CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 22nd, 23rd, 24th and 25th of July 2002, the 9th of August 2002 and the 6th of November 2002, before Anthony Ernest Schapel, a Coroner for the said State, concerning the death of Patricia Susanne Jericho.

I, the said Coroner, find that, Patricia Susanne Jericho aged 43 years, late of 71 Tenth Avenue, Royston Park, South Australia died at Royston Park, South Australia on the 28th day of November 1999 as a result of neck compression due to hanging.

1. Introduction

1.1. Patricia Susanne Jericho was a 43 year old divorced woman with four children. Three of the children were from the union with her former husband. The fourth child, the youngest, had been born out of another union.

1.2. At about 12:50pm on Friday, 28 November 1999 the deceased was found by her brother, Philip Jericho, hanging by her neck from a tree situated in the backyard of her home at 71 Tenth Avenue, Royston Park. A pair of pantyhose was tied around the deceased's neck and the other end of the garment was tied around a branch of the tree. A chair was situated on the ground close to the position of the deceased's feet. The deceased was already dead when located by her brother. She had died from neck compression due to hanging.

1.3. Earlier that same morning, at about 9:30am, the deceased had spoken to her mother in the backyard of the premises. Mrs Laura Jericho had been staying with her daughter since 15 October 1999. During the conversation, the deceased had raised the subject of her cousin's suicide and had asked her mother whether the cousin had been forgiven and whether he had been bestowed with eternal life. Mrs Jericho had told

the deceased that God was merciful and that it was not for her to say that her cousin did not have eternal life. The deceased had asked her mother if God would love her the same to which Mrs Jericho had replied that God loved her.

1.4. The deceased and her mother later that morning attended church. Before they entered the church, the deceased gave her mother a ring saying that she would like one of her daughters to have it. The deceased also made reference to another ring that she wished another daughter to have, but which she could not locate at that time.

1.5. The deceased left the church service before it had concluded. At the conclusion of the service, Mrs Jericho could not locate her daughter in the vicinity of the church. She returned home, but could not locate her there. The body was concealed by a shed which she evidently did not look behind. She asked her son Philip to come to the house and the discovery of the deceased's body then occurred.

1.6. The police and ambulance were called.

1.7. I find that the deceased intentionally took her own life by her own deliberate actions.

1.8. The deceased had been treated for depression for several years and had been seen by a number of medical practitioners in relation to her depression. She had recently consulted medical practitioners in general practice and a psychiatrist and on two occasions had recently presented at the Emergency Department of the Royal Adelaide Hospital (RAH) and been examined there. At the time of her death, she was under the care of Eastern Assessment and Crisis Intervention Services (EACIS), an arm of the South Australian Mental Health Service (SAMHS).

1.9. In spite of all the medical assistance she received, or had sought to receive, her suicide was not avoided. This inquest examined how that may have transpired.

2. Medical history of the deceased

2.1. The deceased had, for several years, been under the care of Dr Joseph Massolino, a general practitioner who practised at the Payneham Family Practice (now East Adelaide Healthcare). Dr Massolino gave evidence before me. In addition, the practice notes in relation to the deceased were tendered (Exhibit C15). Mr Halliday appeared for Dr Massolino and took me through the entire history of his interaction with, and treatment of, the deceased. It is worthwhile examining Dr Massolino's

evidence in some detail as it reveals an important insight into the deceased's attitude to treatment. I say at the outset that I accept Dr Massolino's evidence in its entirety.

2.2. Dr Massolino told me that he first saw the deceased on 3 August 1993. I observe, however, that the practice notes describe consultations with other practitioners from September of 1992. There is a reference to a 'recent traumatic separation from husband – has been seeing counsellor' in September of 1992, but the notes at that point do not reveal a diagnosis of any psychiatric illness.

2.3. On 3 August 1993, Dr Massolino noted symptoms of depression, which in part seemed to be based upon feelings of guilt, particularly over the failure of her marriage and subsequent divorce. Dr Massolino formulated a treatment plan for her which he described in these terms:

> 'I felt that it was important that we try to work through her feelings of guilt and deal with them as I felt they were fuelling her depressed feelings. Together with her we felt that it may have been important to try and find some new friends who weren't part of her original church, since she felt that guilt was a big issue there and I tried to do a bit general practice based therapy, instructing her on how to deal with her own self-criticism by giving herself the benefit of a doubt a bit more instead of being so harsh on herself, hence the expression 'benefit of the doubt'.' (T438)

He could not recall whether on 3 August 1993 he had considered her to be an appropriate candidate for any form of medication. Suffice it to say, he did not prescribe any at that time.

2.4. Between 1993 and 1999, the year of the deceased's death, Dr Massolino saw the deceased on several occasions in relation to her mood. He told me that she would fluctuate from quite noticeable lows to quite exuberant highs. It is evident from this history that depression in varying degrees of intensity would be re-established from time to time.

2.5. There is no evidence that Dr Massolino raised the possibility of prescribing antidepressant medication with her until June 1994 when he observed that she was moderately depressed with feelings of loneliness. Dr Massolino had considered the question of antidepressants in October 1993, but at that time there had been the suspicion of pregnancy, which as it transpired was well founded, and he had thought that in the circumstances antidepressants may have been contra-indicated.

2.6. Dr Massolino saw the deceased on 20 June and 24 June 1994. On 24 June, he had noted moderate depression and feelings of loneliness. He arranged to see her again some days later and had written a note to remind himself that on the subsequent occasion he should consider antidepressant medication. He may have raised that possibility with her on that occasion. However, Dr Massolino said that in the time over which he had treated the deceased, she had exhibited an opposition to antidepressants. He told me:

> 'A. She was substantially opposed to antidepressants.
>
> Q. Did you come to know why.
>
> A. It was one of her core beliefs. She felt that her problems didn't – couldn't be fixed by a chemical. It was pretty obvious to her that an antidepressant was literally barking up the wrong tree.
>
> Q. Was that to your mind a conscientious view on her part? In other words, did she believe it.
>
> A. Very much so.
>
> Q. Was it a reasonable view, having regard to your observation of her condition.
>
> A. I think it was an ill-informed view … but nonetheless it was very much a fixed view. (T457)
>
> …
>
> A. She had as I mentioned before, sir, a core belief that they just weren't right for her and they weren't good things to have in her system. Trish would be perhaps classified as an alternative person and she did have to substantiate that, a very negative experience with a particular antidepressant that I tried to introduce on one occasion.' (T458)

2.7. In contrast to her presentation in June, in September 1994 Dr Massolino recorded that the deceased was at that time 'positively beaming' which led him to conclude that her mental state at that time was perfectly adequate and that neither antidepressant medication nor other intervention was necessary. Nevertheless her depression was thereafter to return.

2.8. Dr Massolino again raised the question of antidepressant medication with the deceased on 21 June 1995 when the recurring theme of loneliness was expressed. Although Dr Massolino could not recall the deceased's attitude to antidepressants on that specific occasion, he felt that it would have been the 'usual party line', that is to say, she did not want them.

2.9. On 26 June 1995, Dr Massolino observed that the deceased seemed better or at least seemed normal. He noted that she was not keen on Prozac, an antidepressant.

2.10. Dr Massolino again saw the deceased on 14 August 1995. She was noted as being 'still depressed'. Dr Massolino has also noted 'will consider Prozac'. Prior to this appointment Dr Massolino had received a letter from the deceased dated 1 August 1995. The letter formed part of the practice notes and recorded an attitude on the part of the deceased that was quite in keeping with that described to me by Dr Massolino. In that letter the deceased had described herself as being 'very, very low', but not suicidal. However, there are references to the drug Prozac that illustrate her aversion to the idea of taking it. The following passages are lifted from the letter:

> 'It is exactly 2 years that I have been seeing you for counselling and in this time I have done 2 circles arriving back at Prozac. Even though on my strong days I have said a definite No to this drug.
>
> …
>
> What do you want in your profession to only give drugs to dull the hurts and pains and struggles in peoples lives or do you honestly care about their well-being.
>
> …
>
> I'm not suicidal, I don't want to be patronized anymore by you or given an option to have Prozac. If you have NO HELP for me then for God's sake say so and don't mess with me.'
>
> (Exhibit C15)

I infer from these passages, looked at in the context of the letter as a whole, that the deceased was angry that after two years of counselling by Dr Massolino little had been achieved, and that Prozac was not the solution to her problem. This is all consistent with Dr Massolino's evidence that the deceased had verbally expressed a deep-seated aversion to antidepressant drugs.

2.11. As already observed, on 14 August 1995 Dr Massolino had recorded 'will consider Prozac'. Dr Massolino told me that this entry revealed a concession by the deceased that she would give Prozac some consideration. On that same occasion, Dr Massolino arranged for the deceased to see a Dr Helen Tingay who is a psychiatrist. This is the first occasion on which there had been any discussion between Dr Massolino and the deceased about the deceased obtaining specialist psychiatric treatment for her condition. Dr Tingay saw the deceased in November 1995 because on 28 November

1995 the deceased told Dr Massolino that she 'got on very well' with Dr Tingay and that Dr Tingay had diagnosed 'Post Traumatic Stress Disorder' (PTSD).

2.12. Dr Tingay's report, dated 7 December 1995, forms part of the practice notes. Dr Tingay expressed the view that the most likely diagnosis is PTSD following multiple traumas throughout her life. However, Dr Tingay reported that:

> 'Her episodes of depression are becoming less and less frequent and less and less intense.'
>
> (Exhibit C15)

It so happened that at the time the deceased saw Dr Tingay she was five or six weeks pregnant. Consequently Dr Tingay told Dr Massolino that she would like to see the deceased again before she decided on medication. However, she stated that in her view the most appropriate medication would be Aurorix or Zoloft, but that she would see how she was before she prescribed such medication. Dr Tingay expressed the view that the deceased was suitable for psychotherapy and perhaps that would be enough, although she doubted it.

2.13. Dr Massolino did not see the deceased again until August 1996. The evidence is not clear as to what happened in the intervening period as far as treatment at the hands of Dr Tingay is concerned. Dr Massolino told me, however, that judging by the fact that he had not received any more correspondence from Dr Tingay he had formed the impression that the relationship had not continued and that indeed there must ultimately have been a falling out between the deceased and Dr Tingay. In the period between the end of 1995 and August 1996, the deceased had been pregnant with her fourth child. Dr Massolino told me that this was probably a positive time for the deceased and he had no reason to suppose that she had consulted anybody about her depression in that period.

2.14. When Dr Massolino saw the deceased in August 1996 he had noted that she was coping with her new child and was not depressed. He saw her in November 1996 when he noted that she was well and, again, not depressed. However, in December 1996 she consulted Dr Massolino and it was observed that by then she was depressed, either by way of a post-natal depression or, as he noted, more probably a continuation of the PTSD which had been diagnosed by Dr Tingay. On 20 December 1996 Dr Massolino prescribed a two week course of Prothiaden, which is an antidepressant.

Because of the deceased's reluctance, and indeed as Dr Massolino put it, fear and loathing of antidepressants, he thought it was wise to introduce her to the medication in a very gentle fashion. Accordingly, he prescribed a low dosage. Dr Massolino was ultimately to adopt a similarly cautious approach to medication just before her death.

2.15. He again saw her on 7 January 1997 when he noted that she seemed to be 'very together'. The deceased on that occasion had exhibited no side effects to the Prothiaden and so he decided to keep her going on that drug for the time being.

2.16. Dr Massolino saw her next on 6 March 1997 when the deceased told him that she had taken Prothiaden until the end of January 1997 and that she felt better. Dr Massolino told me that he had been disappointed that she had decided to take herself off the drug as it seemed to be having a positive effect. He had felt that the course had not been long enough. Dr Massolino said that her taking herself off the drug was consistent with the nature of the deceased, in the sense that she got better so why take them? He said that, from his knowledge of the deceased, she probably would have taken the view that she then didn't have anything wrong with her and that there was therefore no need to take drugs any longer.

2.17. Dr Massolino saw her on only one further occasion in 1997. That was in July and, as Dr Massolino put it, she seemed to be coping with the rigours of life. He saw no reason to reintroduce antidepressants or to make any future appointment.

2.18. Dr Massolino saw the deceased on a number of occasions in 1998. He noted in January that, according to the deceased, her depression was resolved and that she was very satisfied with the outcome. In July 1998 he has noted 'no longer depressed'.

2.19. However, in 1999 it is evident that the deceased's wellbeing took a marked turn for the worse. On 29 April 1999 Dr Massolino saw the deceased. Although she denied depression at that time, Dr Massolino formed the view that she was irritable and angry. Piror to this consultation, Dr Massolino had spoken to the deceased's mother in two telephone conversations. The deceased's mother had referred in at least one of the conversations to her daughter's cyclical depression. In addition, as is evident from the practice notes, the deceased's mother had written to Dr Massolino in March 1999, wherein she had expressed her concern, particularly in relation to some alarming comments made by the deceased along the lines of what might happen to her children if something happened to her. There was also reference in the letter to the

fact that the deceased had mentioned the existence of an insurance policy. On this occasion Dr Massolino counselled the deceased and suggested that an opinion be obtained from a Dr Hafner, a very experienced psychiatrist who visited the practice on a regular basis and who assisted the practitioners in psychiatric cases. Dr Massolino on this occasion has made reference in his notes to the fact that the deceased was very much against medication. She was also exhibiting a reluctance to see Dr Hafner. As it transpired, she was not to see Dr Hafner until a few days before her death in November of that year.

