation, anxiety, sweating, some depression*". She also said she would have discussed with Dr Khong "*the potential of the suicidality re-emerging, primarily because it's, I guess it's the most important symptom*". But there is no note of any of this having been mentioned.

495 Dr Tang said that she told Charmaine about the side effects of nausea and headaches, but would also have specifically informed Charmaine about the risk of agitation and suicidality when coming off the Efexor. She accepted that at the time of the consultation on 16 October she did not consider Charmaine to be a suicide risk at all; the only mention of this was a fleeting incident some two weeks earlier when she was on her way to see Dr Khong.

496 Dr Tang was taken to Simon's evidence that Charmaine had told her that psychiatrists reduce antidepressant medication slowly over a period of time and coming off one completely before starting another. Dr Tang denied ever telling Charmaine this. Simon said that Charmaine implied that Dr Tang's treatment was going to get her off the Efexor "*rather quickly, rather than the gradual process*". Dr Tang said that if this was Charmaine's impression then it was wrong.

> *I think she may have wanted a quick process but it would have been too dangerous for me to change medications too quickly so in fact the method of which I was changing the medication, switching medications was actually a gradual process which I though more safe.*

497 Dr Tang was taken to the evidence of Charmaine's mother. Charmaine had told her that Dr Tang's treatment was "*revolutionary*" and that Dr Tang had had a former patient (a music teacher) and her treatment "*turned his life around*". Dr Tang said she could not account for this evidence. She said that her treatment was "*quite orthodox*…*there's nothing revolutionary about it".* She denied ever telling Charmaine anything about a patient who was a music teacher. This "*was certainly not something that I said to her*".

498 Dr Tang denied that fish oil was part of her treatment; the treatment involved the Efexor and the Lexapro and the fish oil was just augmenting this. She agreed that she may have discussed increasing the fish oil dose from 3 or 4 per day to 12 per day.

499 The evidence discloses a very significant divergence between Dr Tang's expectations and those held by Charmaine. Charmaine certainly expected to be off the Efexor (if not off all antidepressants) fairly quickly but Dr Tang says that she expected the Efexor to be given for one or two more months and that Lexapro (if that was found to be the best medication) would be continued indefinitely.

500 Dr Tang said that it sounded as though Charmaine was "very very hopeful of particular outcome and perhaps that coloured her perception of what I was saying…".

501 Dr Tang said

> *Patients often agree to seeing a psychiatrist because it feels like a last resort to them that they've tried everything. There's a lot of shame about seeing a psychiatrist and to see a psychiatrist is to acknowledge that you are unwell and you have a condition so a lot of patients do struggle to cure themselves before they see a psychiatrist, which is in fact the wrong message. It's something that should have occurred throughout, well, from the start. Perhaps she was allowing herself to see about, she allowed herself to be hopeful on that level given that she had, she had resisted seeing psychiatrist for such a long time.*

502 This view ignores the fact that Charmaine knew she was unwell and was seeking professional help from a number of sources. She was concerned about a bipolar condition and this would have merited a psychiatric review but Dr Khong said she did not meet the criteria. She was concerned that the increasing Efexor was not working but Dr Clowes told her to give it more time rather than see a psychiatrist, even though Dr Khong had suggested a review of her medication at this time. Charmaine was given, and accepted, referrals to two psychiatrists, Dr Tang and Professor Parker.

503 It is probably right that psychiatric review was required much earlier in 2007. But to say that Charmaine was ashamed to see her, and so enraptured by the prospect of "cure" that she was not thinking straight and fundamentally misunderstood what Dr Tang was saying, is hard to accept particularly in view of the fact that Charmaine was high functioning and I do not think she would have misunderstood so badly what she had been told.

504 Dr Tang eventually agreed with counsel assisting that Charmaine was hopeful about her proposed treatment plan.

> *She was hopeful. And she was very willing to proceed with it and work with me on it, so she was hopeful that it would work.*

505 But Dr Tang emphasised that she told Charmaine "because she's been unwell for such a long time it was never going to be a quick fix and I certainly did not give her the impression that she was going to come off the medication".

506 Dr Tang was shown the "switching guidelines" from Lundbeck, the manufacturer of Lexapro, which say that when switching from Efexor to Lexapro there should be 1-2 drug free days in between. She accepted that this is what the guidelines said and that she did not follow them. She stressed that this was just a guideline (a point made emphatically by her counsel when cross-examining Dr Pelser, the representative of Lundbeck). She said that in her clinical experience, and based on her theoretical knowledge, her "cross-tapering" plan was safe and appropriate. She said she had regard to the guidelines from the Maudsley Hospital in the UK which refer to "cross-tapering". She was taken to the criticism of this cross-tapering regime made by the expert witness Dr Phillips but

maintained that her decision to cross-taper the Efexor and Lexapro was an appropriate exercise of her clinical judgment.

507 Counsel assisting took Dr Tang to the issue of monitoring. Dr Tang said that the reason she wanted to monitor Charmaine every 2 or 3 days by phone was that she was coming off Efexor and that this level of monitoring was needed specifically because of the risk of agitation and suicidality.

> *I would be looking at a whole range of potential side effects and withdrawal effects. It wasn't what I expected, I did not expect her to have any withdrawal given that I was withdrawing her slowly but it would be something that I would be aware of and you have to inform the patient of the greatest risk, which would be the agitation and suicidality, so it's not something that I would have watered down.*

508 Dr Tang was asked about any plans to have Charmaine's family or Simon assist in the monitoring of the potential side effects and withdrawal effects. The product literature for Efexor and Lexapro actually encourages this. She insisted that Charmaine refused to give permission for Dr Tang to talk with her mother and Simon (who she agreed knew what was going on) about side effects, and in particular about suicidality. She said she considered it to be in Charmaine's best interests that she be monitored by others "*for the reason that she may not notice something about herself that other people may notice*". She said that Charmaine's refusal to permit her to enlist her mother and Simon in the monitoring was contrary to what she thought was best for her. There was no note in her records of any refusal of the request for monitoring by others. Dr Tang said it was her usual practice not to make a note of this. She said that "*the vast majority of my patients given that it's a psychiatric practice would not give me permission*." The expert evidence was that such a refusal, in circumstances where the doctor believed it was in the patient's best interest to be monitored, is something they would expect to see noted in the records.

509 Dr Tang was then taken to the evidence of Emma Ritchie who described Charmaine's anxiety, agitation and panicky behaviour and two minor car accidents on the drive to the Josh Pyke concert on 27 October, after 8 days of reducing Efexor and on the day that the Lexapro was started. She agreed that this could have been caused by drug effect, although other causes were

possible. She was asked whether she would have expected Charmaine to report these events to her when asked about side effects of the drugs. She said, "*Yes, absolutely*". But Charmaine did not report any of this to Dr Tang.

510 Dr Tang denied categorically the suggestion that when she wrote her retrospective notes of the phone calls she had with Charmaine on 29 October and 1 November, which say that Charmaine denied any anxiety or suicidal issues, that this had not actually been said at all. She said that "*the phone calls we had were specifically to address these symptoms*".

511 Dr Tang agreed with counsel assisting that if the only side effects that were spoken of on at the 16 October consultation were headaches and nausea (as noted by Dr Khong) then Charmaine would not have known to report the anxiety, agitation and panicky behaviour on the night of 27 October to Dr Tang when asked of side effects. But Dr Tang did not resile from her position that she did tell Charmaine about such other side effects, including suicidality, at the consultation on 16 October.

512 On 28 October Charmaine went to Watson's Bay and then appeared to be distracted, confused and distant at Selina Day's house for the "Scrabble challenge". Mr Webster described the look in the photograph taken that afternoon to be the one that Charmaine had when she was deeply upset. If Charmaine was thinking about suicide that day it did not come up in the phone call with Dr Tang on 29 October when she was still noted to be feeling "flat" and was encouraged to give the Lexapro more time "*to kick in*". Dr Tang did not think that Charmaine's confusion or distraction was something that an observer would necessarily be concerned about, even if told of the need for careful monitoring of Charmaine's behaviour. But Selina Day said that this behaviour from Charmaine was out of character.

513 Although Selina Day would not have been a person contacted by Dr Tang to monitor Charmaine (if anyone it would have been her mother and Simon, neither of whom were present), if Charmaine herself had been told to be alert to this kind of behaviour as a sign of possible drug effect to be reported one expects that she would have.

514 After her phone call with Dr Tang on 29 October (following the weekend of the Josh Pyke concert, Watson's Bay and the "Scrabble challenge) Charmaine doubled the Lexapro dose to 10mg. Dr Tang's evidence was that during that phone call Charmaine said

> *She had no side effects in terms of agitation or any change in her mental state, any negative thoughts and that she had felt so well that she felt she didn't need to contact me in regards to increasing the medication.*

515 It is obvious that Charmaine doubled the dose of Lexapro on her own for a reason. It is certainly open to find that the reason was that the events over the weekend were distressing and indicated that she was not getting better, but rather worse. The phone calls to her mother and Sarah Bamford support the conclusion that Charmaine was expecting to feel better by then and, when this did not happen, she increased the dose of Lexapro. She told this to Dr Tang later that day (after being encouraged to do so by her mother) and Dr Tang confirmed that she should give the Lexapro a few more days "*to kick in*".

516 Counsel assisting asked Dr Tang why she did not ask Charmaine to come in for a consultation after the phone call on 1 November when she again reported she was still "flat" and had been so since 26 October. She said she did not arrange a consultation "*because there was no change in her mental state and she hadn't deteriorated, so there was no reason to ask her to come in*". One might question how Dr Tang could have formed the view that there had not been a change or deterioration of Charmaine's mental state. The answer is that Dr Tang described Charmaine's "flatness" as "*her normal chronic depressed state*".

517 Counsel assisting submitted that Dr Tang's evidence should not be accepted on a number of points and he gave reasons for this. His submissions on Dr Tang's evidence can be summarised as follows:

- Dr Tang obtained a reasonably thorough history from Charmaine, but she did not believe that she was a suicide risk; the only mention of suicidal thoughts was a fleeting episode some two weeks earlier just before Charmaine saw Dr Khong. If she had been told by Dr Khong over the phone on 28 September during her "urgent" phone call of Charmaine's suicidal thoughts, or if she had been told by Dr Khong that four days before the consultation on 16 October

she had taken Charmaine on the Bobbin Head walk to lift her then very depressed mood with suicidal thoughts, Dr Tang would have explored the possibility of a bipolar condition more thoroughly.

- Dr Tang was right to recognise that there was a clear biological component to Charmaine's condition and that her major depression (which is what she had understood from both Dr Khong and Charmaine is what she had) had been under treated. She was not clear about the diagnosis and did question whether there may have been a seasonal adjustment disorder (SAD) component to this, or a bipolar condition, although there was no evidence of mania at the time. Her contemporaneous notes refer to the SAD and bipolar possibilities as do the notes of her conversation with Dr Khong and so do Dr Khong's thorough notes of that conversation.
- Dr Tang's evidence about the reference in her transcribed notes to "*BDP (bipolar disorder)"* not being about a bipolar disorder but rather about a borderline personality disorder – and the reference in her transcribed notes was an error – should be rejected. He says that the reference to "BPD" must have been to a bipolar disorder because it is consistent with all of the other notes and further there was no basis for thinking that Charmaine had a borderline personality disorder. Not only was such a diagnosis inconsistent with the evidence of her character (as described by Dr Seidler) but if she had considered this there would have been a reference to this in the Axis II part of the DSM IV diagnosis recorded in the records. There was no such reference.

518 It follows from the above that Dr Tang's evidence that the issue of a bipolar disorder first being raised by Dr Khong during the phone conversation on 18 October must be rejected as well; it must have come from Dr Tang herself and this is what Dr Khong recorded and what she said in evidence was the case. It was never put to Dr Khong by counsel for Dr Tang that the reference to a bipolar condition originated from her and not from Dr Tang. Furthermore, the reference to treatment with lithium was consistent with the contemplation of a bipolar disorder, and not a drug to be given if for some reason the new antidepressant medication was ineffective.

