CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 30th day of April 2018, the 1st, 2nd, 3rd, 4th and 31st days of May 2018 and the 19th day of July 2018, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Chrystal Jessica Ross.

The said Court finds that Chrystal Jessica Ross aged 24 years, late of 30 Belmont Crescent, Mount Barker, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 22nd day of January 2015 as a result of hypoxic brain injury secondary to hanging. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Chrystal Jessica Ross died on 22 January 2015. She was 24 years of age at the time of her death. She had been found hanging from the shower rail in her bathroom while an inpatient at the Mount Barker Hospital on 19 January 2015. She was transferred to the Royal Adelaide Hospital and remained in the Intensive Care Unit until her death on 22 January 2015. The cause of death was hypoxic brain injury secondary to hanging.

2. Background

2.1. Ms Ross' life and background were the subject of evidence given by her mother, Michelle van Dyk. Ms van Dyk gave evidence that Chrystal was an outgoing and vivacious person. Soon after leaving high school she worked in retail employment and in about 2011 she became a process worker at the Jurlique company near her home. In 2012 Chrystal and her fiancé built their own home and she was enthusiastic about their future, although they were indebted, the house being subject to a mortgage.

2.2. In early 2011 Chrystal suffered a wrist injury at her workplace. As a result she made a Workcover claim and that claim had been ongoing between 2011 and the date of her death. It appears that the claim was accepted at least to some extent and that she had undergone two surgeries and had had other treatment. However, the prolonged period of recovery and rehabilitation had begun to affect her emotionally. There were many aspects of her life that she was unable to enjoy after her injury. For example, she was unable to do housework and could not drive a motor vehicle. Particularly upsetting for her was that she had been a very talented self-taught artist but with the pain and discomfort from her wrist she was no longer able to engage in that activity. She had begun to have panic attacks and felt uncomfortable around other people and was embarrassed to invite others in to her home due to her inability to perform household duties adequately.

2.3. Ms van Dyk said that Chrystal started closing herself off to other people. Over a relatively short period she lost a considerable amount of weight and became, to use Ms van Dyk's words, 'zombie like' in her demeanour. Rather than looking at people she would look at her lap and would not engage.

2.4. On 7 January 2015 Chrystal phoned her mother about her concern about lightning strikes nearby. Chrystal was very distressed and Ms van Dyk took her to see Dr Sargeant who was Chrystal's treating general practitioner. Ms van Dyk had previously discussed with Chrystal the possibility of 'time out' in hospital. She said that Dr Sargeant was 'taken aback' by her (Ms van Dyk's) presence and that he 'visibly flinched'. Ms van Dyk said that during the consultation Dr Sargeant said that he did not specialise in mental health, but obstetrics and made a remark to the effect that it was ironic that Chrystal's wrists were better and now 'it's all in her head'. Ms van Dyk had a very clear recollection of words to this effect having been said. She said that the episode stayed with her as if it were yesterday.

2.5. Ms van Dyk was insistent that Chrystal not be admitted to hospital under a Workcover arrangement. She said that to Dr Sargeant because she had been informed that Workcover involvement would mean that the admission would take longer. Ms van Dyk saw it as an obstacle to treatment. Ms van Dyk said Dr Sargeant contacted the Mount Barker Hospital and arranged for Chrystal to be admitted. She took Chrystal home to pack a suitcase and she and Chrystal informed Kevin, Chrystal's fiancé, of the situation. Kevin then raised his concerns about information that Chrystal had not been

sharing with her mother. Chrystal was begging him not to pass the information on but he did so. He informed Ms van Dyk that Chrystal had been drinking and cutting herself. Ms van Dyk had not previously heard anything about Chrystal cutting herself and was shocked to hear this. Chrystal was ashamed and embarrassed but the three of them agreed that something had to be done.

2.6. Chrystal was duly admitted to the hospital.

2.7. Ms van Dyk was aware that a telepsychiatry assessment took place with Dr Downs, psychiatrist. Chrystal told Ms van Dyk that Dr Downs had told her that she may be bipolar[1] and Chrystal appeared to be relieved to have received a diagnosis. By that stage Chrystal's health seemed to be better in that she was eating and was talking about potentially having a shower and washing her hair. Ms van Dyk thought that Chrystal was thriving with proper care, was more engaging and was happier in the last four days of her life than she had previously been.

3. The evidence of Maureen O'Neill-Ferrie

3.1. Ms O'Neill-Ferrie gave oral evidence at the Inquest. I found Ms O'Neill-Ferrie to be an excellent witness and I had no hesitation in accepting her as a witness of truth. Ms O'Neill-Ferrie was a mental health nurse who was a part of the Adelaide Hills Community Mental Health Team in January 2015. In that capacity she was involved with Chrystal in the early part of her care. Ms O'Neill-Ferrie saw Chrystal on 12 January 2015 following a referral which had arisen as a result of the telepsychiatry assessment that had been carried out by Dr Downs on 9 January 2015. Dr Downs had sought input from the Adelaide Hills Community Mental Health Team. Ms O'Neill-Ferrie saw Chrystal in her room at the hospital and conducted a mental health assessment. Dr Sargeant was initially presented and introduced her to Chrystal. At the time of conducting the mental state examination Ms O'Neill-Ferrie had not seen Dr Downs' report from the telepsychiatry assessment conducted three days previously. As a result of the assessment Ms O'Neill-Ferrie completed a report[2]. She noted that Chrystal was lying on her bed and had poor eye contact initially but that once rapport was established it improved. The conversation involved negative themes throughout. Chrystal's affect was blunted but this was perhaps related to the amount of medication

[1] The evidence shows that this was incorrect. Chrystal may have said this to her mother, but there was no such suggestion by Dr Downs.
[2] Exhibit C17, Appendix A

she was currently taking. There were no perceptual disturbances but Chrystal was describing internal thoughts and images relating to her thoughts of self-harm. Chrystal was oriented in time, person and place and her insight was reasonable. She was aware that she needed to be more truthful when talking with her psychologist in order to address her issues. Ms O'Neill-Ferrie judged that she had achieved superficial rapport with Chrystal and that Chrystal's judgment was intact. Chrystal could not sleep without medication and reported having vivid dreams relating to her thoughts of self-harm. Chrystal reported poor energy levels, poor motivation and poor self-care. She reported poor concentration, no appetite but that her memory was good.

3.2. Ms O'Neill-Ferrie assessed Chrystal's current stressors as being fleeting suicidal ideation on a background of chronic self-harming behaviours and worry that she would not be able to contain these feelings. She had a feeling that her partner would be better off without her and felt guilty that she was unwell. She was stressed at the prospect of dealing with Workcover and had concerns about her desire to start a family.

3.3. Ms O'Neill-Ferrie agreed goals with Chrystal. These were for her to agree to identifying her issues and being honest and upfront with her next psychologist and for her to engage with the Drug and Alcohol Service South Australia to address her drug and alcohol issues. Ms O'Neill-Ferrie decided to await the outcome of the telepsychiatry report and noted that because Chrystal was currently a Workcover client the post-discharge arrangements would not involve the Community Mental Health Team.

3.4. Ms O'Neill-Ferrie said that on 12 January 2015 Chrystal told her that she had not self-harmed in the previous 12 months but she disclosed that she had harmed herself since her admission to the Mount Barker Hospital. She also said that when she was drunk she was 'more suicidal'. She did not report any previous suicide attempt and admitted that she had been smoking cannabis more heavily recently. She had last used cannabis on the day of her admission.

3.5. Ms O'Neill-Ferrie expressed the opinion that Chrystal's status as a Workcover client represented an obstacle to her treatment. She said that the public health system could only cover any 'gaps' in Chrystal's medical needs that were not covered by Workcover. This inevitably involved a need for some resolution between Workcover and the public health system as to what those gaps were, clearly with a need to involve the patient as

well. To my mind it is self-evident that such a system is far from satisfactory. Ms O'Neill-Ferrie said that if Chrystal needed more than Workcover could provide then that was the role of the public health system, but that Workcover was a stressor for her and her case was complicated. Ms O'Neill-Ferrie noted that the Workcover complication is simply a matter of funding - a different stream of funding is applicable for Workcover issues than the stream of funding applicable to ordinary public health patients.