2.20. Dr Massolino said that he did not formulate a referral to Dr Hafner in April 1999. He said that if she had acquiesced in his advice regarding Dr Hafner then he would have made an appointment for her to see him, as it would have been quite a relief for him if she'd actually accepted seeing someone else.

2.21. It is evident that the deceased, later in 1999, did seek medical assistance from other sources. She consulted the SAMHS/EACIS from 26 July 1999. On that date it was noted that she was 'currently depressed', 'totally out of control - desperate' and there was reference in the notes to her having seen Dr Massolino in early July and that Dr Massolino had reported that she was 'suicidal' at that time. Dr Massolino has no recollection nor note of any consultation with the deceased in early July. It is evident from the EACIS records of July and August 1999 that the deceased saw somebody from that service on a number of occasions in those months. The salient features of her consultations with EACIS at that time were that her mood plainly varied from one day to the next and that she had manifested her usual disinterest in taking antidepressants.

2.22. However, it is plain that at around this time, that is July 1999, she had been prescribed an antidepressant drug, Zoloft by another private practitioner. On 30 July 1999, she returned to see Dr Massolino and she told Dr Massolino on this occasion that the Zoloft had caused bad side effects. The documentation reveals that she had stated that Zoloft had made her feel 'horrid' and that she had refused to take that medication. This of course is all in keeping with Dr Massolino's prior experience with this particular patient. On 30 July 1999, Dr Massolino has recorded that he discussed the deceased's care with a Dr Siklich of EACIS. Dr Siklich had seen the deceased two days earlier. Dr Massolino gleaned from Dr Siklich that the latter had recommended Aurorix, another antidepressant. Dr Massolino has noted on 30 July 1999 that the

deceased indicated that she was very reluctant to take Aurorix because of her experiences with Zoloft which she said had caused insomnia. Dr Massolino encouraged her to take Aurorix notwithstanding that reluctance. He achieved a negative result. The deceased also told EACIS on 2 August that she was not interested in antidepressants, saying she felt much better.

2.23. On 17 August 1999 Dr Massolino again saw the deceased and again noted that she was reluctant to take antidepressants and indeed was upset that he had even suggested them. On this same occasion she again mentioned her severe reaction to Zoloft. There is also a reference to the deceased having become suicidal. Dr Massolino formed the view that she was still depressed. On this occasion the deceased made reference to her annoyance with EACIS and that she would not be calling them again. The deceased told Dr Massolino that she had been seeing a naturopath and it was left on the basis that he would continue to support her as best he could. Dr Massolino's dilemma is neatly summarised in his own words in the witness box:

> 'As I've said in the notes there on that particular entry on 17 August, by now I'd realised that Trish was going through highs and lows and that I saw as she wasn't detainable that I saw that my mission was really just to basically enable her to keep going. I couldn't practice my trade in the sense that I couldn't prescribe anything. She wouldn't really allow me to refer her on. It seemed to me that regrettably the buck stopped with me. I was the only one that she was intent on seeing and I wasn't even able to do what I was wanting to do. So I guess with hindsight, I guess that my mission was really just to keep her going. Just to sort of get her through the lows, support her as best and I could until the next crisis.' (T491)

2.24. Dr Massolino was not to see the deceased again until 4 November 1999, which was less than three weeks before her death. Although Dr Massolino did not give evidence of this, it is plain from the SAMHS notes that on 23 August 1999 he had spoken to somebody at SAMHS and said that he would like EACIS to make sure that the deceased knew that she could go to EACIS when in crisis. EACIS had made contact with the deceased on 23 August 1999 when she had told EACIS that she did not want to use that service again. She had told the EACIS worker that she was seeing a naturopath, in accordance with what she had already told Dr Massolino. On this occasion she had said that she was better and that she would not find herself in a black hole again.

2.25. In spite of the foregoing, on 4 November Dr Massolino observed that the deceased was still having difficulties and was prone to depression.

2.26. From the SAMHS records she consulted EACIS again on 8 November 1999. A home visit was scheduled for the following day. The visit appears to have been cancelled as a result of the deceased telephoning SAMHS and saying that she had found 'other avenues' of assistance and did not require any further EACIS intervention. This pattern of seeking assistance and then eschewing it is repeated in the days leading up to her death, later that month. She was to consult Dr Massolino on 18 November for the last time. I refer to this consultation later.

2.27. I have set out the psychiatric history of the deceased in considerable detail. I have done so in order to demonstrate a number of matters that shed light on the tragic events of late November 1999. Firstly, it is evident from her history that the deceased maintained a strong resistance to antidepressant medication. Her two experiences with antidepressant medication, namely Prothiaden at the end of 1996 and the beginning of 1997, the use of which she had discontinued, and Zoloft in mid 1999, which had caused her unpleasant side effects, had been unsatisfactory. Attempts to get her to take Aurorix and Prozac were unsuccessful. Secondly, her psychiatric history in my opinion demonstrates a marked changeability in mood and attitude from time to time, all in keeping, of course, with her illness. Thirdly, her correspondence with, and other verbal statements to, Dr Massolino exhibit an occasional air of frustration on her part with the efforts of the medical profession to assist her. Fourthly, the deceased would seek medical assistance only to refuse it on many occasions.

2.28. It is against this backdrop that one can properly examine the events of mid to late November 1999 when she was seen by a series of medical practitioners, both in practice and hospital settings.

3. <u>The first presentation to the Royal Adelaide Hospital on 17 November 1999</u>

3.1. The deceased saw Dr Richard James Goodwin, another medical practitioner at the same practice as that of Dr Massolino, on 16 November 1999. On this occasion she presented with her mother who had been staying with the deceased for some weeks. This was the first time Dr Goodwin had seen the deceased. Dr Goodwin provided an affidavit and statement to the inquest (Exhibit C7a). Dr Goodwin noted her long

history of major depression. He also noted her adverse reaction to Prothiaden and Zoloft in the past. He diagnosed profound depression and noted that the deceased expressed some suicidal ideation, however she had said that she would not act on this ideation for the sake of her children. She told Dr Goodwin that she had never attempted suicide in the past.

3.2. The deceased told Dr Goodwin that she wanted some respite in an inpatient facility away from her children. Dr Goodwin formed the view that, at that time, the deceased was willing to go into a hospital on a voluntary basis. Dr Goodwin did not feel that she was detainable under the Mental Health Act 1993. Dr Goodwin wrote a letter of referral to the RAH. The first sentence of the letter reads:

> 'Thank you for considering this 43 year old woman for admission and inpatient care of profound major depression with suicidal ideation.'
>
> (Exhibit C13)

Dr Goodwin's expectation was that the deceased would be admitted or at least considered for admission by the Psychiatric Registrar to whom the letter was addressed. The reader would not necessarily infer from the introduction to this letter that Dr Goodwin was insistent on admission, but the letter went on to describe that the deceased was 'requesting some inpatient respite'.

3.3. The deceased went to the RAH with her mother on 17 November 1999. On this occasion she was seen firstly by Dr Adriana Latanzio, a General Registrar, and then by Dr Mark Shillito, a Psychiatric Registrar. Both medical practitioners gave evidence before me.

3.4. A question has arisen as to the thoroughness of the deceased's examination at the RAH on this occasion. In particular, the thoroughness of Dr Shillito's assessment has been the subject of some criticism by Professor Robert Goldney, who is a Professor of Psychiatry and a Psychiatrist of wide experience in clinical practice. Professor Goldney is a Fellow at both the Royal College of Psychiatrists and the Royal Australian and New Zealand College of Psychiatrists. He has practised in mental and general hospitals, has practised privately and has a part-time chair in psychiatry at the University of Adelaide. He is an acknowledged expert in suicide prevention and has given evidence in this Court on other occasions. I received three reports from Professor Goldney and he gave evidence in this matter. In effect he conducted a

complete review of the deceased's treatment from the time of her attendances at the RAH until her death.

3.5. On 17 November 1999 the deceased presented with her mother at the Emergency Department of the RAH. She was in possession of the letter that had been written by Dr Goodwin. She was seen at first by Dr Latanzio who took a history from her. It was during Dr Latanzio's examination that Dr Shillito came down to see the patient. Prior to this however, Dr Latanzio had been told by the deceased that on the previous Saturday she had taken her younger child by bike to the Christmas Pageant and had to control herself because she wanted to ride out in front of a vehicle. She told Dr Latanzio that she had thoughts of harming herself and her children but in the end she was scared that she would succeed in harming only her children. The deceased had told Dr Latanzio that she felt that she was in a 'dark tunnel' and that she did not see any light at the end of that tunnel. Dr Latanzio's interview with the deceased was suspended due to the appearance of Dr Shillito who took over. Dr Latanzio thought it appropriate in the circumstances for the Psychiatric Registrar to become involved. The reasons for this were firstly, that the letter from Dr Goodwin had been addressed to the Psychiatric Registrar and secondly, that the matter to her seemed complicated insofar as Dr Goodwin had described 'profound major depression with suicidal ideation' in his letter of referral. When Dr Shillito took over from Dr Latanzio, Dr Latanzio left the room to compile notes of what had been said as between her and the deceased.

3.6. Dr Shillito read Dr Goodwin's letter before he commenced his examination. He also had a brief discussion with Dr Latanzio. It is evident that Dr Shillito did not read the notes made by Dr Latanzio because at that time Dr Latanzio's notes had not been prepared. In addition, Dr Latanzio did not have an opportunity to discuss with Dr Shillito, at a time before the latter's examination, the deceased's alarming revelations about the Christmas Pageant incident or about being in the 'dark tunnel' with no light, revelations that are plainly in keeping with Dr Goodwin's assessment that the deceased had suicidal ideation. Professor Goldney said in relation to the deceased's comments to Dr Latanzio (T277).

> 'I think it is of considerable significance because it indicates that she has got suicidal thoughts and she has got the typical ambivalence about suicide: 'Will I do it? Won't I do it?' Perhaps I am reading too much into this but 'If I rode out in front of vehicles on the pageant, I might not die, or the children may be injured'. And very often there are

> sort of homicidal feelings as well as suicidal feelings, you know, there is that wish to take children with you. In the extreme case, people have delusional thoughts that 'The world is going to better once I am dead and I am helping my children to a better life' . That is a very worrying sort of a clinical situation. But for a person to have those intrusive thoughts, suicidal thoughts, at a Christmas pageant when you are meant to be distracted and enjoying your children and the Christmas pageant, it is of some significance, I think, that even in that sort of social context, the person has got intrusive suicidal thoughts. So I think it is very important.' (T277)

What Dr Latanzio thought she would have done was explained in her evidence at T75:

> 'Q. Did you say to Dr Shillito anything about what Ms Jericho had said to you in terms of thoughts of harming herself and her children.
>
> A. I don't recall saying anything, but what I would have done is when I would have written up these notes I would have put them in the pigeonhole corresponding to the room where Ms Jericho was, where she was being interviewed. That is where we put all the information. So I would assume that he would have got the information from that pigeonhole. When you write the notes you put everything together, so I am assuming he would have seen the notes that were in that pigeonhole.'

3.7. There is no suggestion in the evidence of Dr Shillito nor in his notes that the deceased repeated the same statements in relation to the Christmas Pageant incident and the 'dark tunnel' to Dr Shillito. Dr Shillito said that he was not aware that Dr Latanzio had received that history and that Dr Latanzio had not written her casenotes by the time he was asked to see the patient. However, Dr Shillito said:

> 'What I did obtain was a history that although she had ideas of a fleeting nature, from time to time, that she had not acted on them and that she felt very certain and important that she should take care of her children, and that she wouldn't act on those ideas that she had from time to time because she cared for her children.' (T21)

There is no note of this history in the RAH medical files. There are other aspects of Dr Shillito's examination of which there are also no notes. I will return to this issue later as the lack of notation originally led Professor Goldney to conclude that Dr Shillito's examination was inadequate.

3.8. Dr Shillito's notes of his examination occupy 19 lines in the Emergency Department record. They are contained in a pro-forma document known as a UR10. The notes set out a brief account of the deceased's family situation including difficulties with a daughter. The only reference to any psychiatric symptomatology is as follows:

> '? conduct symptoms of underlying maj depression + possibly PTSD' (Exhibit C13)

PTSD is an abbreviation for Post Traumatic Stress Disorder. This of course adds very little to the situation as described in Dr Goodwin's letter of referral. Dr Shillito maintained before me in his evidence on oath that he made other notes on a document called a UR30 which, for a reason that has not been properly explained, has not made its way onto the RAH file. Professor Goldney was critical of the thoroughness of Dr Shillito's examination. His criticism was largely based upon the absence of any proper notation. This criticism was, in large measure, withdrawn by Professor Goldney as a result of Dr Shillito's assertion that he had conducted a proper examination, the details of which I will come to, and his assertion that he had in fact made notes of that examination, the notes which appear to be missing.