519 Counsel assisting said the discussion about side effects was limited to the usual side effects of Efexor withdrawal being headache and nausea. This is what Dr Khong wrote in her notes and if Dr Tang actually did tell Dr Khong about the most significant side effects, namely agitation, increased depression and suicidality, then Dr Khong would surely have written this down. Counsel assisting submitted that Dr Tang's evidence that she told both Charmaine and Dr Khong about the agitation, depression and suicidality side effects (or withdrawal effects) should be rejected. He added that if Charmaine had been told to look out for these as the effects of medication then she would have reported these to Dr Tang on 29 October after the events of 27 October (the drive to the Josh Pyke concert) and 28 October (the visit to Watson's Bay and the "Scrabble challenge"). There was no such report to Dr Tang but Charmaine decided to increase her dose of Lexapro from 5mg to 10mg even before speaking with Dr Tang on 29 October, at which time she told Charmaine to give the Lexapro a few more days "*to kick in*". It followed, he submitted, that Charmaine did not recognise these events, which were a clear worsening of her condition compared to the elation she reported to her mother and Simon when in Perth from 17 to 22 October, to be related to the drugs. He says that the reason she did not recognise these as drug effects is that all she knew to look out for was headache and nausea, neither of which she had.

520 On the subject of monitoring, counsel assisting submits that Dr Tang's evidence about Charmaine's refusal to allow her to speak with her mother or Simon to help monitor side effects and withdrawal effects should also be rejected. There was no note of this refusal and, given the close relationship with her mother and Simon, no reason to think that Charmaine would have refused this if Dr Tang really thought she should be monitored by others. The experts also considered that if a patient refused advice of this kind then it should be noted in the doctor's records.

521 Concerning her expectations from Dr Tang's treatment plan, counsel assisting submitted that Charmaine was left with the impression that she would be off Efexor in about 10 days (according to Dr Khong's notes and Charmaine's daily diary) and that getting off Efexor quickly was one thing she was hoping for. He

said that Charmaine was given hope and got the impression from somewhere that Dr Tang's treatment was "revolutionary" in some way and that with her treatment there was "*a light at the end of the tunnel*". Dr Tang says that she expected Charmaine to remain on both Efexor for one to two months depending on her improvement with Lexapro during that time (when both drugs were to be given concurrently). She said that she warned Charmaine that there was "*no quick fix*" and that she would be on medication (but not Efexor) for a very long time to come. Dr Tang said that she did not convey the expectations that Charmaine apparently had and suggested that she was influenced by an unrealistic hope of a cure. Against this counsel assisting said that Charmaine gave a comprehensive and coherent history and appeared to Dr Tang to be well and this presentation was not consistent with someone likely to misinterpret or ignore the advice that Dr Tang said she gave.

522 In addition to these submissions on Dr Tang's credit, counsel assisting submitted that Dr Tang's management could be criticised in some respects. He said that she could be criticised for not exploring the history of suicidal ideation further having obtained at least some history of this. She should have investigated episodes of hypomania because this needs to be excluded by definition if one were to arrive at a diagnosis of Major Depression according to the DSM IV, which Dr Tang did. Had she explored this properly she could have obtained the kind of history that Dr Berenson obtained about Charmaine's mood swings. He said that if it were found as a fact that Dr Tang did consider a bipolar diagnosis then she could be criticised for not exploring this further on 16 October.

523 He said that even if the "cross-tapering" of Efexor and Lexapro was permissible according to the Maudsley Hospital guidelines (though it was against the manufacturer's "Switching Guidelines") it had to be done with great caution and attention to monitoring. He said the monitoring by telephone was insufficient. He said that even though this was understandable in the first week of treatment when Charmaine was in Perth, there should have been a face to face consultation when she was back in Sydney and feeling "flat" and reported this on 26 and 29 October and again on 1 November, the day before she died.

524 Counsel for Dr Tang made submissions on her behalf both orally and in writing. He said that the reference to "BPD" in Dr Tang's notes was, in fact, a reference to a borderline personality disorder. In support of this (and despite all of the evidence to the contrary none of which was referred to in submissions) he cites the report of Dr Phillips who had assumed that "BPD" meant "borderline personality disorder". But in his oral evidence, having heard more evidence about Charmaine's mood swings and the history obtained by Dr Berenson, Dr Phillips said that his assumption about this was wrong and that "BPD" could not have meant "borderline personality disorder" because it was clear that on no view of it could it be said that Charmaine had this problem.

525 Dr Tang's Counsel further submitted that she did consider bipolar disorder as a possible diagnosis (although according to Dr Tang's evidence this idea came from Dr Khong and not from her) and could not be criticised for not making the diagnosis herself which he said was not an easy diagnosis to make at the best of times. He said that Dr Berenson was partly to blame because in her brief referral letter to Dr Tang she made no reference to her own concerns about a bipolar disorder (which was specifically referred to in her equally brief referral letter to Professor Parker). Dr Berenson said only that she was referring Charmaine "*who has been seeing Belinda Kong [sic], as discussed with you would like your opinion as to medication*".

526 It should be noted that Dr Tang did know of the proposed appointment with Professor Parker although whether Charmaine showed her the referral letter is not known.

527 Dr Khong made a note of her conversation with Dr Tang on 18 October that states: "WM [Dr Tang] said that CDR [Charmaine] will defer appointment with Black Dog first because seeing a registrar not Gordon Parker. Because happy with WM".

528 Even if she had not seen the referral letter to Professor Parker it was open to her to consider why Dr Berenson wrote two referrals – one to her (as discussed with Dr Khong "*who would like your opinion as to medication*") and one to Professor Parker, presumably for a reason other than to check her medication.

529 Counsel for Dr Tang emphasised that Dr Tang did not have access to information about Charmaine's mood swings as she did not have Charmaine's diaries, had no information about the Emma Ritchie and Selena Day's observations and had none of Dr Khong's notes, and had no corroborative evidence from Charmaine's family or friends.

530 However, this misses the point completely: It was for Dr Tang, if she was considering a bipolar disorder, to explore this in the history just like Dr Berenson did. Furthermore, she ought to have explored the hypomania issue before concluding that Charmaine had a Major Depression according to the DSM IV criteria.

531 The fact that she did not obtain the history that was available just goes to show that if Dr Tang considered a bipolar disorder at all, she did not consider it seriously, and did not explore this properly. However, one cannot be too critical because Dr. Tang was not told of Charmaine's suicidality on 28 September by Dr. Khong nor how that had persisted on 12 October but was reversed by the Bobbin Head walk some four days before her consultation with Dr Tang on 16 October.

532 Had she known this then a more thorough history would have been taken and the patterns of mood swings and their triggers (or lack of them in this case) would have been explored more thoroughly.

533 Counsel for Dr Tang said that diagnosing a bipolar disorder is not easy and one of the reasons is that people do not come to psychiatrists complaining of feeling good, only about feeling bad. He said that Charmaine concealed her feelings from her friends and did not present with any signs of mania at the time of the consultation. He also said that there was a difference of opinion in the psychiatric community about whether a Bipolar II Disorder was a distinct entity at all.

534 This ignores two facts: First, Dr Tang did know about a Bipolar II Disorder because this was noted in Dr Khong's records of the conversation on 18 October. So Dr Tang never pretended that this condition did not really exist.

Second, she said in her evidence that she knew that people did not come to psychiatrists when they were feeling good, only when they were feeling bad. This only goes to show the importance of exploring mood swings (hypomania as well as mania) when a psychiatrist is confronted with a patient who presents for the first time with depression as the only problem.

535 would have thought that it does not matter that a patient conceals their feelings from their friends; it is the psychiatrist's job to obtain a thorough and accurate history from the patient.

536 Counsel for Dr Tang said that Dr Tang's "cross-tapering" plan to remove the Efexor and introduce the Lexapro should not be criticised. Even though it was contrary to Lundbeck's own guidelines it was not contrary to some overseas guidelines. Further, there was expert evidence that some psychiatrists would follow the manufacturer's guidelines and others would not, so the mere fact of doing something different should not be a basis for criticism.

537 I agree with this. But the reason for the caution is that the side effects of withdrawal and introduction at the same time can be enhanced, as is the risk of serotonin syndrome. So if one chose to "cross-taper" it means that the need for careful monitoring for these effects is even greater.

538 Counsel for Dr Tang anticipated the submission that Dr Tang did not tell Charmaine or Dr Khong of any side effects other than headache and nausea, because this is all that Dr Khong noted from her conversation with Dr Tang on 18 October. He said that Dr Tang should be accepted when she said that it would have been her practice to tell a patient about agitation, anxiety, depression and the potential for re-emerging suicidality. He said that there were some deficiencies and inaccuracies between Dr Khong's typed notes and her handwritten notes and that the handwritten notes were abbreviations of what was said. He submitted *that Dr Khong's notes are a summary and could not be read as a comprehensive account of everything of relevance said by Dr Tang and /or Dr Khong* during the course of that conversation.

539 I do not accept the submission. First, the discrepancies referred to are minor. Second, Dr Khong was an assiduous note taker and it is unbelievable that if Dr

Tang had told Dr Khong about agitation, anxiety, depression and the potential for re-emerging suicidality she would not have noted this and stopped her notes at "headache and nausea". One of the obvious reasons was that she was still seeing Charmaine and would have been on the lookout for any of those signs.

6. Counsel for Dr Tang also submits that even if it were found that Dr Tang did not tell Charmaine of all of the relevant side effects of stopping Efexor she had access to the product information because the information that came with the Efexor box (which was in evidence) referred to these. He said that *"[your Honour] cannot find that Charmaine Dragun did not know of adverse sequelae of reducing Efexor as that information was in her possession*."

540 With all due respect just because there is product literature in her possession does not mean she read it.

541 There is no evidence that Dr Tang ever asked whether Charmaine had read the product literature and whether her denial of side effects/withdrawal effects took this information into consideration.

542 Counsel for Dr Tang submitted that although the events on 27 and 28 October (the weekend of the Josh Pyke concert, Watson's Bay and the "Scrabble challenge") might have been associated with serotonin syndrome (and therefore the fact that both Efexor and Lexapro were being taken concurrently) there was no evidence of increased temperature and shivering so this reaction did not occur.

543 This may or may not be right. She may not have had a "full blown" serotonin syndrome but this is not the point. Other experts, and Dr Tang herself, accepted that what Emma Ritchie and Selina Day described could have been drug effect, even if not serotonin syndrome.

544 Counsel also said that Dr Tang's monitoring of Charmaine by telephone was, admittedly, not ideal. But Dr Tang gave her reasons for doing this. He did not address the submission made by counsel assisting that a face to face consultation should have taken place after Charmaine returned to Sydney from Perth on 22 October and told Dr Tang on 26 and 29 October and again on 1

November that her mood remained “flat”, that she was expecting some effect by then, and had actually increased the Lexapro dose from 5mg to 10mg herself.

545 In his oral submission counsel for Dr Tang said that no finding should be made about the preventability of Charmaine’s suicide other than that that it would have been prevented if she did not have access to the cliff at The Gap. He says that no findings should be made about the management by the doctors (his clients being not only Dr Tang but also Dr Cugadasan and Dr Clowes). In making this submission he was relying on comments in the written report of Dr Dudley.

546 This does not address the fact that all of the experts, including Dr Dudley, said in evidence that if Charmaine did have a bipolar disorder (which they thought she probably did) and if this had been treated properly, then her suicide was avoidable.

THE EXPERT EVIDENCE

547 The inquest received expert evidence from a psychologist, Dr Katie Seidler. Three psychiatrists, Professor Gordon Parker, Dr Jonathan Phillips, and Dr Michael Dudley also gave evidence. Each of these experts provided a written report and gave evidence at the inquest. The reports were prepared before all of the evidence eventually presented at the inquest was obtained. The psychiatrists gave their oral evidence jointly and were made aware of new evidence presented at the inquest.

PSYCHOLOGIST

DR KATIE SEIDLER

548 Dr Seidler is a clinical and forensic psychologist with, among other qualifications, a Masters degree in clinical psychology and a PhD in the area of culture and interpersonal crime. The particular expertise that she brought to the inquest was her knowledge and experience in the diagnosis and treatment of mental disorders from the perspective of a psychologist.

549 From her review of Charmaine's diaries Dr Seidler made certain observations and formed certain views which are summarised as follows:

- The notes demonstrate that Charmaine suffered both depressed mood and anxiety.
- Her thinking was ruminative, exaggerated, distorted and often coloured by perfectionist themes.
- She was at times a logical and rational thinker, who was insightful.
- She was able to identify and challenge distorted thinking and appreciated the connection between thoughts, feelings and behaviour.
- She suffered from poor self-esteem and was self-blaming.
- She was preoccupied with fears of gaining weight.
- She felt inadequate, hopeless and ill-equipped, with a strong need to control situations.
- She considered herself to be immature and unable to cope in the world.
- She was highly motivated to gain the attention and approval of others.
- She felt her condition was deteriorating despite the psychological treatment she was receiving.
- She was contemplating suicide since July 2007 and evaluating this in the period prior to her death.
- She practised techniques to help her to disengage from her thoughts and feelings. These included "thought stopping", "distraction" and "activity scheduling".
- She was encouraged to identify her core beliefs and was directed in her goal setting and encouraged to set and complete homework tasks.
- Her thinking related to mindfulness based therapeutic practice.
- She made attempts at not judging, or rather accepting her feelings and to "normalise" her concerns and recognise those that became "dysfunctional".
- She was encouraged to "externalise" her negative and distorted thinking through exercises like the "C1-C2 dialogue".
- She tried to meditate, but had difficulty doing so.

