



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 7th and 8th days of December 2016, the 28th, 29th, 30th and 31st days of March 2017 and the 29th day of November 2017, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Tiffany Jayne Michie.

The said Court finds that Tiffany Jayne Michie aged 22 years, late of 37 Sturt Avenue, Clapham, South Australia died at Noarlunga Hospital, Alexander Kelly Drive, Noarlunga Centre, South Australia on the 26th day of October 2013 as a result of plastic bag asphyxia, possibly contributed to by neck compression. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

- 1.1. At the time of her death Tiffany Jayne Michie was an inpatient at the Noarlunga Health Service (the Hospital). She was there detained under the Mental Health Act 2009. Ms Michie occupied a room within the Morier Ward which is the Hospital's mental health facility. Ms Michie was 22 years of age when she died on 27 October 2013.
- 1.2. Ms Michie was found deceased during routine patient observations conducted at around midnight during the night of Saturday 26 and Sunday 27 October 2013. Ms Michie was in her room. She was on her bed lying on her back with a plastic shopping bag over her head. The bag was secured around Ms Michie's neck by a USB cable or similar. The nurse who discovered Ms Michie immediately ripped the bag open. There were no signs of life. Ms Michie was cold to the touch. The application of a defibrillator resulted in no shock being advised which suggests that Ms Michie had been deceased

for some time with no prospect of resuscitation. Resuscitative measures were nevertheless immediately undertaken but they were unsuccessful. Later observations would suggest that the cable was not particularly tight around the neck. Photographs taken of Ms Michie in the position in which she was found do not reveal marks on or around the neck that one would normally associate with strangulation by means of a ligature. The contribution of the USB cable other than as a means of securing the plastic bag is not certain.

- 1.3. Ms Michie had last been observed during the previous patient observation round conducted at about 11pm. At that time Ms Michie was apparently asleep. Regular breathing was observed. To my mind Ms Michie was probably deceased before midnight. Accordingly, the date of Ms Michie's death is given as Saturday 26 October 2013. The evidence suggests that Ms Michie had gained sufficient familiarity with the timing of the patient observation routine to enable her to undertake an act of self-harm with little or no prospect of detection.
- 1.4. A post-mortem examination was conducted in respect of Ms Michie that included a full autopsy and toxicological examination. No drugs such as alcohol, cannabis or other drugs of abuse were found in Ms Michie's post-mortem blood. Only therapeutic concentrations of her usual medications as prescribed and administered on the ward were found in her post-mortem blood. Drugs played no part in Ms Michie's death.
- 1.5. Dr Karen Heath, a forensic pathologist at Forensic Science South Australia, conducted the autopsy. Two post-mortem reports, both compiled by Dr Heath, were tendered to the Inquest¹. The first report dated 17 April 2014 consists of a full post-mortem report. The second report dated 30 November 2016 is an addendum report. In her first report Dr Heath stated that the cause of Ms Michie's death was 'undetermined'. Dr Heath stated:

'Whilst the circumstances of death are in keeping with plastic bag asphyxia, no plastic bag was positioned on the head of the deceased on arrival in the mortuary and there are no specific findings for plastic bag asphyxia.'

Dr Heath noted the lack of ligature mark around the neck. She reported that it was possible that the cable caused a degree of neck compression that had resulted in petechial haemorrhages which were present in the skin of the right and left upper and

¹ Exhibits C25a and C25b

lower eyelids. Nevertheless, the cause of death was given as undetermined at that point in time.

- 1.6. In light of Dr Heath's opinion that the cause of death was undetermined, she was invited by counsel assisting, Ms Cacas, to consider further evidence including the statement of the enrolled psychiatric nurse who initially discovered Ms Michie as well as the material gathered by the crime scene examiner that includes photographs. As a result Dr Heath revised her view about the cause of Ms Michie's death being undetermined. In her addendum report she asserts that having regard to the evidence as a whole, Ms Michie's death can be attributed to plastic bag asphyxia with a possible contributing factor of neck compression. The relevant material brought to Dr Heath's attention included the fact that the nurse who located the plastic bag over Ms Michie's head had to remove it by way of ripping. The photographs taken by the crime scene examiner included photographs not only of Ms Michie but also of her environment. The plastic bag that had been positioned over her head and then removed by the nurse is visible in some photographs. In her addendum report Dr Heath explains that if the Court accepted the evidence that the deceased was found with a plastic bag positioned over her head, the death could be attributed to plastic bag asphyxia. A death in these circumstances would result from a combination of suffocation due to progressive oxygen depletion within the plastic bag and smothering resulting from the bag occluding the nose and mouth.
- 1.7. The Court does accept the evidence of the observations of the nurse who originally located Ms Michie with the plastic bag secured over her head. Acting upon that evidence I find that Ms Michie died as a result of the positioning of the plastic bag over her head and that the mechanism of her death was that suggested by Dr Heath in her report. Accordingly I find that the principal cause of Ms Michie's death was plastic bag asphyxia but that this may have been contributed to by neck compression occasioned by the application of the USB cable around her neck.
- 1.8. The cause of death will be stated as plastic bag asphyxia, possibly contributed to by neck compression.
- 1.9. At various stages during her hospitalisation Ms Michie had indicated that she was suicidal and had specifically stated that one method she had contemplated was the use of a plastic bag. This assertion was documented. I mention this at this stage because

in both of Dr Heath's reports she has suggested that while there is no evidence to suggest that another person or persons were involved in Ms Michie's death, the possibility that another person may have been involved cannot be entirely excluded. I took Dr Heath to mean that there was no anatomical finding or other circumstance revealed during the course of her post-mortem examination that completely excluded the possibility that some other person was involved in Ms Michie's death, that is to say it was a theoretical possibility only. In any event, the evidence as a whole, not confined to the results of the post-mortem examination, have satisfied me beyond any doubt that no other person was involved in Ms Michie's death. I find that Ms Michie was solely responsible for the act that caused her death. I find that Ms Michie acted alone, that she applied the plastic bag to her own head as well as the USB cable that secured it and that she did so with the intention of ending her life.

2. Reason for Inquest

- 2.1. I have already referred to the fact that at the time of her death Ms Michie was detained under the Mental Health Act (the Act). The detention arose by virtue of successive Inpatient Treatment Orders (ITO) that had been imposed pursuant to the Act.
- 2.2. Ms Michie's involuntary detention had commenced on 3 October 2013 when she was brought to the Flinders Medical Centre (Flinders) pursuant to section 56 of the Act. She had displayed a significant level of depression. A Dr Bhujbal² that day imposed a level 1 ITO which if confirmed imposes detention in an approved treatment centre, of which the Hospital is one, for a period of seven days. The following morning that order was confirmed by a consultant psychiatrist, Dr Conrad Newman³. Following that confirmation she was transferred from Flinders to the Morier Ward at the Hospital. On 9 October 2013 Ms Michie was placed on a level 2 ITO pursuant to the Act. A level 2 ITO imposes detention in an approved treatment centre for a maximum period of six weeks. The level 2 order was imposed by Dr Priscilla Rathjen, a consultant psychiatrist at Morier Ward. This order was still in place at the time of Ms Michie's death. Accordingly, this death was a death in custody as defined within the Coroners Act 2003. It was therefore mandatory for an Inquest to be held into the cause and circumstances of Ms Michie's death. These are the findings of that Inquest.

² Exhibit C16

³ Exhibit C14

- 2.3. There is no suggestion other than that Ms Michie's continuing involuntary detention pursuant to the successive ITOs had been appropriate and necessary. I need say no more on that subject.
- 2.4. Quite apart from the mandatory nature of this Inquest, there were a number of issues connected with Ms Michie's death that required investigation. These principally included whether in the light of Ms Michie's history of suicidal acts and ongoing suicidal ideation the risk of her committing suicide within the ward had been properly assessed and whether in all of the circumstances Ms Michie was adequately protected during the course of her admission within Morier Ward of the Hospital. In short, the key issue was whether Ms Michie's death could and should have been prevented. I should indicate here that an issue that did not require ventilation was the quality of Ms Michie's psychiatric and clinical care during the course of her admission. There is no suggestion that this was not appropriate. Rather, the issue was whether adequate protective means had been instituted in relation to her.

3. Background

- 3.1. A detailed account of Ms Michie's life is contained within the statements of her mother, Ms Sandra Leanne Mott⁴. Ms Mott also gave oral evidence in the Inquest.
- 3.2. I need not describe Ms Michie's earlier years in any great detail. Of some note, however, is that when Ms Michie was about 15 years of age, and when on a Navy Cadet camp on Hindmarsh Island, Ms Mott was advised that Ms Michie had deliberately cut herself on the wrist with a razor blade.
- 3.3. Ms Michie developed an association with a male person through a church group. She would ultimately move in with this young man and his father. After some months Ms Michie fell pregnant to the man but ultimately their relationship ended. In September 2010 Ms Michie gave birth to a boy. Ms Michie was 19 years of age at the time. By the time of her death the boy was nearly 3 years of age.
- 3.4. Ms Mott describes the boy as a difficult child from the beginning and that Ms Michie was always tired and quite often depressed. There was an arrangement by which the father had access to the boy. Ms Mott states that Ms Michie continued to struggle with depression and was not enthusiastic about motherhood. She had also harboured a

⁴ Exhibits C3 and C3a

measure of disappointment about the fact that her life did not conform to that of an ideal family. She also deeply missed a friend in Queensland where for a time she and her family had lived. After a visit to Queensland to attend her friend's wedding she was very down. At the conclusion of visits from her friend to South Australia, Ms Michie would become noticeably more depressed.

- 3.5. Ms Mott states that Ms Michie attended a youth health service in the city for counselling. The arrangement came to an end when the counsellor had a baby.
- 3.6. Ms Michie had worked at McDonalds at Darlington. Ultimately she lost that job but gained another at a KFC outlet.
- 3.7. In January 2013 Ms Michie became very depressed when her friend from Queensland who was visiting was due to leave. Some weeks later the friend located an extract from Ms Michie's diary in the suitcase that she had used when she had visited Adelaide. The extract referred to Ms Michie's plan to jump off a building while her mother and sister were interstate. The plan had not been carried out because the interstate trip had been cancelled.
- 3.8. A trip to the Gold Coast in September 2013 involved Ms Michie and her sister Christine having something of a positive experience. Ms Michie had seemed to be in good spirits. Once they returned Ms Michie descended back into depression.
- 3.9. In her statement Ms Mott reports that on Wednesday 2 October 2013, at a family dinner, Ms Michie told Ms Mott and her sister Christine that she had been to the Domain Medical Centre at Marion that day. She said that she had told the doctor that on three occasions in June and July 2013 she had tried to take her own life by consuming tablets. The statement of Dr John Muirhead of that medical centre⁵ indicates that Ms Michie consulted him on 2 October 2013. She did in fact tell Dr Muirhead that about six weeks earlier she had attempted suicide on more than one occasion by using sleeping tablets and alcohol. She had said that she suffered with depression and that lately she had been feeling suicidal. Dr Muirhead assessed Ms Michie as being in a depressed mood with low self-esteem. He prescribed mirtazapine which is an antidepressant. He had no further dealings with Ms Michie following this consultation.

⁵ Exhibit C20

- 3.10. On Thursday 3 October 2013 Ms Mott spoke to Ms Michie about what she had revealed the day before. As a result they attended the Adelaide Health Care clinic in Carrington Street, Adelaide where Ms Michie saw Dr Rosie Brennan. The statement of Dr Brennan⁶ confirms this. Ms Michie told Dr Brennan that she had attempted suicide by overdose on multiple occasions. She advised that the tablets had included ibuprofen and paracetamol. She stated that she had been depressed for about the last eight months and felt that she was '*finished with this life and ready for the next*'. Dr Brennan could see that Ms Michie's affect was very blank, that she was not reactive and that she looked depressed. Dr Brennan formed the view that Ms Michie was '*profoundly depressed*' with a need for immediate help. As a result Dr Brennan called the Assessment and Crisis Intervention Service (ACIS). That was the last occasion on which Dr Brennan saw Ms Michie.
- 3.11. Later that day a representative of the ACIS mental health team attended at Ms Michie's home. The representative was Mr Jeff Jensen⁷, a mental health worker who had been contacted by Dr Brennan. Mr Jensen conducted a number of telephone conversations with Ms Michie. In the first telephone conversation Mr Jensen was told, as Dr Brennan had been told, that Ms Michie was finished with this life and felt ready for whatever was next. However, she denied any current suicidal plans or intentions for that day. In a subsequent telephone conversation Ms Michie explained to Mr Jensen that she had a relapse of depression which had worsened over the past three months. She had been taking Lovan (fluoxetine) at one point but had been advised to discontinue its use. As to the reason for her relapse into depression Ms Michie referred to an illness that her sister had experienced and to the stress caused by her son's behaviour which made her feel like a poor parent. Ms Michie did not believe that she had the qualities necessary to be a parent and blamed herself for her son's behaviour. She also told Mr Jensen about the multiple overdoses in the recent past. She said that all overdoses had been taken with suicidal intent and with the desire that she would go to sleep and not wake up. Ms Michie also described self-lacerating several times in the past. She also said that although she had considered hanging herself or walking in front of a train, an overdose would be her preferred method of suicide. There is no evidence that she indicated to Mr Jensen or to anyone else to this point that she contemplated suicide by way of plastic bag asphyxia. Ms Michie also said that she harboured homicidal

⁶ Exhibit C19

⁷ Exhibit C18

thoughts about her son that had included smothering him with a pillow, her thinking being that she would not want to *'leave him behind'*. Mr Jensen responsibly communicated with the Child Abuse Report Line later that day. Mr Jensen assessed her risk of self-harm and harm to others, primarily the boy, as *'significant'*. He rated her overall risk as *'high'* taking into account her perceived failure as a parent, her statement that she was finished with the world, her ambivalence towards suicide, the cessation of taking her antidepressant medication and her recent suicide attempts. One is compelled to conclude that Mr Jensen's assessment was accurate. This was the only dealing he had with Ms Michie. She was taken to Flinders.