3.9. Dr Shillito made a statement which was supplied to the Coroner via solicitors in January 2002. In that statement he said that his signed case note entry was not included in the RAH file. This was in spite of there having been a search for the same at both the RAH medical records department and at the Adelaide Women's and Children's Medical Centre, to whom he had believed all of his notes had been faxed. In his statement, and indeed in his evidence before me, Dr Shillito stated that he had an independent recollection of Mrs Jericho's presentation at the RAH on 17 November 1999. Dr Shillito said in his statement and in his evidence that he had enquired about Mrs Jericho's mood and depression and had found an absence of the following relevant symptomatology, namely sleep disturbance, diurnal mood variation, appetite loss, weight loss, bowel disturbance, and loss of concentration. He said that the deceased told him that she had been able to continue to do all her usual home duties and care for her children well. Dr Shillito said that there had been no psychotic features and no excessive pathological 'guilt'. He had established through Mrs Jericho that there was no past history of actual self-harming, overdoses or suicidal gesture although he recalled that she had confirmed that she felt overwhelmed at times of crisis but that she had never seriously considered harming herself. He said that he had asked her if she had current suicidal thoughts or plans currently but she had denied that. He recalled that she had told him that this had been her 'first ever assessment by a psychiatric department'. He recalled asking her if she had thoughts of harming herself, her children or anyone else and she had said 'no'. This answer in my view plainly contradicts what she had earlier said to Dr Latanzio. If what she had told Dr Latanzio had been conveyed to Dr Shillito, Dr Shillito no doubt could have tackled her about that inconsistency.

3.10. Dr Shillito said that he had been led to the conclusion that the current level of her depressed mood had not warranted detention under the Mental Health Act 1993. As far as voluntary admission to the RAH is concerned, she declined his offer because she said that she was feeling better having discussed a number of options with Dr Shillito. She also said that she was concerned for the care of her youngest two children then aged 10 and 3½ years, if she were to be hospitalised.

3.11. Dr Shillito said that he also discussed with the deceased the option of medication for her mood. He had noted from Dr Goodwin's letter that the deceased had a preference for 'natural therapies' and the deceased in effect confirmed this when she said that she could manage on her own if she could get help with her daughter. Dr Shillito said that despite his efforts to encourage her otherwise, she was insistent that she should not have medication. At the root of the deceased's difficulties was an ongoing unsatisfactory situation regarding her relationship with a 12 year old daughter. This difficulty had been explained to Dr Goodwin when he saw her on 16 November 1999. In Dr Goodwin's statement of 11 December 2001 Dr Goodwin explains that the deceased had told him that the daughter was refusing to go to school and was quite belligerent and aggressive towards her mother and had become physically intimidating towards her. There were also some concerns that the sister, who was two years younger, had started to copy the younger daughter's behaviour. There was a brother aged 13 who was behaving appropriately but there was a problem with communication between the 12 year old daughter and her mother and there were difficulties in getting her to see a counsellor. It was also mentioned to Dr Goodwin that the daughter had been threatening to run away. These problems were explained in the first paragraph of Dr Goodwin's letter of referral. Dr Shillito has noted the difficulties with the daughter in his record.

3.12. Dr Shillito, as already seen, had offered the deceased both admission to hospital and medication and, according to Dr Shillito, both had been refused. Dr Shillito told me that the deceased was 'quite adamant' (T26) that she felt that she was 'ok', and that what she really wanted help with was the family crisis. Dr Shillito's statement describes the following strategy designed to assist the deceased:

> 'Further assessment
>
> I recall we spoke further for some time and I asked her specifically whether any assistance to help her resolve the problems with her eldest daughter would assist her with

> her own peace of mind. She agreed. I discussed the option of involving the AWCMC (Adelaide Women's and Children's Medical Centre), who have special expertise in the handling of cases of suspected sexual abuse of children. Also that at the AWCMC she could receive assistance to convey her daughter to the hospital to facilitate this intervention. I recall that at this point she became more relieved in her demeanour and expressed thanks that the Royal Adelaide Hospital took her major worries seriously and could be of meaningful assistance.'
>
> (Exhibit C10, p3)

To this end Dr Shillito spoke to the Psychiatric Registrar at the AWCMC. He went over the case with the Psychiatric Registrar whom he states agreed with his approach. He said that the Psychiatric Registrar was willing to see the deceased as soon as the deceased could come to AWCMC Casualty that same day. Dr Shillito arranged for his case notes to be faxed to the AWCMC for their immediate use. He then informed the deceased and her mother as to the arrangements and the deceased thanked him. That was the last thing that Dr Shillito had to do with the deceased.

3.13. A number of issues arise out of Dr Shillito's evidence. Firstly, much of what Dr Shillito said in his statement and much of what he said in his evidence was not the subject of any formal notation that can be identified. However, he swore that he had completed the UR30 which set out the details of his examination of the deceased. As already seen, he made arrangements for his notes to be faxed to the AWCMC. Dr Latanzio told me she faxed Dr Shillito's notes to the AWCMC. However, it is evident that all the AWCMC received by way of fax that day, at least as far as Dr Shillito's notes were concerned, were the 19 lines of handwritten notes to which I have already referred, that is the UR9. The existence or otherwise of notes setting out the details of the examination is therefore a matter that worries me.

3.14. Secondly, there is nothing in the RAH notes that I have in evidence that might corroborate Dr Shillito when he says that the deceased refused the offers of admission to hospital and medication.

3.15. Thirdly, the attitude of the deceased at the RAH seems to be at variance with that manifested to Dr Goodwin the day before. According to Dr Goodwin, the deceased stated that she wanted 'some respite' in an inpatient facility away from the children and for that reason he had referred her to the RAH with the referral letter. In addition, it is plain from the referral letter that in spite of the deceased's previous negative

experiences with Prothiaden and Zoloft, she had indicated to Dr Goodwin that she might be amenable to trying another antidepressant.

3.16. Fourthly, I find that there was a marked variation between the assessment of Dr Goodwin on 16 November 1999 and the assessment of Dr Shillito on 17 November 1999. Dr Goodwin formed the view that the deceased was suffering from 'profound major depression' with a 'long past history of major depression with intermittent suicidal ideation'. On the other hand, Dr Shillito said that he would reserve a diagnosis of profound depression for people who had psychotic features or for people who were in danger of harming themselves or other people, individuals that were suffering from neuro-vegetative signs such as diurnal mood variation, loss of appetite, poor concentration and who did not usually present in a coherent straight-forward sort of fashion (T54). As noted earlier, Dr Shillito said that he did not note any such symptomatology. However, Dr Shillito said that profound major depression with suicidal ideation, as expressed by Dr Goodwin in his letter, could be viewed as a longitudinally correct diagnosis not inconsistent with his view. Nevertheless, I think that there is a marked variation in the assessment of Dr Goodwin and that of Dr Shillito. As to what Dr Shillito would have done if an analysis of profound major depression had been supported in his examination he said:

> 'Then I think we'd have to think about if she was a danger to herself and to others and if she declined voluntary admission I probably would still offer voluntary admission first in an attempt to have a co-operative plan with any patient. If I was concerned about the safety of the patient or of the people around her, then there was not a possibility of proceeding in a voluntary fashion, then I think I would discuss with the patient the features that I found, that I was very concerned, attempt again to get a voluntary commitment for inpatient stay and if I was gravely concerned about the safety of other people then I would unfortunately have to follow the guidelines of the Mental Health Act and use the appropriate forms and inform the patient that it was my sad situation that I just felt that was the right thing to do. I believe Dr Goodwin could have used the same Act and the same concerns if he felt that she was suffering with a profound major depression with suicidal ideation and that he felt that she was not safe to herself or to her children as well.' (T56)

3.17. Fifthly, there is an issue as to whether or not anyone from the RAH informed Dr Goodwin of the results of the RAH examination and the strategy that had been suggested as far as her management was concerned. Dr Goodwin said that he could not remember getting any feedback from the RAH about the deceased's visit on 17 November 1999 and that there did not appear to be any record of that in the practice

notes. However, Dr Latanzio told me, and she has noted this in the RAH notes, that following the deceased's attendance at the RAH on that day, that the general practitioner was contacted. Dr Latanzio told me that she had a 'vague recollection' of contacting the general practitioner, being Dr Goodwin.

3.18. Sixthly, neither Dr Goodwin nor Dr Shillito thought that the deceased was detainable under the Mental Health Act 1993. This was because the deceased had indicated to both of them that she would not act on any suicidal ideation. Dr Goodwin added that other reasons for not imposing detention were that she was willing to go into hospital voluntarily, at least that was what her attitude was when he had seen her. On this issue Dr Goodwin concedes, as he must, that the sentiment from the first paragraph of his referral letter was an expectation that the deceased would be admitted or, and this is the concession, at least considered for admission by the Psychiatric Registrar to whom the letter was addressed.

3.19. I have considered carefully whether there is any criticism to be directed towards those at the RAH who were involved with the examination of the deceased on 17 November 1999. Certainly, it is regrettable that an examination of this importance should not be fully supported by written material in the form of hospital notes and records. This means that there is no written verification of Dr Massolino's assertion that he offered mediation and admission to hospital, offers that were refused. However, in all the circumstances, given the attitude of the deceased at the RAH on 17 November 1999 is an attitude that would not have been unexpected given her previous history, I find on the balance of probabilities that Dr Shillito did offer the deceased admission to hospital and medication and that the deceased refused both. Dr Massolino, a practitioner who had known her for years, at T513 said that 'her attitude on things changed remarkably'. He said that a change of mind about being admitted to hospital would have been consistent with the way she had responded to his own suggestions of treatment. Similarly, her refusal of medication at the RAH was also consistent with his own experience.

3.20. I find that Dr Shillito did take a history from and examine the deceased in the terms that he described in his evidence. Given the deceased's refusal to be admitted to hospital and her refusal to be prescribed any medication on 17 November 1999, it is somewhat difficult to see what more Dr Shillito nor anyone else at the RAH could have done for the deceased on that day. Professor Goldney was still, in some

measure, critical of Dr Goodwin's handling of the matter. Professor Goldney said that Dr Shillito's assessment was certainly reasonable if one accepts what Dr Shillito said in his statement as to the detail of his examination. However, Professor Goldney referred to Dr Shillito's assessment being quite at variance with that of Dr Goodwin because in his words:

> '… the assessment of Dr Shillito, really, is quite at variance of somebody with profound major depression and, in clinical practice, you don't see such a marked difference in a person in 24 hours if they have – if, in fact, the original diagnosis is correct. I mean, it may not have been correct.' (T271)

3.21. Professor Goldney said that if a person has a profound major depression, the main indication in those circumstances is for the prescription of antidepressant treatment, possibly with an anti-psychotic drug as well (T273). Professor Goldney did, however, concede that where a patient is unwilling to accept antidepressant medication then it can be very challenging and that one's hands in those circumstances 'are tied'. He said:

> 'I can accept the fact that if the medication was offered and it was refused, that there will be very little that one could do.' (T274)

This observation of Professor Goldney must in my view be accepted, especially in light of the deceased's own undoubted attitude to medication in the past. Professor Goldney nevertheless said that communication between Dr Shillito and Dr Goodwin concerning the divergent assessments should have taken place. I agree, but the issue as to whether Dr Goodwin was informed is a difficult one. Dr Latanzio said that she did contact the general practitioner and that would have been Dr Goodwin in this instance. Dr Goodwin in his statement, made over two years after these events, said that he had no recollection of such a communication. However, it is evident from a document that was tendered through Dr Massolino before me (Exhibit C15) that there had been a communication of sorts from the RAH about the outcome of the deceased's visit to the RAH. It does not record with whom the communication was made. However, Professor Goldney was to concede that if Dr Latanzio had had a discussion with Dr Goodwin and related to him the plan for the deceased that had been explained in evidence by Dr Shillito, and in circumstances where the deceased had refused admission to hospital and had refused medication, the deceased's treatment in the hands of Dr Shillito was perfectly reasonable.

3.22. In my opinion it is more likely than not that Dr Latanzio did communicate with some person at the Payneham Medical Practice. I am unable to conclude whether that person was Dr Goodwin. Plainly, such a communication would have been appropriate. It should have been carefully documented in the RAH notes, given what I have found to be, as supported by the evidence of Professor Goldney, a marked variation between the presentation of the deceased as assessed by Dr Goodwin on 16 November 1999 and as assessed by Dr Shillito on 17 November 1999. Moreover, such a communication should ideally have occurred while the deceased was still at the RAH so that Dr Goodwin could have been afforded the opportunity to have some input into the deceased's management that morning. Dr Latanzio did not remember whether her communication with the general practitioner occurred while the deceased was still at the RAH. Again, careful notation would have provided the answer to this question.