3.6. Ms O'Neill-Ferrie next saw Chrystal the following day, 13 January 2015. On that occasion they went for a walk in the community garden. Chrystal mentioned that her mother worked at the Adelaide Hills Community Health Service and was concerned about the privacy of her medical notes. Ms O'Neill-Ferrie provided her with an appropriate assurance about the confidentiality of Chrystal's medical records. Chrystal told her that she was worried about having a baby, being a good partner and having a career and Ms O'Neill-Ferrie counselled her to focus on the here and now rather than longer term issues. She encouraged Chrystal to write down things she was concerned about and encouraged Chrystal to be truthful with her psychologists in future. Chrystal denied any current thoughts of harm to herself or others and did not display any psychotic phenomena. She agreed with the plan suggested by Ms O'Neill-Ferrie, namely to walk regularly when going for a cigarette, to compose a letter to Workcover and her lawyer seeking extra supports post-discharge, to maintain a healthy dietary intake and to continue her current medication regime. She suggested that she could provide Chrystal with a workbook in relation to her panic attacks and anxiety.

3.7. Ms O'Neill-Ferrie saw Chrystal again the following day, 14 January 2015. On that occasion Chrystal was experiencing a panic attack when Ms O'Neill-Ferrie visited her. Dr Sargeant was also present. It was unclear what had caused the panic attack but Chrystal's fiancé had suffered a minor workplace accident that day and her guilt that she was not there for him may have been the trigger. By this stage Chrystal had been in hospital for a week and had been on regular medication but did not seem to be improving. It was Ms O'Neill-Ferrie's view, and that of Dr Sargeant, that because Chrystal's condition was not improving she required specialist mental health care and it was decided that Chrystal should be referred to Glenside under the Rural and Remote Health Service.

3.8. On that day Ms O'Neill-Ferrie was about to go on leave and that was another factor in her mind. It was her view that after a week in hospital without improvement an admission to a psychiatric unit was warranted. Ms O'Neill-Ferrie made a note in the Mount Barker Hospital notes[3] that although accepting of the plan to go to Glenside Hospital, Chrystal may still possibly change her mind and at that point consideration should be given to detention under the Mental Health Act 2009.

3.9. That same day Ms O'Neill-Ferrie contacted Dr Downs to talk about Chrystal. They exchanged email messages[4] and Ms O'Neill-Ferrie reported to Dr Downs that she had phoned Rural and Remote Health Service and asked for Chrystal to be put on the bed waiting list. Ms O'Neill-Ferrie reported to Dr Downs that there had been little change in her presentation and that she continued to have significant panic attacks and was doing very little apart from lying on the bed. Dr Downs replied:

> 'Yes she is a complex case and although I think we could get her home safely enough given her multiple issues an index admission sounds like a reasonable plan. Feel free to give me a call anytime.'

Ms O'Neill-Ferrie also spoke to Dr Downs on the telephone in the midst of the email exchange because it was her view that she needed to advocate for Chrystal as things were not progressing and Chrystal needed access to a psychiatrist on a ward.

3.10. As indicated in the email Ms O'Neill-Ferrie had contacted the Rural and Remote Health Service, in particular Ms Browne, and forwarded a typed copy of her assessment[5]. Ms O'Neill-Ferrie said that when she went on leave it was her expectation that Chrystal would go to the Rural and Remote ward where she would have daily reviews under a psychiatrist. After that Ms O'Neill-Ferrie assumed that she herself would be involved in Chrystal's follow-up in the community because all discharges from the Rural and Remote Health Service are the subject of mandatory follow-up in the community. She said that because her position would not be backfilled while she was on leave she left a note in the medical records of the hospital[6] suggesting that nursing staff should follow-up with the Rural and Remote Health Service to obtain a bed for Chrystal. She was also aware that Dr Sargeant would review Chrystal on a daily basis.

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[3] Exhibit C11
[4] Exhibit C17a
[5] Exhibit C17, Appendix A
[6] Exhibit C11

3.11. Finally, Ms O'Neill-Ferrie said that although she did not have a specific memory of having done so, she believed that she would have had a handover discussion with a member of her Community Mental Health Team about Chrystal and the fact that she was waiting for a bed. She did not make a note of any such discussion, but as I say I was impressed by her as a witness and I have every reason to believe her evidence on this topic.

4. The evidence of Dr Martin Downs

4.1. Dr Downs has recently completed his final examinations and is awaiting a Fellowship in the specialty of psychiatry in a couple of months. In 2015 he was a fourth year registrar in psychiatry working with Country Health. His main work was telepsychiatry sessions which he performed in a consultation/liaison model.

4.2. He conducted a telepsychiatry consultation with Chrystal on 9 January 2015 in the afternoon. At that time he had a referral which he had received from Dr Sargeant requesting the assessment[7]. The assessment lasted for approximately an hour. Dr Downs said that it consisted of taking a formal history, mental state examination assessment and a management discussion with the referrer afterwards, but that it was essentially a once-off assessment[8]. Dr Downs said that it was very much an initial assessment in which he tried to get a broad understanding of all of the issues. He said that Chrystal presented as very anxious. She was pacing around but this did improve with the development of some rapport. He said he started to break down the different domains of symptoms. He said Chrystal mentioned that over the past three months her mood had become more depressed and more anxious and that she was using a significant amount of alcohol and cannabis. She was worried about her body image and her weight and concerned about the physical aspects of her self-worth[9]. Dr Downs said that ultimately his impression was that Chrystal was suffering from a major depression of a moderate severity and there were complicating differential diagnoses of an eating disorder (possibly) as well as substance misuse[10]. Dr Downs also said that there were underlying borderline personality traits that seemed evident to him '*even at the initial assessment*'[11].

[7] Exhibit C15, page 11
[8] Transcript, page 122
[9] Transcript, page 124
[10] Transcript, page 125
[11] Transcript, page 125

4.3. Dr Downs described that to have an underlying borderline personality trait does not mean that the patient necessarily has the disorder, but that it is an indication that borderline personality disorder structure is playing a significant role in the clinical presentation. He mentioned as indicia of these traits Chrystal's identity confusion, her problems with emotional regulation in her impulsivity, anger in interpersonal relations and a '*really prominent fear of abandonment*'[12]. Importantly Dr Downs said that he did not feel that there was enough to make a diagnosis of borderline personality disorder[13].

4.4. Dr Downs also considered that Chrystal was not at an acute risk of suicide because she was not having active suicidal thoughts and was being quite open about the subject. She also admitted that she had had such thoughts in the past few weeks when she had been feeling overwhelmed and this frankness added to his confidence in what she was telling him[14].

4.5. Dr Downs suggested changes to Chrystal's medication. He was aware that she was already on the antidepressant fluvoxamine at a dose of 50mg daily for a week and he increased that dosage to 100mg per day.

4.6. He continued quetiapine to reduce her anxiety. He said that he thought that she was genuinely in a mild state of alcohol withdrawal and that needed to be treated with benzodiazepine. Dr Downs did not prepare a written report on his consultation with Chrystal until the following Thursday which was 15 January 2015. Confusingly, the report is dated 9 January 2015 which was of course the date of the consultation. To add to the confusion the report also appears in the CBIS notes maintained by the mental health service as having been made on 9 January 2015. Dr Downs said that the report was not only informed by the consultation he had on 9 January 2015, but also by further information that he had received from Ms O'Neill-Ferrie on 14 January 2015, the day before he distributed the report. In particular, paragraphs 5 and 6 of the report were a reflection of the information he had received from Ms O'Neill-Ferrie. They are as follows:

> '5 At the time of writing Maureen O'Neill-Ferrie has also seen Chrystal and recommended a voluntary admission to the Rural and Remote ward at Glenside. If willing to proceed this is a reasonable option as this is an index presentation and there are multiple issues requiring further clarification.

[12] Transcript, page 126
[13] Transcript, page 127
[14] Transcript, page 129

> 6 If Chrystal improves and wishes to be followed up in the community however, I think this is also reasonable with assertive follow-up through the Mount Barker CMHT.'