- 3.12. Ms Mott confirms that on 3 October 2013 Ms Michie was taken to Flinders where she was assessed the following day by Dr Conrad Newman, a consultant psychiatrist at the Margaret Tobin Centre which is the mental health facility of Flinders. Dr Newman saw Ms Michie at about 11am on 4 October 2013. By then Ms Michie had already been detained on the level 1 ITO imposed by Dr Bhujbal. One of Dr Newman's tasks was to review Ms Michie and to determine whether the ITO should be confirmed or not.
- 3.13. Dr Newman provided a statement to the Inquest⁸. Dr Newman's assessment of Ms Michie is of some importance. Apart from the fact that Dr Newman assessed her as being depressed, in the course of the assessment Ms Michie herself said it was the most depressed she had ever been and said that she was hopeless about her future, believing that her son would be better off without her. She described suicidal thoughts lasting from a few minutes to several hours per day and stated that her plans for suicide included overdose, hanging herself, driving into a tree or placing a plastic bag over her head and sealing it around her neck. She stated that her preferred method of suicide was overdose. She repeated what she had said to others, namely that this would enable her to go to sleep and never wake up. She referred to the three overdoses in the recent past. There was also reference to her sister's illness and to her own reaction to her son's behaviour. Ms Mott told Dr Newman about a family history of depression. Dr Newman assessed Ms Michie as suffering from a major depression superimposed on long-standing dysthymia with a background of personality vulnerability. He rated her as being at high risk for suicide. He confirmed the level 1 ITO. Due to the fact that both her mother and sister worked at the Margaret Tobin Centre, Dr Newman recommended that she be transferred to Morier Ward at the Noarlunga Hospital. He

⁸ Exhibit C14

deemed that she would be suitable for an open bed but that she should not be permitted unescorted leave from the facility until further review.

- 3.14. There were other statements of Flinders clinicians tendered to the Inquest from which it is apparent that Ms Michie gave a remarkably consistent history including her reference to thoughts of taping a plastic bag over her head as a method of suicide. In particular she had mentioned the plastic bag method of suicide to Dr Bhujbal who was the doctor who initially imposed the level 1 ITO.

4. Ms Michie is admitted to Morier Ward at Noarlunga

- 4.1. In light of the relative narrowness of the issues at hand it has not been necessary to embark upon a detailed commentary in relation to each and every facet of Ms Michie's clinical management while detained in Morier Ward. However, there are certain features of her history and admission to the ward that require evaluation.
- 4.2. Tendered to the Court was a bundle of documentation that contained the Community Based Information System (CBIS) summary for Ms Michie which appears to cover the period from February 2012 to 4 October 2013. There are also some handwritten progress notes from Flinders dated 3 and 4 October 2013. Contained within the same exhibit⁹ are the Enterprise Patient Administration System (EPAS) notes from the Hospital. These entries include mental health progress notes compiled on a daily basis, mental health risk screens that were also compiled on a daily basis and mental health multidisciplinary team (MDT) reviews that were conducted on a weekly basis. The CBIS notes, including those from assessments made at Flinders on 3 and 4 October 2013, were available to clinical staff at Morier Ward.
- 4.3. Thus Ms Michie's history prior to her arrival at the Hospital was no secret. Indeed, as will be seen, EPAS records of the MDT reviews that were conducted on a weekly basis and at which the treating psychiatrist was a participant, made specific and consistent reference to Ms Michie's thoughts, as articulated at Flinders, that she had contemplated killing herself by taping a plastic bag over her head. Although this theme is constantly repeated, there is no evidence that the MDT actually raised the issue with the patient or that active consideration was given to the obvious question as to whether it was undesirable or downright dangerous for Ms Michie to have plastic bags in her

⁹ Exhibit C27

possession while on the ward. Rather, as far as this issue was concerned, the EPAS entries consist in large part of a parroting of historical matters.

- 4.4. As well, the mental health risk screening documentation that was compiled on a daily basis makes no reference whatsoever to the patient's thoughts of killing herself by way of plastic bag asphyxia, a matter that was clearly relevant to an assessment of risk of suicide within the ward environment, if not the most relevant matter. The risk screening documentation seems simply to consist of cutting and pasting of already created documentation and the perpetuation of that documentation from one day to the next. As will be seen later, this issue was the subject of comment by senior clinicians who gave evidence in this Inquest. This naturally gives rise to a question as to whether in truth there was a daily risk assessment or whether it was a case of the rolling over, as it were, of existing documentation without any meaningful thought being given to its contents or to the patient's actual risk as it existed from day to day. The latter scenario strongly suggests itself. This seems to have been facilitated by what appears to be a flaw of EPAS, namely the ability of staff serially to carry over documentation already in existence and to dress it up as new documentation when the reality is that it is simply a repetition of the same old documentation that has existed all along. The flaw is classically exemplified by the risk screening documentation.
- 4.5. Although the Court did not have the opportunity to view the EPAS documentation in electronic form, that is to say as it may have appeared on a computer screen in a clinical setting, it examined the EPAS material reproduced in paper form. It occurs to the Court that viewing of EPAS in electronic form in any court would have its difficulties. For this Court's part it is not difficult to understand the critique that has existed since the system's rollout insofar as among other things there is much repetition of documentation, confusing obliteration of documentation and at times a lack of complete certainty as to the identity of the creator of a particular entry. In many ways an individual entry can pose more questions than it answers. Such as, the identities of the persons who participated in the event to which the entry relates, whether the entry was created by one person, by more than one person or by way of a collaboration of different persons, whether the entry has in truth been made in its entirety by the person who has signed off on it, whether the entry was made all at the one time or over a period of time, and so on.

- 4.1. It is pertinent here to set out the salient events in Ms Michie's clinical course between 4 October 2013, the day of Ms Michie's admission to Morier, and 27 October 2013, the day of her death.
- 4.2. The first MDT review in fact occurred on the day of Ms Michie's admission. I am not certain who participated in this review, except that the EPAS record appears to have been signed off by a registered nurse by the name of Tjallie Ybema. It would be nurse Ybema who was on duty on the night of Ms Michie's death and who had last seen Ms Michie alive at about 11pm on Saturday 26 October 2013. It was noted in the MDT record for 4 October 2013 that Ms Michie had been admitted with suicidal ideation, that she had attempted suicide three times in the past three months by way of overdose and that she had entertained thoughts about jumping in front of a train and taping a plastic bag over her head.
- 4.3. Also on 4 October 2013 the first mental health risk screen was prepared. This document was signed off by a registered nurse William Spalding. It consists of four pages and records such matters as level of risk of self-harm, which was recorded as medium, the symptoms of major mental illness, which in Ms Michie's case were recorded as depression, and other matters such as access to firearms and whether there were any child protection concerns. It does refer to the reports of three previous attempts at suicide by taking pills. Much of this document did not necessarily relate to an assessment of risk while in the hospital. However, it records that she was denying current thoughts of harming herself or her son and that such thoughts had been fleeting in the past with no intent to act upon them. This latter observation appears to be a reference to the thoughts in relation to her son and not herself. It recorded that she presented no risk of harm to others or of absconding and that she was '*happy to be in hospital*'. As indicated earlier this document would to all intents and purposes remain exactly the same from the beginning of Ms Michie's admission almost to the end despite a number of concerning events relevant to risk that occurred in the intervening period.
- 4.4. On 8 October 2013 Ms Michie was reviewed by a medical officer who noted, among other things, that Ms Michie was carrying a plastic bag with a laptop. In addition, the medical officer recorded that Ms Michie had ongoing suicidal thoughts and that she had said that she was not safe to walk out that door, but denied that she had plans to hurt

herself within, or to leave, the psychiatric unit¹⁰. On this occasion it was noted as part of the plan that Ms Michie would be seen by the psychiatrist, Dr Priscilla Rathjen, in the next few days and that she would continue to be medicated with mirtazapine.

- 4.5. No connection is drawn within this document or elsewhere between the patient's possession of a plastic bag and Ms Michie's assertions that she contemplated plastic bag asphyxia as a method of suicide.
- 4.6. On the morning of 9 October 2013 Ms Michie was seen by the psychiatrist, Dr Rathjen, and another medical officer. It was on this occasion that Dr Rathjen imposed the level 2 ITO. The EPAS record of that review records that Ms Michie felt that she saw no hope in the future, that she exhibited symptoms suggestive of major depression and that her suicide risk was medium to high with ongoing intent if discharged. In the normal course of events the level 2 ITO would have persisted for six weeks following its imposition on 9 October 2013. It is recorded on EPAS that on 9 October 2013 Ms Michie's mother, Ms Mott, expressed concern about the length of time over which Ms Michie would be admitted and expressed uncertainty as to whether she could look after Ms Michie's son for that length of time. Also on 9 October 2013 a progress note entered by a registered nurse revealed that Ms Michie maintained that if she were released from hospital she would end her life by way of overdose.
- 4.7. A further MDT review occurred on 10 October 2013. This was attended by Ms Michie's psychiatrist, Dr Rathjen. The same information as to Ms Michie's thoughts about jumping in front of a train and taping a plastic bag over her head is expressed in the record of this meeting. A mental health risk screen of that same date continues to assert that Ms Michie was denying current thoughts of harming herself despite what she had said about ending her life by overdose if she was released from the hospital.
- 4.8. A mental health progress note of 11 October 2013 reveals that Ms Michie indicated to a medical officer that she still had fleeting thoughts about suicide and believed that if she was to go out on her own she would commit suicide, although she had no plans to do so. The risk screen for that day and the following day perpetuated the assertion that Ms Michie was denying current thoughts of harming herself.

¹⁰ Exhibit C27, page 95

- 4.9. On 12 October 2013 it was recorded by a registered nurse in a mental health progress note that Ms Michie was not actively claiming that she would end her life if she was not in hospital, but that themes of hopelessness and helplessness remained strongly evident.
- 4.10. On 13 October 2013 a mental health progress note made by a registered nurse records that Ms Michie reported ongoing suicidal ideation with ongoing plans to overdose, but that she would not act on such thoughts while she was in hospital. She reluctantly agreed to approach staff if she felt unsafe.
- 4.11. On 14 October 2013 Ms Michie was seen for the first time by Dr Jacob MacKenzie who had just returned from leave. Dr MacKenzie was a registered medical officer at that time. He was in his second post graduate year. He was on a three month rotation. He was responsible to the consultant psychiatrist, Dr Rathjen, who was his supervisor. Dr MacKenzie's role within that team was to assist in the assessment of patients, to communicate to the team any concerns that he identified and to enact the patient treatment plan under the guidance and instruction of the consultant. Dr MacKenzie provided a statement to the Inquest¹¹ and gave oral evidence. Dr MacKenzie's note of his consultation with Ms Michie on 14 October 2013 records that she was teary, was having a flat day and was experiencing ongoing suicidal ideation, saying that she '*can't believe that she is still alive*'. She also queried why people in her position could not be allowed to die. Ms Michie did express some eagerness to see a psychologist. On the same day another progress note recorded by registered nurse Juan Pablo Mancera (known in the ward as Pablo), who also gave evidence in the Inquest, recorded Ms Michie's feeling of worthlessness and hopelessness, with suicidal ideation still present with no plans to act on them and with an assertion that she would not attempt to take her own life while in Morier Ward.
- 4.12. The next mental health risk screen following Dr MacKenzie's and Mr Mancera's assessments on 14 October 2013 is dated 15 October 2013. The usual refrain to the effect that Ms Michie was denying current thoughts of harming herself is contained within this document despite what she had said on 14 October 2013 and on prior occasions. Indeed, on 15 October 2013 in the afternoon Ms Michie is recorded as continuing to have suicidal ideation although she felt safe in her current environment.

¹¹ Exhibit C38a

However, she made it plain that were she to go home she would '*be going straight for some tablets*' with an intent to end her life. That was recorded by Dr MacKenzie.