550 It was clear that Charmaine had been exposed to "mindfulness-based Cognitive Behaviour Therapy" (CBT) and she was "obviously provided with

psychoeducation about mindfulness and Buddhist philosophy, as well as being encouraged to be 'mindful' of her thinking and body sensations and to practice meditation".

551 Dr Seidler noted that Charmaine had written at one point that "*Belinda (Dr Khong) can guarantee it will get better*". She was critical of this because it was inadvisable to guarantee progress or recovery especially where, as in this case, there was a long history of disturbance despite intervention.

552 Dr Seidler reviewed the transcript of the extensive notes kept by Dr Khong of her 16 sessions with Charmaine. About these Dr Seidler made certain observations and formed certain views which are summarised as follows:

- Dr Khong's interventions included challenging and/or rationalising Charmaine's negative, pessimistic and distorted thinking.
- Charmaine raised a pattern of self-destructive behaviour and/or thinking to Dr Khong.
- The themes of perfectionism, inadequacy, unlikeability and being out of control were found in the notes as they were in Charmaine's diaries.
- Charmaine's mood was persistently low throughout much of her work with Dr Khong with depression as an almost constant theme.
- Suicide was raised in the sessions from late July 2007 and it was concerning that Charmaine appeared to demonstrate a sense of "resignation" in response to her mood and a loss of interest in things.
- There appeared to have been a hormonal dimension to the fluctuation of moods in relation to her menstrual cycle.
- Dr Khong had instituted a "suicide contract" with Charmaine under which Charmaine was to contact Dr Khong if she was feeling suicidal but the notes say that Charmaine "*expressed a dislike for bothering people*".
- A risk assessment for suicide was evidently done in her last session (on 24 October 2007).
- Charmaine's diary entry about Dr Khong's "guarantee" that she would get better is corroborated in Dr Khong's notes.
- The issue of a bipolar disorder was raised and the notes indicate "*that there was little evidence of mania"*.

553 Dr Seidler reviewed Dr Tang's statement and clinical records. One point that was highlighted, and became very relevant at the inquest, was that Dr Tang realised that there "*was a significant biological component underlying Ms Dragun's depression*".

554 Dr Seidler reviewed Dr Khong's qualifications based on her statement to the inquest and her website. According to these Dr Khong was a "Consulting Psychologist" and a "member of the College of Counselling Psychologists".

555 She observed that Dr Khong's original qualifications were in law and then she obtained a Bachelor's degree in psychology before obtaining a Doctorate in psychology, bypassing a Master's degree. She said this was very significant because undergraduate training in psychology (ie a Bachelors degree) does not involve any clinical training; this is only available at a Master degree level. She explained that Dr Khong's qualifications in psychology were earned through her theoretical expertise; her clinical training was very limited. She added that the "*PhD pathway was discontinued as a form of a pathway to registration because of the recognition that there was no clinical supervised practice as part of that"*

556 Furthermore, Dr Seidler said that the title "Consulting Psychologist" is not recognised and is not an accredited title with the State Registration Board of New South Wales, although the Board does not disallow use of this title. As for Dr Khong being a "member of the College of Counselling Psychologists" Dr Seidler explained that this was a college of the Australian Psychological Society (APS). Membership normally required a Master's degree in Counselling Psychology (which Dr Khong did not have) but it was possible to be "grandfathered" into the APS without such a degree and it appears that this is how Dr Khong was able to use the membership accreditation that she did.

557 Charmaine's counselling sessions with Dr Khong were normally 1.5 hours in duration. Dr Seidler said that normally sessions are only 1 hour in duration, but this is not a matter that is regulated and may reflect the particular philosophical approach of the therapist. She did, however, raise a concern about extended treatment sessions, basically because this could lead to problems for the

therapist who must maintain "*a reflective and reflexive stance in relation to their work*". This observation gains some relevance because of the many witnesses who understood Dr Khong to be a "friend" of Charmaine's; most of them did not even know that she was a psychologist. What is important, of course, is not whether their relationship was one of "friendship" (and Dr Khong maintains that from her perspective it was always a counsellor/patient relationship) but whether Charmaine perceived (or was allowed or encouraged to perceive) it in this way.

558 Dr Seidler said that the therapist/patient relationship was different to the doctor/patient relationship in that the relationship between a patient and a therapist (including a psychologist) is more collaborative. Having said that, she considered it inappropriate for Dr Khong to have said (as she recorded in her notes) "*Congratulations, I'm proud of you*" in respect of Charmaine's completion of the video project for Brad Hodson. She felt that this did not maintain the necessary therapeutic distance because it demonstrated that Dr Khong had an emotional investment in Charmaine's success. This could lead Charmaine to not want to let Dr Khong down if she deteriorated – as it might reflect a failure on Dr Khong's part. She added "*you're there as a therapist, you're not there as a friend and I think you have to keep that in mind*".

559 Dr Seidler was not critical of the "C1-C2" dialogue exercise although she said it was "*not a formally recognised therapeutic approach in and of itself*". She explained that to the extent that it permitted the separation of herself from her problem thinking in order to achieve some perspective and distance it had a role in the treatment.

560 On the subject of the correct diagnosis for Charmaine, Dr Seidler explained that the primary diagnoses of interest to Dr Khong would have been "mood disorders". She referred to five possible diagnoses related to depression; a bipolar disorder was included in this list. A personality disorder might also have been considered depending on the history and presentation.

561 Regarding the diagnosis of a bipolar disorder and the use of "instruments" that provide, basically, a "checklist" of criteria, Dr Seidler said that "*conventionally, instruments should not be used to establish whether or not a condition exists*".

She said that diagnosis should only follow "*a clinical interview in reference to the established diagnostic criteria*". She described the mood swings seen with bipolar disorders. She said "*it would have been reasonable for Dr Khong to question the presence of a Bipolar Disorder in Ms Dragun's case*" but she added that on the face of the documents she had seen there were no episodes of clinically elevated or manic mood. "*Rather, Ms Dragun's primary mood concerns seemingly related to anxious and depressive symptomatology*". This begs the question, of course, of whether anything other than Charmaine's depressed mood states was ever explored. The evidence makes it plain that this was not done by Dr Khong, or any other doctor, other than Dr Berenson. It was only when she asked Charmaine about her "ups" as well as her "downs" that the full picture of her mood swings was revealed.

562 Dr Seidler said that psychologists were "*not allowed to diagnose*" a condition like a bipolar disorder, but they could look for symptoms consistent with a condition. Diagnosis was a matter for a *clinical psychologist* and not for one with Dr Khong's level of training.

563 Dr Seidler said that it was common to enter into "suicide contracts" with patients whereby the patient agrees not to self harm and to contact the psychologist (or other support service) if thoughts of suicide or self harm intrude. She explained that this was a "holding" measure that allowed the psychologist to intervene therapeutically. She said that she found them to be beneficial. She said it was inadequate and inappropriate for a psychologist to be the only source of support and unrealistic to offer to be available 24 hours per day 7 days per week. She considered that when Charmaine said "*I don't want to be a burden*" (as Dr Khong wrote in her notes) this could be a signal that Charmaine could not be counted on to keep the contract.

564 Dr Seidler said that the "mindfulness-based CBT", based as it was on Buddhist philosophy, was not espoused by the APS but that body did not aim to regulate this. She acknowledged that different approaches work with different people. She referred to a review of literature in 2007 that found that there was a positive role for "mindfulness-based CBT" for patients who are in remission from depression.

565 Regarding Dr Khong's walk with Charmaine at Bobbin Head Dr Seidler said "This is not something that I would ever practice with my clients, as it does not fit with my philosophical approach or style of practice". She noted, though, that it would be consistent with Dr Khong's philosophical approach and it appeared to be helpful to Charmaine.

566 Counsel assisting took Dr Seidler to the reference in Dr Khong's notes from the 28 September 2007 consultation in which she wrote that Charmaine was "*wallowing in self-absorption, quite suicidal*" and to notes that followed this. This was also the day that Dr Khong called Dr Tang to make the "urgent" referral discussed in Dr Khong's evidence, above. Dr Seidler said that this distress and these suicidal thoughts should have been conveyed by Dr Khong to Dr Tang. She also said that when Dr Khong learned that it would be two weeks before Charmaine could see Dr Tang she should have arranged an earlier appointment elsewhere.

567 Dr Seidler also said that Dr Khong should have told Dr Tang about the walk to Bobbin Head on 12 October, four days prior to Charmaine's consultation with Dr Tang. This was important because according to Dr Khong's notes on 12 October Charmaine reported her depression to be 9/10, her negative thinking was still there, the mindfulness practice not working, and she was looking for a suicide method that was "*quick and easy*". But after the walk Charmaine became calm. The opportunity to mention this arose when Dr Tang spoke with Dr Khong over the phone on 18 October and Dr Tang related that Charmaine was "*Energetic, well today".* Dr Seidler explained that this was important for Dr Tang to know for a number of reasons, including that

> *…it's fairly well established in the psychological field that any sudden improvement in mood can actually signal a warning sign that a person is resigned to suicide so it actually may be an increased risk rather than a decrease risk…*

568 Dr Seidler expressed concern about Dr Khong's clinical acumen. She felt that Dr Khong failed to take proper account of the "*entrenched nature of Charmaine's … mental illness*". She noted that Charmaine's difficulties began with an eating

disorder in her teens, that there were 10 years of depression in various forms and that the problems continued despite changes in medication. This is why she considered the problems to be "entrenched".

> *To me that would signal that Charmaine was most likely struggling with an endogenous or biological depression that was based in a disturbance in neurochemistry in her brain and that psychological treatment alone would not have been sufficient to assist her to resolve that successfully.*

569 Dr Seidler said that if Dr Khong had taken proper notice of the entrenched nature of Charmaine's problems referral to a psychiatrist should have occurred

570 Dr Seidler explained that she estimated that about 10% of people coming to a psychologist with depressed mood have an endogenous or biological depression. She said it was crucially important for psychologists to pick out the 1 in 10 because with that patient usual psychological techniques simply will not work. This is because the patient's mental illness prevents them from thinking clearly, and if they cannot think clearly then whatever benefit may be available from the psychological treatment will be wasted because the message simply does not get through. She described it this way:

> *If someone is experiencing acute state of mental illness or psychological disorder, whether it be anxiety, depression, what have you, I imagine that as white noise in the system, a virus in a computer, something that's interrupting the psychological system from working effectively the way it should, and that prevents a person from being able to distance themselves from what's going on for them, to be able to have insight, to be able to be objective about what they're going through and it also makes them harder to utilise psychological treatment…it can prevent the action of psychological treatment, if you like.*

571 She said that ruminations and churning thoughts (both features were noted by Dr Khong and Dr Tang) are examples of the "*white noise*" referred to above. She also said that the inability to meditate can be an indication that a person is affected by this "*white noise*" and that this should have been considered by Dr Khong who had been told repeatedly that Charmaine could not, or at the very least had great difficulty, in meditating.

572 Dr Seidler said that she did not personally use the DASS questionnaire in her practice. But she said that if she had been made aware of Charmaine's DASS

scores from 29 November 2006 (in which she scored in the "extremely severe" range for depression, anxiety and stress) then this would have prompted her to do a full clinical assessment and possibly further psychometric testing. But she said that being provided with a DASS (or other) assessment score from a GP had little if any effect on her management because she would take it upon herself to do a proper clinical assessment simply on the basis that a patient had been referred to her with depressive symptoms. It was during this clinical assessment that Dr Seidler said she would be looking for the 1 in 10 with an endogenous or biological mental illness. She said that such an assessment takes time – and it would take her about one or one and a half hours.

573 It will be noted that Dr Cugadasan did not provide Dr Khong with the DASS results, but Dr Khong said that even if she had read them she would not have treated Charmaine any differently. But it does not appear as if she conducted anything that would approximate a thorough clinical assessment of Charmaine.