4.7. In the CBIS notes Dr Downs inserted the following information immediately above the copy of his telepsychiatry report:

> 'I have received further correspondence with an assessment and progress notes from Maureen O'Neill-Ferrie and Chrystal has been placed on the list for a voluntary acute bed as Maureen revealed she has been minimising her substance use, she has self-harmed on the ward over the weekend and anxiety levels excalating (sic). Please see her report. I am happy to be contacted to discuss … thanks.'

4.8. Returning to the telepsychiatry assessment on 9 January 2015 I note that Dr Downs, at the completion of the session, spoke with Dr Sargeant for five to seven minutes about the case[15]. He said that they discussed overall impressions and the management plan. He said that at that time his view collectively with Dr Sargeant was that they were anticipating that by the middle of the following week there would be significant improvement and they were contemplating how Chrystal might be managed after her discharge and how she would access psychology services. Dr Downs was aware of the fact that she was on Workcover and that Workcover had refused to pay for further psychology sessions. It was Dr Downs' thought that this could be overcome by the preparation of a mental health care plan by Dr Sargeant for a private referral to a psychologist which would then be covered by Medicare[16].

4.9. Dr Downs said that his next involvement after 9 January 2015 was on Wednesday the following week, 14 January 2015 when Ms O'Neill-Ferrie rang him and emailed him about Chrystal. He said that she reported that Chrystal was not improving and that there had been some deliberate self-harm on the ward which was a new factor as far as Dr Downs was concerned. Chrystal was not really engaging in a lot of suggestions that were being made and Ms O'Neill-Ferrie was worried about her. The result of that discussion was that Dr Downs agreed with Ms O'Neill-Ferrie that Chrystal should be put on the bed list to come to Rural and Remote at Glenside[17]. Dr Downs said that it was against this background that he wrote the passages I have quoted above in his report. He emphasised that his intention when he wrote about the possibility of Chrystal not being admitted to the Rural and Remote ward, but followed up in the community, was that the two conditions mentioned in point 6, namely 'improves' and 'wishes'

[15] Transcript, page 137
[16] Transcript, page 137
[17] Transcript, page 133

needed to be fulfilled. He emphasised that discharge into the community would not happen in his mind unless there was a clinical improvement. If, after proper participation in discussions about treatment preferences and an opportunity to weigh up her options, Chrystal really did not want to go to Glenside, then it was his intention to leave open the option that things could be put in place to manage her in the community[18].

4.10. Dr Downs also said that from the information he had received from Ms O'Neill-Ferrie on 14 January 2015 it was not his view that risk alone was the main indication for an admission for Chrystal. He said that it was because things were not getting better and she was a complicated case. Those factors were valid reasons for admission[19].

4.11. Dr Downs said that he did not ever suggest to Chrystal that she might have been suffering from bipolar disorder[20]. Dr Downs also said that one could not diagnose borderline personality disorder for a condition that was not better explained by another mental illness such as major depression, substance misuse, psychosis and the like[21]. He added that when placed under enough stress, '*we all have borderline personality disorder*'[22] so one has to be very cautious in diagnosing it '*because we all do what we can to cope in certain situations*'[23].

4.12. Dr Downs had a further involvement with Chrystal's case on 16 January 2015 when he had a conversation with Vanessa Browne who was the transfer of care coordinator, or bed coordinator, for the Glenside Campus. He explained that it was Ms Browne's role to manage the priority list for beds throughout the service and to work out where each patient fits in a triaging process of prioritisation. Accordingly it was necessary for her to gain information as to how much a patient needed to have a bed and how acute their condition was[24]. Dr Downs said that he spoke with Ms Browne and made it quite clear that he had not had any further contact with Chrystal in the week since his consultation on 9 January 2015. He then summarised the issues in the case and said that he thought it was complex. He said that an admission would certainly be reasonable and he explicitly remembered stating that there would be plenty of work to do on the ward. He

[18] Transcript, page 134
[19] Transcript, page 143
[20] Transcript, page 138 - See also footnote 1
[21] Transcript, page 162
[22] Transcript, page 163
[23] Transcript, page 163
[24] Transcript, page 144

said that he had spoken to Ms O'Neill-Ferrie who was concerned about Chrystal's self-harming and that she was not getting better. He also repeated that he did not have further information and emphasised that if there was going to be any change in management there needed to be a reassessment for Chrystal. He repeated in his evidence that he stressed again at the end of the conversation with Ms Browne '*very clearly … if there's going to be any change, as in not being admitted, that needs to be discussed with Chrystal and there needs to be a reassessment of where she's at*'[25] because Dr Downs himself had not had any further first-hand information. After his conversation with Ms Browne he was of the understanding that Chrystal would stay on the bed list for a reassessment.

4.13. Dr Downs was asked about Ms Browne's note of that conversation which appears in the Rural and Remote Mental Health Service notes[26]. I set out that note in full:

> 'Call to Dr Downs and left message.
>
> 1520: Call back from Dr Downs. Pathways[27] spoke with him about this client and the need for a bed in R&R IPU[28].
>
> Dr Downs advised that client would benefit from community follow-up with psychology and psychiatry input.
>
> Advised that she is currently on the R&R IPU list.
>
> He stated that she most likely does not need such an admission. That she would require assurance from the CMHT that she will be followed up.
>
> 1530: Call to CMHT to speak to them about client not requiring an R&R IPU admission.
>
> Her keyworker Maureen has gone on leave and the T/L[29] was on a home visit. Spoke with the duty worker[30].
>
> Advised of Dr Downs' advice regarding community follow-up.
>
> Duty worker agrees that client may not require an admission to the R&R IPU. That she has logged in the duty log that client needs to be reassessed on Monday as to need for bed. Will let pathways know.
>
> Pathways advised that Dr Downs is happy to discuss management of client in the community.'

4.14. Dr Downs was asked about this note. As to the passage reporting that he had said Chrystal would benefit from community follow-up with psychology and psychiatry

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[25] Transcript, page 145
[26] Exhibit C15, page 3
[27] 'Pathways' is another expression for the role of bed coordinator in the jargon employed by the service
[28] Rural and Remote's inpatient unit
[29] Team Leader
[30] From other evidence it was established that the duty worker to whom she spoke was Anne Dunn who also gave evidence

input Dr Downs said that he also said with the '*exact same emphasis*' that she would also benefit from an admission to the ward[31]. Dr Downs said that he certainly did not say 'most likely does not need such an admission'[32]. Dr Downs wondered whether Ms Browne might have misconstrued his comments about the impressions he had formed on 9 January 2015 when he initially saw Chrystal because it was at that point only that he did not think she would necessarily need an admission to Glenside. He did make it clear that this would be misconstruing what he actually said in the conversation however[33]. Dr Downs suggested that Ms Browne certainly did get his message that there could be no changes in plan without having a reassessment because Ms Browne's note reflected the need for a reassessment on Monday 'as to need for bed'. Dr Downs' intention had been that Chrystal could not *not* be on the list without being reassessed which he described as '*the fundamental point*'[34].

4.15. At this point it is necessary to interpolate that the note I have quoted above of Ms Browne contains a note not only of her conversation with Dr Downs but also with her subsequent conversation at 1530 hours with the Community Mental Health Team at Mount Barker. The evidence in the case shows, and it is apparent from the note, that Ms Browne first attempted to speak with Ms O'Neill-Ferrie, but learnt that she was on leave. She then asked for the Team Leader and was told that person was on a home visit. She spoke with the duty worker who turned out to be Anne Dunn. Anne Dunn also gave evidence at the Inquest along with Vanessa Browne.

4.16. Anne Dunn's record of the conversation with Ms Browne was written in handwriting on a duty log maintained by the Community Mental Health Team. A notation for 16 January 2015 for Chrystal records that Ms Browne made contact in the following terms:

> 'Dr M Downes (sic) who reviewed Chrystal via Telemed is of the opinion that R&R admission not required. For comm follow-up only preferably psychology. He has spoken to Dr Sargeant and recommended same. Advised for MSE before D/C from Mt B Hosp possibly Monday 20/1/15.'

There is a note under the heading 'outcome' as follows:

> 'MSE R/V on Monday 20/1/15.'