- 4.13. A MDT review was conducted on Wednesday 16 October 2013. Ms Michie's assertions at FMC about jumping in front of a train and taping a plastic bag over her head are repeated in the note relating to this review. It was recorded that Ms Michie was teary, still voicing suicidal ideation but was feeling safe in her current environment. Again she asserted that if she went home she would commit suicide. The review was conducted by Dr Rathjen, the psychiatrist, and Dr MacKenzie. A plan was noted that included the encouragement of 'safety contracting' with staff. There are a number of other measures suggested, none of which related to the removal of plastic bags from Ms Michie's environment. A mental health risk screen of the same date under the signature of Dr MacKenzie repeats and perpetuates the dubious assertion that Ms Michie was denying current thoughts of harming herself. On this same date Ms Michie was seen by a psychologist, one Trond Eirik Loset. The note of this consultation states that she was feeling very depressed and that she still had thoughts of suicide and would likely commit suicide if released.
- 4.14. Also on 16 October 2013 a family meeting occurred in the afternoon. Present at this meeting were Drs Rathjen and MacKenzie, Ms Michie's mother and sister, Ms Michie herself, a social worker and a medical student. The EPAS notation is under the electronic signature of Dr MacKenzie. Ms Michie is recorded as having said that she is '*still as foggy with the main thoughts being that of wanting to die*'. The mental health risk screen document of the following day, 17 October 2013, repeats the assertion that Ms Michie denied current thoughts of harming herself. That day Ms Michie participated in a ward group activity consisting of a walk to the Colonnades Shopping Centre at Noarlunga.
- 4.15. The progress note of 18 October 2013 under the electronic signature of Dr MacKenzie constitutes the first upbeat assessment of Ms Michie. Dr MacKenzie recorded that Ms Michie's mental state had significantly improved since admission in that despite starting the interview as flat and quiet, she had then responded by smiling, laughing and joking at times. She indicated that seeing the psychologist on 16 October 2013 had been a very positive experience and stated that she wanted to continue seeing that person '*exclusively*'. Dr MacKenzie recorded that Ms Michie was comforted by the fact that there was no plan for her discharge with the likelihood being that her admission

would be greater than two weeks. On that same day Ms Michie indicated to nursing staff that she would like leave for the following day, which was Saturday 19 October 2013, to go home. The leave was granted.

- 4.16. On the afternoon of Saturday 19 October 2013 Ms Michie is recorded as having told nursing staff that she had enjoyed her leave from the ward but felt that it had not been long enough to attend to the domestic chores that she had needed to undertake.
- 4.17. Throughout these days the mental health risk screens were updated on a daily basis but remained to all intents and purposes unaltered, including the reference to her denying current thoughts of harming herself.
- 4.18. On Sunday 20 October 2013 Ms Michie went on an escorted walk to the shops where she purchased some items for a birthday gift. It was recorded that she would be going out for dinner with her family that evening and was expected back by 8pm. She is recorded as having had a bright affect during the walk and that she had been quite reactive in conversation. The following day it was recorded that she in fact had returned to the ward at 10pm with her mother and that she had reported that she had a good day. The note of these assertions appears to have been compiled by a registered nurse, or at least signed off by one, in the early hours of the morning of Monday 21 October 2013.
- 4.19. On Monday 21 October 2013 the mental health risk screen remained materially unaltered. It was signed off by a registered nurse and is timed at 11:13am. Dr MacKenzie signed off on a mental health progress note timed at 1:51pm which recorded that Ms Michie had not enjoyed the experience with her family on the Saturday and felt that a meeting with her family had contributed to her current low mood. Dr MacKenzie noted that Ms Michie was flatter in her affect and wanted to spend the day in bed. She had attended the interview with Dr MacKenzie in her pyjamas. Dr MacKenzie recorded that she continued to show signs of neuro-vegetation with a poor appetite and reduced concentration. He noted, *'her failure to enjoy the company of her son or family over the weekend is concerning for ongoing anhedonia'*. Dr MacKenzie also recorded that Ms Michie again acknowledged ongoing thoughts of suicidal ideation stating that if she left the ward and was unaccompanied her intention would be to purchase tablets so that she could overdose and end her life. She states that she feels safe on the ward and was *'safety contracting'*. However, Dr MacKenzie recorded that she stated that she had fleeting thoughts of taking a butter knife from the

kitchenette back to her room so that she could stab herself, but felt that the knives were too blunt and that therefore she would not act on those thoughts. As will be seen, this revelation ought to have been regarded as a matter of significant concern. Ms Michie requested that she be permitted to leave the ward the following day to return home and spend the day with her sister in preparation for a house inspection. Dr MacKenzie noted correctly that the final decision as to this would have to be made by Dr Rathjen. Indeed, on that day Dr Rathjen reviewed Ms Michie and gave permission for accompanied extended day leave the following day. Also on Monday 21 October 2013 nursing staff recorded that Ms Michie continued to express suicidal ideation, stating that she was finding it difficult to stop thinking about '*finishing it all*'. She said that she would know what to do if the anxiety became overwhelming, namely go to a pharmacy and buy tablets. The nurse recorded:

'Tiffany has intent and potential to formulate a plan.'

- 4.20. On Tuesday 22 October 2013 it was recorded in EPAS that the leave of that day had not gone well. Her mother reported that Ms Michie had done very little and had spent much of the time sleeping. Ms Michie's mother indicated that she, the mother, was exhausted and finding it difficult to be positive given the limited progress in her daughter that had been observed over the previous three weeks. It was also said that Ms Michie's sister was now at breaking point, for reasons including having to look after Ms Michie's boy. This was recorded by Dr MacKenzie. Nursing staff recorded for their part that Ms Michie had experienced high anxiety prior to going on leave that she had required PRN quetiapine. There was also another negative assessment of the day's leave including reference to Ms Michie being tearful on her return and needing PRN lorazepam. There was also recording of the fact that Ms Michie's hospitalisation was having a negative impact on both her mother and her sister who was described as '*overwhelmed and exhausted*'. I am not certain whether these negative comments were made in Ms Michie's presence. There is no note of that.
- 4.21. An MDT review occurred on Wednesday 23 October 2013. This is the final occasion on which Dr Rathjen saw Ms Michie. The EPAS note of this review was signed by Dr MacKenzie and Dr Rathjen. The usual recitation of thoughts about jumping in front of a train or taping a plastic bag over her head were present in the review note. It was noted on this occasion that there was concern about possible issues of personality

disorder and of Ms Michie's ambivalence for the care of her child. It was recorded that Ms Michie:

'Continues to be of a low mood with ongoing suicidality. Mental state has show (sic) very little change since admission.'

The plan included a number of strategies which did not include vigilance about plastic bags in Ms Michie's possession. Within the plan there is the following entry:

'-? Need to make pt voluntary in the future and facilitate the transfer of responsibility back onto Tiffany.'

Both Dr Rathjen and Dr MacKenzie are recorded as having applied their electronic signatures to this entry. A mental health risk screen was raised on 23 October 2013. In fact there are two such documents within the EPAS notes. The first purports to have been the subject of Dr MacKenzie's electronic signature timed at 10:02am. For the first time this version of the risk screen asserts that Ms Michie was experiencing '*Current ongoing thoughts of harming herself. Not acting on*'. This replaces the previous constantly repeated assertion within the risk assessment document that Ms Michie was '*Denying current thoughts of harming herself*'. This was the first material alteration to the risk assessment. A second mental health risk screen apparently facilitated by a registered nurse timed at 1:05pm repeats the assertion of current ongoing thoughts of self-harm.

- 4.22. Although still detained under the ITO, on Wednesday 23 October 2013 Ms Michie was able to leave the hospital undetected and without leave. She was located only when she walked through the front door. She had been out '*shopping*'. That afternoon she was seen by the psychologist whose notes appear in the EPAS record. The psychologist recorded that Ms Michie, in respect of her absence without leave, stated that she knew she had to be quick because she was not supposed to leave by herself. She also stated that while she was out she had entertained thoughts about buying pills so that '*all of this could be over with*'. However, she stated that she realised that she did not have sufficient time to buy anything so she came back to the ward. It is apparent from a nursing note that Ms Michie expanded on how she was able to remain outside the ward undetected, saying that she knew she had a short time in the hour between checks to do her shopping before her absence without leave from the ward would be discovered. She told the psychologist that her coming back to the ward was, in her words, a '*small win*', meaning, one supposes, that she was pleased that she had overcome the urge to purchase

pills to end her life. Either way, her absence without leave was a worrying development. As was the fact that Ms Michie had identified opportunities to engage in undetected behaviour given the regularity of the hourly observations that were imposed in relation to her. More of that later.

- 4.23. On Thursday 24 October 2013 Ms Michie is recorded as having told registered nurse Pablo Mancera that she denied current suicidal ideation. She appeared brighter with good eye contact. These relatively positive observations need to be seen in the light of a review that Dr MacKenzie conducted on the same day. That day Dr MacKenzie discussed Ms Michie's absence from the ward the day before. Dr MacKenzie noted that while she had entertained thoughts of purchasing tablets on which to overdose, she had resisted those thoughts and instead purchased chocolates and had then quickly returned as she had missed the daily walk. She indicated that the detention order was keeping her safe and that she was not yet at the point where she would not choose to attempt suicide. Dr MacKenzie also noted on this occasion that Ms Michie acknowledged that her mother and sister were unhappy with her for having fallen asleep on the day of her leave and having left much of the work to her sister. She indicated that she had found the day to be quite overwhelming, that she was crying and could not put into words why she was feeling this way. She asserted that she felt a lot of pressure from her mother for not getting better in the last three weeks and for leaving the care of her son to her family. This note was signed off by Dr MacKenzie shortly before 5pm. The only EPAS entry for the ensuing night was a nursing note apparently authored in the early hours of the morning by an enrolled nurse that recorded that Ms Michie had experienced a settled evening, had maintained a low profile and had retired after her nightly medication. She had been observed asleep on all rounds overnight. The events of the following day and the ensuing weekend need to be seen against that background.

5. The events of Friday 25 October 2013 and Saturday 26 October 2013

- 5.1. The events of these days should have shaped the manner in which Ms Michie's risk of self-harm within the ward was assessed and managed. They should have dictated a greater measure of scrutiny in relation to her movements and well-being. Ms Michie's actions and statements made it clear that she was at significant risk of self-harm.

- 5.2. Paul McMillan was a registered nurse employed in the Morier Ward. Mr McMillan provided a statement to the Inquest¹² and gave oral evidence. In both his statement and his oral evidence Mr McMillan told the Court that on Friday 25 October 2013 he was one of two nurses, the other being Pablo Mancera, who were tasked to perform a medication round in the morning. When Ms Michie came to the treatment room to receive her medications and to have her daily observations taken, Mr McMillan noticed bruising on her right upper arm. The bruising extended from the elbow towards her shoulder area. She was wearing a short sleeve top. Mr McMillan asked Ms Michie how she had sustained the bruises. She told him that she had done this to herself. Mr Mancera then became involved in the discussion. Mr Mancera also gave a statement¹³ to the Inquest and gave oral evidence. Ms Michie went on to explain in the presence of both gentleman that she had tried to suffocate herself with a pillow. She had tried to stop breathing by holding her breath. Mr McMillan's statement uses the words '*smother herself*' whereas Mr Mancera's statement uses the words '*suffocate herself*'. To my mind this is a distinction without a difference. As to the bruises, Mr McMillan told the Court that Ms Michie had given a description in which she had forcibly applied her fingers onto her arm. In Mr Mancera's statement he states that Ms Michie said that she had deliberately bruised her arms by grabbing them.
- 5.3. Mr McMillan told the Court that he believed that Ms Michie had attempted to kill herself by smothering¹⁴. He also said that he took her statement at face value as an assertion that she had attempted to take her own life in her own room¹⁵. In his oral evidence Mr Mancera reiterated that he believed that Ms Michie had used the word '*suffocate*'. He told the Court that Ms Michie's statements were concerning '*because for me it was actually an indication that she tried to kill herself that day, that night*'¹⁶.
- 5.4. As a result of Ms Michie's revelation Mr Mancera sought out and spoke to Dr MacKenzie. He said that he did this because what Ms Michie had told him was concerning. Mr Mancera said in evidence that he told Dr MacKenzie that Ms Michie had tried to suffocate herself with a pillow¹⁷. According to Mr Mancera, Dr MacKenzie responded by asking how Ms Michie was. Mr Mancera had replied that at the moment

¹² Exhibit C34

¹³ Exhibit C9

¹⁴ Transcript, page 41

¹⁵ Transcript, page 55

¹⁶ Transcript, page 316

¹⁷ Transcript, page 314

she was denying suicidal ideation because she had denied that she felt like killing herself or had any plans to do so at that time¹⁸.

- 5.5. In cross-examination by Mr Homburg of counsel for Dr MacKenzie, Mr Mancera said that Ms Michie had asserted that the night before she had been very anxious and that she tried to suffocate herself with a pillow and that the explanation that she gave for the bruises was that her level of anxiety had been such that she had '*thoroughly pinched her arms as well*'¹⁹. Mr Mancera told Mr Homburg that he was completely certain that Ms Michie had used the word '*suffocate*'²⁰. He was adamant that he had told Dr MacKenzie that Ms Michie had said that she had tried to suffocate herself with a pillow when she was feeling very anxious. He also said that he told Dr MacKenzie about the bruises. When it was put to him by Mr Homburg whether it was possible that what he may have told Dr MacKenzie was that Ms Michie had tried to stop breathing until she had to breathe again and had not mentioned the word '*suffocate*', he said:

'No. No. I did use the word '*suffocate*', yes.'²¹

Asked by me as to the significance of the word '*suffocate*' in his mind Mr Mancera said that it signified '*an intent pretty much to kill herself*'²². He added that what he was endeavouring to tell Dr MacKenzie was that she had tried to kill herself²³. Although he did not recall using the words '*killing herself*', that was the meaning he had been implying to Dr MacKenzie²⁴.

- 5.6. Dr MacKenzie's version of this conversation differed from that of Mr Mancera. Dr MacKenzie's position is that the nursing staff informed him that Ms Michie had reported that she had been grabbing her arm out of anxiety and in the same context mentioned that '*she had been burying her face into her pillow*'²⁵. He asserts that the way the incident was described to him was that it consisted of an episode of anxiety on her part. The pillow aspect of the matter had involved her holding her breath in the pillow followed by her taking another breath. In short, Dr MacKenzie's position is that this incident was not conveyed to him as an attempt on the part of Ms Michie to commit suicide²⁶.