574 Dr Seidler was asked about borderline personality disorder and whether she had any experience with these kinds of people. There followed this exchange with counsel assisting:

> *Q. Do you have any experience treating people with [borderline personality disorder]?*
>
> *A. Yes, unfortunately, quite a lot, yes.*
>
> *Q. Why unfortunately?*
>
> *A. Because they're very, very difficult clients to deal with.*
>
> *Q. In what way?*
>
> *A. Manipulative, unstable, deceitful, self destructive, don't turn up to sessions then expect sessions at a moment's notice, very difficult clients to deal with because they are very hard to contain.*

575 The extensive evidence at the inquest makes it plain that Charmaine could not have possibly had a borderline personality disorder as described by Dr Seidler.

PSYCHIATRISTS

PROFESSOR GORDON PARKER

576 Professor Parker is a psychiatrist and the executive director of the Black Dog Institute in Sydney, a facility that specialises in research and treatment of mood disorders.

577 Professor Parker was the person to whom Dr Berenson wrote the referral for Charmaine on 29 September 2007. Dr Berenson knew that Professor Parker had a special interest in bipolar disorders and that is why she wrote the referral. Charmaine decided to continue her treatment with Dr Tang rather than see Professor Parker, but in any event she died before any consultation with him could have been arranged.

578 Professor Parker's written report addresses only the issue of the diagnosis of a bipolar disorder. Based on the written material provided to him, including Charmaine's diaries and statements from the lay witnesses, he considered it most likely that she was suffering from a Bipolar II Disorder. The fact that she had a history of anorexia nervosa was also relevant because this condition is often seen in people who are later diagnosed with a bipolar disorder.

579 He explained that in the last few decades the term "bipolar disorder" has replaced the older diagnosis of a "manic depressive illness". This condition, with alternating states of depression and mania, is now called "Bipolar I Disorder". The Bipolar II Disorder that he believed Charmaine had is characterised by "hypomania" and depression rather than "mania" and depression. He explained that a Bipolar II Disorder is less "*severe*" than the Bipolar I Disorder, but from the point of view of suicide risk it was the same or even more dangerous. He explained that in a Bipolar II Disorder

> *The hypomanic episodes in true bipolar disorder can last only minutes, hours or a couple of days… Individuals with this condition tend to experience frequent and briefer periods of mood elevation, may experience brief or extended periods of depression, and tend to be less likely to have extended periods of euthymia [normal mood] than those with a Bipolar I Disorder.*

580 Professor Parker explained that in Bipolar II Disorder there were oscillations of mood and energy. "Hypomanic episodes involve the individual feeling energised and wired. They tend, at such time, to be buzzy, playful, creative, energised and enthusiastic." He said that when the individual is in a depressed phase there is low mood and low energy. "At such times, individuals tend to lose the light in their eyes, and often have difficulty in getting out of bed in the morning due to lack of energy." It was noted that there is controversy in some circles as to whether Bipolar II Disorder actually exists as a separate entity rather than a point on a bipolar disorder spectrum, but clearly Professor Parker believed it did.

581 Professor Parker made the following observation which has obvious relevance in Charmaine's case, especially in relation to the events of 27 October (starting to take Lexapro, the agitation observed by Emma Ritchie during the drive to the Enmore Theatre), the events of 28 October (going to Watson's Bay and then the "Scrabble challenge" with Selina Day where Charmaine could not concentrate and had a faraway look in her eyes as seen in the photograph and as described by Tim Webster), and the events of 29 October (the phone calls to her mother and Sarah Bamford when she was sounding very flat and complaining that she thought that she would be feeling better by then):

> *The high suicide rate in this condition probably reflects the severity of the depressed mood state and the desperation that many people feel when they "come off a high" and are aware that they are going back into a depressed phase and start to anticipate the "torment". During the depressed phase, some may experience 'retardation' (marked by slowed thinking and impaired concentration, as well as by a lack of energy) but some may experience agitation (where they will have great difficulty in settling and often have a myriad of morbid worries and concerns). The latter agitated state provides a higher risk to suicidal ideation.*

582 Professor Parker said in oral evidence that one possible explanation for the events on 27 and 28 October was that Charmaine was having a serotonergic reaction to the Efexor and Lexapro. He said *"…it is a state of gross mental agitation and distress. That's probably the most important component because some people have said to me that that takes them into a pretty suicidal space*." He also said that Charmaine's belief that she would lose her job because of the supposedly flawed newsreading on the evening of 1 November, and her worry

on the morning of 2 November that she could not finish her massage course (as explained by Simon) was evidence of an "*increasingly severe depressive phase with a lot of self critical thinking."*

583 Professor Parker said that Bipolar II Disorder is largely unrecognised even though it occurs 5-10 times more commonly than Bipolar I Disorder. He said that diagnosis is often very late (10-20 years from onset). He said "*it is incumbent on all health professionals to screen those with clinical depression for the possibility of a bipolar disorder*".

584 The history of Charmaine's mood fluctuations (details of her "ups" as well as her "downs") obtained by Dr Berenson was put to Professor Parker for comment. He said that there were "*a number of features there that are the lexicon of somebody describing a hypomanic mood*". He considered on the basis of this history that "*there was a fairly clear cut probability of a Bipolar II Disorder until proved otherwise.*"

585 Professor Parker was asked about Dr Tang's reference to "BPD" in her notes and the subsequent telephone call with Dr Khong details of which include a reference to Dr Tang considering the use of Lithium. He said that this would indicate that Dr Tang was concerned about a bipolar disorder (it will be recalled that Dr Tang said the reference to "BPD" was to "borderline personality disorder" and not "bipolar disorder"). He also said that even if there could be a role for antidepressants in the treatment of a bipolar disorder, he could see no reason to continue with another one (Lexapro) when Charmaine's condition was not controlled with two others (Zoloft and Efexor). He considered that if Dr Tang had considered a bipolar disorder then Charmaine should have been put on a mood stabiliser straight away rather than be given yet another antidepressant. Dr Tang's management plan was consistent with her believing that Charmaine had a recurrent major depression, not a bipolar disorder (and this is borne out by Dr Tang's evidence).

586 He said that where bipolar disorder is treated only with antidepressants (as in Charmaine's case) it is "commonly ineffective while, for some, it can worsen the

condition (by increasing the risk of more "rapid cycling', highs and 'mixed states')". Regarding treatment and prognosis he said

> *Most individuals with this condition will need a mood stabiliser as well as education and a 'stay well plan' designed to address the mood oscillation. Most importantly, they need confirmation of the diagnosis so that they can be made aware of what they need to learn about and how to address their condition. In a percentage, mood stabilising medication will bring the condition under total control alone, while the combination of medication, education and a stay well plan will bring it under complete or almost complete control for another significant percentage. Such successful management is usually contingent on making the diagnosis.*

587 Professor Parker said that the failure of Dr Khong to provide her with a history of Charmaine's suicidal thoughts at the time of the referral phone call on 28 September, and the failure to tell her about the further deep depression relieved by the Bobbin Head walk four days prior to Dr Tang's consultation with Charmaine put her "*at a substantial disadvantage by lack of knowledge about the depth of depression and the risk of suicide*". He said that independent of this Dr Tang should have obtained a more thorough history. But he emphasised the need for "*very open and accurate communication between the parties in this case, the parties were a general practitioner, the psychologist and the psychiatrist*".

588 Professor Parker expressed concerns about "contracts" between a doctor and a patient where the patient agrees not to commit suicide or self harm and agrees to contact the doctor if these feelings emerge. He thought this was "*naïve, unsophisticated and at times guilt inducing and it doesn't recognise that there's no support in the literature*."

589 Professor Parker said that if Dr Tang was to embark on a "cross-tapering" management plan (reduction of Efexor and introduction of Lexapro with both drugs being given simultaneously for a period of time) certain clear warnings were needed. He said that Charmaine needed to be told about the risk of the depression coming back, about the withdrawal effects of Efexor, and the risk of serotonin syndrome from the combination of Efexor and Lexapro.

590 Professor Parker said that for the last four years there has been a bipolar screening test on the Black Dog Institute website, now used by some 15,000 people each month. Regarding diagnosis by a health professional he said "*A clinician really needs to only ask a few questions of a patient and they go along the following lines. In addition to times when you are feeling depressed and apart from the times you're depressed or mood is completely normal do you have time when you're more energised and wired?... The logic of going about making this diagnosis is really one of the easiest things in psychiatry*."

DR JONATHAN PHILLIPS

591 Dr Phillips is a consultant psychiatrist. He provided a report based on certain information from statements and other documents (including Charmaine's diaries and the notes and statements of Dr Khong and Dr Tang) then available in the coroner's brief but was not aware of the evidence of Dr Berenson, Emma Ritchie and Selina Day. He had also met with and obtained a history from Mrs Dragun. The summary of that history accords with the evidence given by her, and others, at the inquest.

592 Dr Phillips noted that Charmaine's history was one of unstable mood with problems in the anxiety and depression spectrums. He said the "*separation of anxiety symptoms and depressive symptoms is often difficult, as both groups of symptoms are probably the result of the same causal pathway, be it environmental in origin, biological in origin, or both*." Using common diagnostic criteria he said that "*her minimum diagnosis*" was "*a recurrent adjustment disorder with mixed anxiety and depressed mood*". More likely, though, was that she suffered from "*a more serious major depressive disorder*". Importantly, Dr Phillips noted that there may be some doubt about the major depressive disorder diagnosis because to arrive at this one needs to exclude any manic or hypomanic episodes.

593 Dr Phillips explained that hypomania can be a deliberate strategy; the depressed person chooses to keep busy and active as a "*hypomanic defence*" against depression. In this sense the presence of hypomania does not exclude a diagnosis of a major depressive disorder. But hypomania can have biological

causes not under the control of the person. In this case a major depressive disorder is not the correct diagnosis and one would consider another, like a bipolar condition.

594 Dr Phillips referred to the evidence of episodic upshifts in Charmaine's mood. Whilst he accepted the possibility of a Bipolar II Disorder he considered that the hypomanic defence explanation may have been equally valid. He considered that Charmaine had a number of personality traits that, whilst not evidence of a definable personality disorder, did render her more vulnerable to anxiety and depression, particularly at times of stress. Those personality traits included being "*a constitutionally anxious person, concerned about body image, rather driven, ambitious, extremely perfectionistic and with a strong desire/need to assist others*". He described her as having "*a relative immaturity of her personality, with a high degree of sensitivity (particularly in her relationship with others)*."

595 Dr Phillips was somewhat critical of Dr Khong's management. He noted that "*the treatment … does not appear to have been particularly useful*". He was concerned about long sessions of up to 2 hours. He was also concerned about Dr Khong's technique of separating parts within Charmaine (the C1-C2 exercise) because this might increase the risk of developing "*alters and/or a dissociative identity disorder*". He also thought that the walk to Bobbin Head was "*an unconventional step in therapy if not a break of the normal boundaries which apply in therapy*". Dr Phillips necessarily had a psychiatrist's perspective on this; but Dr Seidler, herself a psychologist, did not share these criticisms noting that the therapist/client relationship in counselling was different to the doctor/patient relationship that would apply with a psychiatric treatment.

596 Dr Phillips was quite critical of the pharmacological management of Dr Tang. He accepted that Dr Tang had concluded, after one consultation, that Charmaine had a major depressive disorder, having evidently excluded a bipolar disorder. He said it was not appropriate for her to have started Charmaine on a revised drug treatment (reduction of Efexor and introduction of Lexapro) when Charmaine was about to leave Sydney and travel to Perth. He was also critical of giving Efexor and Lexapro at the same time because this increased the risk of

her developing serotonin syndrome (a condition that did not, in fact, develop in any fulminant way, if at all).

597 On the possibility that the reduction of Efexor and/or the introduction of Lexapro caused Charmaine to have become suicidal Dr Phillips said that it was "*cautiously accepted within the psychiatric profession*" that this can happen. Of the two he considered it was possible that the Efexor withdrawal exacerbated the worsening of Charmaine's mental state but did not consider that Lexapro would have had much of an effect in this way.

598 Although Dr Phillips remained open minded about whether the correct diagnosis was a major depressive disorder (as Dr Tang thought) with hypomanic defence, or a Bipolar II Disorder, he said that if the inquest were to find that the correct diagnosis was a Bipolar II Disorder then Dr Tang's treatment would attract considerable criticism. What was needed in that case was a mood stabiliser, not a new antidepressant. He felt that Dr Tang may not have obtained an adequate history in her one face to face consultation before arriving at a diagnosis and embarking on the treatment plan as she did.