3.23. It was unsatisfactory that Dr Shillito was not informed of the comments made to Dr Latanzio concerning the Christmas Pageant incident and the 'dark tunnel' experience. The importance of this piece of information cannot be overlooked. Dr Shillito himself acknowledged that this information certainly seemed different from comments made to him by the deceased about self-harm, despair, depression and harming her children. He said:

> 'The matters raised suggest that there was a great deal of concern and anguish that she had and it was fleeting ideas about suicide and fleeting ideas that she had of a dangerous nature. I think I would have gone back and spoken to the patient had I known that sort of information, just for myself and to try and evaluate how best to help her. I certainly believed that the plan that we devised to actually look after this woman in concert with her children, in a more comprehensive fashion, by involving the family approach at the Woman's and Children's Hospital, addressed all areas under concern and certainly that she was going to a treatment program that would be most useful for her.
>
> …
>
> Certainly they're in keeping with her presentation the day before to Dr Goodwin.'
>
> (T49-50)

The breakdown of communication between Dr Latanzio and Dr Shillito was unfortunate as it deprived Dr Shillito of important information. On the other hand, it is easy to be critical, and it has to be borne in mind that Dr Latanzio would have had reason to suppose that the deceased would repeat the same statements to Dr Shillito when he examined her.

3.24. As far as the plan that was implemented in relation to the referral to the AWCMC was concerned, Professor Goldney was of the view that it was partly appropriate. He said:

> 'But I think it missed the point that, really, this woman was profoundly distressed in her own right. It is a little bit like if somebody is in a disaster where a building has collapsed. You don't just lift of the debris and expect people to walk away: you have still got to treat the person that you rescue, so to speak. So in this particular case, it is terrific – it is very appropriate that arrangements were made for her children and I think in subsequent days others of her children were placed in temporary foster care, but that does not obviate the need for vigorous treatment of that person in their own right, because just taking away the stressors doesn't necessarily make the person free of depression.' (T278-9)

Again, this observation, containing as it does criticism of Dr Shillito, has to be examined in the light of the deceased's attitudes to hospitalisation and medication, matters about which the deceased had a fixed attitude on 17 November.

3.25. In the event it is impossible to say that anything that occurred at the RAH on 17 November 1999, or failed to occur at the hospital on that date contributed to the unfortunate outcome in this matter. Subsequent events were in large measure to overtake anything that took place at the RAH.

3.26. For instance, whether Dr Latanzio spoke to Dr Goodwin as to the outcome of the 17 November visit becomes somewhat academic because, as it transpired, the deceased herself telephoned Dr Massolino later that day. The deceased told him that it had been recommended to her by a doctor at the RAH that she should take her daughter to the Women's and Children's Hospital for inpatient treatment. The daughter had refused to go and she had called an ambulance to accompany her but the daughter had still refused to go in the ambulance. Dr Massolino told me that the deceased had called him to see if he could facilitate the daughter being taken to the Women's and Children's. He left his practice and went to her house in the hope that he might be able to convince the daughter that the trip to the hospital wasn't such a bad thing. Following this the daughter agreed to go. Dr Massolino told me that in relation to the scenario concerning the ambulance and the deceased's daughter:

> 'The situation was really quite tense because there were police there and an ambulance and ambulance drivers and Trish just wasn't coping. The daughter was being obstructive as Trish had been describing. So it was a very stressful time for all concerned, actually.' (T503)

4. Dr Massolino's consultation on 18 November 1999

4.1. Dr Massolino again saw the deceased on 18 November 1999. This was his final consultation with the deceased. This of course was the day after the deceased's first visit to the RAH. Dr Massolino said he was pleasantly surprised that on this day she had finally indicated a willingness to take antidepressants, or as he noted, to 'trial antidepressants'. Dr Massolino prescribed a starting dose of a ¼ of a 150mg tablet of Aurorix, daily in the morning. The plan was to increase that dosage every two to three days until she reached a maximum of 150mg twice a day. Dr Massolino acknowledged that this was not a therapeutic dose. The reason he prescribed a dose that was sub-therapeutic was as follows:

> 'Because of my familiarity with Patricia's intense reluctance to try medications and with the previous reported side effects, I felt that by starting her on a sub-therapeutic dose would decrease the probability of her having side effects and therefore increase the chances of her staying on the medications and being compliant with them.' (T495)

I have no hesitation in accepting Dr Massolino's evidence about this. Professor Goldney said at T330-331

> 'I think it's reasonable to have started a very low dose, because Dr Massolino knew this lady and knew her history of reactions to antidepressants. However, as soon as one would gain the confidence of the patient that one was not going to get marked side effects one could increase it fairly rapidly. So I can well understand his prescription of such a low dose in the first instance, but it still remains a very low dose. It could be argued that it is not prudent, on the other hand I can understand why it was done.' (T330-331)

It also has to be considered that as part of his strategy, Dr Massolino arranged for a referral to see the specialist psychiatrist, Dr Hafner, on 24 November 1999, some six days after his own consultation. Dr Massolino told me and I accept his evidence, that this was an unusually short referral period given that it can take a long time to secure an appointment with a private psychiatrist. This short referral period was due to Dr Hafner's close association with the practice.

4.2. In my opinion, Dr Massolino did everything in his power to help Mrs Jericho, particularly in relation to attempting to effect a proper regime of medication.

5. The second presentation to the Royal Adelaide Hospital on 19 November 1999

5.1. On 19 November 1999 the deceased re-attended at the RAH in the early hours of that morning. On that occasion the deceased was conveyed by ambulance from her home to the RAH Emergency Department and it is noted in the Ambulance Officer's report that the deceased has been sitting in a corner of a room holding a teddy and a pillow, shaking and talking with her mother. The deceased attended at the RAH at the recorded time of 5:00am. She was seen by a Dr Ravindran. Dr Ravindran was not called during the inquest, nor was a statement taken from him during the course of the investigation conducted by the Police. This was because Dr Ravindran could not be located, it being understood that he no longer resided in Australia. It seems that the deceased was not interviewed in detail until 6:30am and it is noted in the RAH 'History and Examination' (UR30) that between her arrival at 5:00am and the commencement of her interview at 6:30am she had been fast asleep.

5.2. The dramatic circumstances in which she came to be taken by ambulance from her home to the RAH Emergency Department are incongruous with the eventual outcome of her attendance at that Department. Her triage assessment on arrival was recorded blandly as 'depressed'. By the time she was seen by Dr Ravindran her attitude had changed. It is recorded in the RAH notes that when she was eventually seen she said that she was 'feeling alright and feels like seeing her children'. She went onto say that her children did not know that she had gone to the hospital as they had been asleep when she had left home. The deceased described the difficulties with the eldest daughter, the recurring theme in past histories. She was asked about the reason for her attendance and she had said that she felt unhappy and had therefore called the ambulance. At about 7:00am, in the course of the interview, she insisted that she be allowed to go home as her children had been unaware that she had left the house. She was asked whether she was still feeling unhappy and she said no. She was insistent that she wanted to go home before her children woke up. She told Dr Ravindran that she received 'prompt support from her mother'.

5.3. The UR30 records a 'mental state examination'. It records that she was adequately dressed, that she exhibited satisfactory cleanliness but with uncombed hair. The notes go onto describe good eye contact during conversation, appropriate facial expression and no interruption whilst talking. Her conversation is described as normal in terms of rate, flow and tone. In relation to her mood the notes record 'she was rather

anxious than depressed at the time of interview as she was in a hurry to get back home'.

5.4. As far as suicidal thoughts or ideation is concerned the hospital notes variously describe this as 'has no suicidal ideation,' and 'when she was asked whether she has any suicidal ideation said 'no' and apparently no history of suicidal attempts in the past but could not verify clearly'. As far as detention is concerned it is noted at that stage that the patient need not be detained as she was not feeling suicidal, that she had good insight and was living with a supportive mother. The notes record that the deceased said before leaving that she would return to the Emergency Department if she felt suicidal.

5.5. It is not clear whether the documentation from her earlier visit at the Emergency Department of the RAH on 17 November 1999, which documentation would have included a copy of Dr Goodwin's letter, was available to the Emergency Department staff on the morning of 19 November. It is also unclear from the notes compiled on 19 November as to whether or not the deceased had informed the Emergency Department staff on that occasion that she had presented at the same Department two days earlier. However, in the Ambulance Officer's report it is noted that the patient had not been coping at home, that her mother had been trying to help, that the patient had not been able to improve for the past two days since 'discharge'. The report does not describe in any more detail the nature of the deceased's 'discharge'. Moreover, there is no way of discerning whether or not any person in the Emergency Department, be it Dr Ravindran or any of the nursing staff, paid any attention to the significance of any previous discharge from hospital.

5.6. The notes in relation to the attendance on 19 November do not in terms record any offer of admission to hospital or of medication. However, I think it is implicit from her recorded insistence on going home that her admission was at least contemplated by Emergency Department staff. Again, the deceased's attitude on this particular occasion is consistent with her attitude to admission to hospital two days earlier on 17 November. I am unable to say whether the question of medication was discussed or even considered on 19 November. There is no note of such an enquiry. It has to be borne in mind, however, that she had been prescribed medication by Dr Massolino the day before.

5.7. Professor Goldney was critical of the way in which the deceased was handled at the Emergency Department of the RAH on 19 November. In Professor Goldney's opinion the assessment on 19 November 1999 was inadequate with no recorded diagnosis nor recommendation of optimum treatment, even if such was ultimately to be rejected. Professor Goldney had a number of criticisms to level at those responsible for the deceased's examination on 19 November. Professor Goldney was of the view that it would have been naïve to accept that the deceased had called an ambulance at that time of the morning merely because she was 'unhappy'. Professor Goldney said that such a situation demanded close enquiry which did not happen here. For example, there was no indication in the notes made by Dr Ravindran of any enquiry in relation to or assessment of the biological features of depression. Professor Goldney also thought it was inappropriate to describe the deceased as having 'good insight,' when, only a matter of hours earlier, she had been unhappy enough to have an ambulance taker her to hospital at that unusual time of the night. He thought that the arrival by ambulance and her subsequent denial of unhappiness only a matter of hours later was 'quite bizarre' (T334). I agree. This paradox certainly required careful psychiatric evaluation.

5.8. It is not clear whether Dr Ravindran had access to the notes, in whatever form they existed, of the deceased's attendance at the same hospital on 17 November, two days earlier. In all likelihood he didn't as his own notes make no reference to this earlier presentation. In addition, there does not appear to have been any recorded inquiry into the deceased's longitudinal history by Dr Ravindran, another matter attracting criticism from Professor Goldney.

5.9. Professor Goldney's criticisms have validity at face value, but in fairness it has to be recognised that Dr Ravindran has not had the opportunity to put any explanation before the Court that might mitigate such criticism. Furthermore, it would be dangerous to assume that Dr Ravindran's handwritten notes which form UR9 and UR30 reflect the entirety of his examination and assessment. There is also the fact that the deceased, in keeping with her attitude on 17 November and with her previous resistance to treatment in the past, flatly insisted that she wanted to go home. In my view it is impossible to say whether anything that occurred or failed to occur on 19 November at the RAH contributed to the eventual outcome in this matter.

6. Further consultations at the Payneham Family Practice

6.1. 19 November 1999, the day that the deceased presented herself at the RAH on the second occasion, was a Friday. An appointment had been made by Dr Massolino to see Dr Hafner on 24 November. There is no evidence as to the deceased's condition over the weekend of 20 and 21 November 1999, but on 22 November 1999 she again presented at the Payneham Family Practice and on this occasion saw Dr Goodwin. By then Dr Massolino had gone on leave. The deceased's mother's statement (C5a) describes the deceased coming into her room at 2 o'clock that morning and saying how suicidal she was feeling. As a result they consulted Dr Goodwin.

6.2. On 22 November 1999 Dr Goodwin noted that the deceased had seen Dr Massolino on 18 November and had started her on antidepressants. However, Dr Goodwin noted on 22 November that the deceased 'remains profoundly depressed'. The remaining children were now off the deceased's hands, the child Tirzah having been admitted to the Woman's and Children's Hospital on 18 November as already seen. The other children were fostered out to friend's houses. This is a significant fact as it removed an impediment to the deceased's admission to hospital. It is to be recalled that she told Dr Shillito on 17 November at the RAH that she was concerned about her two youngest children in the event of her hospitalisation. The deceased's mother was still staying with her and remained supportive at that time. Dr Goodwin discussed a number of options that were available to the deceased including whether she should have inpatient care. Dr Goodwin said in his statement that he would have been aware of the fact that she had not been admitted to hospital after she had previously consulted him on 16 November. That was the last occasion that Dr Goodwin saw the deceased.

6.3. Professor Goldney was of the view, which I accept, that Dr Goodwin could really have done no more for the deceased on 22 November 1999. It is true that it does not appear that an increase in the deceased's antidepressant medication was discussed on that occasion and that the deceased's prescribed dosage of Aurorix was still non-therapeutic. Dr Goodwin did, however, prescribe Normison which is a sleeping tablet and Dr Goodwin was conscious of the fact that the deceased was due to see Dr Hafner two days later on 24 November. He noted that he would await Dr Hafner's review.

Professor Goldney assessed the two day gap between 22 and 24 November as not ideal but observed:

> 'But I can imagine that Dr Goodwin wouldn't have felt in a position to try and expedite it any further because of what had happened several days before. I know that's not documented but I think that he would probably have felt quite delighted that the psychiatrist was seeing her within a couple of days. So, again, the gap is not ideal but I think it's a pretty good service that was provided.' (T350)

Professor Goldney said that there was not many general practices that could offer the promptness of the psychiatric service that was provided in this case.