¹⁸ Transcript, page 315

¹⁹ Transcript, page 338

²⁰ Transcript, page 339

²¹ Transcript, page 339

²² Transcript, page 340

²³ Transcript, page 340

²⁴ Transcript, page 340

²⁵ Transcript, page 241

²⁶ Transcript, page 260

- 5.7. The only notes of relevance to this issue are respectively contained in an EPAS note compiled by Mr Mancera and an EPAS note that Dr MacKenzie compiled in respect of a family meeting that had taken place in the afternoon. The Mancera note was made at 4pm and was made after the family meeting. Dr MacKenzie's note is timed at 2:30pm, also after the meeting. No note was ever made specifically about Mr Mancera's conversation with Dr MacKenzie by either man. I will return to Dr MacKenzie's evidence in detail in a moment. I say here that for reasons I will describe I have preferred the evidence of Mr Mancera as to what was discussed between them as to Ms Michie's earlier assertions to Mr Mancera.
- 5.8. I now deal with the family meeting. Friday 25 October 2013 was a day on which Dr Rathjen, the consultant psychiatrist who was Dr MacKenzie's supervisor, was regularly not rostered to work. The family meeting that took place in the afternoon of that day was recorded as being an '*impromptu*' meeting. That meeting was between Dr MacKenzie and Mr Mancera on the one hand and Ms Michie, her mother Sandra Mott and her sister, Christine on the other. It was *impromptu* in the sense that there was little notice of the arrival of the members of Ms Michie's family. In the normal course of events such a meeting ought to have occurred on a day on which Dr Rathjen was available. As things were to transpire the resident medical officer, Dr MacKenzie, was ill equipped to deal with what turned out to be an emotional and stressful event, particularly for Ms Michie herself despite the fact that she had been sedated. That day Dr MacKenzie was informed by nursing staff that Ms Michie's mother and sister would imminently be attending the ward in order to speak with him. They arrived in the early afternoon and were shown into one of the interview rooms on the ward. Ms Michie's mother, Ms Sandra Mott, told the Court that the meeting had been arranged through Ms Michie by way of a text message. Ms Mott testified that she did not have personal contact with any staff from Morier Ward in respect of any such arrangement and that the arrangement had been made purely through her own communications with Ms Michie. It was unfortunate that Dr MacKenzie was not told about this well in advance. There appears to have been an assumption that Dr MacKenzie would be capable of conducting such a meeting and could be expected to follow through on anything that would transpire during the meeting, simply on the basis that he was a doctor working in a psychiatric unit when in reality a consultant psychiatrist would have been a more appropriate medical practitioner to have been involved in such an event.

- 5.9. Accordingly, the meeting proved to be unhelpful and counter-productive. Mr Mancera detected that Ms Michie had been experiencing a measure of anxiety about the impending meeting and had requested the sedative lorazepam. As a result, 1mg of lorazepam was given to Ms Michie. In the event, 2mg would need to be given to Ms Michie after the meeting.
- 5.10. Ms Mott told the Court that she had only a very short discussion with her daughter before the meeting started. She said that Ms Michie seemed ‘*okay*’ and not really ‘*down*’ like she had been before. Prior to the meeting Ms Michie had said nothing about the pillow incident of the night before²⁷. I accepted that evidence.
- 5.11. During the meeting Ms Michie was teary. Ms Mott expressed frustration at the time being taken in respect of her daughter’s care and treatment, having regard to the fact that to that point Ms Michie had been hospitalised for about three weeks. Ms Mott told the Court that during the meeting her daughter was upset and was crying a lot. She said that Dr MacKenzie’s characterisation of Ms Michie’s demeanour as simply having been teary was not accurate. She said that in fact Ms Michie was really upset, ‘*she was crying, heavily crying*’²⁸. Ms Mott told the Court that during the course of the meeting she noticed some significant bruising on her daughter’s arms. This was noticed at a point at which the meeting had become quite upsetting for those present. Ms Mott told the Court that something was mentioned about the bruising and it was then that her daughter said that she had tried to suffocate herself and had punched herself because of her lack of success. Ms Michie added that she had tried to suffocate herself with a pillow and that this had taken place the previous night. This discussion occurred in circumstances in which everyone present at the meeting could hear what was being said. It was at that stage of the meeting that Ms Mott recorded her frustration that after three weeks of hospitalisation her daughter was still talking about killing herself. To this Dr MacKenzie responded that three weeks was not really a long time to be in hospital in these circumstances. In her evidence Ms Mott was adamant that the assertion by her daughter that she tried to suffocate herself was made during the meeting and not made privately to her prior to the meeting. She also said that it was not possible that Ms Michie told her about this at a time subsequent to the meeting. Ms Mott told the Court that at no stage during the meeting did Dr MacKenzie express any plan or

²⁷ Transcript, page 295

²⁸ Transcript, page 302

describe any course of action that he would take as a result of what Ms Michie had said. Ms Mott did not ask Dr MacKenzie to provide her with any such information. Her expectation was that there would be extra care devoted towards her daughter such as might be provided by a nurse special, that is to say one-on-one nursing attention.

- 5.12. A statement taken from Ms Michie's sister, Christine Dodd, was tendered to the Inquest²⁹. This statement was taken on 30 March 2017 during the course of the Inquest. Ms Dodd had been present during the 25 October meeting. Ms Dodd states that during the meeting she noticed that Ms Michie had bruises on her arms. She asked her sister why she had these bruises. Ms Michie responded by starting to cry. Ms Michie then told the meeting that on the previous night she had tried to suffocate herself with a pillow. She went on to say that she had punched herself on the arms in frustration at not having been able to suffocate herself. Ms Dodd states that she does not remember any reaction on the part of Dr MacKenzie or Mr Mancera to this information. Ms Dodd states that her mother's frustration became evident; she confirms that Ms Mott asked Dr MacKenzie about the lack of progress despite the three weeks of hospitalisation. Ms Dodd's statement supports the evidence of Ms Mott that the incident involving Ms Michie attempting to suffocate herself was raised and clearly understood during the meeting.
- 5.13. In assessing Ms Mott's evidence I take into account the fact that she had earlier been present in court during the entirety of Dr MacKenzie's oral evidence. In assessing Ms Dodd's statement I take into account the fact that Ms Dodd had also been present during the entirety of Dr MacKenzie's evidence in Court and the fact that she had also been present in court during the evidence of her mother, Ms Mott.
- 5.14. In Mr Mancera's statement dated 27 November 2013 he states that at the meeting Ms Michie told Dr MacKenzie what she had previously told him, namely that she had tried to suffocate herself the previous night. She was very distressed and crying. In his oral evidence Mr Mancera described the Friday afternoon meeting as having been very emotional for Ms Michie and her family who voiced frustration. He reiterated that Ms Michie was crying. He told the Court that Ms Michie volunteered the information about trying to suffocate herself with the pillow. He could not recall exactly what she had said, but she spoke about what had happened the previous night and said that she

²⁹ Exhibit C41

had been very anxious and that she had tried to suffocate herself with a pillow. Mr Mancera said that this utterance by was made by Ms Michie apparently in response to Dr MacKenzie asking her how she was feeling. Mr Mancera said that following this Ms Michie had spoken freely about what had happened the night before. Mr Mancera told Mr Homburg, counsel for Dr MacKenzie, that he believed that Ms Michie had used the word suffocate during her explanation to Dr MacKenzie³⁰.

- 5.15. It was later in the afternoon following this meeting that Mr Mancera made his entry in the EPAS progress notes. Although the note recorded the attempt on Ms Michie's part to suffocate herself with a pillow, it does not record that Ms Michie's statement about that matter was repeated during the meeting with Dr MacKenzie and Ms Michie's family. Mr Mancera told the Court that he also included reference to the suffocation event in a handover note that would be made available to later shifts on Morier Ward. The handover note was not within the material tended to the Court. It had probably been electronically overwritten by the time of Ms Michie's death.
- 5.16. After the Friday afternoon meeting Mr Mancera was approached by Ms Michie and although she appeared calmer by then, she said she was feeling anxious about the meeting. As a result, Mr Mancera administered 2mg of lorazepam to her. Later she told him that she was not feeling suicidal.
- 5.17. I now turn to the versions of the Friday afternoon meeting as given by Dr MacKenzie in his statement and in his oral evidence. Firstly, it should be noted that nowhere in Dr MacKenzie's EPAS note relating to the meeting is there any reference either to the information that had been given earlier in the day to him by Mr Mancera concerning Ms Michie's attempt to suffocate herself or to the issue having being raised during the course of the meeting. The note is completely silent as to the issue of an attempted suffocation having been raised by anyone. In his witness statement³¹ Dr MacKenzie asserted that the information that had been given to him by the nursing staff during the morning of Friday 25 October 2013 was to the effect that during the night Ms Michie had become anxious and that she had been gripping her arms which had caused bruising. She had also been holding her breath and had been burying her face into her

³⁰ Transcript, page 343

³¹ Exhibit C38a

pillow and that is when she had become short of breath and had to take another breath.

His statement asserts:

'I viewed this to be consistent with a manifestation of her anxiety and to me was not an increase of her suicidal ideation.'

The statement goes on to assert that the topic of Ms Michie's bruising was raised during the meeting with Ms Michie and her family. He states that Ms Michie explained that she had been grabbing her arm and had demonstrated a grabbing motion with her right hand gripping her left upper arm. She stated during the meeting that while she was doing this she had held her breath and she had made reference to burying her head into her pillow, but had stated that when she had run out of breath she took another breath. He saw the bruising on Ms Michie's upper left arm and had concluded that it was consistent with having been gripped as Ms Michie had demonstrated. Dr MacKenzie asserts that there had been no indication to him that there had been any increase in Ms Michie's suicidal ideation. He asserts that if he had been concerned about such an increase he would immediately have informed Dr Rathjen. He did not believe that there was anything to suggest that her risk of self-harm had changed. He did add in his EPAS note that Ms Michie's mental state needed to be monitored over the weekend in the light of ongoing stressors. Dr MacKenzie's witness statement mentions nothing of the use of the word '*suffocate*' in connection with Ms Michie's activities of the night before the meeting. Nor was that word used in connection with a conversation that he had with nursing staff about Ms Michie's actions, nor in the context of the meeting with Ms Michie's family.

- 5.18. Before dealing with Dr MacKenzie's oral evidence about the events of Friday 25 October 2013 I should say something of the background against which those events occurred insofar as they may have affected Dr MacKenzie's situation. I refer here to the meeting that Dr MacKenzie and Dr Rathjen conducted with Ms Michie during the afternoon of Thursday 24 October 2013 at which, among other things, Ms Michie's absence from the ward without leave the day before was discussed. It will be remembered that during that period of absence she had entertained thoughts of purchasing tablets in order to overdose. She had also been recorded as saying that she felt that the ITO was keeping her safe and that she was not yet at the point where she would not choose to attempt suicide. The plan recorded was for her to continue with the current detention. In his evidence Dr MacKenzie asserted that at the conclusion of

the meeting Dr Rathjen voiced an assessment that Ms Michie '*probably was not suicidal*'³². This assertion was made both in Dr MacKenzie's statement and in his oral evidence. In her evidence Dr Rathjen would refute this suggestion. No note was ever made of this alleged conversation between Dr MacKenzie and Dr Rathjen.

- 5.19. As far as the conversation with nursing staff on 25 October 2013 was concerned, Dr MacKenzie stated in his oral evidence that the way the incident was described to him was that it was portrayed as an episode of anxiety on Ms Michie's part. He did not plan to contact Dr Rathjen about this incident as he had planned to further assess the story by speaking to Ms Michie directly. As things would transpire he did not speak to Ms Michie directly about this. In his oral evidence Dr MacKenzie said that during the meeting, the episode of the night before was discussed. Ms Michie gave an account that amounted to a reiteration of what Dr MacKenzie had already been told prior to the meeting. His assessment was that it was consistent with anxiety. In his oral evidence Dr MacKenzie was asked to explain his conclusions. He said as follows:

I'm aware that after going through this event over and over in my head for three years, there's some difficulty in me distinguishing what I knew at the time to what I now know. I realise now, and I was not aware of it at the time, that I entered into that room - I was surprised by the meeting, I wasn't expecting it and I entered into that room with a preconception of what had occurred with regards to any arm-grabbing incident or any pillow incident and that preconception was that it was anxiety and I had a preconception about her suicidality based on what my consultant had just informed me the day prior.'³³

Dr MacKenzie added that during the meeting he had been mediating between the family. He said that the very heated and tense interaction had constituted something of a distraction for him. Thus, in forming an assessment that the episode of the night before had been one of anxiety, he now appreciated that he had not had his full focus on the matter as much as he thought he had. From what he had observed at the meeting, and from what he had been advised by Dr Rathjen and the nurses, he had formed the opinion that there had been no change in Ms Michie's suicidality.

- 5.20. In cross-examination by Ms Cacas, counsel assisting, Dr MacKenzie said that he had no recollection of the word '*suffocate*' having been used in the description of the event of the night before³⁴. Specifically he told the Court that he had no recollection of the word '*suffocate*' being used during the afternoon meeting. He said that if it had been

³² Transcript, page 240

³³ Transcript, page 244

³⁴ Transcript, page 260

conveyed to him that what had happened was an attempt on her part to stop herself from breathing, he would have raised the matter with Dr Rathjen. However, it had not been conveyed to him that it had been an attempt at suicide. Nothing in the course of that day had made him believe that it had been a genuine attempt at suicide. Dr MacKenzie ultimately conceded that his assessment of the incident may have been an error³⁵.