599 He was critical of the "cross-tapering" treatment plan and said that if Dr Tang felt she had no option but to use two antidepressants concurrently "*the risks of this action should have been made clear to Ms Dragun, and to some other responsible person, with this process being within the business of obtaining informed consent.*" He was also critical of the monitoring of Charmaine's condition by SMS saying "*this cannot be a substitute for face to face interview*", although it may be acceptable in situations of emergency. When Dr Tang considered that Charmaine's mood had become flat (during a phone conversation) "*a face to face evaluation had by then become very important*".

600 In his oral evidence Dr Phillips emphasised the importance of informing the patient of all side effects when embarking on a "cross-tapering" plan (which he did not endorse).

> *More importantly I would say it is critical that if you do have symptoms of any time, I need to know about them when you get them, you are not to wait and sit on this, you are to call me…. And I would say additionally 'Look, if you are happy about it and I hope you are, I would like to involve*

> *your husband or your mother or whoever in the process to that we have some person independent of yourself who might be able to assist me if anything should go wrong.' So it's caution, caution caution.*

601 Dr Phillips said that if a patient refused to allow the psychiatrist to contact a family member or other third party to monitor side effects this should be noted in the doctor's records: "*Well, it's common sense, clearly this is … It suggests that something in fact might be amiss, that something might worsen, that something might go wrong.*"

602 Dr Phillips made some observations about the need for good communication between the treating practitioners. "The psychologist should have reported regularly to medical practitioners at Wetherill Street Clinic, noting that the general practitioner is always the gate keeper and pivotal person in the management of a person referred elsewhere for specialist services."

603 He accepted the mindfulness was a recognised therapy but said "Sadly, I do not think that a therapy based on mindfulness was appropriate for a person suffering either from a diagnosable depression spectrum disorder with episodic suicidal thinking, or for a person who may have been suffering from an undiagnosed bipolar 2 disorder".

604 When Dr Phillips was made aware at the inquest of the evidence of Emma Ritchie and Selina Day he reconsidered the possibility of drug effect. He said that while it may not be the only explanation, drug discontinuation syndrome could explain Charmaine's heightened state and erratic behaviour on the drive to the Enmore Theatre on 27 October and her depressive behaviour the next day at the "Scrabble challenge" after going to Watson's Bay.

605 Regarding Dr Berenson's evidence he said

> *This is new information to me and it's very important information. This is the single most obvious description of an elevated mood state that I have come across in my readings in this case. I would agree with Professor Parker that this at face value is a careful description of somebody suffering a hypomanic mood swing, certainly consistent with a bipolar two disorder but not necessarily diagnostic of a bipolar two disorder.*

606 Dr Phillips said that whilst bipolar disorders had been known about for a very long time, and there has been quite a bit about this "*in the public space*", this has not filtered down into the medical profession itself, which has been slow to keep up to date. He said that most people see a doctor with complaints of depression, not of feeling well. And "*there is a closure of mind at that point*". He said "*The important thing…is for the physician, the psychiatrist to ask the question 'Could this, despite the prominence of depression reflect an underlying bipolar disorder?'*" She said of Dr Berenson "*She is an excellent example of a general practitioner on top of the topic and asking the right questions*."

607 In his oral evidence Dr Phillips explained the practical problem in diagnosing a bipolar condition:

> *To put it bluntly the risk here is diagnostic shutdown where the clinician, as it were, colludes with the client before him or her, who says "I'm depressed doctor" and you leave it at that and you treat from depression. That is not good enough. The important thing is to follow the possibility of an unstable mood disorder with hypomanic features.*

608 Dr Phillips was asked about Dr Khong's strategy for Charmaine to keep busy and get out of herself absorption. He said "I would have thought that in this particular case it would have been far better to spend a great deal more time exploring the actual nature of the mood swings" and then added "business per se is no treatment for depression". Following one's interests is a good thing, but it is secondary when dealing with a biological disorder as he accepted was the case here.

609 Regarding the supposedly bad news read on 1 November over which Charmaine thought she would lose her job, and her worries the next day about the massage course that she might not complete, Dr Phillips said "*these events went well beyond and one would have to expect that the depressed mood was quite significant and therefore she became more ruminative and these became loci of focus and probably made her feel under an ever greater burden."*

610 Dr Phillips said there was strong evidence that Charmaine's death was suicide and that she was not in a psychotic state when she jumped. He referred to the suicide SMS to Simon and the references in her diary to wanting a method that

was quick and certain; "*So there is a number of indications that she knew precisely what she was doing*". The fact that she appeared to be making plans for the future was actually quite characteristic. He said that "*suicidality is characterised by ambivalence*" about wanting to live or to die. He agreed that the combination of perfectionism, negative thinking and hopelessness were well recognised associations to suicidal thinking.

611 On the subject of Dr Tang's reference to "BPD" in her notes and whether this was to "borderline personality disorder" or "bipolar disorder" Dr Phillips originally thought it was the former, but he said "*I don't think there's evidence in the material that I looked at which would support a diagnosis of borderline personality disorder in this particular case*." If noted in the DSM IV criteria it would be in Axis II. Dr Tang did not write in Axis II in her notes that Charmaine had a borderline personality disorder – she noted "*obsessional, perfectionistic traits*". Dr Phillips explained that these traits to not make a diagnosis of borderline personality disorder.

612 Regarding contracts with patients not to commit suicide or to self harm, and to call the doctor if they are having self-destructive thoughts, Dr Phillips said "*I think contracts are a nonsense to put it mildly*".

613 On the subject of the preventability of suicide he wrote in his report

> *It can never be said that a depressed person, will inevitably commit suicide, even when there is a resolve to die. Appropriate treatment including emergency counselling, the introduction of appropriate pharmacological agents (including short term tranquilisers) and the movement of the person to a safe place can be immediately beneficial.*

614 In his oral evidence Dr Phillips said

> *If it were to be found that Charmaine's diagnosis had been wrong and that she suffered from a Bipolar II Disorder, and if she had been properly treated in an evidence based manner for Bipolar II Disorder and formed a proper therapeutic alliance with one person, be it the psychiatrist or the psychologist, then on the balance of probabilities, she would have stabilised, she would not have made a total recovery, that she would have stabilised and she would have gone on to live a relatively normal life thereafter.*

DR MICHAEL DUDLEY

615 Dr Michael Dudley is a Senior Staff Specialist in Psychiatry at the Prince of Wales and Sydney Children's Hospitals and is also the Chair of Suicide Prevention Australia.

616 Dr Dudley provided a report based on the same information provided to Dr Phillips. His opinion focused on the issue of suicide generally and clinical management by psychologists and psychiatrists as it relates to the risk of suicide.

617 Dr Dudley noted that Charmaine's diagnosis according to both Dr Khong and Dr Tang was "*major depression and an anxiety disorder*". He noted some uncertainty about this given there was also evidence of "*melancholic features*". He said that a diagnosis of "*generalised anxiety disorder*" was also possible. A diagnosis of Bipolar II Disorder was possible as well and he noted that this was considered by Dr Khong (at Charmaine's request – Dr Khong told her she did not have this), Dr Berenson (who arranged to referral to Professor Parker for this reason) and Dr Tang (who discussed this with Dr Khong after seeing Charmaine).

618 He noted that there was much confusion and variation of views amongst practitioners about Bipolar II Disorder but said that it had become "*an area of significant change in the psychiatric profession in recent years*". He said the diagnosis was difficult to make without the living patient to interview but he identified a number of matters from Charmaine's diaries and emails that he said evidenced mood swings that would support the diagnosis of a Bipolar II Disorder. After learning of the history of mood swings obtained by Dr Berenson, Dr Dudley said that excluding Bipolar II Disorder would be mandatory, "*the top of the list basically*".

619 Dr Dudley could not identify any evidence that Charmaine was psychotic in the sense that she was unable to form the intention to want to commit suicide. Even though it might be said that "*her sense of hopelessness and worthlessness was profoundly out of touch with reality*" this was common in people who commit

suicide. He referred to the SMS sent to Simon moments before she jumped and to the diary entries that confirm that she had been contemplating suicide for some months. It was his opinion that Charmaine did commit suicide.

620 Dr Dudley said that "suicide is never predictable" because "for every person who kills him/herself with a set of risk factors there are many more with the same risk factors who do not do so." Nevertheless, "there is much that can be done to prevent it, using strategies to target whole populations, as well as high risk groups and individuals". He said that "most…have predisposing mental health or social risk factors". He said this about suicide generally:

> *Suicide is a rare event with multiple yet non-specific causes. Through the life-span and across countries and cultures, suicide and suicidal behaviour arise from complex social, situation, illness and other individual factors, which isolate people and erode their hope. It is a recognised complication in a significant minority of those who suffer with affective and other disorders. Suicidal people often suffer mental disorders, unbearable psychological pain and/or intolerable situations, and from the wish to die, which is frequently characterised by ambivalence. Those attempting suicide frequently state they want the pain to stop, cannot think of alternatives, and want time out. Interpersonal motivations include a cry for help, the wish to make reparation, or punishing oneself or others. Suicidal behaviour is complex, often indirect, communication, frequently driven by feelings of disconnection and burdensomeness, and often the misperception that one's death will relieve others. Associated stigma (including the way suicidal people are treated) increases risk. It has an enormous impact on family, friends, and professionals.*

621 Dr Dudley noted that bipolar disorders carry an increased risk of suicide attempts and suicide. Anorexia nervosa has a very strong relationship with suicide as well. A sense of hopelessness is a very large factor as well. On a more particular level Charmaine's "*negative cognitive self, self-criticism and low self-esteem; high trait anxiety; and her concealment of how she felt from nearly all her friends*" all had a clear relationship with suicidal thinking and behaviour.

622 Dr Dudley said that just because a person commits suicide whilst under the clinical care of a health professional this "*is not automatically an indication of system or individual professional failure*", but when it occurs a review is required. "*This is so all systemic learning may be taken on board… Where system errors*

or flawed processes are identified, there must be a commitment to correct these through quality improvement processes."

623 Having regard to the published studies about the increased risk of suicide associated with antidepressants Dr Dudley considered the evidence of a causal relationship questionable. "*The far more compelling link is between suicide, depression, and the absence of treatment with antidepressants*". (But see the above referenced article cited by Dr Pelser and the limitations of such studies.) He said that while Efexor withdrawal "*is noted to be quite problematic in many people*" he said there were no clear evidence-based guidelines on the safest methods of withdrawal.

624 Overall, Dr Dudley was not critical of the management of either Dr Khong or Dr Tang, based on what he understood from the documentary evidence. But his opinions changed somewhat when he gave oral evidence at the inquest.

625 He said that if Dr Tang was considering a bipolar disorder (and if the reference to "BPD" was to bipolar disorder and not borderline personality disorder then she was), she should have asked more probing questions of Charmaine about her mood swings. He also said that if the only side effects that Dr Tang informed Charmaine about were headache and nausea (according to Dr Khong's notes of her conversation with Dr Tang) that this was inadequate. "*The side effects that people need to know about with these drugs are the really serious ones and you know, the ones that you worry about most is… serotonergic syndrome… but also activation or agitation which is like treatment emerging suicidality which, you know occurs probably in about 1 to 2% of people stopping or starting these drugs*".

626 Dr Dudley was not persuaded by the efficacy of "no-suicide contracts". He said that "*if used coercively, they may potentially obscure risk*". He felt that statements of "*commitment to treatment*" might be a better alternative than having the patient promise not to commit suicide.

627 He said that there was a common misconception that suicide cannot be prevented: "Once an individual decides to complete suicide, intervention is

fruitless because the individual will simply attempt or complete suicide at another time". He said that if warning signs had been recognised by others then Charmaine's death could have been prevented. He recognised, though, that Charmaine was being secretive, not discussing the depth of her depressed feelings with others. He said that the stigma attached to suicide is an impediment to suicide prevention efforts. It prevents people from seeking help.

> *These types of attitudes and the punitive responses expressed by many heath care professionals have major implications; one being the loss of contact with people who could otherwise be helped. Often, the ideas and prejudices surrounding suicide discourage people from talking about their suicidal thoughts.*

628 He added

> *While evidence for this is inferred rather than being directly available in Ms Dragun's case, there is a strong suggestion that her sense of hopelessness and worthlessness led to a sense of shame, which may have made her even more isolated.*

629 He mentioned that most people who exit psychiatric hospitals or attend emergency department do not get a "crisis plan" about what to do if their situation deteriorates, but he said that such plans should be given routinely.

630 There is one matter about which Dr Dudley said there were good, well-validated strategies for preventing suicide and that is restricting access to the means of suicide.