6.4. As scheduled, the deceased saw Dr Hafner on 24 November 1999. Dr Hafner is an eminent psychiatrist. He has a Doctorate of Medicine from the London University in 1972. He has a Fellowship of the Royal College of Psychiatrists obtained in 1973 and has a Fellowship of the Royal Australian and New Zealand College of Psychiatrists obtained in 1978. He has been practising for thirty years. He came to Australia as a senior lecturer in psychiatry at the London University. This occurred in 1977. He was a staff specialist at Flinders Medical Centre from 1977-1982. From 1982-1998 he was an Associate Professor of Psychiatry and a Senior Staff Specialist at Flinders and the associated university. In 1998 he had a full-time post as a Director of the Dibden Research Unit and when he left that position he decided to develop a role as a consultation liaison psychiatrist within a number of general practices. By the end of 1999 he was involved in two general practices, one of which was the Payneham Family Practice. His role at the Payneham practice was basically to work with the general practitioners there, seeing patients whom they were concerned about as soon as possible. He had rooms within the practice so that referrals could be made in writing within the patient's case notes. He would then see the patient and he described the arrangement as being very effective and efficient.

6.5. Dr Hafner was in my opinion an impressive witness and I accept the entirety of his evidence.

6.6. Dr Hafner recorded his examination of the deceased in the practice notes to which he had access. Dr Hafner has recorded in the practice notes the following:

> 'Thank you for asking me to see this woman. It's quite clear that she has major depression with significant endogenous features such as, feeling empty, with no feelings, thought retardation and inability to shed tears. The development of frank psychotic

> symptoms is close I think, especially in the absence of therapeutic doses of medication (currently she's taking 75mgs Aurorix mane). I don't think that her mother – who joined us after ten minutes – is able to cope adequately with the situation and may inadvertently be exacerbating it because of her strong religious views. I contacted EACIS and explained that I thought she needed urgent admission. They agreed to pursue matters accordingly – fortunately they knew me, and both patient and her mother agreed to the admission. I'll be happy to follow-up as appropriate.'
>
> (Exhibit C6a)

6.7. Dr Hafner's diagnosis of Mrs Jericho was unequivocal in that she suffered from severe depression with significant endogenous features. He thought that she was close to developing psychotic features and he formed the view that she was legally detainable at that time. He did not detain her for a number of reasons that I will discuss, but it is plain from his statement as verified by his affidavit and from the evidence on oath that he gave before me that he placed his faith in EACIS and expected that they would see to it that she was admitted on a voluntary basis to hospital. He understood from the deceased that there would be no difficulty about that on this occasion.

6.8. Dr Hafner telephoned EACIS and it is recorded in the EACIS notes that he spoke to Mr Kosta Lebessis, a psychologist at EACIS, at about 9:30am on 24 November 1999, that is to say, when he was seeing Mrs Jericho. The notes compiled by Mr Lebessis are as follows:

> 'Dr Hafner contacted EACIS requesting admission Ms Jericho as she has Major Depression with endrogenous (sic) features and some psychotic features. Current stressors include her children being taken into care due to inability to care for her children due to her depressions. She has not been admitted to hospital before. She ambivalent about taking medication, but she has ½ an Aurorix tablet per day.
>
> Dr Hafner also reported that she wants to harm herself, but she should be able to be managed in an open ward. Dr Hafner was advised a bed was not available at present, and Ms Jericho would be contacted at home when a bed became available. Her mother will be staying with her until a bed becomes available.'
>
> (Exhibit C17)

Dr Hafner's own note states that he explained to Mr Lebessis that the deceased needed 'urgent' admission. The other important feature of the EACIS note is that the deceased 'wants to harm herself'.

6.9. Dr Hafner told me that EACIS was the appropriate pathway for the deceased to be admitted to hospital. His experience was that it was impossible to arrange admission to hospital without going through EACIS – he described them as the 'gatekeepers to psychiatric admissions'. He said that Lebessis knew him and that he made the assumption that EACIS would act appropriately and make arrangements for the deceased to be admitted 'as soon as possible'. He said that he also assumed that if they couldn't admit her immediately they would provide proper supervision and follow up until they could admit her. His hope and expectation was that she would either be admitted to the RAH or to Glenside, but with a strong preference for the former as it provides a much less traumatic environment. Dr Hafner agreed that Mr Lebessis' notes accurately reflected what he had said to him on the telephone that morning. As a result of that conversation, Dr Hafner assumed that the deceased would be admitted as soon as possible, notwithstanding the lack of availability of a bed at that time. In my opinion that belief is corroborated by the terms of Mr Lebessis' notes. Dr Hafner said that he expected her to be admitted at the latest on the following day and within 24 hours. He also said that Mrs Jericho herself had the expectation that she would be admitted and that she actually wanted to go into hospital. He said that 'she had the clear understanding that help of a substantial kind, ie. admission to hospital, was going to take place' (T95). In the event, the deceased was not admitted to hospital at any time prior to her death.

6.10. Dr Hafner told me that EACIS knew that he was a very experienced psychiatrist and that it would have been understood from his conversation that he was very concerned about the deceased. I have already alluded to Dr Hafner's eminence in the profession. He has published widely and he has over a hundred scientific papers and book chapters to his credit and, to use his own words, would have been reasonably well known in South Australia as an experienced psychiatric practitioner.

6.11. In short, Dr Hafner did not expect his diagnosis and recommended course of action to be second-guessed. Given the clarity of Mr Lebessis' note to which I have already referred, Dr Hafner's expectations as far as admission to hospital was concerned were reasonably held in my view.

6.12. Dr Hafner was of the view that the deceased was detainable under the Mental Health Act. He did not detain her as he believed that she would voluntarily subject herself to admission to hospital and in any event he said:

> 'In my view detention is for people who need to be admitted to hospital but who either are unwilling to agree to that, or who don't that (sic) enough insight to understand that that is necessary.' (T91)

Professor Goldney agreed with such an approach saying:

> 'There is no need to detain a person if they are willing to go to hospital.' (T380)

Dr Goodwin held a similar view about detention. Dr Hafner said that detention did not seem appropriate at all, being of the view that detention is a 'fairly traumatic thing apart from anything else.' (T92) In any event he said that in this particular case he had already made it clear that he believed that she needed urgent admission to hospital. He reiterated in cross examination that he didn't issue a detention order because she had agreed to go into hospital, that her mother supported that and that he had every reason to believe that she would be admitted voluntarily to hospital within a reasonably rapid period of time and that in the meantime she would have appropriate supervision. He described the deceased as being 'very, very willing to be admitted' to hospital (T102). Dr Hafner was left with the impression, as is plainly evidenced by Mr Lebessis note, that the deceased would be admitted when a bed became available. There is an issue as to whether or not Dr Hafner expressed the opinion to Mr Lebessis at EACIS that the deceased was in fact not detainable. I return to this issue later, but the observation has to be made now that nowhere in Mr Lebessis' notes is the issue of detention, its appropriateness or otherwise, mentioned. What the notes do reflect is that Dr Hafner requested admission for the deceased but indicated that she should be able to be managed in an open ward.

6.13. In my opinion, there was in those circumstances little need for Dr Hafner to follow anything up with EACIS, particularly bearing in mind that there was the assurance that when a bed become available the deceased herself would be contacted at that time.

6.14. On 24 November Dr Hafner did not give any consideration to increasing the deceased's level of medication or varying it in anyway. He did this because he

believed that the deceased would imminently be admitted to hospital and that issues such as medication would be addressed there.

6.15. It is important to recognise that Dr Hafner told EACIS on 24 November 1999 that in his opinion the deceased was suffering from major depression with endogenous features all of which was noted by Mr Lebessis. In addition it is important to observe that Dr Hafner told EACIS in the same conversation that the deceased wanted to harm herself. Dr Hafner told me that she had an elevated risk of self-harm and such was implicit in the diagnosis of endogenous depression or as he otherwise put it, 'major depression with melancholia'. Such a diagnosis implies that there is a significant risk of self-harm.

6.16. Dr Hafner received no further notification from EACIS after his conversation with Mr Lebessis at about 9:30am on 24 November 1999. Contrary to his reasonably held expectations, the deceased was not admitted to hospital as we shall see. Dr Hafner was not told that EACIS, as it transpired, had adopted a course of management that involved the deceased being seen by EACIS staff in her home. He was not told of any differentiation as far as the deceased's diagnosis was concerned and not told of any differing view that may have been formed within EACIS as to Mrs Jericho's suicide risk. As to his reason for not making contact with EACIS after he had learned that on 24 November that no bed was available he said:

> 'It would not be appropriate or necessary to do so because I had the assumption that they would deal with matters professionally and appropriately and they would contact me only if there was some problem.' (T110)

6.17. Aside from the matters expressed at the time of Dr Hafner's referral, another significant piece of information was conveyed to EACIS on 24 November 1999. This took the form of a telephone call from the deceased's mother, Laura Jericho. The details of her call are recorded in the EACIS notes and it is evident that the telephone call occurred at a time prior to the deceased being seen by EACIS medical staff that day. It has been noted in EACIS' records that the deceased's mother had told a social worker that she felt that she was not qualified to manage her daughter. She also said that all of the deceased's children had been placed outside the home. Of particular significance is the fact that the deceased's mother had told the social worker at EACIS that her daughter had asked her to remove knives and that the daughter had been

questioning the mother along the lines of 'will I make it'. At the end of this entry in the notes the writer has written:

> ''plan' Dr Sidhu plus Jill Milburn to h/v today at 15.30 – may need medication change.' (Exhibit C17)

'h/v' refers to a scheduled visit to the deceased's home that day. A Dr Sidhu and a Nurse Millburn were told to see her.

The note confirms in my mind that the phone conversation occurred prior to Dr Sidhu and Nurse Milburn seeing the deceased on the afternoon of 24 November. I so find.

6.18. The reference to the deceased asking her mother to remove knives and questioning whether she would make it or not in my view is indicative of the deceased, at the very least, entertaining the idea of self-harm. Any reasonable person, whether qualified medically or not, would have drawn such a conclusion. This piece of information I find was of particular significance to the manner in which EACIS should have dealt with the deceased. Dr Sidhu, who was called to give evidence, effectively agreed with that proposition. I return to this issue.

7. Treatment effected by Eastern Acute Crisis Intervention Services

7.1. Following Dr Hafner's telephone referral of the deceased to EACIS, the matter was discussed at a meeting at the office of EACIS at about 1:30pm. A number of persons were present at that meeting including Dr Gurdial Sidhu and a registered psychiatric nurse Jillian Millburn. Dr Sidhu was not a full time employee of EACIS. He obtained an MBBS in 1980 from the Christian Medical College at the University of India and obtained a Fellowship of the Royal Australian College of General Practitioners in 1998. He worked in psychiatry for one year in the Royal Derwent Hospital in Tasmania. That was in 1993. He spent another three months in the same hospital as a Senior Medical Officer and then worked in a psychiatric ward at the Repatriation Hospital and then spent six months in Cleland House at the Glenside Hospital as a resident. Dr Sidhu does not have a formal psychiatric qualification, but has psychiatric experience as described. He told me that his association with EACIS had consisted of working two sessions a week. After a time this was reduced to one session a week. He was performing one session a week in November 1999. He worked for EACIS on Wednesday afternoons. Dr Sidhu also works in private

practice. Nurse Millburn is and was at all material times a full time employee of EACIS. She has been registered as a psychiatric nurse since 1981 and has been employed at EACIS since about 1984 when it was known as the Eastern Emergency Service. Both Dr Sidhu and Nurse Millburn gave statements to the police which were subsequently verified by affidavit. In addition they both gave evidence in this inquest.

7.2. EACIS was described as an acute crisis intervention service that assesses and provides a service to people in acute crisis from a mental health point of view. It provides immediate assessment and hospital admission, if required. It can provide other services such as referral to private psychiatrists or referral to other services such as counselling services. An EACIS team comprises medical practitioners, psychiatrists, nurses and social workers. Each team in EACIS has a team leader who is responsible for the delivery of the services provided by the team. The leader is also responsible for coordinating resources. At the material time, Anna McNair, who is also a psychiatric nurse, was the relevant team leader.

7.3. The day of the Dr Hafner's referral of the deceased to EACIS, namely 24 November 1999, was a Wednesday. Dr Sidhu was therefore on duty in the afternoon of that day. Dr Sidhu commenced his duties at 1:30pm which was the time for the handover between shifts. At that time it was customary to have a clinical staff meeting. The meeting was attended by the team leader and other members of the team. At that afternoon meeting there was discussion as to the plan of action to be adopted in relation to the deceased.