- 5.21. Dr MacKenzie's account of what was discussed at the meeting was much more benign than the descriptions given by Mr Mancera, Ms Michie's mother, Ms Mott, and Ms Michie's sister. It would be surprising that if Ms Michie had described the pillow incident of the night before in the terms ascribed to her by Dr MacKenzie that Mr Mancera would not have corrected Ms Michie's assertion, either during the meeting itself or afterwards. For instance, Mr Mancera at no stage intervened and said to Ms Michie words to the effect of '*well, that's not what you told me. Please tell Dr MacKenzie exactly what you told me*'³⁶.
- 5.22. I unhesitatingly accept the evidence of Mr Mancera in relation to his conversation with Dr MacKenzie before the meeting. I do not accept Dr MacKenzie's version of that conversation. I believe that Mr Mancera intended to convey to Dr MacKenzie, and did convey, that Ms Michie had asserted that she had attempted to suffocate herself, in other words attempted to take her own life.
- 5.23. I also unhesitatingly accept the evidence of Mr Mancera, Ms Mott and Ms Dodd that during the course of the meeting Ms Michie said that she had tried to suffocate herself, either using that word or using words that plainly conveyed a meaning that she had attempted to commit suicide. I do not accept Dr MacKenzie's more benign version of that aspect of the meeting. The evidence is overwhelmingly to the contrary.
- 5.24. A nursing note compiled in the early hours of the morning of Saturday 26 October 2013 indicates that Ms Michie had spent the evening of Friday 25 October 2013 in the lounge colouring in and listening to music with no overt distress or voicing of suicidal ideation. She is recorded as having requested and having been given PRN 2mg of lorazepam at around 9pm to assist with sleep. She appeared to be asleep on all rounds from 10pm and remained so at the time of the nursing note at 4:33am.

³⁵ Transcript, page 270

³⁶ Transcript, page 271

- 5.25. The mental health risk screen timed at 11:05am on Saturday 26 October 2013 duplicates the observation that Ms Michie was experiencing current ongoing thoughts of harming herself.
- 5.26. On Saturday 26 October 2013 Ms Michie was accompanied by Morier Ward staff on an escorted walk to the Colonnades Shopping Centre. She was accompanied by two nurses, Mr Phillip Collins and Ms Kathleen Jones. According to the statement of Mr Collins³⁷ he was informed that Ms Michie had approached a staff member asking if she could go on an escorted walk to the Colonnades. As a result of this Mr Collins and Ms Jones took Ms Michie and two other female patients to the Colonnades Shopping Centre. Mr Collins states that as they were walking to the shopping centre Ms Michie said to him '*I don't want to be here anymore*'. He asked her what she meant by that statement and she said words to the effect that she did not want to live anymore. Mr Collins' statement then says this:

'Having worked in the mental health industry for eleven (11) years, this is a statement that I have heard many times before from depressed patients and was not one that would overly cause alarm.'

That might be so in some cases, but one would also need to take into account the longitudinal history of the patient before any sense of assurance could be derived. At one point during this excursion Mr Collins and Ms Michie separated from the others. They went to Big W where Ms Michie purchased a DVD. The DVD was contained in a white plastic bag with the 'Big W' logo on it. Ms Michie also went to JB Hi-Fi where she purchased further DVDs. Mr Collins believed that she acquired another plastic bag as a result of her purchases at JB Hi-Fi. It was the Big W plastic bag that Ms Michie would use to suffocate herself. During the walk back to Morier Ward Mr Collins asked Ms Michie how she felt her treatment was going to which she said that she did not feel that there was a lot of change. They returned to the ward just before 4pm. The next time Mr Collins saw Ms Michie was at about 6:50pm when he performed his final round of visual observations prior to the end of his shift. She was at that time watching a DVD on her computer. He asked her how she was going and she replied that she was alright.

- 5.27. Mr Collins gave oral evidence in the Inquest. In that evidence he told the Court that before he took Ms Michie out he had permission to do so from the shift co-ordinator,

³⁷ Exhibit C35

Phillip Roberts. He said that Mr Roberts felt that she would be fine to go with staff on the walk³⁸. Mr Collins told the Court that he had not been aware until a matter of days before this Inquest commenced that Ms Michie had said to Dr Newman at FMC anything about putting a plastic bag over her head and taping it. He did not see reference to that in the Morier Ward paperwork. This is despite the fact that it was mentioned in each and every EPAS record of the MDT weekly reviews. Mr Collins said that had only gone as far back in the notes to 23 October 2013³⁹. Mr Collins acknowledged in his cross-examination by Mr Homburg for Dr MacKenzie that he had read Dr MacKenzie's note about the family meeting on 25 October 2013 and had read Mr Mancera's note of 25 October 2013 in which Mr Mancera recorded that Ms Michie had attempted to suffocate herself with a pillow. This being the case one would have thought that this would have placed Ms Michie's utterances to him on the Colonnades walk into sharper focus. But Mr Collins said that he did not regard that act as serious *'because no other reference was made to it, there was no follow-up and it certainly was not handed over'*⁴⁰. This was a reference to his assertion that there was no mention at a shift handover about that incident. Mr Collins was challenged about his assertion that he knew nothing about Ms Michie's statements concerning the possible taping of a plastic bag over her head. The challenge to this assertion was made in the light of the fact that Mr Collins acknowledged that he had read other EPAS entries from Wednesday 23 October 2013 including the risk assessment documentation and the psychology review documentation and that he would have had access to the MDT review documentation which set out the information about the plastic bag. As to why he would not have read the MDT review entry, he said he could not honestly answer. He said he wished he had read that document. He said that if he had read that document on 26 October 2013:

'I would have actually talked to the co-ordinator of the shift and said 'Look, that's in the notes, this is what she's brought back, what do we do?'"⁴¹

His reference to what Ms Michie had brought back was a reference to things in plastic bags. Mr Collins maintained a lack of knowledge about Ms Michie's assertions about a plastic bag. He was reminded that he was under the oath that he took at the beginning of his evidence. Mr Collins acknowledged that it would have been more likely for him

³⁸ Transcript, page 65

³⁹ Transcript, page 69

⁴⁰ Transcript, page 102

⁴¹ Transcript, page 112

to have seen something recorded on a paper file to the effect that Ms Michie might harm herself with a plastic bag than would be the case on EPAS because EPAS requires one to consciously select a particular document. He was asked:

Q. So you can miss stuff on EPAS, can't you.

A. Yes, you can.

Q. You say in this case you did miss that document.

A. I most certainly did.

Q. And that had consequences or possible consequences.

A. Yes. As I said, a week ago, I was devastated to hear that.⁴²

- 5.28. Mr Collins' EPAS note for the afternoon of 26 October 2013 simply records that Ms Michie had spent most of the day in her room watching movies, that she had been on the staff escorted walk to Colonnades, was appropriate in behaviour and that she had returned without incident. He recorded:

'Suicidal thoughts continue stating that she doesn't want to be here and that it is all too hard.'

There is no reference to plastic bags or the risk that might be posed by the same. That indeed is the final EPAS entry made while Ms Michie was still alive. The only further entries are those that were made on the discovery of her death just after midnight the following morning.

- 5.29. The final mental health risk screen which was compiled on the morning of 26 October 2013 at a time prior to the Colonnades excursion does not contain any reference to Ms Michie's utterances to Mr Collins on the excursion. It simply repeats that she had current ongoing thoughts of harming herself. There was no further risk assessment undertaken or recorded following the Colonnades excursion that, for instance, may have made reference to these most recent utterances regarding desire to self-harm. In his evidence Mr Collins acknowledged that if he had chosen to, he could have performed and recorded such a risk assessment.

- 5.30. According to the statement of Ms Kathleen Jones⁴³, on Wednesday 23 October 2013, after Ms Michie had returned from shopping during her absence without leave, Ms Jones had searched Ms Michie's room. Ms Jones' statement asserts that on that occasion Ms Michie had returned to the ward carrying some shopping bags. She

⁴² Transcript, page 121

⁴³ Exhibit C26

recalled that Ms Michie had a lot of shopping with her. Ms Michie had revealed to Ms Jones that she had entertained thoughts of buying tablets while she was out, but knew that she did not have sufficient time as she needed to get back to the ward prior to the next visual check. It was then that Ms Jones had searched the room. Her statement asserts that she did not locate any tablets and that she could not recall seeing any plastic shopping bags during the search. The statement is silent as to whether she actually searched for bags or whether she would have noticed them if they had been present in the room. I infer that bags were not looked for. One can only conclude that the presence or absence of plastic bags in Ms Michie's environment was a matter of complete irrelevance.

- 5.31. Indeed, the presence or absence of plastic bags in Ms Michie's room must have been a totally inconsequential matter to nursing staff in general. There is no note within the EPAS notes or anywhere else as far as one can see of any suggestion that plastic bags should be kept out of Ms Michie's environment including her room. This was so despite the fact that Ms Michie's assertions that one of her preferred methods of suicide would be plastic bag asphyxia had been well documented within the MDT notes and that such an objective would plainly be achievable within a ward environment that only dictated hourly observations conducted at predictable regularity.
- 5.32. It is apparent that upon the return from the excursion to the Colonnades no effort was made to prevent Ms Michie from taking the Big W bag into her room.

6. The handover between shifts on the Saturday evening

- 6.1. Handover is the process by which one nursing shift hands over to the next. I have already referred to handover documentation that was electronically recorded. It is the handover sheet that forms the basis for the briefing of the members of an oncoming shift. The methodology for the compilation of the handover sheet was explained in the course of the evidence. Some of the information such as that recorded under the headings '*Situation*' and '*Background*' was static in that the information was repeated from one handover entry to the next. However, that part of the document entitled '*Assessment/Clinical Handover*' would, depending on the circumstances, likely alter from shift to shift. Furthermore, the information in that section was overwritten as shifts pass from one to the other. A handover sheet was tendered to the Court⁴⁴. This

⁴⁴ Exhibit C24h

was the handover sheet that was in existence at the time of Ms Michie's death. It relates to the handover from the Saturday evening shift to the Sunday morning shift. Under the heading '*Situation*' it refers to previous attempted suicides on three occasions by way of overdose. It also refers to her thoughts of hanging, driving her car into a tree and her thoughts of smothering her three year old son. The '*Background*' section contains personal information about Ms Michie and her diagnoses. This document mentions nothing about Ms Michie's contemplated method of suicide by way of plastic bag asphyxiation. To that extent the document was flawed in that it made no mention of a contemplated and feasibly implemented method of suicide that might actually have been carried out within a psychiatric ward. The most recent handover sheet which I believe relates to a handover to the nursing staff who were on duty at the time of Ms Michie's death, commencing at about 7pm, refers simply to her being reactive and settled and to the fact that she had been on staff escorted leave with nil problems. It refers to her suicidal ideation continuing. The previous handover sheet refers to events during the evening of Friday 25 October 2013, as recorded in a nursing note timed at approximately 4:30am on Saturday 26 October 2013. It is likely that the handover sheet previous to that would have covered the events during the day of Friday 25 October 2013, including, one would have thought, Ms Michie's revelation that she had attempted to suffocate herself the night before. However, it is also likely that that sheet had been overwritten by the next two handover sheets.

- 6.2. As a briefing document for the oncoming nursing shift for Saturday evening 26 October, the handover sheet was ineffectual because it made inadequate reference to the acuity of Ms Michie's risk of self-harm based upon recent events and circumstances including the pillow incident and her possession of at least one plastic bag in her room. There was nothing that would have alerted the members of the oncoming shift to any acute difficulties as far as Ms Michie was concerned. Thus the likelihood that she would be subjected to closer scrutiny during the course of that night was not great. In fact, Ms Michie would simply be subjected to the usual hourly observations. And there was the fact that on her own admission Ms Michie had established that the observation regimen was so routine that it would enable her to commit an act of self-harm between observations without the fear of detection.
- 6.3. Nurse Rosemary Dubas who discovered Ms Michie deceased at about midnight, was one of the nurses who had commenced duties at about 7pm on the Saturday evening.

In her witness statement⁴⁵ Ms Dubas asserts that at the handover at the start of her shift nothing was mentioned about Ms Michie being at any risk higher than normal.