> *Restricting means of suicide is highly effective, frequently deterring suicide by the method in question but also overall suicide rates… Placing barriers in conspicuous suicide sites has prevented jumping, not only from those sites, but elsewhere.*

631 Dr Dudley believed that "*the absence of any effective barriers or other forms of intervention was crucial in the death of Ms Dragun*". He noted that coroners have made recommendations in the past regarding fencing at The Gap and installing phones. He said that although there were now some CCTV cameras they were not manned 24 hours per day and the images do not go to the police.

632 He said that the Australian Suicide Prevention Advisory Council endorsed certain infrastructure proposals but funding was not forthcoming from the Federal Government. He referred to details of a "*masterplan*" developed by Woollahra Council "*to effectively deal with The Gap as a suicide hotspot. The intent is to simultaneously enhance The Gap as an international tourist destination, and to destigmatise it and prevent it being used as a suicide hotspot."* He said that the Federal Government was assessing the plan.

FINDINGS ON THE ISSUES IN THE INQUEST

1. DID CHARMAINE COMMIT SUICIDE?

633 In relation to suicide it "..is not to be presumed. It must be affirmatively proved to justify the finding." (*Sellers LJ in Re Davis (deceased)(1967) 1 All ER 688.* The Coroner must be 'comfortably satisfied' that the person intended the consequences of his or her actions. (*Briginshaw v Briginshaw (1938) 60 CLR 336 at 361)*

634 I am comfortably satisfied that Charmaine's death was an act of suicide. Her jump from the cliff at The Gap was done with intent and in the full knowledge of its consequences. This is supported by her mobile phone text message to Simon that included the following: *"Sime, I'm so sorry for what I'm about to do. I can't conquer my thoughts. Please know this is no one's fault but mine."* Charmaine had been contemplating suicide and writing about this from at least the end of July 2007. She was looking for a method that would be "*quick and easy*" and certain.

635 Although she had been reducing the dose of Efexor and introducing Lexapro in the two weeks before she died, and although there are warnings of increased suicidality in these circumstances, it cannot be said that these drugs "caused" Charmaine's suicide in the sense that they put the idea of suicide into her head or "caused" her to behave in an irrational way and with no control over her

actions. The antidepressant drugs may well have been involved in Charmaine's suicide, but only in an indirect way.

636 The fact that Charmaine chose a violent method whilst most women do not, and the fact that people often make several attempts at suicide and this was Charmaine's first, do not displace the clear evidence that Charmaine meant to die when she did and the way she did. These matters, whilst they may be unusual in a statistical sense, do not lend support to any theory that she was somehow acting irrationally or without control.

637 Similarly, the fact that Charmaine was making future plans to see a concert in December or to attend work functions the following year does not argue against her death being a suicide. The expert evidence was that most people who commit suicide are ambivalent about whether to live or die and making future plans whilst at the same time making plans to end one's life is not uncommon.

2. WHAT WAS THE TRUE NATURE OF CHARMAINE'S MENTAL ILLNESS?

638 Charmaine had been diagnosed with an anxiety disorder with depressive symptoms. She had been taking antidepressants from the age of 18 after battling with anorexia nervosa. She began taking the drug Zoloft in 1996. This was changed to Efexor in 2004. Two weeks before she died Charmaine was reducing the Efexor and introducing Lexapro. All of these were antidepressant drugs and all were given in the belief that Charmaine was suffering from depression.

639 The diagnosis of depression (or an anxiety disorder with depressive symptoms) was understandable. Charmaine often found herself in dark moods with signs and symptoms that affected both her mind and her body. The inquest was mostly concerned with the period after she moved from Perth to Sydney in 2005, and in particular the period from late in 2006 to her death in 2007 when she was being treated by many health care professionals here. During this time Charmaine reported despondency and crying, feeling very unhappy with no

control over it, lacking in energy and motivation and being beset by negative thoughts. In November 2006 she completed a self-assessment questionnaire and scored in the "extremely severe" range for depression, anxiety and stress.

640 Charmaine also had personality features that were relevant to her emotional problems. She was a perfectionist, was highly self-critical and had low self esteem. She felt inadequate despite objective success in her field as a news presenter. She was fearful of confrontation of any kind and eager to please others.

641 Charmaine was also a very private person who would not talk about herself and would deflect the topic of conversation from herself to others whenever possible. She wanted to stop taking antidepressants because they made her feel "artificial" and she considered her need for these drugs to be a sign of personal weakness and failure. She was fearful of being judged and disadvantaged at work if anyone found out that she had depression and was taking medication and seeing a psychologist.

642 But Charmaine's depressive symptoms were far from continuous. She reported to one of her GPs that she could feel "*happy one minute then really down the next".* She told her psychologist that she was concerned about her mood swings and asked whether she might have a bipolar condition. In both cases the diagnosis of depression was maintained. In the latter a bipolar condition was excluded.

643 While Charmaine's treating health professionals saw and heard only the dark side of her life, her friends saw a very different side. One described her as "*the happiest person in the room*". Another said "*it was infectious… the amount of joy that she radiated to see you for the first time was amazing"*. One of her work colleagues described her as "*The Energiser Bunny*". Another friend said "*She loved her friends and family, loved her life*". With one notable exception Charmaine's many friends had no idea that she suffered from depression, or was taking medication or seeing a psychologist. They were completely shocked when she died, believing that Charmaine was the last person in the world they ever thought would commit suicide.

644 Whilst the diagnosis of depression that followed Charmaine since her teenage years may have been understandable, it was almost certainly wrong. Of all of the health professionals who saw Charmaine in Sydney only one – the most experienced one – questioned the diagnosis of depression.

645 The evidence from the three expert psychiatrists in the inquest supported a finding that Charmaine probably had a Bipolar II Disorder and that while her *downs* certainly presented as "depression" there were *ups* characteristic of "hypomania". A Bipolar II Disorder is thought to be 5 to 10 times more common that a Bipolar 1 Disorder (previously known as "manic-depression") and is associated with a very high risk of suicide – higher than with a Bipolar 1 Disorder. The reason for the difference is probably that a Bipolar II Disorder is more easily missed and therefore goes untreated in the vast majority of cases. This appears to be what happened in Charmaine's case.

3. CHARMAINE'S MANAGEMENT BY HER GENERAL PRACTIONERS DR CUGADASAN, DR CLOWES AND DR BERENSON

646 When Charmaine first saw Dr Cugadasan at the end of 2006 she presented with a history of increased moodiness and complaints of anxiety, reduced self-esteem, lack of motivation and job dissatisfaction. She learned that Charmaine had been taking Efexor for the last two years. Although she obtained a history that Charmaine "*can feel happy one minute then really down the next"* she considered this to be consistent with a diagnosis of depression.

647 Dr Cugadasan increased the Efexor dose from 75mg to 112.5mg per day, arranged for her to be seen by a psychologist, and asked to see Charmaine a week later. At the second consultation Charmaine reported that she had seen the psychologist and was feeling much better. Dr Cugadasan looked at the self-assessment questionnaire (the DASS) that Charmaine had filled in soon after the first consultation with scores in the "extremely severe" range for depression, anxiety and stress. She did not consider that the significant improvement in

Charmaine's mood within one week could be the sign of a mood swing. She considered this improvement to be consistent with depression.

648 At the next consultation Charmaine requested Dr Cugadasan to write a referral to a new psychologist that she had found, Dr Khong. Dr Cugadasan obliged and her brief referral note mentioned that Charmaine had "*anxiety, depressive symptoms and is on Efexor 75 mg 1.5 tablets daily."* No further information was provided.

649 Dr Clowes took over Charmaine's management after Dr Cugadasan took maternity leave. In late July Charmaine complained of worsening depression. This was after her return from the trip to Europe with Simon (described as "*the happiest time*" he had seen her) and after she was writing about suicide in her diary. Dr Clowes noted that Charmaine was "*struggling with depression again*" and "*actually had thoughts of death, never before this*." She did not consider Charmaine to be at risk of suicide at the time of the consultation and so did not arrange referral to a psychiatrist. She knew that Charmaine was still seeing psychologist Dr Khong regularly. She increased the Efexor dose from 112.5mg to 150mg per day and told Charmaine to come back in three weeks.

650 When Charmaine returned for review three weeks later she complained that she was not much better and was impatient for the increased dose of Efexor to take effect. Her impatience was well founded because Dr Clowes had expected improvement by three weeks and there was literature to the effect that if there was going to be improvement it would probably be seen in about two weeks. Although it appeared that her management plan was ineffective Dr Clowes told Charmaine to give the increased Efexor a further three weeks to work. She had a chat with Charmaine about "*making the transition to adulthood and being self-determining*". This was consistent with a belief that Charmaine's problems were primarily psychological and her encouragement was consistent with the kinds of messages that Charmaine was getting from Dr Khong.

651 There was no further consultation with Dr Clowes for review three weeks later (and no appointment for this in Charmaine's daily diary). The next time Charmaine went to the GP clinic was on 29 September when she expected to

see Dr Clowes and get a referral to see the psychiatrist that Dr Khong had recommended, Dr Tang. But Dr Clowes had left the clinic and Dr Berenson saw Charmaine.

652 Dr Berenson applied her 38 years of experience as a GP to Charmaine's case. She read the records and was concerned by the note "*can feel happy one minute then really down the next*". She was also concerned by the fact that Charmaine had been taking increasing doses of Efexor and had been seeing a psychologist all year but had not shown any consistent improvement. In her opinion the diagnosis of depression did not fit the picture because with all of this intervention she should have been much better. "*I didn't think it was right – it didn't feel right at all to me, didn't have a good fit. Sometimes you feel you know the diagnosis is right, but this didn't feel right at all.*"

653 She then asked Charmaine to describe not just her "downs" but also her "ups". This discussion took about half an hour. Dr Berenson heard enough to raise a concern that Charmaine might have a bipolar disorder. She prepared two short referral letters and gave them to Charmaine. One was for Dr Tang, as requested, and this was to review her medications. The other was to Professor Parker at the Black Dog Institute, and this was to consider a diagnosis of a bipolar condition. Charmaine eventually saw Dr Tang, but she never saw Professor Parker. It is not known whether Dr Tang saw the referral letter to Professor Parker that specifically referred to a bipolar disorder, but Dr Tang was aware that such a referral existed.

654 The difference between the management by Dr Cugadasan and Dr Clowes on the one hand and Dr Berenson on the other was stark. While it is true that Dr Berenson had more information available to her than was available to each of the others, she was impressed by the history of mood swings when Dr Cugadasan was not, and she considered the lack of improvement following the increase in Efexor from 75mg to 150mg to be significant when Dr Clowes did not. She asked questions about Charmaine's "ups" and not just her "downs". She was prepared to entertain a diagnosis other than depression while the other general practitioners were content to maintain this despite mounting evidence that cast doubt on that diagnosis.

4. CHARMAINE'S MANAGEMENT BY PSYCHOLOGIST DR. KHONG

655 Dr Khong saw Charmaine on 16 occasions in 2007. She had more opportunity than any other health practitioner to obtain a thorough history and explore diagnoses other than depression. She was not provided with much information from Dr Cugadasan at the time of original referral. She was not aware of the DASS scores nor was she provided with notes from the consultations with her that included "*can feel happy one minute then really down the next"*. She said that even if she had this information it would not have changed her management of Charmaine. Dr Khong was very confident about her clinical skills and her ability to assess a patient.

656 Dr Katie Seidler, an expert psychologist who gave evidence at the inquest, said that Charmaine was the 1 patient in 10 who presented to a psychologist with a biologically-based, endogenous mental disorder. Dr Khong failed to recognise Charmaine as such despite the fact that there were strong reasons to suspect it. The history of anorexia nervosa, the longstanding nature of her supposed depression that persisted despite increases in medication, and her difficulty meditating (a core practice of her "mindfulness" technique), all pointed to Charmaine having a problem that was greater than just "*several episodes of depression and high anxiety relating to development issues of self-esteem*" – which is what she told Dr Tang over the phone on 28 September when arranging an appointment for Charmaine to see her.

657 Dr Khong's Buddhist approach to psychotherapy, with its emphasis on "mindfulness" and the need to take personal responsibility for one's emotions is not objectionable in itself.

658 All of the experts agree that there is a place for such techniques. But Charmaine was unable to get whatever benefits were available from Dr Khong's techniques because her mental illness prevented the message from getting through.

659 Dr Seidler described Charmaine's mental illness as causing a "*white noise*" in her brain and likened it to a "*virus in a computer*" that prevented her brain from working properly. All of the experts, as well as Dr Tang, agreed that Charmaine's mental illness had a "*significant biological component*"; there was a problem with brain chemistry and this was not going to be fixed by exhortations to meditate, exercise self-compassion or assume more personal responsibility.