7.4. Dr Sidhu and Nurse Millburn were present at the meeting as was Ms McNair. By the time this meeting had occurred, Dr Hafner had referred the matter to EACIS in the telephone conversation to which I have referred and a note of that telephone conversation had been prepared by Mr Lebessis. There can be no doubt that either at that meeting or at sometime before Mrs Jericho was seen by Dr Sidhu and Nurse Millburn later that afternoon, Mr Lebessis' note, or at the very least the information contained in that note, was read and imparted to those responsible for the deceased's care. Dr Sidhu said that he had been given the note from Mr Lebessis and he identified the note of 9:30am on 24 November 1999 as that note (T116). Dr Sidhu understood that at that time there were no beds available for the deceased, as the note states.

7.5. What is not clear is whether the note of the mother's conversation with EACIS on that day was available at the 1:30pm meeting. Dr Sidhu said in evidence that whilst he had available to him Mr Lebessis' note of the conversation with Dr Hafner, he had not been aware of the conversation between the deceased's mother and the EACIS staff member. On the other hand, Nurse Millburn said that the contents of the note of the mother's call was discussed at the team meeting at 1:30pm. She said in her evidence in chief that she remembered this. She told me that such a note would generally be read out by the person who took the call or wrote the note. That person would have been a member of the team that day. That person was in fact a woman by the name of Sandra Mattner, a social worker. However, in cross-examination (T195) Nurse Millburn told Counsel Assisting the Coroner that she could not specifically recall the information about the deceased having asked her mother to remove knives being mentioned at the meeting, but she imagined that it would have been. She said that she could not recall precisely whether that part of the mother's conversation that described her daughter posing the question 'will I make it' was mentioned at the meeting. Ms McNair, the team leader, who said she would have been present at the meeting, could not say whether the note of the mother's conversation was mentioned, but assumed that it would have been. There is no evidence as to precisely when the mother spoke to Ms Mattner that day, but, as I say, it is evident that it must have been at a time prior to Dr Sidhu and Ms McNair arriving at the deceased's home later that afternoon. Dr Sidhu and Nurse Millburn could have been contacted by mobile phone if necessary if any further relevant information about a patient they were about to see came to light.

7.6. Dr Sidhu and Nurse Millburn saw the deceased at her home on the afternoon of 24 November. The time 1500 hours is noted in the record as being the 'time of assessment'. Dr Sidhu examined her and made some notes of his examination. He noted that the deceased at that time was:

> 'Feeling low, sad and depressed for last few weeks. Has felt depressed for many months but worse in last few weeks.'
> (Exhibit C17)

7.7. Dr Sidhu noted that she was taking Aurorix and that she had experienced an adverse reaction to Zoloft in the past. Dr Sidhu recorded his provisional diagnosis as 'major depression'. He noted in his 'Brief Opinion' that she had low level suicidal ideation with no plans of suicide.

7.8. It has already been observed that on this day there was no bed available for the deceased. Dr Sidhu decided upon a management/treatment plan that would not involve hospitalisation. He did not ask EACIS to continue looking for a bed. As to why he did not pursue that:

> 'To begin with, when I assess her, I had this impression that that option wasn't available and once she was being assessed then it was to be – the further plan was to be – the further management plan was to be made according to what her mental state was like, which could change on a day to day basis.' (T143-144)

However, Dr Sidhu said that the management/treatment plan that he instigated was not done so simply because of the lack of a bed. He took the view that management of the deceased within her home was an appropriate regime of treatment in any event. He said:

> 'Q. In terms of the assistance that that plan was going to give to Ms Jericho, how would that have differed, if at all, from what would have been provided by way of voluntary admission.
>
> A. Personally I don't think that an open ward would have made much difference, because the open ward, the patient is there voluntarily, they can choose to leave ay time they like, they're free to roam in the grounds, they're free to go to another room by themselves or they're free to go to the bathroom by themselves and they still have all their belongings, everything with them, so if they decide to do something in an open ward, they still wouldn't be able to stop them. Detain ward, that's a different story.' (T143)

As to medication, he decided to continue the deceased with Aurorix, the antidepressant, and to increase the dose next week. It is to be noted here that Dr Sidhu was only working one day a week for EACIS and that in the normal course, he would have next seen her on Wednesday 1 December. In that intervening period she would not have been seen by a qualified medical practitioner under the EACIS umbrella. However, Dr Sidhu put in place a plan whereby the deceased would receive a daily visit from the EACIS team and that he would review the situation when he was again performing EACIS duties the following Wednesday. Although he did not modify the deceased's Aurorix intake, Dr Sidhu prescribed a drug to relieve anxiety, Thioridazine.

7.9. Dr Sidhu said that the usual practice would have dictated the making of a phone call to the referring doctor, but that didn't always happen on the same day for various reasons. He said that the call was to provide the referring doctors with 'feedback on what we are doing' (T141). He had no recollection of calling Dr Hafner after his

examination. Nurse Millburn did not contact Dr Hafner, saying that it would have been the Doctor's decision in this instance. On 27 November Nurse Millburn spoke to another nurse by the name of Hadden. Nurse Hadden had seen the deceased the day before and she told Millburn that she would contact the deceased's private psychiatrist. I find that no contact was made with Dr Hafner after 24 November and before the deceased's death. I accept his evidence about that. It was not challenged. Indeed, there is no note in any of the EACIS records of any communication with Dr Hafner between 24 November 1999 and 28 November 1999 when Dr Hafner was advised of the deceased's death.

7.10. I find that the management/treatment plan put in place by Dr Sidhu was at odds with what Dr Hafner in his professional opinion had considered to be an appropriate regime of management for the deceased, namely admission to hospital. Furthermore, Dr Hafner was given no real opportunity to provide any input into the deceased's management and treatment because he quite reasonably acted on the recorded assurance of an EACIS employee that the deceased would be contacted at home when a bed became available and that her mother would be staying with her until that happened. He expected the deceased to be admitted to hospital in accordance with his expressed wishes. He expected that it would happen within the next 24 hours. It appears that to all intents and purposes the question of admission to hospital was put to one side by EACIS, except insofar as admission to hospital might have been considered appropriate were the deceased to deteriorate. Dr Sidhu rejected the notion that he had 'over-ridden' Dr Hafner's management plan. He was asked:

> 'Q. Are you saying that your plan over-rode really these initial arrangements, or initial intentions that Ms Jericho was to go to hospital unless something else happened which showed that there was a more immediate need for her to go to hospital.
>
> A. Didn't over-ride it, but that was an alternative that because there was no bed available, so that was an alternative when I saw her but that didn't mean that this plan will not become - or will become inactive, if at any stage that situation arose, it would be.' (T151)

The fact of the matter was, however, that the plan to admit the deceased to hospital did become inactive. No-one could positively tell me, for instance, whether the deceased was still on the waiting list for a bed. Dr Sidhu was asked:

> ' Q. Was (sic) all bets off, as it were, as far as a bed was concerned, was the idea put to one side entirely. Do you know or not.

A. I'm not sure on that because when I saw her, it wasn't available, and once I'd planned that, as I said, the plan was to monitor daily, but whether they were still looking for a bed, I'm not sure.' (T152)

Admission to hospital was only to be considered if there was a deterioration in the deceased's presentation. The initial lack of a bed in reality was of no particular significance in any event. I was told by Dr Sidhu, by Nurse Millburn and by Ms McNair that notwithstanding the unavailability of a bed at the RAH or Glenside, a bed could have been 'bought' at a private institution. This refers to the practice of admitting a patient to a private facility for a fee. Dr Sidhu told me that this occurred in rare cases and with the approval of an EACIS team leader. Ms McNair told me, however:

'I mean, the fact that there wasn't a bed doesn't really impact on how the client should be managed. And, I mean, certainly in how we say, look, the fact that there's no bed shouldn't change the way we manage people, the way we treat people. If a bed had been required we would have created one, even if it meant buying a bed in the private sector, which is what we were doing in those days.' (T252)

There was no evidence before me as to how long the waiting list for a bed may have been at that time and whether a bed in the public sector would have been made available by the time the deceased took her own life. However, a bed in the private sector could have been obtained with Ms McNair's approval. The reality was, I think, that hospitalisation was never really considered after 24 November, notwithstanding that a bed in a hospital was in fact required by Dr Hafner.

7.11. Ms McNair, the EACIS Team Leader, said that Dr Hafner's recommendations carried a lot of weight. She described him as a 'very reputable, very competent psychiatrist' (T232). In those circumstances, I find it extraordinary that the opinion of a psychiatrist as eminent and as experienced as Dr Hafner was effectively second-guessed by another practitioner of considerably less experience, and in circumstances where Dr Hafner was not afforded the opportunity to comment on the proposed course of management of his patient. Extraordinary again is the fact that he was not told about the management plan that was then put in place. Nurse Millburn said that where, as was the case here, the plan created by EACIS was different from that proposed by the referring doctor it would have been normal for that change to be conveyed to the referring doctor. As observed, that was not done in this case. Ms McNair also told me candidly that there had been a 'falling down in communication

with Dr Hafner' (T232). Plainly, Dr Hafner should have been contacted before a plan different from his was implemented. Quite apart from depriving Dr Hafner of the opportunity of bringing his professional influence to bear on what he perceived to be an urgent situation, he was also in reality denied an option that would still have been open to him, namely that of detaining the deceased under the Mental Health Act.

7.12. Criticism has been made of Dr Hafner insofar as he did not contact EACIS to see what treatment plan had been put in place. I reject that criticism. Dr Hafner referred the deceased to EACIS requesting admission. He was advised in effect that the deceased would be admitted as soon as a bed became available and there was nothing after the conversation of 24 November which would have led Dr Hafner to any conclusion other than that in the normal course of events the deceased would have been admitted to hospital in accordance with his wishes.

7.13. The question of the deceased's admission to hospital on or about 24 November was an important matter. Of course, it cannot be said with certainty whether if the deceased had been admitted to hospital, her suicide could have been avoided. However, the risk of that occurring may have been reduced if she had been admitted to hospital on 24 November or the following day. Dr Sidhu himself acknowledged that hospitalisation, without removing the risk of self-harm altogether, may have reduced it. Dr Hafner told me that if he had been informed that the deceased had not been admitted to hospital he would almost certainly have spoken to Dr Goodwin and discussed what more they could have done. Dr Hafner told me that he could have spoken to one of the senior doctors connected with EACIS and asked that practitioner to have a second look at what had been implemented. Dr Hafner also said that if he had been contacted by EACIS and been told that their assessment had been that the deceased presented a low risk of suicide, he would have restated his views that she had major depression with endogenous or melancholic features, that she was on the threshold of psychosis and that she was at significant risk for self harm and that in the light of such an opinion being restated he would have expected them to listen to what he would say and to have admitted her to hospital. In my view given Dr Hafner's eminence, experience and his knowledge of the deceased's history of depression, there is every reason to suppose that his expectations would have been met.

7.14. As to the reason why Dr Hafner's wishes were not implemented, the following evidence is also relevant. Dr Sidhu told me that he had been made aware of the

contents of Mr Lebessis' note of his conversation with Dr Hafner and had taken particular note of the fact that it had been recorded that, notwithstanding that the deceased wanted to harm herself, she 'should be able to be managed in an open ward'. The quotation is taken from Mr Lebessis' note. Dr Sidhu told me that he understood from this that Dr Hafner did not consider that the deceased was detainable under the Mental Health Act. Dr Sidhu said that he had been given the note by Mr Lebessis and was also told by him that Mr Lebessis had specifically inquired from Dr Hafner whether the patient had been detainable. The answer had been negative as Dr Hafner had thought she could be managed in an open ward. The note of Mr Lebessis does not say anything about detention. Dr Hafner told me that he considered that the deceased was indeed detainable. I accept his evidence that he was of this view. It is inconceivable that a psychiatrist of Dr Hafner's experience would in the same breath express a view to EACIS that the deceased wanted to harm herself but then say that she was not detainable. Dr Sidhu nevertheless said that he somehow divined a mixed message from the Lebessis note. The note described psychotic features but carried the implication to him that she was not detainable notwithstanding such features. Asked at T153 as to where in Mr Lebessis' note it says that the woman was not detainable, Dr Sidhu pointed to Dr Hafner's recorded view that she should be able to be managed in an open ward, whereas detention is administered in a closed ward. However, Dr Sidhu's evidence that he had understood that the word 'detention' had been mentioned in terms in the conversation between Mr Lebessis and Dr Hafner has to be examined in the light of a later assertion that 'admission in an open ward is voluntary, there is no mention of the word detention' (T154). At the end of the day I am not sure what Dr Sidhu was trying to convey to me as to whether or not he believed that Dr Hafner had specifically said that the deceased was not detainable. I find that Dr Hafner did not say that the deceased was not detainable. He told me in his evidence that she was in fact detainable, and this is in keeping with his view that the deceased wanted to harm herself. All of this is reinforced by the fact that there was absolutely no mention of the word 'detention' or any of its derivatives in the note of his conversation with Mr Lebessis. In any event, the point that had been conveyed to EACIS very firmly in my opinion was that Dr Hafner wanted the deceased to be admitted to hospital as soon as was possible. If there was any doubt about what Dr Hafner's wishes and desires were that day he should have been contacted before any management/treatment plan was implemented.