- 6.4. Ms Dubas also gave oral evidence at the Inquest. Ms Dubas told the Court that she did not read the EPAS notes for Ms Michie. Ms Dubas had not worked on either 24 or 25 October 2013 overnight or during the day. She was not aware of any suggestion that Ms Michie had attempted to suffocate herself. She asserted that she was not one of the nurses responsible for Ms Michie for the Saturday night shift. She identified Nurse Tjallie Ybema as the responsible person. She said that during the course of the night shift Ms Ybema mentioned nothing to her to the effect that she had read any note about the attempted suffocation issue. Ms Dubas told the court that she had no knowledge of Ms Michie's assertions that she had entertained thoughts about jumping in front of a train or of placing a plastic bag over her head. There had been no occasion for her to have read Ms Michie's EPAS notes because at no time had Ms Michie been one of her patients⁴⁶. Ms Dubas asserted that if she had known that Ms Michie had expressed thoughts of using a plastic bag to harm herself she would have spoken to the other members of her shift about that and they would have removed any plastic bags from her room.
- 6.5. Ms Tjallie Ybema is a registered mental health nurse who obtained that qualification in 2013. She obtained her original general nursing qualification in 2000. She has worked at Noarlunga since 2012. Prior to that she was an intensive care nurse at Flinders. Ms Ybema witness statement⁴⁷ asserts that at the shift handover they were advised that Ms Michie had that day attended the Colonnades Shopping Centre and had purchased DVDs. She states that there was no mention of Ms Michie having bruises on her body or of her having attempted to suffocate herself on the night of 24 October 2013. Her statement asserts that it was not until the nightshift of Sunday 27 October 2013 that she read the case notes relating to Ms Michie. On that occasion she saw that there was a note dated 25 October stating that Ms Michie had attempted to suffocate herself the night before. Her statement goes on to say this:

'Even if I'd have been aware of this information I would still have only performed hourly checks on Tiffany. More frequent checks are only performed if we are advised by the

⁴⁵ Exhibit C36a

⁴⁶ Transcript, page 142

⁴⁷ Exhibit C39a

doctor that the patient's risk assessment has increased. If this happens we are told verbally by our bosses and also the written risk assessment would be updated.'⁴⁸

I found this assertion to fly in the face of common sense and to demonstrate a lack of initiative on Ms Ybema's part. In her oral evidence Ms Ybema stated that at handover nothing was mentioned about an episode of attempted suffocation. She did not have an opportunity to look through Ms Michie's notes. She also reiterated that if she had been provided with information about an attempt to suffocate herself, she would not have done anything differently that night in relation to Ms Michie. She said:

'No. Again on my clinical assessment there was no increase in suicidal ideation.'⁴⁹

Ms Ybema said that she did not see a plastic bag in Ms Michie's room. However, she acknowledged that she had known that at one point Ms Michie had voiced thoughts of taping a plastic bag over her head⁵⁰, and she acknowledged that she knew that Ms Michie had been shopping during the course of that day. While I accepted Ms Ybema's evidence that she knew nothing of any attempted suffocation episode, to my mind her attitude to the question of risk indicates that she is in need of significant re-education.

- 6.6. The supervising psychiatric nurse who conducted the handover to the shift during which Ms Michie would suicide, registered nurse Phillip Roberts, asserts in his witness statement that at the handover he passed on the information recorded on the handover sheet. It will be remembered that this document did not say anything about Ms Michie's plastic bag propensities, nor of her attempted suffocation on the evening of 24 October 2013. Mr Roberts states that he recalls having verbally informed the staff that Ms Michie was unpredictable and impulsive. Mr Roberts acknowledges in his statement that he was aware that Ms Michie had attempted to suffocate herself on 24 October 2013 and that this was mentioned on the handover sheet from Friday 25 October 2013. However, he asserts that this recorded information would have been overwritten. The statement asserts:

'I can't recall if I mentioned anything to the nightshift staff about her attempt to suffocate herself.'

⁴⁸ Exhibit C39a, pages 6-7

⁴⁹ Transcript, page 378

⁵⁰ Transcript, page 380

- 6.7. Mr Roberts gave oral evidence in the Inquest. In his evidence Mr Roberts told the Court that he was responsible for creating that part of the handover document entitled ‘*Situation*’. As seen, this was the section of the document that mentioned thoughts of hanging and driving a car into a tree, but nothing about suicide by means of a plastic bag. Mr Roberts said that as far as he could recall he had not been aware of a reference to that method⁵¹. Mr Roberts acknowledged that during the nightshift handover he did not impart specific information about the attempted suffocation incident. He agreed that it was important information for him to have handed over, but the information had been deleted from the handover sheet⁵². Mr Roberts acknowledged that the suffocation incident should have escalated the risk assessment, regardless of whether it had been a manifestation of anxiety or the result of chronic suicidal ideation⁵³. I agree with that acknowledgment. In cross-examination by Mr Homburg for Dr MacKenzie, Mr Roberts asserted that the EPAS case notes was the operative and definitive document that clinical staff read and that it was all up to date, whereas the handover document that was altered from time to time⁵⁴. In October 2013 the EPAS case notes were not consulted at handover. Mr Roberts stated that there was an expectation that nursing staff allocated to specific patients would read the EPAS case notes in respect of those particular patients⁵⁵. He said that if a nurse had no prior experience with a particular patient he or she would have to go to the beginning of the notes. If, on the other hand, they were familiar with the patient they might only read the most recent entry. If the nurse or primary carer for the patient had not worked for a number of days they would be required to read the EPAS notes in respect of the days on which they had not worked.
- 6.8. In cross-examination by Ms Cacas of counsel assisting, Mr Roberts acknowledged that if he had gone far enough into the CBIS notes he would have seen the information regarding Ms Michie’s assertions that she might use a plastic bag to self-harm. He acknowledged that this piece of information should have been contained within the ‘*Situation*’ section of the handover document, a section that he himself prepared⁵⁶. Mr Roberts accepted the possibility that during the handover he had said nothing about

⁵¹ Transcript, page 158

⁵² Transcript, page 169

⁵³ Transcript, page 180

⁵⁴ Transcript, page 185

⁵⁵ Transcript, page 186

⁵⁶ Transcript, page 195

the episode of attempted suffocation⁵⁷. He told Ms Cacas that he could not recall why he did not mention it. He stated that he could not say whether it had slipped his mind⁵⁸. He said:

'....., I didn't have a prompt for it for some reason, and I normally would've, or will've handed over, but it was not forefront in my mind at that time. And also I'd seen the patient during the day and seen her bright and reactive, but as I said in my statement, she still remains impulsive.' ⁵⁹

He added, however, the staff would have known about Ms Michie's ongoing risk as they would have read the EPAS notes. He was asked:

'Q. What would you say to the suggestion that neither of the night shift nurses for the general ward knew about the smothering episode.

A. I can't comment. I'd only assume that they would have read the documents.' ⁶⁰

6.9. In questioning by me, Mr Roberts stated that he had not read the reference to Ms Michie's assertions about taping a plastic bag over her head within the MDT review documentation. He did not at any stage read those entries. He acknowledged that it was the same information as what had been contained in the CBIS notes that he also said he did not read. Asked as to how it was that he had not read the relevant material he said:

'How it occurred is I do not have the time in the day to read through all patients' case notes, I rely on staff members looking up the patient to relay information to me and this has occurred and normally it would have been flagged - well today's practice is that would have been flagged that there was an issue here and a management plan would have been created.' ⁶¹

He suggested that a management plan would include nurse specialising the patient in the High Dependency Unit⁶². He agreed that one other relevant measure would be to ensure that Ms Michie would not keep plastic bags in her room.

7. The evidence of Dr Priscilla Rathjen – psychiatrist

7.1. Dr Rathjen was the consultant psychiatrist caring for Ms Michie. Dr Rathjen gave evidence at considerable length in this Inquest. It can be summarised relatively briefly.

⁵⁷ Transcript, page 200

⁵⁸ Transcript, page 198

⁵⁹ Transcript, page 198

⁶⁰ Transcript, page 202

⁶¹ Transcript, page 206

⁶² Transcript, page 207

- 7.2. In 2013 Dr Rathjen worked three days a week at Morier Ward, namely on Mondays, Wednesdays and Thursdays. She told the Court that three psychiatrists worked in Morier Ward but that none of them worked a five day week. Dr Rathjen explained that psychiatric registrars and resident medical officers worked within the ward on a daily basis but not on weekends. On the weekends a consultant was rostered to be on-call, the method of communication being by phone. Dr Rathjen had responsibility in relation to the supervision of resident medical officers such as Dr MacKenzie. Other psychiatrists would be on duty on the days on which Dr Rathjen did not work. There was an expectation that the other consultants would cover the ward for those days and would deal with any issues that arose with patients. Dr Rathjen's phone number was available if it became necessary for her to be called by staff on her days off.
- 7.3. In her evidence Dr Rathjen referred to an orientation folder that was provided to junior doctors and interns at the time they commenced employment in Morier Ward. One instruction within this document stated that junior doctors will have a consultant psychiatrist supporting their work and that when the consultant psychiatrist was not available they should seek out a senior registrar, the unit manager or other medical and nursing staff. There is nothing unusual or arcane about such an instruction. One would have thought that this would be a standard instruction in any environment in which junior professionals are supervised by senior professionals.
- 7.4. In Dr Rathjen's witness statement and in her oral evidence she gave a detailed account of her interaction with and care of Ms Michie. It does not require detailed analysis. Her involvement with Ms Michie began on 9 October 2013 which was the day on which the first MDT review took place. She last saw Ms Michie on Thursday, 24 October 2013.
- 7.5. In her oral evidence Dr Rathjen made a number of important acknowledgments about Ms Michie's level of care in the days preceding her suicide on the ward. I accepted all of this evidence. The salient features of this were as follows:
- Ms Michie's fleeting thoughts of taking a butter knife from the kitchen to stab herself and her having refrained because the knives were too blunt was evidence that she had contemplated suicide even within the hospital. Dr Rathjen

acknowledged that this as a novel and important development having regard to Ms Michie's contradictory assertions that she felt safe on the ward⁶³.

- Ms Michie's risk assessment should have been reviewed in the light of her statements about her contemplated use of a butter knife and also having regard to her statements about an intent to purchase tablets so she could overdose and that the risk assessment documentation should have reflected this information.
- The butter knife revelation in particular meant that from that point forward there was an increased risk, not only that Ms Michie might attempt to take her own life were she to be discharged from the hospital, but a risk that she might even attempt it on the ward. This was a possibility that would need to be monitored.
- The circumstances surrounding Ms Michie's absence without leave from the ward would lead to a conclusion that she was observant about the frequency at which she was checked⁶⁴ and that this could translate into an opportunity for her to self-harm within her room.
- The suffocation attempt was a matter that needed to be reviewed with the patient. Dr Rathjen would have expected Dr MacKenzie to have sought and obtained advice from a more senior doctor or have asked for Ms Michie to be reviewed by someone more senior⁶⁵.
- There should have been more scrutiny in respect of plastic bags, particularly after the suffocation attempt on the Thursday evening⁶⁶.
- Following the suffocation incident on the Thursday night and the distressing family meeting on the Friday, there should have been a re-assessment of Ms Michie's risk. As well, discussion about the level of observation that would be required should have ensued. It would not have been unreasonable for Ms Michie to have been placed on a high level of observation⁶⁷. Dr Rathjen asserted that it would have been good practice to have increased the observations, certainly in the short term, and to

⁶³ Transcript, page 412

⁶⁴ Transcript, page 148

⁶⁵ Transcript, page 426

⁶⁶ Transcript, page 428

⁶⁷ Transcript, page 429

have reviewed this the following day. Ms Michie should have been reviewed before being allowed to go on the walk on the Saturday.

- Dr Rathjen would have expected Dr MacKenzie to have made a note in the EPAS record of the suffocation incident and for him to have discussed the matter with her privately⁶⁸.
- Ms Michie's possession of the plastic bag on the Saturday afternoon should have been scrutinised and considered by nursing staff. An assessment should have been made as to whether or not it constituted an item of potential harm⁶⁹. I would extrapolate here that it is manifest that such an assessment should have led to no conclusion other than that the plastic bag in Ms Michie's possession was an item of potential harm.
- The suffocation incident was an important development in that Ms Michie had progressed from thinking about what she might do to actually doing something. Dr Rathjen characterised this development as '*a big change*'⁷⁰.
- Dr Rathjen herself would participate in or manage family meetings because she believed that this task was '*really beyond the expertise of the junior staff*'⁷¹. Dr Rathjen added that without meaningful training in psychiatry and experience it would be very difficult for a resident medical officer to manage on his own a family meeting. She observed that she did not believe that Dr MacKenzie would have gained any such experience in his time on the ward.
- It would have been appropriate for the MDT review plan to have contained an instruction that Ms Michie should not have plastic bags in her possession⁷².
- Having regard to what had happened on the night of 24 October in relation to the suffocation incident, Dr Rathjen should have been advised of the escalation of Ms Michie's case as of 25 October. She said her number was available for her to

⁶⁸ Transcript, page 430

⁶⁹ Transcript, page 445

⁷⁰ Transcript, page 447

⁷¹ Transcript, page 490

⁷² Transcript, page 494

be contacted. She would not have expected Dr MacKenzie to have dealt with this issue on his own. She said in evidence:

A. I would have liked to have seen him, yeah, get some help with it.'⁷³

- Based on the events as they unfolded on 25 October 2013, discussion with senior personnel and with nursing staff should have occurred. One-on-one nurse specialising should have been discussed and considered as an option for Ms Michie.
- Even on Dr MacKenzie's asserted interpretation of the suffocation incident as being anxiety related, the matter should have been viewed as infliction of self-harm by Ms Michie or as an attempt to effect self-harm. Given that Ms Michie herself had foreshadowed possible suffocation by way of plastic bag asphyxia, her admitted actions on the Thursday evening needed to be considered as an act of self-harm and needed to be assessed by staff in that light⁷⁴.