[31] Transcript, page 147
[32] Transcript, page 147
[33] Transcript, page 147
[34] Transcript, page 147

The following Monday was in fact 19 January 2015 and not 20 January 2015 and it is necessary to read the note in that light. Dr Downs was asked if he thought that Ms Dunn's note was an accurate description of the position after he had spoken to Ms Browne and he responded that it was a '*gross misrepresentation*'[35]. He denied that he had spoken to Dr Sargeant and '*recommended the same*', pointing out that he had not spoken to Dr Sargeant at all since 9 January 2015. He said that he did not suggest to Ms Browne that he had spoken to Dr Sargeant at all[36]. Dr Downs also noted the reference 'advised for MSE before discharge' and he said that he assumed that this was a reference to his insistence that she needed to be reassessed before a change in plan was made. He said that an MSE is '*shorthand for a very brief kind of review*' as '*opposed to a reassessment*'[37]. He also said that the note implies that regardless of the outcome of the MSE Chrystal would be discharged and he said that that was a gross misrepresentation of the original conversation[38]. Dr Downs said that a mental state examination is merely part of an assessment, but that an assessment also takes into account recent clinical data and the patient's history.

4.17. Dr Downs said that since January 2015 there has been a change in the process for removing a patient from the bed list. He said there is now a '*more formalised process*' under which if someone is on the bed list any decision for removal has to be made by the assessing psychiatrist, the duty consultant or the clinical director.

4.18. Finally Dr Downs said that the borderline personality disorder traits that were evident in Chrystal meant that it was important for there to be continuity of care in the form of therapeutic alliance '*to prevent feelings of - to prevent the repetition of severance and perceived abandonment and particularly to be reassured that a discharge isn't an end of care, it's not an abandonment experience*'[39]. He said that her borderline personality disorder traits made it important in his view that there be proper community follow-up for Chrystal. However, it is obvious from that passage of evidence that he would have wished any discussion about discharge to be handled in a very careful and sensitive manner. He was asked whether the fact that discharge was raised with Chrystal on 19 January 2015 could have brought the abandonment aspects of her personality to the

[35] Transcript, page 149
[36] Transcript, pages 149-150
[37] Transcript, page 150
[38] Transcript, page 150
[39] Transcript, page 189

forefront and he agreed that was possible. He also agreed that it may have been a contributing factor in her decision to take her own life[40].

4.19. Dr Downs was asked about his expectations of the Community Mental Health Team. He said it was his expectation that they would review Chrystal on the ward in a similar manner to the way Ms O'Neill-Ferrie has been carrying out that function. He thought that someone would continue the role that she had been carrying out for the three days she had been seeing Chrystal as an inpatient[41]. He had by the time of giving evidence become aware that that did not happen and he agreed with the proposition that this was not an adequate service:

> 'No, I agree because as I understand Maureen's role is the clinical practice consultant so she'd take the lead with people who are in-patients and ... assessments.' [42]

It is sufficient for present purposes for me to observe that Dr Downs' impressions of what the Community Mental Health Team could or were prepared to provide by way of a service were a far cry from the reality on the ground as revealed by the evidence in this Inquest.

5. The evidence of Anne Dunn and Vanessa Browne

5.1. Anne Dunn

Ms Dunn was a mental health nurse working with the Community Mental Health Team in January 2015. At the time of giving evidence she was retired. Ms Dunn was able to identify the notes that she made on the duty log to which I have already referred. She was asked about them when interviewed by police in September 2015 when she said that she could not recall any further about the conversation than what appeared in the notes. She said that the notes that she made would have been based on what Ms Browne told her over the phone[43]. When giving her evidence her memory was no better[44]. She did say that as at 16 January 2015 she did not have any understanding of what involvement, if any, Dr Downs had had with Chrystal nor did she have access to any case notes or other patient records relating to Chrystal[45]. She also denied any knowledge of what involvement if any Dr Sargeant had had with Chrystal[46]. She said

[40] Transcript, page 190
[41] Transcript, page 204
[42] Transcript, page 205
[43] Exhibit C19
[44] Transcript, page 213
[45] Transcript, page 218
[46] Transcript, page 219

that by making the note in the duty log that Chrystal should have a mental state examination on the following Monday, she expected the note would be reviewed on the Monday morning at a meeting of the mental health team. At that meeting the task would be allocated to one of the workers at the meeting[47]. She denied that it was her responsibility to book the mental health state examination review herself[48]. She was not at work on 19 January 2015[49].

5.2. Ms Dunn was asked about the general practices of the Community Mental Health Team. She was asked about the duties of the duty worker in the Community Mental Health Team and whether they would have involvement with inpatients at the Mount Barker Hospital next door if requested. Her response was that they would not generally do so. She said that if someone from the hospital wanted to request the Community Mental Health Team to come over to review a patient they would most likely speak to the duty worker. She was asked whether she agreed that in such a situation the hospital's request should be met and responded:

> 'Well it depends on priorities. There's actually a telephone service that country facilities can use to call to get information, get support from a duty psychiatrist in Glenside.' [50]

She noted that the team did have a specified liaison person who could go to the hospital to support them. This was a reference to the role Ms O'Neill-Ferrie was playing at the relevant time. However it appeared to be Ms Dunn's position that in the absence of Ms O'Neill-Ferrie no other member of the team had any role in assisting with hospital inpatients[51]. Even in the situation where the inpatient was awaiting a Rural and Remote bed, as was the case with Chrystal, Ms Dunn was not prepared to concede that the Community Mental Health Team would have any oversight of the patient:

> 'Not necessarily because the mental health team isn't part of the hospital services.' [52]

5.3. Exhibit C20 consisted of some records maintained by the Community Mental Health Team in the form of minutes of morning meetings and a separate weekly meeting. These were the subject of some questioning of Ms Dunn. She could not explain why the morning minute of 15 January 2015 contained no record of anyone having discussed

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[47] Transcript, page 219
[48] Transcript, page 219
[49] Transcript, page 220
[50] This is a reference to another service apart from the Community Mental Health Team. In essence this answer was to the effect that it was not the Community Mental Health Team's sole responsibility to assist if it had any responsibility at all.
[51] Transcript, page 232
[52] Transcript, page 234

the fact that Chrystal had been placed on the R&R bed list the previous afternoon[53]. She also could not explain why there was no mention of Chrystal's case the next morning, 16 January 2015[54].

5.4. She said that she would have expected the morning meeting for the following Monday, 19 January 2015 to contain some reflection of the action required to follow-up on the mental state examination that she had noted in the duty log. She could not explain why there was no mention of Chrystal in the minutes for the morning of Monday 19 January 2015 despite her earlier evidence that she expected the task would be allocated at the team meeting on the Monday morning. She said she would have expected it to be allocated to someone but suggested that the hospital staff should be able to do the mental state examination themselves and:

> '… depending on the availability of mental health, if there was no-one in the hospital staff that was able to do that someone from the mental health team would be allocated to go over.' [55]

She said that the priority would be for hospital staff to perform a mental state examination, not the mental health team[56]. She said that this was because the mental health team is not part of the hospital staff and that '*realistically we are not clinically involved with the care of patients in the hospital*'[57].

5.5. Ms Dunn was then asked about a note that appears in the Mount Barker Hospital records for Chrystal[58] that records that at 12:20pm on 16 January 2015[59]"

> 'I rang MH team next door who said that she was on waiting list for Rural & Remote MH and that they were too busy to come over and review her.'

This note followed some observations of the hospital staff that Chrystal was particularly distressed and that Chrystal had been placed on 15 minute visual observations for that reason. Ms Dunn was asked about that note. She said she did not recall having the conversation. She did not accept that it was most likely to have been her even though she was the duty worker on that day[60]. She said that being duty worker did not mean that she took all of the phone calls. Another mental health worker may have taken the

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[53] Transcript, page 238
[54] Transcript, page 239
[55] Transcript, page 240
[56] Transcript, page 241
[57] Transcript, page 241
[58] Exhibit C11, page 29
[59] When Ms Dunn was at work and was the duty worker
[60] Transcript, page 247

call. She was asked whether in light of the history of the matter the decision not to accede to the request for assistance by the nursing staff was an error and she replied:

> 'No because that's a definite statement. I don't know what the other workload was on that particular day on the mental health team.' [61]

5.6. Ms Dunn's position in relation to her conversation with Ms Browne was that although she had no independent memory of the call, it was her belief that she was simply agreeing with what Ms Browne was saying as to a '*clinical decision that was made between her and the psychiatrist*'[62].