7.15. A matter worthy of note is that according to the evidence of Nurse Millburn there was an expressed reluctance on the part of deceased to be admitted to hospital. This would be consistent with her attitude to admission to hospital on 17 November when she first presented at the RAH. Nurse Millburn said in her evidence in chief that the deceased 'preferred the idea of staying at home than going to hospital. She was quite distressed at the idea of going to hospital' (T176). As to how she knew that the deceased was distressed about the idea of going to hospital she thought it was because they had talked about her staying at home, but she couldn't swear to that. She then went onto say that they must have discussed hospitalisation because the deceased had talked about being very anxious about that. When questioned closely as to what she wasn't able to swear to Nurse Millburn said:

> 'Whether or not – see I wouldn't have talked to her about going to hospital. Whether or not Dr Sidhu talked to her about going to hospital or staying at home I can't recall that but I do recall her being very anxious about having psychiatric intervention and about hospital. I just know that she was anxious about that so it must have been raised. But we felt that she could – we have worked very well with her at home.' (T176)

Later in her cross examination Nurse Millburn was again questioned about her recall as to whether or not there was discussion with the deceased about treatment at home or admission to hospital. The witness referred to her earlier answer that I have set out. She again said that she couldn't completely recall that, although it must have been raised because she had been aware that the deceased didn't really want to go to hospital and was anxious about going into a psychiatric hospital and so therefore the deceased must have been given the option of being treated at home. Nurse Millburn's evidence on the topic of whether there was discussion about hospitalisation for the deceased is quite vague in my view. Dr Sidhu said that he could not recall discussion on the topic of admission to hospital with the deceased (T155). Dr Sidhu made no record of any discussion about the deceased going to hospital. Dr Hafner, as observed, had said in evidence that the deceased wanted to go to hospital. However, given the deceased's past propensity to refuse admission one has to consider whether she did in fact say to Dr Sidhu and Nurse Millburn that she was distressed about the idea of going to hospital. It is to be observed that since the deceased's two presentations to the RAH, her children had been taken off her hands, thus removing at least one impediment in the way of the deceased being admitted. I think it is highly unlikely that on 24 November the deceased flatly refused admission to hospital.

Nurse Millburn does not go so far as to say that there was any refusal expressed as such. She said:

> 'I didn't say she was unwilling.' (T197)

I have my doubts as to whether there was any discussion about hospitalisation during the course of the examination by Dr Sidhu and Nurse Millburn on the afternoon of 24 November. If there was any such discussion, I am unable to find that the deceased expressed anything more than an understandable reluctance to go to hospital. I think that by the afternoon of 24 November, she was probably resigned to going to hospital in accordance with what she had said to Dr Hafner. In any event, if there had been any concern about her attitude, that would have been another compelling reason for Dr Hafner to have been contacted before any plan that did not involve admission was implemented.

7.16. One matter I have to consider is whether the deceased's presentation when seen by Dr Sidhu and Nurse Millburn on the afternoon of 24 November was so different from that seen by Dr Hafner in the morning of that day that Dr Sidhu and Nurse Millburn were misled as to the urgency of the matter. Dr Sidhu assessed her suicide potential as 'low risk' whereas Dr Hafner had told Mr Lebessis that she wanted to harm herself. In this regard, Ms McNair referred to a mental state assessment as being a 'snap shot in time'. This is to a certain extent valid, but it has to be borne in mind that lability of mood is a common feature of depression. Indeed what has been referred to in this inquest as 'diurnal mood variation' is one of the classic endogenous features of depression. Diurnal mood variation refers to variation of mood during the course of a day. Mood may improve as the day progresses so that by the afternoon, for instance, a depressed person's mood may have lifted. Professor Goldney observed that there was no documented enquiry by Dr Sidhu as to how the deceased had been feeling that morning. He said that an experienced psychiatrist seeing someone late in the afternoon, knowing that a colleague had seen the patient earlier, would need to explore the issue of mood variation with the patient. In this regard Dr Hafner's recorded view that the deceased wanted to harm herself was known to EACIS. In addition, the deceased's mother's information concerning the removal of knives and utterances of despair by the deceased had also been documented on 24 November. In my opinion, it is overly simplistic to say that Dr Sidhu's assessment was a snapshot in time given that other important diagnostic material was available to EACIS.

There was also the fact that the deceased had presented twice to the RAH Emergency Department in the previous fortnight and the evidence is by no means clear as to whether EACIS knew even that. If no enquiry was made of the deceased as to mood variation, such an enquiry could have been made of Dr Hafner, illustrating another reason as to why Dr Hafner should have been contacted before the management/treatment plan was implemented.

7.17. Dr Sidhu defended his management/treatment plan by suggesting that a daily visit would enable EACIS to keep a close eye on the mental state of the deceased and if at any point there was any sign of a sudden deterioration, then the necessary action could be taken. He referred to the 'hospital at home' scenario, which has recently been implemented as a formal psychiatric measure, as being a legitimate form of treatment whereby the patient is assessed daily by nursing staff and is seen by a doctor at regular intervals. Dr Sidhu, as observed, said that if the deceased had been admitted to an open ward there would not have been much difference between that and the plan that he instigated because of the openness of the regime. He said that the philosophy behind treatment at home was as follows:

> '…the main thing is that it's better that if a patient can be treated and made better at home, that's always preferable than in the hospital because once you change their environment, you bring them into the hospital, they get better, but as they get back into their own environment, same stresses come on, same difficulties come on and they tend to relapse. But if they get better in their own environment, the chances of staying well are better.' (T144)

7.18. Dr Hafner on the other hand had this to say about admission to hospital:

> 'She would have been in a hospital ward where she would have been I assumed, feeling safe, feeling looked after, feeling cared for and where she would be under close and careful observation by skilled nursing staff.' (T100)

He rejected the notion that patients in open wards had carte blanche to come and go as they please. He said that patients in open wards are carefully observed by the nursing staff and if someone judged at risk wanted to leave then the nursing staff would deal with that appropriately, and that might include asking a doctor to detain and keep them in the ward that way. Dr Sidhu himself acknowledged that a person who wants to harm herself is probably better off at a hospital rather than at home (T154). Professor Goldney said that in a hospital setting patients are encouraged to stay because there are programs for their benefit such as occupational therapy in which

patients are expected to participate. He acknowledged that voluntary patients can come and go, but he stated this:

> 'But the other side of the coin is that hospitalisation is a very symbolic, sort of caring for the person and that caring is in danger of being lost. I think in some recent years, treatment approaches – the so-called hospital-at-home really isn't equivalent to what the hospital treatment is. People are writing about them in literature as if it is. It may be the same for somebody who has – you know, is in the recovery from surgery where, you know, the person needs some sort of surgical procedures or wound dressings or whatever. I accept that that can be very sort of analogous to being in hospital but for some persons with psychiatric illnesses, I think it is absurd to call it hospital-at-home.' (T288)

7.19. Professor Goldney also made the observation that it is important that medication can be adjusted, sometimes on a daily basis, and this is of particular concern where antidepressants take several days before their therapeutic effect bears fruit. He was of the view that it was not adequate to see a patient on a weekly basis because in the first week of hospitalisation 'almost invariably you would be juggling that medication around in that first week'. To illustrate his point he observed that the deceased's dosage of Aurorix for the deceased was non-therapeutic and that it had to be built up fairly quickly. He was not certain whether that could have been done appropriately in the hospital-at-home situation. In addition, he observed that if Dr Sidhu was not to see her for a week, as was the case here, then there would not be any opportunity for appropriate adjustment of medication in that period. It is to be considered here that Dr Sidhu did not alter her medication on 24 November and that he did not envisage it being altered until the following Wednesday, 1 December. Dr Sidhu said that by the time that he saw the deceased she was said to be taking 150 milligrams of Aurorix in the morning and at midday. This is different from Dr Hafner's understanding as recorded in his note of 24 November, namely that 'currently she is taking 75mgs Aurorix mane'. However, Dr Sidhu in any event acknowledged a total daily dose of 300mgs was a 'beginning dose' (T123). He said that the dosage could go as high as 900 milligrams in rare cases but that the average dosage was 600 milligrams in a day. He acknowledged that the drug took about three weeks to have therapeutic effect. He said that the dosage would depend upon how the patient was responding and if it was not adequate it would be increased until an adequate dose was achieved. The fact that the dosage as of 24 November was not to be altered for another week seems in itself to be inconsistent with Dr Sidhu's acknowledgement that the appropriate dosage depends on the patient's response. One wonders how such a response was properly to

be gauged in those circumstances. The patient's response would be more ascertainable in a hospital setting as Professor Goldney plainly stated. He said:

> 'If one had the person in hospital, one would really want to increase the dose.' (T293)

In the event, although the deceased's condition could in theory be monitored by the nursing staff at her home on a daily basis, the fact remains that any change in the dosage or nature of medication would have to require consideration by a medical practitioner and preferably a psychiatrist (T293). I agree with Professor Goldney's views as to the appropriateness of hospitalisation in the context of medication management.

7.20. Professor Goldney's views as to the implementation of a management plan different from that originally envisaged is put succinctly where he said:

> 'I think it's inappropriate in light of her having been seen by an experienced psychiatrist, who recommended admission. It seems to me that I would have to be guided by my experienced psychiatric colleague who considered that she needed admission. I would take Dr Hafner's judgment on that over and above those members of ACIS team.' (T294)

I agree with Professor Goldney's assessment in this regard also.

7.21. There is also the issue as to whether due consideration was given to the contents of the mother's conversation with the social worker Ms Mattner concerning the removal of knives. The issue as to whether that information was imparted to Dr Sidhu is a difficult one. Dr Sidhu said he was not aware of the mother's telephone conversation. There was some evidence that it was mentioned at the team meeting that afternoon. Dr Sidhu may well have forgotten being informed of this conversation. I am not able make any finding as to whether Dr Sidhu was made aware of the conversation, and, in particular, whether he was told of the reference to knives and the 'will I make it' utterance. If the information was not imparted to him, it was a significant and regrettable deprivation of important material from him. If he did hear of it, then he did not give it sufficient weight because Dr Sidhu himself acknowledged that the material was important. Dr Sidhu was asked at page 157:

> 'Q. If what the mother had said was correct, namely that the daughter had asked to remove knives and the daughter had been questioning, will I make it. If you'd seen

that in conjunction with what Dr Hafner had said, would your decision to have adopted the course of management that you did adopt, been different.

A. I'm not sure on that because obviously that makes it more serious – she still kept saying that I have no plans or I will not do it, so it would be difficult to assess.'

However, he was asked at T158 that if the deceased was only going to be seen on a daily basis and had deteriorated there was scope for the possibility of her taking her own life in such an environment. Dr Sidhu acknowledged at T158 that if he had access to the information from the mother then he would have admitted the deceased to hospital at the first available opportunity. Nurse Millburn acknowledged that what the deceased told her mother, as related to Ms Mattner, was inconsistent with the deceased's presentation when she and Dr Sidhu saw her on the afternoon of 24 November. She said:

'If I had felt that she had presented like that we would have admitted her to hospital.' (T196)

Professor Goldney said that the information from the mother should have had an impact on Dr Sidhu's conclusion that the deceased was low risk as far as suicide was concerned. The relevance of that information to his mind was that it should have made those treating the deceased at EACIS more alert to suicidal thoughts and actions or potential action, and it may have impressed upon them the need to arrange for admission rather than continuing to treat her as a outpatient. He said that it may also have prompted an adjustment of the dose of antidepressant.

7.22. As I say, either the information from the mother was not conveyed at all to Dr Sidhu or in my opinion he did not give it sufficient weight. The importance of this information was such that had it been properly evaluated, it was yet another reason why admission to hospital, as had been plainly envisaged by Dr Hafner, should have taken place at the first available opportunity.

8. The management of the deceased after 24 November 1999

8.1. The management/treatment plan adopted by Dr Sidhu involved the deceased being visited by an EACIS team member on a daily basis.

8.2. The deceased was visited at her home on 25 November by Nurse Millburn and Nurse Hadden, on 26 November by Nurse Hadden alone and there was no visit on 27 November, but Nurse Millburn spoke to the deceased on the telephone during the

afternoon of that day and made an arrangement for a home visit to take place at 2:00pm the following afternoon, that is 28 November 1999. The deceased took her own life during the morning of 28 November.

8.3. Certainly no legally qualified medical practitioner under the EACIS umbrella saw the deceased between 24 November and 28 November, and there is no evidence that any other medical practitioner saw her in that same period.

8.4. There is no evidence of any alteration in the deceased's medication as far as antidepressants are concerned within that same period. Certainly, there was no alteration caused by any further medical or nursing intervention.

8.5. On 25 November Nurses Millburn and Hadden made a home visit to the deceased's home. The EACIS notes reveal that there was discussion about how the deceased was feeling at that time. She had slept well the previous night but was still feeling numbed, blunted and still having difficulty organising herself. It is recorded that the deceased was less anxious but was still feeling hopeless about the future. The deceased on this occasion expressed a willingness to continue to take antidepressants, but there was no adjustment to her medication on that day. There is no note which records any enquiry of or statement by the deceased about suicidal thoughts.