660 Dr Khong recognised that Charmaine's problems did have a biological component, but her approach to this was to use "mindfulness" as a technique to "re-wire" the neurophysiology of the brain. It was not until late September that she arranged a referral for Charmaine, who was then feeling quite suicidal, to see Dr Tang for review.

661 Although she said the review was to look at medications and the whole picture, the referral note from Dr Berenson to Dr Tang, said to have been based on discussions with her, was to check the medications.

662 Long before then, during the month of May, Charmaine told Dr Khong that she was concerned about her mood swings and asked whether she could have a bipolar condition. Dr Khong consulted a book, read through the criteria for "mania" and reassured Charmaine that she did not meet the criteria. This was a very cursory exploration of a very significant issue.

663 Dr Khong said that she considered not only Charmaine's answers to the criteria for "mania", she had regard to "hypomania" as well and took into consideration the whole of her knowledge of Charmaine from all of her consultations up to that time. But Dr Khong never observed Charmaine to be "up" and never obtained a history of her "ups" like Dr Berenson was later able to do. That is because she did not know to ask the right questions, or to ask them in a way that would elicit the answers that Dr Berenson was able to get.

664 Dr Khong did not tell Dr Tang of Charmaine's suicidality when she made the phone call on 28 September to arrange a referral. Why she did not do so is not known; in fact Dr Khong's evidence was that she was quite sure she did tell Dr Tang but I have rejected her evidence on this point. She certainly should have

told her. Dr Tang said that if she had known that Charmaine was having suicidal thoughts she would have directed Dr Khong to find someone else to see Charmaine urgently as she herself was unavailable for the next two weeks.

665 Charmaine's emotional state worsened in early October. On 12 October she saw Dr Khong again with suicidal thoughts but no specific plans. She rated her depression as 9/10. Dr Khong decided that it was important to change Charmaine's mood (because, as she once noted, "*thoughts create the depression and the depression creates the thoughts – mood is low, thoughts are negative*"). She took Charmaine on a walk to Bobbin Head National Park.

666 That walk had a profound impact on Charmaine. Her diary reveals that she became calm after contemplating the impermanence of life and the need to accept change. These were the kinds of messages that she was getting from her treatment with Dr Khong and were consistent with Buddhist teachings.

667 Whether impermanence was discussed in those terms during the Bobbin Head walk is not clear, but the issue probably came up. Both Dr Seidler and Dr Tang thought that such ideas could lead to unintended problems for a person already thinking about suicide. Dr Khong said she did not intend the walk to somehow give Charmaine permission to accept death and surely she could not have intended this. But such acceptance may have been an unintended consequence.

668 Sarah Bamford was the only one of Charmaine's friends to have known the truth about her mental illness, her antidepressants and that she was seeing a psychologist. She saw Charmaine the day after the Bobbin Head walk.

669 Charmaine was observed to be unusually calm. Ms Bamford said "I was thinking I wonder if this is something I should be worried about given that she'd been quite depressed leading up to that night". Her concern was well founded because there was expert evidence that most people are very calm when they resolve to commit suicide.

670 Four days after the Bobbin Head walk Charmaine saw Dr Tang. She was noted by Dr Tang to be "*Energetic. Feeling well*". The lift in mood after the walk

allowed her to complete the Brad Hodson video project, which was a source of considerable stress.

671 Dr Khong discussed the consultation on 18 October but did not tell Dr Tang that on 12 October Charmaine had been feeling suicidal again and that her mood only lifted after being taken on the walk. Dr Tang said that if she had known this she would have called Charmaine back for review because her upbeat presentation was so different from how it was days earlier it could be the sign of mood instability.

672 Charmaine had a good relationship with Dr Khong. From Dr Khong's perspective it was always a therapist/client relationship and although more collaborative in nature than the doctor/patient relationship in psychiatry, she always maintained her professional distance.

673 From Charmaine's perspective the relationship was more of a friendship, or at least this is how it came across to others including her mother, Simon and Sarah Bamford who knew that Dr Khong was a psychologist and that Charmaine went to her for treatment.

674 The importance of the therapeutic relationship cannot be understated. Dr Seidler explained that the therapeutic relationship itself is probably more important than the techniques actually used by the therapist.

675 One potential problem when a client like Charmaine sees her therapist as a friend is that, Charmaine's character being what it was, she would not want to say or do anything to upset a friend. When Dr Khong made her "contract" to be available 24 hour a day 7 days a week if she ever felt the need to talk, Charmaine balked at this saying she did like to bother people. She also had great confidence in Dr Khong and was thankful for all that she had done with her. Dr Khong's own notes refer to Charmaine telling her "*You are tough and good*" and that she would do "*Whatever it takes to continue the counselling"*.

676 The fact is that Charmaine did not tell Dr Khong about her thoughts of throwing herself in front of a truck (which she did tell Dr Tang). When confronted by Dr

Khong about this in a later session Charmaine said she did not tell her because the thoughts were negative and fleeting. Nor did Charmaine call Dr Khong in the days leading up to 2 November. It may be that Charmaine did not contact Dr Khong because she was already speaking with Dr Tang. But it may also be that she felt she could not call Dr Khong because she may have felt that she had failed her by not getting better despite all of the care and treatment she had been given for the previous 9 months.

5. CHARMAINE'S MANAGEMENT BY PSYCHIATRIST DR. TANG

677 Dr Tang denied that she had considered a diagnosis of a bipolar disorder during her one and only consultation with Charmaine on 16 October. But I am satisfied that she did consider this, however the diagnosis of an under-treated Major Depression seemed to better fit the facts as she understood them.

678 The problem is that Dr Tang was not given a proper history from Dr Khong. She was not told of Charmaine's suicidal thoughts on 28 September, the day Dr Khong phoned her to arrange a consultation. She was not told of the Bobbin Head walk on 12 October which lifted Charmaine from deep depression and suicidal thoughts, and would have explained Charmaine's positive presentation on 16 October.

679 It is true that some criticism may be made of Dr Tang for not getting from Charmaine directly a more complete history of suicidal thoughts. Equally, Dr Tang may be criticised for not getting a history of her "ups" as well as her "downs" which should have been explored as part of the exclusion of "any hypomanic episode" before arriving at a diagnosis of Major Depression according to the DSM IV criteria. But Dr Tang was able to obtain a very comprehensive history, which, even if it did not explore the bipolar issue deeply, at least led her to think about it.

680 If she had been given more complete information from Dr Khong there is every reason to believe that Dr Tang would have looked at the issue of mood swings more carefully and have come to a diagnosis of Bipolar II Disorder. I am

satisfied that she actually mentioned this very diagnosis to Dr Khong when they spoke on 18 October and that this idea did not originate with Dr Khong.

681 Dr Tang was right to consider that there was a clear biological component to Charmaine's mental problems because the diagnosed depression was out of proportion to the social and psychological triggers that were thought to be the main cause.

682 She was also right to think that this condition had been undertreated up to that time. Her treatment plan was to remove the antidepressant that did not appear to be working and was causing what she considered side effects of agitation (Efexor) and introduce another antidepressant with a lower side effect profile (Lexapro). This made sense in the context of what Dr Tang believed she was dealing with: depression that had not been adequately treated by the antidepressants being taken so far.

683 The "cross-tapering" of Efexor and Lexapro was a practice that was not endorsed by the experts in the case and it was contrary to the "switching guidelines" of the manufacturer of Lexapro. But it was a recognised technique and one with which Dr Tang said she was familiar.

684 Such a practice required very careful monitoring not only because of the well known and often significant withdrawal effects of Efexor and the side effects of introducing Lexapro, but also the potential for both to act together which might lead to a patient developing serotonin syndrome. Central to proper monitoring is advice to the patient about what withdrawal effects or side effects to look for.

685 It is difficult to understand why, if increased agitation and suicidality are the major concerns when "cross-tapering" Efexor and Lexapro, Dr Tang would not have made this clear to Charmaine. She insists that she did and also that she told this to Dr Khong. But Dr Khong's notes of this conversation refer only to the drug effects of headache and nausea; nothing is written about agitation and suicidality.

686 It is hard to believe that Dr Khong, who took extremely careful notes, would not have noted these major drug effects if Dr Tang had told her. It is also hard to

understand why, when Charmaine was clearly anxious and panicky and had two minor car accidents on 27 October (the night of the Josh Pyke concert with Emma Ritchie) and was confused, distant and distracted on 28 October (after going to Watson's Bay and then for the "Scrabble Challenge" with Selina Day) she would deliberately fail to tell this to Dr Tang when they spoke on 29 October.

687 The events of 27 and 28 October must have had significance to Charmaine. She told her mother and Sarah Bamford that she expected to be feeling better by then and could not understand why the drugs were not working. She increased the Lexapro from 5mg, which she started on 27 October, to 10mg on 29 October even before speaking with Dr Tang. Either Charmaine did not want Dr Tang to know that she was having withdrawal effects and side effects from the drugs, or she did not recognise these as drug effects. The latter explanation is more likely.

688 There was expert evidence that a patient who was having drug effects like anxiety, panic attacks and re-emerging depression, but was not told to expect them, might become very distressed. When one adds to this that Charmaine was told by Dr Tang to give the Lexapro a few more days "*to kick in*" it invites the possibility that Charmaine may have felt that anxiety, panic and depression was her "natural" state – the state she was in before drug treatment "*kicked in*".

689 We know that Charmaine's mood remained low throughout that week and her mother and Dr Tang, both of whom spoke with her on 1 November, corroborate this.

690 We also know that on the night of 1 November she was distraught at what she described as her "worst read ever" on the news and was fearful of losing her job. In fact, the news read was virtually flawless and the fear of losing her job utterly irrational. The next morning she told Simon she was worried about not being able to complete a massage course – a concern that was completely unnecessary.

691 It is against this background of probable drug effect that was not recognised as such, and ongoing depression and anxiety and increasing irrationality endured while waiting for the Lexapro to take effect, that we must understand

Charmaine's last message: *"Sime, I'm so sorry for what I'm about to do. I can't conquer my thoughts. Please know this is no one's fault but mine."* She thought the problem was with her. She did not appreciate that the distressing feelings and behaviour she was exhibiting were probably due to the "cross-tapering" of her antidepressants – the withdrawal effects of Efexor, the side effects of the introduction of Lexapro and possibly also the serotonergic effects of both of these drugs being given at the same time.

692 The other issue arising from the increased risks from "cross-tapering" concerned the monitoring of drug effects by others.

693 Dr Tang said that she specifically asked Charmaine if she could contact her mother and Simon to enlist their help in monitoring but Charmaine refused to give permission for this. There was no record of such permission being refused although such a note might be expected. It is certainly possible that Charmaine did not want Dr Tang to contact them because she felt able to monitor herself and did not want to worry them with talk about suicide. This is not something about which a finding can comfortably be made either way.

694 Finally, I am satisfied that Charmaine left Dr Tang full of hope that her mental problems would finally be solved and that she would soon be off Efexor. Whether Dr Tang used the word "*revolutionary*" or told her of successful treatment of another patient is not clear.

695 What is clear is that Charmaine made a huge emotional investment in Dr Tang's treatment and saw it as "*a light at the end of the tunnel*". It is likely that Dr Tang did encourage this hope and not likely that Charmaine was so overwhelmed by her own wishful thinking that she was somehow unable to take on board the warnings of drug effect – especially increasing anxiety, agitation and worsening depression – that Dr Tang claims to have imparted. If she had, it is hard to understand why when Charmaine experienced all of these in her last week she did not say so to Dr Tang.

6. RISKS, SIDE EFFECTS AND WARNINGS ASSOCIATED WITH THE ANTIDEPRESSANT DRUGS EFEXOR AND LEXAPRO

696 The product literature for Efexor and Lexapro warns of risks and side effects. To a large extent those warnings were “generic” and required by the Therapeutic Goods Administration to accompany all antidepressants sold in Australia.

697 The product literature states that suicidality is strongly linked to depression and this is so whether or not a person is taking antidepressants. The risk of worsening depression and suicidality is, however, increased when antidepressants are being introduced for the first time, when the drug is being withdrawn, and at any time that there are dosage changes, either increases or decreases.

698 here are many side effects of taking these drugs or withdrawal effects when they are stopped or the dose is reduced. Relevant to Charmaine’s case these included, in addition to worsening depression and increased suicidality,

- Headache
- Nausea
- Agitation
- Anxiety
- Confusion
- Nervousness
- Panic attacks
- Impaired driving
- Psychomotor restlessness
- Other unusual changes in behaviour
- Hypomania

- Serotonin syndrome

699 The product literature recommends that family members or other similarly placed persons be contacted by prescribing doctors to enlist their support in observing a patient for these drug effects because sometimes the patient may not be able to recognise these effects for what they are.