5.7. It was pointed out to Ms Dunn that although her handwritten note talked about discharge from Mount Barker Hospital possibly on the Monday, the typed note made by Ms Browne in CBIS said nothing about discharge. Despite this Ms Dunn said that she interpreted her own note to be an indication that Ms Browne had told her the information about a potential discharge on the Monday and the need for a mental state examination before that happened[63]. However, Ms Dunn did concede that it was possible that she misinterpreted what Ms Browne was talking about[64].

5.8. In short, Ms Dunn was at pains during her evidence to minimise the role of the Community Mental Health Team and in particular she minimised her role in the telephone conversation with Ms Browne which she described as being administrative and not clinical[65]. I found this curious because she no longer works in the health service and she had no recollection of the events beyond what she had noted in the duty log[66].

5.9. <u>Vanessa Browne</u>

Ms Browne said in an affidavit that she was unable to elaborate on the content of her conversations with Dr Downs and Ms Dunn as reflected in the CBIS entries made by her on 16 January 2015[67]. She said that although she could not remember anything beyond that note, she could say that she did not remove Chrystal's name from the waiting list. She also observed that she did not make a note in CBIS that Dr Downs

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[61] Transcript, page 248
[62] Transcript, page 256 - the reference to 'the psychiatrist' is Dr Downs
[63] Transcript, pages 261-262
[64] Transcript, page 269
[65] Transcript, page 282
[66] Exhibit C17
[67] Exhibit C22, Annexure VAB1

told her he had spoken to Dr Sargeant and she had no recollection of having heard Dr Downs say any such thing[68].

5.10. At the time of giving her evidence Ms Browne had no better recollection than she did when making that affidavit[69]. Ms Browne gave evidence that on Fridays such as 16 January 2015 it was her role to ring the various community mental health teams associated with whoever was on the waitlist to establish the status of those patients so that she could provide information for those on duty over the weekend if a bed became available[70]. Ms Browne was asked whether her note (attributed to Dr Downs) that Chrystal 'most likely does not need such an admission' were the words used by Dr Downs and she said they were[71]. Given that Ms Browne claimed to have no recollection of the events and she was merely relying on the notes she had made, I prefer the evidence of Dr Downs because he was much clearer in his recollection of the events surrounding Chrystal's death. Ms Browne had no recollection of what she told Ms Dunn about what she had been told by Dr Downs[72]. She agreed that Ms Dunn may have simply agreed with whatever she, Ms Browne, was saying[73] but was clearer that she would have told Ms Dunn that Chrystal needed to be reassessed on the Monday '*as to need for bed*' because she had made a note to that effect[74].

5.11. <u>Conclusion regarding the role of Ms Dunn and Ms Browne</u>

It is clear from her note in CBIS[75] that Ms Browne had formed the view that Dr Downs was telling her that Chrystal '*most likely does not need such an admission*'. At 1530 hours this is affirmed in her call to the Community Mental Health Team to Chrystal 'not requiring an R&R IPU admission'. In my opinion she misinterpreted what Dr Downs said to her. She conveyed to Ms Dunn that Chrystal did not require a Rural and Remote inpatient unit admission. In doing so she misinterpreted the conversation with Dr Downs for reasons that I am unable to divine. Dr Downs presented as a careful witness who would not have dealt with this conversation in a cursory manner. I accept his evidence as to what he told Ms Browne. It is possible that Ms Browne was not

[68] Exhibit C22, paragraph 27
[69] Transcript, page 291
[70] Transcript, page 296
[71] Transcript, page 301
[72] Transcript, page 303
[73] Transcript, page 303
[74] Transcript, page 303
[75] Exhibit C22, Annexure VAB1

paying sufficient attention to all that Dr Downs was saying or for some other reason she misinterpreted his meaning. One way or another the communication miscarried.

5.12. When Ms Dunn received a telephone call from Ms Browne, Ms Dunn made a further error in that she, for reasons I am unable to explain, arrived at the conclusion that she was being told that Chrystal not only no longer needed a Rural and Remote admission bed, but that she could possibly be discharged from hospital the following Monday albeit following a mental state examination. This is a complete distortion of what Ms Browne recorded in CBIS and I prefer Ms Browne's version of the conversation as relayed by her to Ms Dunn. Furthermore, Ms Dunn inexplicably noted that Ms Browne told her that Dr Downs had had a confirmatory conversation with Dr Sargeant. How she managed to derive that impression is anyone's guess. I am unable to arrive at any conclusion beyond speculating that she imagined something to that effect. She may have confused what she was being told with information she was receiving about Dr Sargeant in some other connection, perhaps in relation to another patient, but I do not know and the evidence throws no light on the issue. I accept Ms Browne's evidence in preference to that of Ms Dunn's however, and I find that Ms Browne did not say anything about Dr Sargeant. The CBIS notes made by Ms Browne do not record any such advice and the very cursory note made by Ms Dunn in the duty log does not give me any confidence that she accurately recorded what was told to her by Ms Browne, and in particular the information that Chrystal could possibly be discharged on the following Monday.

5.13. In the event, Chrystal was not taken off the Rural and Remote bed list by Ms Browne on the Friday. Chrystal would be the subject of yet further errors made by the Community Mental Health Team the following Monday morning.

6. Peter York

6.1. Peter York is a registered psychiatric nurse who works at the Adelaide Hills Community Mental Health Service, Mount Barker. He is part of the Community Mental Health Team and has been in that team for 7½ years. He qualified in 1982 and so has a very considerable fund of experience in mental health.

6.2. It was Mr York and Mr York alone who conveyed to Chrystal the information that she was going to be discharged from hospital. The evidence shows that following a five minute visit by Mr York to Chrystal's room sometime after 2pm on Monday 19 January

2015 Chrystal was found to be extremely upset by the next person to see her, Ms Byrne. Within approximately half an hour she had harmed herself by placing the ligature around her neck.

6.3. Mr York's first record of his interaction with Chrystal that morning was made after he had heard that she had harmed herself. It takes the form of a typewritten nursing note which he intended to be placed in the Mount Barker Hospital notes and in the Community Mental Health Team notes. The note deals with two events connected with Chrystal that he participated in that day. The first was a telephone call he received in the morning from the bed coordinator at the Rural and Remote Health Service at Glenside to advise that a bed was available for Chrystal. It was Mr York who effectively cancelled that bed by declining it on the basis of the information he had seen in the duty log that had been written the previous Friday by Ms Dunn and also on the basis of the entry of Ms Browne in CBIS on the Friday. The second intervention was when he took it upon himself to attend the hospital and inform Chrystal that she would be discharged the following day. I set out below the note that he made:

> '19/01/15 This morning a call was received from the bed coordinator at ETLS advising that a bed was available for Chrystal Ross, currently inpatient of Mount Barker Hospital. I advised that a call had been received from Dr Martin Downs on Friday the 16th of January advising that Chrystal 'most likely does not need an admission to R&R' and that 'the client would benefit from community follow up with Psychology and Psychiatry input'.
>
> This information was documented on CBIS and in the duty log.
>
> In discussion with the bed co-ordinator, I suggested that this information superseded the tele-psychiatry report dated 9/1/2015, which initially led to Chrystal being placed on the bed wait list for R&R.
>
> Dr Downs advised that on the Friday 16th of January, he had telephoned the GP involved, Dr Peter Sargeant, and had informed him of his decision not to admit Chrystal to R&R.
>
> Thus Chrystal was not offered a bed in R&R today.
>
> This afternoon I took the CBIS entry dated 16/1/2015 to the hospital, where I showed it to Dr Sargeant.
>
> He had just spoken with Chrystal, who had not been able to promise him that if discharged she would not harm herself.
>
> Chrystal is still subject to a Workcover claim, which she confirmed with me was the case, shortly after I spoke with Dr Sargeant.
>
> There was a plan to discharge her tomorrow 20/1/2015, with her GP increasing her dose of anti-depressant.
>
> I offered to speak with Chrystal about the plan.