7.6. There were other matters that Dr Rathjen dealt with in her oral evidence. Dr Rathjen said that she never had any discussion with Ms Michie about possible means of suicide by way of plastic bag asphyxia even though it was documented in Ms Michie's notes. Ms Michie had predominantly discussed her method of choice as being an overdose of medication. It would have been appropriate for Dr Rathjen to have explored all of Ms Michie's contemplated methods of suicide including by way of plastic bag asphyxia, especially given that this was a method that could conceivably be carried out in a ward environment. Close questioning of Ms Michie on that subject may have revealed that she had devised a method of achieving that outcome, which she no doubt had at some point, may have revealed how she planned to acquire the necessary items to carry out any plan and it might have led to a conclusion that under no circumstances should Ms Michie be allowed to possess plastic bags in her room. To my mind it is not being wise after the event to conclude that the failure to explore this subject with Ms Michie was a serious oversight.

7.7. Dr Rathjen stated that at no stage before Ms Michie's death had she been made aware of Ms Michie's attempt to suffocate herself on the night of Thursday 24 October. I accepted that evidence.

⁷³ Transcript, page 508

⁷⁴ Transcript, page 516

- 7.8. Dr Rathjen vehemently denied that following the 24 October 2013 MDT review she had told Dr MacKenzie that Ms Michie was no longer suicidal. She said there was no likelihood of her having expressed that view. I accepted Dr Rathjen's evidence about this matter and preferred it to that of Dr MacKenzie. In my view it is highly unlikely that Dr Rathjen formed the opinion at any point during the course of Ms Michie's hospitalisation that Ms Michie was no longer suicidal. All evidence pointed to a quite different conclusion. There was simply no basis upon which such a conclusion could have been reached. Any assessment to the contrary would have been wholly irrational. There is no written evidence of any such prognosis ever having been made. Not only is it highly unlikely that Dr Rathjen would have formed the view that Ms Michie was not suicidal, it is equally unlikely that she would have said that to Dr MacKenzie.
- 7.9. As to Dr Rathjen's prognosis for Ms Michie, she was asked by Ms Cacas of counsel assisting what she considered Ms Michie's prospects of recovery would have been if she had not chosen to take her own life. She said:

'I certainly thought they were still good and I was still hopeful of continued improvement. That's because with knowing that she was on good therapeutic doses of the medication and we would sort of anticipate seeing something in that following week to two weeks after those doses were increased, and also given the fact that she'd had treatment with antidepressants before and the report suggests that she'd actually responded quite well to antidepressants and counselling. So I would have been hopeful to have seen certainly more improvement in her mental state during that next week or two.'⁷⁵

Dr Rathjen added that she was surprised that Ms Michie took her own life. Dr Rathjen had thought that Ms Michie had a good treatment regime in place.

7.10. In her evidence Dr Rathjen offered some observations about EPAS, particularly in relation to risk assessment documentation. She said that at the time of Ms Michie's death staff were still trying to come to grips with the EPAS change as it related to the risk assessment process. She stated that EPAS added a layer of complexity to the recording of risk assessment. She rightly observed, as has the Court, that in Ms Michie's case, risk assessment documentation would simply be copied and pasted from one day to the next. Dr Rathjen believed that during Ms Michie's admission it would have been important for other pieces of relevant information to have been recorded in Ms Michie's risk assessment documentation such as the butter knife revelation and

⁷⁵ Transcript, page 502

other worrying developments insofar as they affected Ms Michie's level of risk. The Court agrees with those observations.

8. The evidence of Dr Maria Naso

8.1. Dr Maria Naso is a specialist psychiatrist who provided an independent expert opinion in relation to Ms Michie's care in the Morier Ward during the days preceding her death. Dr Naso was not involved in that care. Dr Naso obtained her primary medical qualifications in 1992 from the Flinders University. She became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 2002. She has been employed as a senior staff psychiatrist at the Modbury Hospital since 2002.

8.2. Dr Naso provided a written report⁷⁶ and gave oral evidence at the Inquest.

8.3. Dr Naso made a number of comments in relation to Ms Michie's management, particularly as it existed in the few days prior to her death. Many of these comments related to the manner in which certain incidents involving Ms Michie, and certain statements that she made herself, should have been viewed and handled within Morier Ward.

8.4. Dr Naso told the Court that Ms Michie's statements about possibly using a butter knife was a significant event because Ms Michie was there actually identifying an object that she might use and go on to the next step except that she deduced that it would not work because of its bluntness. Dr Naso agreed that Ms Michie's utterances about this would diminish confidence that she would not do something untoward on the ward. Dr Naso said:

'Most definitely. She's now decided to look around in her ward environment which was meant to be keeping her safe and she's seeing opportunities I suppose where she could sort of harm herself so the ward is no longer necessarily a safe place for her.'⁷⁷

8.5. In respect of the incident during which Ms Michie was absent without leave Dr Naso stated in her evidence that the concerning factor about this was that it evidenced that Ms Michie had recognised that she had an opportunities to potentially harm herself. Dr Naso suggested that this should have triggered an enhanced level of vigilance on the

⁷⁶ Exhibit C32

⁷⁷ Transcript, page 549

part of nursing and medical staff and have prompted a conclusion that observations of Ms Michie on the ward needed to be more random⁷⁸.

- 8.6. As to the significance of the incident of the night of 24 October 2013 in which Ms Michie suggested that she had attempted to suffocate herself, Dr Naso opined that this was a serious development in a series of already worrying events in that Ms Michie had progressed from merely verbalising thoughts that she was suicidal and that she had no desire to live, to action that indicated that she actually wanted to harm herself and end her life⁷⁹. Dr Naso regarded the question as to whether Ms Michie had truly intended to suffocate herself or whether her act had been the manifestation of mere anxiety as not being particularly relevant. There was still an act of self-harm involved in the incident as evidenced by the bruising to her arm. Dr Naso said:

'There was still an episode of distress that needed to be assessed and documented and dealt with.'⁸⁰

- 8.7. Dr Naso regarded the family meeting on 25 October 2013 as an event that would have been '*really traumatic for her*'⁸¹. This was due to the fact that the meeting had involved very tense, very emotive discussions about painful areas of Ms Michie's life. There was also the matter of Ms Michie probably feeling inadequate in respect of her failed period of leave. Ms Michie's need for lorazepam both before and after the meeting was of significance. Dr Naso suggested that it was obvious that Ms Michie had already become quite anxious and worked up at the prospect of the meeting. Moreover, Dr MacKenzie needed to know that Ms Michie had to be medicated in preparation for the meeting. Dr Naso stated that this may have provided Dr MacKenzie with greater impetus to have sat down with her and to have contacted Dr Rathjen or whichever psychiatrist was covering for Dr Rathjen that afternoon⁸². Equally, Dr Naso said that it would have been appropriate for Dr MacKenzie to have been made aware of her having sought out further PRN lorazepam after the meeting.

- 8.8. Dr Naso was also of the view that the Saturday excursion to Colonnades should not have been allowed to take place⁸³. The reason for this was that Ms Michie was understood to have recently tried to suffocate herself. She had then been involved in a

⁷⁸ Transcript, page 551

⁷⁹ Transcript, page 534

⁸⁰ Transcript, page 539

⁸¹ Transcript, page 543

⁸² Transcript, page 544

⁸³ Transcript, page 547

very distressing meeting. She was very much at high risk and so being allowed to go shopping did not make much sense, even if she was accompanied. The inappropriateness of it all was further illustrated by the fact that the accompanying nurse did not go into the store with her but waited for her outside. Dr Naso suggested that this approach to patient care is not appropriate for a person who is currently the subject of an ITO under the Mental Health Act⁸⁴.

- 8.9. Dr Naso expressed a view as to the impact that the comment that Ms Michie made on the Saturday afternoon during the Colonnades excursion to the effect that she did not want to live anymore should have had on her care. Dr Naso suggested that this comment should have been directed to the attention of a more senior clinician and not merely have been documented and accorded no further action⁸⁵.
- 8.10. Naturally the question of the availability of plastic bags was raised in Dr Naso's evidence. Dr Naso was firmly of the view that Ms Michie should not have been allowed to have plastic bags in her possession. Her utterances about using a plastic bag to commit suicide were clearly documented in the CBIS case notes as well as the MDT review documentation in EPAS. Dr Naso said that the fact that there was no policy about plastic bag possession was irrelevant because '*surely we don't need a policy for everything including things like common sense*'⁸⁶. It is hard to disagree. She added that the risk assessment documentation should have made reference to the specific risk associated with plastic bag possession⁸⁷. Dr Naso stated that she was not sure why the plastic bag issue had not appropriately been considered⁸⁸. Similarly, Dr Naso suggested that it did not make any sense that the plastic bag issue was not mentioned in handover documents when other possible methods of suicide as contemplated by Ms Michie were included in that documentation. Dr Naso rightly observed that driving her car into a tree and smothering her three year old were events that were not going to happen while Ms Michie was in hospital and under a detention order whereas a plastic bag was something that appeared to be freely available and could be used on the ward. She said '*it just doesn't make any sense really as to why it was left off*' the handover documentation.

⁸⁴ Transcript, page 548

⁸⁵ Transcript, page 557

⁸⁶ Transcript, page 529

⁸⁷ Transcript, page 531

⁸⁸ Transcript, page 531

- 8.11. Dr Naso suggested that the plastic bag issue and Ms Michie's statements in respect of that possible method of suicide was a matter that Ms Michie should have been asked about as part of her overall clinical assessment. As the patient's psychiatrist, and as part of a patient's initial assessment, Dr Naso would go through all of the CBIS documentation with the patient and in the case of someone who had indicated that they would use a plastic bag to commit suicide, she would explore the patient's thought processes about such an issue⁸⁹. I have already made comment that to my mind the failure to explore this issue with Ms Michie was a serious oversight.
- 8.12. Dr Naso suggested that Ms Michie's utterances about an attempted suffocation should have dictated a thorough assessment of her. Dr Naso would have expected the junior doctor, in this case Dr MacKenzie, to have sat down with Ms Michie and to have performed that thorough assessment⁹⁰. Further, there would have been a need to contact the consultant psychiatrist, in this case Dr Rathjen, or to have discussed the matter with another consultant if Dr Rathjen was not available⁹¹. She would not have expected Dr MacKenzie to take any other action at that point because once the matter was discussed with the supervising consultant or another senior doctor and also with the nursing staff, a management plan would have been prepared and documented in the case notes. Dr Naso suggested that it was not for Dr MacKenzie to have made his own judgment call about the significance of the suffocation incident. She said as follows:

'... his role is to assess and document episodes which have occurred. I don't see his role as being able to pick out the intricacies of was this a true suicide attempt, was this a self-harming attempt, what exactly was this, was it an anxiety disorder. So I would be expecting him to assess and then take it to a more senior doctor who would then provide more advice and perhaps even get Dr MacKenzie to go back and have another chat with her.'⁹²

- 8.13. Dr Naso suggested that following the suffocation incident Ms Michie should have been subjected to closer visual observation, in the first instance being 15 minute observations, until a management plan could be discussed with the treating consultant who may well have considered one-on-one specialling or closed bed intervention. She said:

'But certainly as an emergency sort of acute response just 15-minutely observations and keeping her within view of the nurses station. Sometimes what I've seen happen is that the

⁸⁹ Transcript, page 534

⁹⁰ Transcript, page 535

⁹¹ Transcript, page 535

⁹² Transcript, page 540

team leader will take off one of the primary nurses and get them to special the patient until we come up with a more thorough management plan.'⁹³

8.14. Dr Naso asserted in her evidence that Dr MacKenzie's note of the impromptu 25 October 2013 family meeting that Ms Michie's '*mental state needs to be monitored over the weekend in light of the ongoing stressors*' did not translate into anything practicable for the nursing staff. She said that most nursing staff would regard such monitoring over the weekend as standard practice and part of their usual role⁹⁴. In other words, Dr MacKenzie's note added nothing to Ms Michie's level of care beyond what would have been appropriate for any patient in any event. Dr Naso also observed that in reality there was no change in the way that Ms Michie was being managed in light of the events of 25 October 2013. Dr Naso emphasised that what needed to happen was for Dr MacKenzie to have spoken to a more senior clinician. Dr Naso expressed surprise that this did not happen. She said that it was an expected thing for junior doctors to do.

8.15. Dr Naso commented on the EPAS documentation in this case. She too made the observation that the documentation was by and large cut and pasted from one day to the next. She suggested that filling in boxes in forms can result in vital information not being included where it does not quite fit into what the EPAS system is seeking. She likened it to the CBIS data recording system which she believes is clumsy as well. Dr Naso contrasted these systems with written case notes. Whereas written notes enable one to go through the individual pages with ease because the material is all there in front of the reader, with EPAS the clinician has to make a decision to delve further into the computerised material. One has to click on different kinds of areas. She also suggested that time spent in front of a computer is time away from patients⁹⁵. As to this issue, the following cross-examination of Dr Naso by Mr Homburg, counsel for Dr MacKenzie is pertinent:

'Q. And we appreciate that 2013 I think was in the sort of start-up for EPAS so perhaps things have improved. But just following on and I think you commented on this, that quite a few of the entries are simply just copied over -

A. Yes.

Q. - from day-to-day so there's not a dynamic development of a story within the notes that can be readily followed; is that a fair observation.