700 The representatives of the drug companies who gave evidence at the inquest emphasised that the prescribing doctor has the primary responsibility for ensuring that a patient knows what effects to expect and for putting in place whatever monitoring is appropriate in the circumstances.

701 Dr Tang was the only doctor about whom issues of knowledge of side effects and issues of monitoring arose. She said that she was aware of the potential effects of her "cross-tapering" treatment and in particular about the increased risks of agitation, worsening depression and suicidality. She said she warned Charmaine about these risks and said that her monitoring over the telephone was aimed at precisely these concerns. She also said that she wanted to arrange for Charmaine's mother and Simon to assist in monitoring her, but says that Charmaine refused her permission to contact them.

702 The inquest did not concern itself with whether antidepressants were overused in Australia, or how effective they were and whether the product literature about risks and side effects was as good as it might be. The issue was limited to warnings and I am satisfied that the relevant warnings about withdrawing Efexor and increasing Lexapro and the need for careful monitoring were appropriate.

7. WAS CHARMAINE'S DEATH PREVENTABLE?

703 Suicide is never predictable but there are well known signs associated with suicidal ideation. These include: perfectionism, negative thinking and hopelessness.

704 Charmaine was a perfectionist by nature. Her mother said so. All who knew her observed this. It probably was a positive factor in her achieving the success that she did in an exacting field.

705 All who treated Charmaine noted the negative thinking and two weeks before she died Dr Tang obtained a history that her mind was "*churning +++"* and she had "*negative cogitations +++ verging on irrational*".

706 Towards the end Charmaine was sliding into hopelessness and ultimately was resigned to this with the message: "*Sime, I'm so sorry for what I'm about to do. I can't conquer my thoughts."* In what can only be described as a misplaced assumption of personal responsibility she continued, "*Please know this is no one's fault but mine."*

707 Counsel assisting submitted that Charmaine's death was both tragic and cruel. It was tragic because her thoughts could have been conquered, and cruel because she bore the guilt of believing that she did not have the strength of character to conquer them.

708 Charmaine probably did have a Bipolar II Disorder. Professor Parker explained

> *The high suicide rate in this condition probably reflects the severity of the depressed mood state and the desperation that many people feel when they "come off a high" and are aware that they are going back into a depressed phase and start to anticipate the "torment". During the depressed phase, some may experience 'retardation' (marked by slowed thinking and impaired concentration, as well as by a lack of energy) but some may experience agitation (where they will have great difficulty in settling and often have a myriad of morbid worries and concerns). The latter agitated state provides a higher risk to suicidal ideation.*

709 He went on to say

> *Most individuals with this condition will need a mood stabiliser as well as education and a 'stay well plan' designed to address the mood oscillation. Most importantly, they need confirmation of the diagnosis so that they can be made aware of what they need to learn about and how to address their condition. In a percentage, mood stabilising medication will bring the condition under total control alone, while the combination of medication, education and a stay well plan will bring it under complete or almost*

> *complete control for another significant percentage. Such successful management is usually contingent on making the diagnosis.*

710 Dr Phillips agreed

> *It if were to be found that Charmaine's diagnosis had been wrong and that she suffered from a Bipolar II Disorder, and if she had been properly treated in an evidence based manner for Bipolar II Disorder and formed a proper therapeutic alliance with one person, be it the psychiatrist or the psychologist, then on the balance of probabilities, she would have stabilised, she would not have made a total recovery, that she would have stabilised and she would have gone on to live a relatively normal life thereafter.*

711 It follows that if those health professionals treating Charmaine had made the correct diagnosis of a Bipolar II Disorder she would have been properly treated with a mood stabiliser and she probably would not have committed suicide. Their failure to diagnose a Bipolar II Disorder was therefore causative of Charmaine's suicide.

712 A suspicion of Bipolar II might have been made by Dr Cugadasan or Dr Clowes, especially by the latter who probably should have arranged a psychiatric review when Charmaine was still not getting better after the increase in her Efexor to 150mg per day.

713 The diagnosis should have been explored properly by Dr Khong with referral to a psychiatrist after Charmaine herself brought this issue "*to the table*" at a session in May.

714 Dr Tang would almost certainly have made the diagnosis if she had been given a proper history from Dr Khong either before the consultation on 16 October or on 18 October when Dr Khong should have informed her of the Bobbin Head walk on 12 October.

715 Further, if the events on 27 October when Charmaine was anxious and panicky and had two minor car accidents on the way to the Enmore Theatre, and on 28 October when she went to Watson's Bay and then was observed to be distracted, confused and distant, had been recognised by Charmaine as likely drug effects she probably would have reported this to Dr Tang on 29 October.

716 This would have led to a review of her condition and probably arrested the slide into further agitation and hopelessness that occurred later that week. In this way the failure to properly alert her to drug effects of the "cross-tapering" was an indirect cause of Charmaine's suicide.

717 Quite apart from the deficiencies in her management by her health professionals, Charmaine's suicide would not have happened if she had been prevented access to the cliff edge at The Gap. Dr Dudley, whose special interest was suicide prevention and who was the Chair of Suicide Prevention Australia, said that it was a misconception that if you prevent access to one spot a person wanting to commit suicide would simply go somewhere else. He referred to studies that have demonstrated that

> *restricting means of suicide is highly effective, frequently deterring suicide by the method in question but also overall suicide rates… Placing barriers in conspicuous suicide sites has prevented jumping, not only from those sites, but elsewhere.*

718 The failure to prevent access to the cliff edge at The Gap was therefore a causal factor in Charmaine's suicide.

8. THE EFFECT OF CHARMAINE'S DEATH ON OTHERS

719 It is impossible to fathom the extent of the grief suffered by Charmaine's family and her partner Simon. Her death impacted many others including her many friends and work colleagues that gave evidence.

720 Charmaine's death had consequences for people she never knew. Mr Skalvos, who wanted to approach her at The Gap but was instructed not to, was deeply affected. He has said that faced with the same situation again he would approach a person at The Gap because he said that living with the fact of not having done something is worse than knowing that you did not even try. Hopefully he will not be faced with this kind of situation again.

721 Detective Senior Sergeant Despa Fitzgerald is a veteran crisis negotiator. She described the awful impact that suicide cases have had on her personally and on

other members of the police and rescue teams. Their emotional welfare needs to be taken into account as well and I have made a previous recommendation in relation to that issue.

9. SUICIDE PREVENTION STRATEGIES AT THE GAP

722 Detective Senior Sergeant Fitzgerald set out in a Statement dated 19 March 2010 the work that has currently been completed in relation to the 'Gap Suicide Minimisation Plan'.

723 She stated;

> *"The new fence that has been installed to date starts at a point 8 metres south of the Dunbar Anchor and continues southward following the same alignment of the previous fence as far as the southern boundary of Christison Park, a distance of 1573 metres.*
>
> *The section in front of Macquarie Lighthouse has not been done as this is Commonwealth owned and managed land, not the responsibility of Woollahra Council. The last sections to be undertaken by Woollahra Council are the replacement of the section at The Gap which extends from the boundary with the Sydney Harbour National Park to the Dunbar Anchor"*

724 She has said that there is CCTV that, I believe is monitored by a private security firm, recording defined preset views. There are two phones set up near the main entry points (North and South) and have been in operation since 5 March 2010 one accesses Triple 0 and the other 'Lifeline'.

725 The need for work to be completed at The Gap was reinforced by Dr Dudley who said that

> *a masterplan has been developed to effectively deal with the Gap as a suicide hotspot. The intent is to simultaneously enhance the Gap as an International tourist destination, and to destigmatise it and prevent it being used as a suicide hotspot.*

726 He stated that the funding application to the Federal Government provided for;

- In leaning fencing, which is aesthetic, but also poses an effective barrier

- New lighting in viewing areas

- 9 CCTV cameras at entry points to the Park, also thermal cameras
- Improved surveillance by removing vegetation, and a new stairway to improve visibility
- New seating
- Extended fencing into National Parks and Wildlife land (two sets of cameras have been installed on NPWS land, and a digital camera).
- Improved relationship with local Police, in concert with Lifeline.
- Making local community aware of what is being done through workshops
- Residents who use the park need and can use the skills to help people in distress.

727 The project has been costed at roughly $2 million dollars with Woollahra Council having spent $248,000 on the first phase of the project.

728 Recently the Federal Government announced a grant to Woollahra Council of $1.1 million dollars for work at The Gap, however, I am not sure if that amount means that the masterplan can be finalised. I hope it does.

FORMAL FINDING

I FIND THAT CHARMAINE MARGARET DRAGUN ON 2 NOVEMBER 2007 AT THE GAP VAUCLUSE DIED OF THE EFFECTS OF MULTIPLE INJURIES SUSTAINED WHEN SHE PROJECTED HERSELF FROM THE TOP OF A CLIFF WITH THE INTENTION OF TAKING HER OWN LIFE.

RECOMMENDATIONS

729 I intimated during the Inquest that I was going to make recommendations relating to the adequacy of counselling provided to Officers of the Rose Bay Local Area Command. It has been pointed out that I made recommendations in a previous inquest involving another death at the Gap and that the Commissioner of Police

had responded to that recommendation. I accept that and do not propose to take the matter any further.

730 The issue of funding for the completion of work at The Gap is vital in my view. I know the member for Vaucluse the Honourable Malcolm Turnbull has called for the funding to be made available and the evidence that has been given at this Inquest about The Gap supports his call.

731 I direct that a copy of the findings and executive summary be sent to the Honourable member for Vaucluse, as he may be able to use some of the evidence that was given in assisting the Woollahra Council if further Federal funding is required to finalise the 'Gap Suicide Minimisation Plan'.

732 A number of vitally important aspects relating to the assessment and treatment of depression were uncovered during this Inquest that should be brought to the attention of general practitioners, counsellors, psychologists, psychiatrists and others (who I will call collectively "health professionals") who may be called upon to treat people presenting with signs and symptoms of depression.

733 They include:

- The need for increased awareness by health professionals of the need to exclude a bipolar disorder in all patients presenting with signs and symptoms of depression.

- The need for assessment tools for bipolar conditions being readily available to all health professionals treating patients with signs and symptoms of depression.

- Stress on the importance of all health professionals treating patients with signs and symptoms of depression to provide all relevant information to other health professionals to whom a patient may be referred for ongoing treatment.

- Stress on the importance of all health professionals treating patients with signs and symptoms of depression to keep referring health practitioners informed of their management of the patient.

- Critical consideration of the use of "contracts" between health care professionals and patients whereby the patient promises not to self harm and to contact the health care provider if they are feeling

suicidal. These could usefully be replaced with “commitments to treatment” which are less coercive.

- Discouragement of any indication by a health care professional of being available to patients 24 hours a day, 7 days a week as this can obscure the therapeutic relationship.

- The provision to patients who have suicidal thoughts but are not thought to be at risk of suicide at the time of a “crisis plan” with details of who to contact and how if their condition worsens if the usual treating health professional is not available. This applies to patients being released from hospitals.

- That health professionals stress to the patient the importance of involving family members or similarly placed persons to monitor any side effects associated with having drugs supplied for the first time or any increase, decrease or change of medication because sometimes the patient may not be able to recognise these effects for what they are.

734 The peak bodies that represent general practitioners, psychologists and psychiatrists were not represented and were not asked to make submissions to the Inquest so I cannot fashion these important findings into recommendations to be actioned by them.

735 However, I would urge the peak bodies to carefully consider the findings because advising their membership can only result in an increased awareness of how important certain aspects of the assessment and treatment of depression are and in the end reduce the number of suicides and attempted suicides as a consequence.

736 I direct that copies of the findings and executive summary be forwarded to the Royal Australian College of General Practitioners, the Counsellors and Therapists Association of New South Wales, the Australian Psychological Society and the Royal Australian and New Zealand College of Psychiatrists.

737 I thank Mr David Hirsch, Barrister, Counsel Assisting, and Ms Ngaire Watson whose invaluable assistance should be acknowledged and also Mr Geoffrey Denman, formerly Senior Solicitor with Crown Solicitor’s Office and now at the Private Bar.

738 To the family of Charmaine, I offer my sincere sympathy, and hope that this inquest will have assisted them to understand the circumstances of Charmaine's death. I also hope that my recommendations fulfil their wish that steps be taken to reduce the tragic toll taken by suicide in Australia. I acknowledge that this would be Charmaine's wish as well.

M. MacPherson
Deputy State Coroner
State Coroners Court Glebe
15 October 2010