> I introduced myself and advised Chrystal of the plan for her to be discharged tomorrow. I discussed the formation of a Crisis Management plan with her, emphasising the need for her to contact either ETLS or her GP should she feel like harming herself.
>
> I asked whether she had any current plans to self-harm.
>
> She had none, however, she told me that her body belonged to her and that she could do whatever she wanted to it.
>
> I offered her a brief intervention from the CMHT, via the telephone, of DBT Lite.
>
> I offered to bring clinician Cathy Hennessy to meet with her this afternoon, Cathy being in an in-service lecture at the time. Cathy is the author of the DBT Lite program.
>
> Chrystal agreed to this meeting.
>
> I returned to the CMHT shortly after to print off a copy of the DBT Lite booklet and information on Borderline Personality Disorder for Chrystal.
>
> I did not write immediately in her hospital case notes as Dr Sargeant was still using the notes.
>
> Whilst back in the CMHT I received a call from the duty nurse asking me why Chrystal had not been offered a bed in R&R.
>
> A short discussion ensued on why and some information about BPD was given by me.
>
> Cathy Hennessy returned from the in-service lecture around 3:15pm.
>
> As I was briefing her I received another phone call from the hospital duty nurse informing me that Chrystal had been found in her room with a cord around her neck and that CPR was in process.
>
> The duty nurse then asked me again why she had not been sent to R&R.' [76]

6.4. Mr York was the duty worker in the Community Mental Health Team on 19 January 2015[77]. He was asked about whether it was his role as duty worker to allocate Chrystal's mental health examination that had been noted to be done that Monday by Ms Dunn the previous Friday. He said that that was not the role of the duty worker, but that it would be a team discussion at the morning meeting[78].

6.5. Mr York confirmed that he was aware of Chrystal from the morning meeting of the team the previous Thursday 15 January 2015. From that he was aware that she was on the waiting list for a Rural and Remote bed and that she had suffered from anxiety and panic attacks, '*and had a borderline personality disorder*'[79].

6.6. I note that the duty log contains an entry on 14 January 2015 for Chrystal that was made by Ms O'Neill-Ferrie. That entry contains under the heading 'presenting problem' the

[76] Exhibit C13, page 20
[77] Transcript, page 347
[78] Transcript, page 348
[79] Transcript, page 361

words ‘anxiety, panic attacks, BPD' and furthermore the information that ‘on waiting list for R&R - currently in Mount Barker Hospital’. This would have been the information reviewed by the Community Mental Health Team the following morning, 15 January 2015 and from which Mr York got his understanding of Chrystal’s general situation.

6.7. Mr York gave evidence of the conversation he had with the bed coordinator on the morning of 19 January 2015. The duty bed coordinator that morning was a person called Louise McNamara. Mr York said that he received a call from Ms McNamara to advise of the availability of a bed at Glenside. He said that he told Ms McNamara that he had read through the duty log and that there appeared to have been a change of plan and that ‘*most likely Chrystal doesn’t need an admission*’[80]. Mr York said that during this telephone conversation the information that he had available with respect to Chrystal was the information on the duty log and the CBIS entries made by Ms Browne the previous Friday[81]. Mr York said that he told Ms McNamara that it appeared from these records that Dr Downs had decided that Chrystal did not need a bed and that she did not require Rural and Remote inpatient unit admission[82]. Mr York denied that he told Ms McNamara that Dr Downs had personally spoken to Ms Dunn the preceding Friday[83]. He did not recall saying to Ms McNamara that the reconsideration followed the telepsychiatry session on 9 January 2015 either[84].

6.8. Mr York said that after that telephone conversation he resumed his duties which included a home visit lasting for an hour followed by a lengthy phone call from a general practitioner. He then had lunch and following that went on a second home visit. He said that at approximately 2pm he went over to the Mount Barker Hospital and his purpose was to take over a printout of the CBIS entry dated 16 January 2015 so that Dr Sargeant could read it[85]. Mr York confirmed that at the time he took the CBIS entry over to Mount Barker Hospital it included the note that Ms McNamara had made following Mr York’s conversation with her earlier that morning. He conceded that the note made by Ms McNamara was inaccurate in that it stated that Mr York had informed her that Dr Downs had indeed spoken to Ms Dunn the preceding Friday and that he had

[80] Transcript, page 371
[81] Transcript, page 371
[82] Transcript, page 372
[83] Transcript, pages 374-375
[84] Transcript, page 376
[85] Transcript, page 380

reconsidered his decision following the telepsychiatry session on 9 January 2015, both things that Mr York knew to be false. It would appear that he did not read what Ms McNamara had noted because he did nothing to rectify that inaccuracy.

6.9. When Mr York arrived at the hospital Dr Sargeant was in the nurses' station. Mr York asked him if he had spoken to Chrystal and Dr Sargeant said that he had. Mr York then asked Dr Sargeant 'is Chrystal going home today' and Dr Sargeant said 'no, probably tomorrow' and then Mr York offered to go and talk to her about what the Community Mental Health Team could offer when she was out of hospital[86]. Mr York did not tell Dr Sargeant about his conversation with Ms McNamara earlier in the day including the information that Ms McNamara had offered a bed in Rural and Remote that morning which Mr York himself had declined.

6.10. Mr York agreed that he had never met Chrystal before that afternoon. When he went to her room he said that he introduced himself to her and advised that he worked in the Community Mental Health Team. He informed her that she would probably be discharged the following day and that the Community Mental Health Team could offer her some help to write a crisis plan. At that point he asked her if she had any thoughts of harming herself and she replied that '*it was her body and she'd do what she liked with it*'[87]. Mr York then informed her about a program called Dialectical Behaviour Therapy and offered to arrange a meeting with the author of that program to which Chrystal agreed[88]. Mr York said that he did not undertake a mental state examination during his time with Chrystal because he assumed that that had been done by Dr Sargeant[89].

6.11. Mr York said that when he talked to Chrystal she was looking at her phone and she seemed '*irritable but not upset*'[90]. He said that he thought she was irritable because of her remark that it was her body and she would do with it what she liked[91]. His exchange with Chrystal did not cause him to think there was a need to revisit the question about whether a further mental state examination needed to be done[92]. Mr York said that after his meeting with Chrystal he walked past the nurses' station. He said that he thought

[86] Transcript, page 381
[87] Transcript, page 382
[88] Transcript, page 382
[89] Transcript, page 382
[90] Transcript, page 382
[91] Transcript, page 383
[92] Transcript, page 383

about writing a note of his discussion with Chrystal in her notes at that point but the nurses' station was full and he also noticed that Dr Sargeant was in the nurses' station writing notes which he thought might have been on Chrystal's file. Because it was busy he decided to attend to the notes later on and he returned to the Community Mental Health Team office at that point[93].

6.12. Mr York then received a telephone call from Ms Byrne who was a nurse at the hospital. According to Mr York she asked him about Chrystal and the subject of borderline personality disorder. She also asked him why Chrystal had not been offered a bed in the Rural and Remote section[94].

6.13. Under cross-examination Mr York admitted that it struck him as odd on the Monday morning that the bed coordinator was ringing to offer a bed to Chrystal when on Friday the person acting as bed coordinator on that day had contacted the team to say that she did not need a bed. Mr York agreed that it did strike him as odd, however he did not pursue it[95].

6.14. Mr York also acknowledged under cross-examination that when he spoke to Ms McNamara on the Monday morning his belief was that Chrystal had been on the bed list since 9 January 2015 when Dr Downs first saw her, when the reality was that she was not put on the bed list until after Ms O'Neill-Ferrie expressed concerns that Chrystal was not improving on 14 January 2015. This placed the matter in a different light because the plan to place her on the bed list was much more recent than he actually thought and, furthermore, represented an escalation of her treatment[96].

6.15. In cross-examination Mr York was asked whether he told Ms Byrne when she rang to enquire why Chrystal was not receiving a bed at Glenside whether he said words to the effect that '*these girls need to start taking responsibility for their actions*' and he denied having said that[97]. He also denied saying to Ms Byrne anything about Chrystal having to sign a 'contract' to say she would not harm herself, nor about teaching such patients to take responsibility for themselves[98]. He did acknowledge that he made a reference to a practice he understood existed in New Zealand where borderline personality

[93] Transcript, page 353
[94] Transcript, page 384
[95] Transcript, page 407
[96] Transcript, pages 411-412
[97] Transcript, page 453
[98] Transcript, page 455

patients get four 'passes' a year where they can admit themselves to an Emergency Department[99]. He denied saying that the longer these types of people are in hospital the worse they get[100].