8.6. On 26 November the deceased was visited in her home by Nurse Hadden at 4:30 in the afternoon. Nurse Hadden later that day, on the telephone, gave a description of her examination of the deceased to Nurse Millburn who, on 27 November, made notes of what she had been told by Nurse Hadden. It is recorded in these notes that the deceased was much improved in her presentation and that the anti-anxiety medication appeared to be working. Her presentation was reactive and calmer. It was noted in this particular set of notes that the next planned visit with Dr Sidhu would be on Wednesday 1 December 1999 at 2:30 in the afternoon. It has been noted also that Nurse Hadden was to contact the deceased's private psychiatrist, but I find that that did not take place. In this set of notes there is again no record of any enquiry of or statement by the deceased about suicidal thoughts and Nurse Millburn said she could not recall if she asked Nurse Hadden whether the latter had asked the deceased about this. She said that she was left with the impression from her conversation with Nurse Millburn that the deceased had continued to improve.

8.7. Nurse Millburn rang the deceased shortly after 4:30 on the afternoon of 27 November. Her initial intention was to visit the deceased at her home later that day. However, Nurse Millburn decided that she would not personally see the deceased but instead conducted a lengthy telephone conversation with her. Nurse Millburn also spoke with the deceased's mother. The reason for her not attending personally at the deceased's residence for a daily home visit was that the deceased had visited her daughter and had some contact with her other children since the previous home visit and had been tired and exhausted from the experiences. Nurse Millburn told me that on this occasion the deceased was anxious about a number of matters including the possibility of her daughter moving interstate for a short period. This had upset the daughter. The deceased was also upset by virtue of the fact that her mother had been reading scriptures from the bible to her. It was noted in the EACIS records that the deceased was experiencing confusion generated by thoughts that her depression was 'coming from the Devil'. It is fairly evident that on the afternoon of 27 November the deceased had reached her lowest point in terms of mood and feelings of anxiety since EACIS had become involved on 24 November. The fact that this contact took place over the telephone was a departure from a management plan that was meant to involve daily personal attendances. Nurse Millburn said that she had not made any enquiry on 27 November about suicidal thoughts notwithstanding the deceased's mood and feelings of anxiety on this occasion. Her reason for not broaching that subject was as follows:

> 'Because we had made so many plans to organise. We were going to have a visit the next day and we had made so many plans to - we had made plans to organise and intervene in this with her daughter and we were having some future plans that we were working towards. And she didn't voice them. She wanted to discuss these things with me and how to work them out and she was tired and she didn't want to go in and see her daughter that night.' (T202)

8.8. During the telephone conversation on 27 November, Nurse Millburn advised the deceased to take a Thioridazine tablet, take a warm shower, to attempt relaxation and to plan some strategies in relation to her daughter so as to decrease the daughter's anxiety. She also advised the deceased to spend time in the garden and to do some walking. Nurse Millburn also spoke to the deceased's mother on the phone. She advised the mother against reading scriptures so as to keep religious themes out of the deceased's thoughts as this had been confusing for the deceased. An arrangement was made for EACIS to visit the deceased at 2:00pm the following day. Again, there was

nothing discussed about medication other than Nurse Millburn's advice to take the anti-anxiety drug, Thioridazine.

8.9. The following day the deceased took her own life.

8.10. Professor Goldney levelled a number of criticisms at the manner in which the deceased had been managed between 25 November, the day of the first home visit, and 28 November, the day of her death. He was critical insofar as the notes did not reveal any enquiry about or consideration of suicidal ideation. However, Nurse Millburn told me that on 25 November she had made such an enquiry. In particular she asked the deceased if she had experienced thoughts of suicide and the deceased had answered affirmatively but had said they weren't as intense. Nurse Millburn asked her if she had any plans to suicide. The deceased had said that she would not commit suicide because of the harm that would be occasioned thereby to her children. In addition, Nurse Millburn has noted that the deceased had made a number of plans for the following day. I accept Nurse Millburn's evidence that she did ask the deceased as to suicidal thoughts and obtained the responses she described. However, while Professor Goldney agreed that enquiries as to whether the deceased had suicidal thoughts and whether she had life plans that might contra indicate suicide were appropriate, he said:

> 'It would be adequate so long as it's combined with inquiry about other symptoms and whether or not there is improvement with the medication, although the medication aspect really is more of a medical issue. But in terms of what the nurse could do at the time, it would certainly be adequate, yes.' (T374-5)

Observe here, of course, that there was no medically qualified person involved in this communication.

8.11. As far as the deceased's plans and goals were concerned, Nurse Millburn gave evidence that Nurse Hadden had told her that after Hadden's visit the following day, those goals had been achieved. Nurse Hadden had also told her that the deceased was 'looking much improved from the previous day as well.' (T182).

8.12. As to the fact that Nurse Millburn did not personally visit the deceased on 27 November 1999, the reasons for that and the advice that Nurse Millburn had given her, Professor Goldney said:

> 'A. … Everything you have mentioned is pertinent to a certain extent but it ignores the fact that this woman had a depressive illness that wasn't being treated adequately. It's fine

to deal with all those sort of sociological and interpersonal issues but you have to keep your eye on the ball of the depressive illness. That didn't occur. Nowhere in that list of information that you gave me was there inquiry about how the specific symptoms of depression occur, are progressing; are there suicidal thoughts, are there still suicidal thoughts? The eye has been taken off the ball of the depressive illness. I accept everything you said. It's reasonable to be done, but the reality is that all those issues aren't going to - they are sort of peripheral to the fact that this person has got a major depressive disorder that wasn't treated adequately.

Q. By not treated adequately, what sort of treatment are you putting forward.

A. There was no close observation of her, which could have been provided by hospitalisation. There was no adjustment of medication to get a therapeutic dose of antidepressant, in as short a period of time as possible. The main focus appears to have been on the sociological issues, which certainly they are important, but the reality remains that she had a major depressive disorder which didn't have the potential benefit of very standard treatments.

Q. Those treatments being provided by in-patient care.

A. In-patient care, trying to get the dose of antidepressant as therapeutic, as quickly as possible. We know even when you have got a therapeutic dose of antidepressant, it still takes a week or 10 days before there will be much effect, in terms of resolution of depressive symptoms. Everything you have said is important, and it's good, and it's kind, and it's thoughtful, but there's still that depressive illness there. That wasn't addressed adequately.' (T 378-9)

I am compelled to agree with Professor Goldney's conclusions, particularly in relation to the lack of close observation that could have been provided by hospitalisation. This is no reflection as to the competence or professional integrity of Nurse Millburn. The matters that Professor Goldney raises that in his view were not adequately addressed are medical matters rather than nursing matters. The point is that on 27 November the deceased no doubt required medical intervention and the fact that she did not receive it stems in my view from the nature of the management/treatment plan that was implemented in the first instance.

9. Recommendations

9.1. In the course of the inquest I heard evidence and received material in relation to certain practices that have been implemented at the RAH Emergency Department and practices that have been adopted within EACIS. Some of these innovations were the subject of evidence taken in an inquest conducted into the death of Wayne Mark Thomson who died on 14 February 2000 (Inquest number 25/2001). The inquest in

that matter was held in October 2001 and the findings and recommendations were handed down on the 3 January 2002.

9.2. Evidence was given in the Thomson inquest by Mr Greg R Calder who is a Team Leader at EACIS. I have perused that evidence and have had regard to the recommendations made in the Thomson inquest based upon that evidence. I also received in evidence in the present inquest a letter from Mr Calder to Fountain and Bonig Solicitors dated the 19 July 2002 dealing with progress and improvements since the Thomson findings and recommendations (Exhibit C20b).

9.3. Some of the evidence given by Ms McNair in the present inquest was also relevant to certain changes that have taken place with respect to the interaction between the RAH Emergency Department and EACIS.

9.4. Mr Calder, in the Thomson inquest, gave evidence to the effect that since 24 February 2000 a mental health nurse has been present in the RAH Emergency Department 24 hours a day, 7 days a week. Since that time a person who presents at the Emergency Department triage desk with a mental health issue is initially assessed by a mental health nurse and the assessment is discussed with the Psychiatric Registrar who embarks upon the next process of assessment and makes the final decision as to management. The mental health nurse is able to make recommendations and in urgent situations a recommendation can be made to admit the patient expediently with the assistance of Emergency Department medical staff. In those situations the Registrar is directly involved. There is also the backup of a Consultant Psychiatrist in the department who, in the first instance, is contactable by phone but can sometimes be called in if necessary. I repeat the evidence that was given by Mr Calder in Thomson and which is set out in the recommendations from that inquest:

> 'The advantages are certainly through the expertise of the staff a mental health nurse having the training and background in psychiatry to perform the tasks, and to identify the problems, and the liaison is much, much more efficient as it was previously, both in referring out of the Department but certainly when people require admission to a psychiatric facility the liaison is much smoother.' (Thomson Inquest, T82-83)

9.5. Ms McNair told me that the presence of the clinical nurse in the Emergency Department of the RAH has 'made enormous changes to improving the communication between the Emergency Department and the EACIS team; that has been an enormous benefit.'

9.6. Ms McNair also told me that one of the benefits of the arrangement is that in the situation that prevailed here, namely the deceased presenting twice at the RAH and then being referred to EACIS several days later, these earlier presentations would now be made known to the EACIS team members assigned to deal with the patient. This of course has the benefit of providing the EACIS staff with more information in relation to the patient's history and management in the past.

9.7. I also heard evidence that there is now a significantly more formalised arrangement whereby EACIS team members communicate with the referring medical practitioner. I received in evidence a letter from Professor Brendon Kearney who is the Executive Director - Statewide of the Department of Human Services Mental Health Unit. The letter was sent to the State Coroner and is dated 23 April 2002. The relevant passage in the letter from Professor Kearney states as follows:

> 'In January 2001, the process was formalised so that ACIS medical staff write a letter to the referring GP or psychiatrist, which outlines the outcomes of assessment and recommendations for treatment and management. In urgent cases, and in addition to the letter, a phone call will be actioned and recorded in the case notes. In April 2001 a form was devised and distributed which aims to prompt medical staff for the information required.' (C20a)

Ms McNair told me that EACIS now attempts to involve the referring parties as part of the treatment and management plan. This is to be applauded. She told me that notification to the referring doctor is sent automatically by way of a form that is faxed to that referring doctor. The form describes the interventions involved and also the follow-up plan. The form is faxed, recognising that it is difficult to communicate by telephone with a referring doctor who might be unavailable for various reasons. Prior to the implementation of this measure, the referring practitioner was only advised once there had been an outcome or as Ms McNair put it 'once the case was closed'. This of course did not happen in the present case as Dr Hafner was never advised of the management plan that had been implemented until after the deceased's death on 28 November 1999.

9.8. There have also been changes in procedures for reviewing cases with unfortunate outcomes like this.

9.9. The letter of Professor Kearney also describes innovation in relation to suicide risk assessment. This includes a formalised assessment process, so that every presentation

receives a comprehensive clinical assessment which includes a formal risk assessment. A formal risk assessment is undertaken by an appropriately qualified mental health professional. Education and training is also to be provided to ensure that there is a development of skills, especially pertaining to telephone triage, emergency assessment and management, crisis intervention and risk assessment. Risk assessment aims to minimise the likelihood of adverse events within the context of the overall management of the patient and the risk assessment is to be completed for each patient both prior to admission and thereafter at regular intervals. The comprehensive risk assessment is to have input from mental health nurses, psychiatric medical officers and other professional disciplines. The initial risk assessment is recognised to be an essential part of the admission management plan.

9.10. Pursuant to section 25(2) of the Coroner's Act, 1975 I recommend the following:

1. Where patients present to the RAH with a mental health issue, communication between staff and medical officers should be such that all available information is made known to the medical officer whose responsibility it is to make a diagnosis and decide upon a management/treatment plan. This would avoid the difficulty occasioned in this case by Dr Shillito not being informed of material utterances made by the deceased to another medical officer.

2. Where a patient has been referred to the RAH Emergency Department by another medical practitioner and that person presents with a mental health issue, communication should be made with the referring practitioner, preferably at a time before a management treatment plan is decided upon, thereby enabling the referring practitioner to have input into the management and treatment plan decision;

3. In all cases the referring medical practitioner should be advised by staff of the RAH Emergency Department of the outcome of any presentation and examination of the patient referred. This communication should be in writing and it should contain a detailed description of the outcome;

4. Where a patient presents at the RAH Emergency Department with a mental health issue, the file and notes relating to any previous presentation should be made available to the examining medical staff. I have in mind here the fact that it does

not seem likely that on 19 November 1999 Dr Ravindran had available to him the notes in relation to the deceased's previous presentation on 17 November 1999;

5. Where a patient has been referred to ACIS by a private practitioner who recommends admission to hospital, every endeavour should be made by ACIS staff to communicate verbally with the referring practitioner before any different management treatment plan is implemented by ACIS;

6. I repeat the general recommendation made by the State Coroner in the Thomson inquest, namely that the process of review of ACIS practices and procedures should continue to be supported, not only to improve the performance of ACIS workers, but also to ensure that patients receive access to qualified psychiatric treatment at an early stage.

Key Words: Suicide; Psychiatric/Mental Illness; ACIS Teams

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 6th day of November, 2002.

Coroner

19/2002 (3019/1999)