⁹³ Transcript, page 541

⁹⁴ Transcript, page 563

⁹⁵ Transcript, page 559

- A. Absolutely, I agree. It was quite time-consuming for me to gain new information as I was wading through the EPAS notes. There was a lot of copy and the risk assessments all seemed like they were copied and pasted. So you don't get the continuity that you would normally get. There's a disconnection between so what's happened on the 21st and then what happens on the 24th.'⁹⁶

- 8.16. Finally, Dr Naso commented on Ms Michie's possible prognosis. Dr Naso said that her prognosis would have been difficult to predict as at 26 October. However, she suggested that at the time Ms Michie took her own life she was still in the early days of her treatment⁹⁷. Dr Naso noted that Ms Michie had responded favourably to antidepressants in the past. She felt that with antidepressant therapy, a positive therapeutic relationship with a psychologist and with support in relation to her maternal responsibilities, Ms Michie's prognosis, while being somewhat guarded, was a '*moderately good prognosis*'⁹⁸. This view reprised the opinion that Dr Naso had expressed in her report to the Coroner which states as follows:

'Her prospects of recovery-was she treatable?

Tiffany had a borderline personality structure which left her at long term risk of developing depression/anxiety and at chronic risk of self-harm and suicide. From the Second Story documentation it was apparent that she responded to antidepressants and psychotherapy. My opinion is that she was still in the early phase of her treatment with Venlafaxine (commenced at an initiating dose of 75mg mane on 10th October and an increase to 225mg mane on 21" October), but was beginning to show mild improvement. It is likely based on her past response that she would have eventually responded and with the addition of psychotherapy her depression would have gone into remission. Her personality structure would however maintain her at chronic risk of self-harm and suicide. Her difficulty with her mothering role was another source of chronic stress and a perpetuating factor of her depression and suicidal ideation. Tiffany not only required treatment for her depression but also long term psychotherapy to help her in her mothering role.'⁹⁹

- 8.17. I unhesitatingly accept the evidence of Dr Naso in its entirety.

9. Conclusions

- 9.1. The Court reached the following conclusions.
- 9.2. When Ms Michie died on Saturday 26 October 2013 she was in a relatively early stage of her treatment. The Court has not found it necessary to closely investigate the quality

⁹⁶ Transcript, page 559

⁹⁷ Transcript, page 529

⁹⁸ Transcript, page 548

⁹⁹ Exhibit C32, page 11

of Ms Michie's treatment within the Morier Ward from the time of her admission to the time of her death.

- 9.3. In the days preceding her death, however, Ms Michie displayed a number of behaviours and made certain statements that were relevant to the possibility of risk of self-harm while on the ward. These included a statement which indicated that she had contemplated using a butter knife to inflict self-harm if not death but had refrained from acting upon those thoughts because she concluded that the knives available to her on the ward would not be sharp enough. There had also been an absence without leave from the ward during which Ms Michie on her own admission had contemplated purchasing tablets in order to commit suicide but had decided against this. She had also stated that she had attempted to suffocate herself with a pillow but had been unsuccessful. I find that Ms Michie did in fact describe the pillow incident to nursing staff in those terms and that nursing staff faithfully reported this information to Dr MacKenzie. These concerning events and statements by Ms Michie had to be viewed against a background that Ms Michie had indicated to clinical staff at the Flinders Medical Centre that one method by which she had contemplated committing suicide was by way of plastic bag asphyxia.
- 9.4. Although throughout Ms Michie's admission her thoughts about committing suicide by way of plastic bag asphyxia were recorded serially in the notes of MDT meetings, little regard was paid to that as a possible means of suicide within Morier Ward. There is no evidence that Ms Michie was ever questioned by anyone about this possible method of suicide. She should have been so questioned.
- 9.5. It is highly unlikely, and I so find, that it ever occurred to any person within Morier Ward that Ms Michie might use a plastic bag to commit suicide on the ward. It is highly unlikely, and I so find, that it ever occurred to any person within Morier Ward that Ms Michie should not be allowed to possess plastic bags. Proper consideration of both possibilities should have taken place within Morier Ward.
- 9.6. A family meeting conducted on the afternoon of Friday 25 October 2013 represented an event for Ms Michie that should have given rise to a re-assessment of her risk of self-harm. Ms Michie was deeply upset during the course of the meeting and required sedation both before and after the meeting. I find that during the meeting Ms Michie clearly indicated that she had attempted to suffocate herself the night before.

- 9.7. On Saturday 26 October 2013 Ms Michie was permitted to participate in an excursion to the Colonnades Shopping Centre. She was accompanied by nursing staff. I find that this was not appropriate. Nor was it appropriate for Ms Michie to be allowed to enter a shop without being accompanied by a member of the nursing staff. I find that during the course of this excursion Ms Michie purchased items which resulted in her being able to retain at least one plastic bag in her possession, in particular a plastic bag from Big W. She would later use this bag to commit suicide.
- 9.8. Following the Colonnades excursion Ms Michie was permitted to take the plastic Big W shopping bag into her room in Morier Ward. I find that it did not occur to any of the clinical staff within Morier Ward that Ms Michie might use this bag to commit suicide. It is not being wise after the event to say that nursing staff should have contemplated this possibility. The plastic bag should have been removed from her possession.
- 9.9. Ms Michie's risk of committing an act of self-harm on the ward should have been re-assessed at the very latest on the morning of Friday 25 October 2013 after she had described the incident in which she had attempted to suffocate herself with a pillow during the previous night. I find in this regard that as soon as he was placed in possession of this information Dr MacKenzie should have contacted by phone his supervising consultant, Dr Rathjen, who was not on duty that day, or have contacted another psychiatric consultant on duty within the Noarlunga Hospital that day. He should also have drawn the matter to the attention of senior nursing staff on the ward. In addition, I find that the level of observation of Ms Michie should have been escalated in the light of her statements that morning. Furthermore, I find that in view of Ms Michie's highly emotionally labile state on that particular day, the meeting with her family members should have been discouraged unless it was to take place in the presence either of Dr Rathjen when she was next available or in the presence of another psychiatrist. I find that Dr MacKenzie through no fault of his own was professionally ill-equipped to deal with such a meeting and with the effects that it may have had on Ms Michie.
- 9.10. Close observation of Ms Michie should have been maintained at least until she could be assessed by a psychiatrist, be it Dr Rathjen or another psychiatrist. She should not have been allowed to remain within her room with observations only made at hourly intervals, especially given that she was in possession of a plastic bag.

- 9.11. The handover that was conducted between the day shift of Saturday 26 October 2013 and the night shift miscarried in that no information about Ms Michie's assertions that she had attempted to suffocate herself was imparted from one shift to the next. This information should have been contained within the handover documentation. As well, it should have been the subject of verbal discussion between members of the outgoing shift and the members of the night shift. I have accepted the evidence of nurses Ybema and Dubas that they did not know of Ms Michie's recent attempts to suffocate herself with a pillow. Had they known of this it would have been appropriate for them to have taken the initiative to maintain a much closer level of observation on Ms Michie during the course of that night. As it was, the level of observation, being hourly observation, was wholly inadequate in all of the circumstances.
- 9.12. Dr MacKenzie's note of 25 October 2013 to the effect that Ms Michie's mental state needed to be monitored over the weekend in the light of ongoing stressors was inadequate insofar as it was vague and imprecise and did not require the nursing staff, over the course of the ensuing weekend, to maintain a level of observation of Ms Michie that was above that which would normally be maintained.
- 9.13. Had Ms Michie's not elected to end her own life, I find that her prognosis, although guarded, was moderately good. However, it cannot be stated with complete certainty that if her death had been prevented during the course of the night of 26 and 27 October 2013, her death would have been prevented in the long run.
- 9.14. The cause of Ms Michie's death was as a result of plastic bag asphyxia, possibly contributed to by neck compression. I find that she applied the plastic bag and cord to herself. The regularity and predictability of ward observations provided her with the opportunity to do so. Ms Michie had become familiar with that regularity and predictability and she took advantage of that circumstance. I find that Ms Michie acted with an intent to end her life. No other person was involved in her death.

10. Recommendations

- 10.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

- 10.2. The Court received in evidence the affidavit of Andrew Champion who is the senior consultant psychiatrist within the Noarlunga Emergency Mental Health Services of the Southern Adelaide Local Health Network Incorporated. He previously held the position of Clinical Director Mental Health Outer South.
- 10.3. Dr Champion's affidavit describes a number of measures that have been introduced within Morier Ward of the Noarlunga Hospital and which were undertaken as a result of an internal review of the circumstances surrounding Ms Michie's death.
- 10.4. It is apparent that the review recognised the same shortcomings relating to patient safety that this Inquest has recognised. Naturally one matter that has commonly been identified is that in the light of Ms Michie's statements that she had contemplated suicide by asphyxiation with a plastic bag, it would have been appropriate to have restricted Ms Michie's access to this potential suicide method during her admission to Morier Ward.
- 10.5. Dr Champion's affidavit also states that Ms Michie's case has highlighted a gap in communication between staff in respect of critical incidents and, in particular, it appears that there was a lack of multidisciplinary communication and planning following the act of self-harm and the traumatic family meeting. This is a reference to Ms Michie's statements that on the night of 24 October 2013 she had attempted to suffocate herself with a pillow as well as a reference to the family meeting during the afternoon of the following day. Dr Champion's assertions in this regard are correct and are illustrated by this inquiry. In response, an escalation pathway has been developed to ensure that there an agreed multidisciplinary risk management care plan is properly devised and documented. This has resulted in the instigation of 10-minute '*huddles*' which are consultant led multidisciplinary team meetings that occur twice each day during which each patient is discussed. These meetings provide an opportunity for staff to disclose any concerns such as a change in the behaviour or the mental state of a patient that might indicate an increased risk of self-harm or harm to others. Dr Champion states that as a consequence of this measure an incident such as Ms Michie's act of self-harm would automatically be presented at one of the twice daily huddles. A decision about management plan changes would be made by the treating consultant. I assume that if the patient's allocated treating consultant was not present then another consultant would attend the meeting and implement the necessary changes. I would also pose the question as to whether such a measure could apply on weekends when consultants are

not necessarily present. I would emphasise that this case has demonstrated that tasks such as these should not be left to relatively junior practitioners such as Dr MacKenzie or to nursing staff.

- 10.6. Dr Champion's affidavit asserts that a review has been undertaken of the use of the risk assessment tool. I have already made comment in the body of these findings about the fact that risk assessment documentation appeared to be copied and pasted from one day to the next with little evidence of regular and adequate consideration being given to the question of risk assessment in a particular patient. It was only towards the very end of Ms Michie's clinical course that the document was amended to include reference to a higher degree of risk. This amendment, however, did not appear to generate any further risk management strategies such as an enhanced level of observation. In any event, as indicated by Dr Champion, measures have been instigated to ensure that relevant factors contributing to risk are identified and that relevant mitigation plans are implemented such as the removal of access to means of self-harm, the altering of the frequency of observations as well as the reviewing of access to leave and the implementation of other measures to relieve the distress of a patient. Current practice on Morier Ward now includes scrutiny of written risk assessment plans at least weekly by consultant psychiatrists and senior nursing staff. It would seem to this Court that such scrutiny should more frequently take place than once weekly.
- 10.7. Annexed to Dr Champion's affidavit is a document that is entitled '*Completing a Risk Assessment for Patients in Morier*'¹⁰⁰. Set out in this document is a list describing the circumstances in which a fresh risk assessment would be required. Included among those circumstances are the patient's absence from the ward against medical advice and the development of concerns in connection with the change of the patient's mental state and safety. What the document does not make reference to are fresh assertions by the patient him or herself that they have contemplated or have actually attempted an act of self-harm on the ward. To my mind the list should make pointed reference to that circumstance.

¹⁰⁰ Exhibit C33, Annexure AC9

- 10.8. There are other documents annexed to Dr Champion's affidavit including a document that sets out a number of findings and recommendations based on Ms Michie's death.
- 10.9. It is plain that much positive reflection has occurred within the Noarlunga Hospital as a result of Ms Michie's death. This is to be commended.
- 10.10. There is one matter that nevertheless remains a matter of concern in my opinion and that is the manner in which nursing handovers are conducted. The content of handover notes was deficient in Ms Michie's case. To my mind this Inquest has also demonstrated that progress notes should be read by nursing staff at the beginning of a shift.
- 10.11. The Court recommends that attention be given to the question of the maintenance of handover documentation to ensure that matters of concern are not deleted from that documentation.
- 10.12. The Court further recommends that nursing staff should ensure that they are familiar with recent patient progress notes, particularly those that have been created since their last shift, so that nursing staff are aware of recent events concerning patient safety and in particular events involving self-harm.
- 10.13. I make a further general recommendation that measures are implemented to ensure that important information relevant to a patient's risk is passed from one shift to the next.
- 10.14. I further recommend that those administering the Noarlunga Hospital Morier Ward ensure that junior medical staff are properly supervised and are actively encouraged, both verbally and in writing, to seek advice and assistance from senior medical staff and not to make important clinical decisions autonomously without input from senior medical staff.
- 10.15. I direct these recommendations to the attention of the Chief Executive Officer of the Southern Adelaide Local Health Network.
- 10.16. Finally, the Court acknowledges the remarks made by Mr Timothy Michie who at the conclusion of the evidence addressed the Court on behalf of his family. Timothy Michie is Ms Michie's younger brother. He and members of his family including his

mother and sister were present during the course of the Inquest. Mr Michie poignantly spoke of sister's character and of the deep loss and sense of regret that his family has experienced as a result of her death. Also to be acknowledged is the public apology tendered in Court to Ms Michie's family by Dr MacKenzie. Dr Mackenzie's apology has been generously acknowledged by Mr Timothy Michie and his family.

Key Words: Death in Custody; Psychiatric/Mental Illness; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 29th day of November, 2017.

Deputy State Coroner