6.16. Mr York admitted that it was not appropriate in hindsight to have refused the bed on 19 January 2015[101]. He acknowledged that there was nothing in his conversation with Dr Sargeant that led him to think that Dr Sargeant had broached the subject of discharge the next day with Chrystal[102].

6.17. Mr York acknowledged that it is not good practice for a person such as Chrystal with a potential diagnosis exhibiting borderline personality traits to be approached by a person who is a stranger to them to be told for the first time about her imminent discharge the next day[103].

6.18. Mr York admitted in hindsight that he should have been concerned about Chrystal's safety:

1) Because he knew she had recently spoken to Dr Sargeant and told him she could not promise that if discharged she would not harm herself, and

2) Because she told Mr York shortly afterwards that her body belonged to her and she could do whatever she wanted with it[104].

6.19. Mr York was asked how he satisfied himself that there had in fact been a diagnosis of borderline personality disorder in Chrystal. His explanation was that he had seen it in the duty log. He was operating on the assumption that Dr Downs had given her that definitive diagnosis, although he did not read Dr Downs' report[105]. He was asked whether he regarded it as unusual that Dr Downs might have arrived at such a diagnosis as swiftly as he must have done given the relatively short period of admission and he said that he did not[106]. Later in his evidence he revised those opinions. He agreed that in the context of a person such as Chrystal who was still under the effects of withdrawing from alcohol and illicit drugs, a diagnosis of borderline personality

[99] Transcript, page 455
[100] Transcript, page 456
[101] Transcript, page 465
[102] Transcript, page 466
[103] Transcript, page 467
[104] Transcript, page 474
[105] Transcript, page 475
[106] Transcript, pages 475-476

disorder was not a safe conclusion[107]. He conceded that his earlier evidence on the subject was wrong[108]. He also agreed that borderline personality disorder is a condition that should be reached after excluding other possible causes[109].

6.20. I find that Mr York wrongly assumed that Chrystal's diagnosis was that of borderline personality disorder without properly reading her case notes. Instead he arrived at that conclusion based on a hurried note in the duty log. An experienced mental health nurse such as Mr York should have appreciated that it was very improbable that a diagnosis such as that could have been reached in the circumstances that were applicable to Chrystal's admission. In my opinion Mr York's conclusion that Chrystal had borderline personality disorder coloured his treatment of her. At that point he was bent on securing her removal from the hospital and he was fortified in that conclusion by his reading of the duty log for Friday that the Rural and Remote admission was not required and that she could be treated in the community. He then took it upon himself to go over to the hospital and to ensure that Chrystal was discharged. His first words to Dr Sargeant were to enquire whether Chrystal was going to be discharged that day (the Monday). Dr Sargeant replied that she would probably be discharged the following day. It was then that Mr York took it upon himself to inform Chrystal that it was now a certainty that she would be discharged.

6.21. Having considered Mr York's evidence I note that the first time that he actively involved himself with Chrystal as a patient was when he decided to make arrangements for her discharge. He did not attend the Mount Barker Hospital to do a mental state examination. It was his evidence that that was the task of someone else such as Dr Sargeant. It would only have been if Dr Sargeant did not do it that he would have considered undertaking the task himself if he had had the time. When he saw Dr Sargeant and Dr Sargeant said that he had just seen Chrystal, that was enough for Mr York to reach the convenient assumption that Dr Sargeant had performed the required mental state examination without making any further enquiry. In the course of his evidence it was a theme that many things regarding Chrystal were the responsibility of someone other than Mr York or the Community Mental Health Team. He was at pains to point out that she was Dr Sargeant's patient; that she was in a public hospital bed, with the implication that she was therefore the responsibility of the staff

[107] Transcript, page 496
[108] Transcript, page 496
[109] Transcript, page 496

of the public hospital; that the Community Mental Health Team is only a community health service. Yet against this background on the Monday morning he chose to involve himself actively in Chrystal's case in order to tell her that she would be discharged the following day. Given Chrystal's fear of abandonment that was news that would have been very distressing to Chrystal[110].

6.22. If Mr York had not intervened that day, Chrystal would have remained in the hospital and would most likely not have harmed herself. She may well have been reassessed the following day with the possibility that she may have been admitted to Glenside or some other constructive solution may have been found. At the very least Mr York should have been alert to the possibility that Chrystal might harm herself given her statement that it was her body and she would do with it as she wished. Mr York chose to put this down to what he regarded as Chrystal's irritability and preoccupation with her phone. I find that Mr York approached Chrystal with a label of borderline personality disorder and he was so intent on getting her out of the hospital that he failed to have regard to proper principles of care.

7. Catherine Byrne

7.1. Ms Byrne made two entries in the hospital notes for that afternoon. The first was timed at 1500 hours although that was crossed out and 1430 was substituted. It read:

> 'Senior RN had discussion with patient re query discharge tomorrow. Patient extremely upset and crying. Stated 'I'm scared, please don't send me home'. To discuss situation with mental health registered nurse (Adelaide Hills).' [111]

7.2. The next note was timed at 1440 hours but that was crossed out and substituted by 1500 hours. It read:

> 'N/Staff spoke with Peter York (M Health) re: D/C, good explanation re: personality disorder and treatment. RN to be 'quiet' advocate with next m health worker and treatment options will be given / offered to Chrystal.'

7.3. Ms Byrne was a witness who had formed certain views about what had occurred in Chrystal's case, particularly the role played by Dr Sargeant. She clearly had a negative

[110] Transcript, pages 469-470
[111] Exhibit C11, page 33

view of Dr Sargeant. It was also very clear that Chrystal's death had a strong emotional effect on her[112].

7.4. Ms Byrne's views coloured the manner in which she gave evidence, particularly her evidence when being questioned by counsel for Dr Sargeant. In fact her demeanour during that period of her evidence was unhelpful, combative and did not reflect well upon her. I gained the impression that she had formed views about what had occurred on an incomplete understanding of the facts and this coloured some of her answers. However, her evidence about conversations that she had with Chrystal and Mr York on 19 January 2015 are in my opinion reliable. Her evidence as to her interactions with Dr Sargeant on that day, less so.

7.5. Ms Byrne started work at 1300 hours on 19 January 2015. She had had a number of dealings with Chrystal during her stay in Mount Barker Hospital and so she was aware of her as a patient. She said that when she started her shift on 19 January 2015 she was surprised that Chrystal had not been transferred out to a mental health facility. She said in her statement[113] that after being handed over her patients for that shift, including Chrystal, she had a conversation with Dr Sargeant about Chrystal at approximately 2:15pm. The conversation occurred in the nurses' office. She provided a verbatim account of that conversation, and other conversations, in her statement. She gave evidence at the Inquest that the conversations as recorded in her statement are correct and accurately reflect what happened[114]. Her conversation with Dr Sargeant was as follows:

> 'Ms Byrne: So I take it Chrystal is being transferred somewhere appropriate now?'
>
> Dr Sargeant: No, I am discharging her tomorrow and increasing her fluvoxamine tonight. Rural and Remote don't want her transferred as she's on Workcover. '

Ms Byrne said that Dr Sargeant also mentioned that the Community Mental Health Team wanted Chrystal to sign a contract. Ms Byrne said that she replied words to the effect 'you can't send her home, that's ridiculous'.

7.6. At about 2:30pm Ms Byrne went into Chrystal's room and spoke to her. Chrystal said 'They are trying to send me home. They are trying to get me to sign a contract saying

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[112] See for example Transcript, page 567: 'My thinking process probably wasn't that clear; let's face it. I went back - after the detective came and said 'We need a statement, we want to get this right', as I've reiterated over and over, I thought 'Oh my gosh, let's think about the times. I start my shift here, I saw Dr Sargeant there, this happened, this happened'. My thinking is probably not that clear; I've just seen a 24-year-old girl hanging dead, if you will.'

[113] Exhibit C26

[114] Transcript, page 520

I won't hurt myself. I don't feel safe. I'm scared.'. She said both in her statement and in her evidence that Chrystal had the most terrified look in her eyes and it alarmed Ms Byrne. She said she had not seen her so scared before. She said that Chrystal grabbed her by the arm. Chrystal was on her bed. Ms Byrne said that she asked Chrystal if she would be willing to be transferred to Glenside and she said that she would. She said that she asked Chrystal this because she did not agree with the plan to discharge Chrystal.

7.7. Ms Byrne then went back to the nurses' office and called Mr York who was at that point back in his own office with the Adelaide Hills Community Mental Health Team. According to Ms Byrne's statement the conversation was as follows:

> 'I asked Peter why she wasn't being transferred.
>
> He said, "These types of Borderline Personality Disorder girls need to start taking responsibility for their own actions. She will be signing a contract to say she will not self-harm or do anything to herself. The longer these Borderline Personality Disorders are in hospital, the worse they become. In New Zealand they get 4 passes per year, where they can admit themselves in any ED (Emergency Department) in the country, to a maximum of 48 hours per admission, then they have to leave. It teaches them to take responsibility."
>
> I replied, "So why don't we do the same in Australia?"'

She said that he did not reply and she asked him what the plan was with Chrystal. He replied that he was sending over a person called Cathy to tell her about some therapy that was available. Ms Byrne replied that Chrystal could not go without a clear plan and a psychologist's appointment and Mr York replied words to the effect 'Look, the longer these types are in the worse they get. I will send over Kathy soon'. Approximately half an hour later Ms Byrne became aware that Chrystal had been found in the bathroom of her room having hanged herself.

7.8. I have stated that the times recorded against Ms Byrne's nursing notes were altered. The first was changed to 1500 hours and the second to 1440 hours, although it appears after the first note.

7.9. The original unaltered timings are apparent from the photocopied notes which are contained in the Royal Adelaide Hospital case notes[115]. There is no doubt as to the order

[115] Exhibit C12, page 35

in which the notes were made and that the first note must have been made earlier than the second note.

7.10. I mention these things because it was put to Ms Byrne that she had altered the timing of the notes in an effort to distance her last contact with Chrystal from the time at which Chrystal hanged herself in an effort to deflect responsibility. I do not accept that proposition and it was certainly denied vehemently by Ms Byrne. Ms Byrne was an emotional witness and she would certainly have been emotional on the day. The alterations to the times were made by her in the aftermath of Chrystal's hanging. While the alterations were ill-considered and should have been dealt with by way of an additional or retrospective note, I do not think that they were made for a malevolent purpose. In any event, they do not bear upon the accuracy of her recollection of the conversations she had with Mr York and with Chrystal which I essentially accept as accurate evidence.

7.11. It may well be that Ms Byrne could have handled the situation differently. It appears that when she spoke to Chrystal she perhaps inadvertently reinforced the message that Chrystal had already received from Mr York that she was definitely to be discharged the following day. That was certainly not Dr Sargeant's intention, as will appear presently. Had Ms Byrne relayed Chrystal's distress to Dr Sargeant, or attempted to allay her fears without reinforcing her belief that she was indeed to be discharged the following day, the situation may well have been better handled from her point of view. However, I do not consider that she added materially to Chrystal's distress which had already been well and truly established following Chrystal's interaction with Mr York. The most that could have been achieved by Ms Byrne was to somehow allay Chrystal's fears and this she attempted to do in her own way.

7.12. Ms Byrne said that Mr York had strong and negative views about borderline personality girls. She said that he did give her a good explanation of what constituted borderline personality as she said in her note, but he was certainly negative. She gained the impression that Mr York had a plan in place and it sounded very much like he wanted her gone, he wanted her discharged[116].

[116] Transcript, page 589

8. The evidence of Dr Sargeant

8.1. I heard from Dr Sargeant and he confirmed that he was Chrystal's general practitioner. Dr Sargeant was a good witness and he gave his evidence carefully. I have no criticism of Dr Sargeant's treatment of Chrystal in the period leading up to her admission to the Mount Barker Hospital, nor indeed thereafter. He gave evidence about Chrystal's medical history prior to the admission, but I do not propose to rehearse that evidence in this finding. Instead I will deal with his evidence of what occurred on 19 January 2015, the day that Chrystal hanged herself. Dr Sargeant said that that morning he worked in his clinic. He confirmed that he was being accompanied by Ms Thompkins[117]. He said that they broke for lunch at approximately 1pm with the intention of attending the hospital before returning to continue consulting at 2pm. He estimated that they would have arrived at the hospital at approximately 1340 hours. He said that he went to the nurses' station and spoke to a nurse by the name of Christine Coat who was the patient 'journey coordinator' for the week. He asked her about Chrystal's Rural and Remote bed and Ms Coat told him Chrystal had been taken off the list because she was on Workcover[118].

8.2. Dr Sargeant gave evidence that at this point he was confused. This information was news to him and he was wondering why it had not been discussed with him before a decision was made. He also considered that the issue of Workcover was irrelevant and he could not understand why it was suddenly a problem. He was frustrated at the amount of time that it had taken to get to this point.

8.3. Dr Sargeant said that he then decided to see Chrystal. He remembered going in to see her and said that she was in bed asleep. He woke her up and he said that he had a calm conversation with her about how she was. He said that he discussed with her, her episodes of anxiety and they talked about self-harm and borderline traits. He introduced

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[117] As she then was. She gave evidence at the Inquest that was corroborative of Dr Sargeant's version of events. She was a medical student at the time who was on a placement with Dr Sargeant's practice as part of her training. She took good notes, and spoke evidence clearly and confidently. I have no hesitation in accepting her evidence. By the date of the hearing of this matter she had gained her medical qualification and was referred to in the evidence by the title Dr Thompkins.

[118] There is no evidence as to how Ms Coat came by this knowledge, however there is a nursing note on 16 January 2015 (Exhibit C11, page 30) that refers to a telephone call from the nursing staff to the Rural and Remote Service at 1630 hours. This would have been after the conversations that had taken place between Vanessa Browne and Anne Dunn that day. The note says that the author was informed that Chrystal would be reviewed by the mental health team on Monday. It also said that information regarding Chrystal was faxed from Rural and Remote. In fact, the Mount Barker Hospital notes contain a faxed copy of a CBIS printout (Exhibit C11, page 111) which was faxed on 16 January 2015. It includes the text of the record of the conversation between Vanessa Browne and Anne Dunn. It may have been from that source that Ms Coat obtained the information that she imparted to Dr Sargeant. However, according to Dr Sargeant, Ms Coat added that she understood that the Rural and Remote Service did not want to take Chrystal because she was on Workcover. The source of that information is not apparent to me on the evidence. In any event I accept that Dr Sargeant was told that by Ms Coat.

the subject of there being a problem with the bed at the Rural and Remote Health Service and told her that he needed to find out what that problem was. He said therefore there would be a delay in getting her the bed and considering that she had now been in the Mount Barker Hospital for 12 days, they needed to consider what should happen next. He said that one possibility was that she could go home with some support if she wanted to, but he was concerned about where she would stay because he did not want her home alone. He questioned with her the possibility that she could go to her mother's house. He also said that if he was to entertain her going home he would need a guarantee of her safety. He did discuss with her the possibility that she could enter a contract in which he would agree to send her home but for her part she would agree not to harm herself and would seek help if she had such thoughts. He said that he had used the same concept of a contract when consulting with patients in his rooms in the past. He said that he was really just exploring where Chrystal '*was at*'[119]. It was his intention to explore the issue of the bed and that if Chrystal were to go home she needed support and her agreement not to harm herself. During this conversation Dr Sargeant said that Chrystal was quite calm and seemed quite rational. He said that she was not upset as she had been on other occasions and that the conversation lasted for about 30 minutes. Dr Sargeant said that he thought that Chrystal was calm but that she blatantly said that she would not give him a guarantee not to harm herself. Dr Sargeant said that he thought that was a big hurdle to her potential discharge. He did not perform a formal risk assessment but he was clearly of the mind that she could not have been sent home without that. At the end of the discussion Chrystal could not give him the guarantee he wanted and he said something along the lines of 'okay, we will leave you here overnight, I will need to see you tomorrow and work out what is happening with the Rural and Remote bed'. It was Dr Sargeant's intention to deal with the issue properly the following day which was Tuesday. At this stage he had three patients sitting in his waiting room and his plan was to leave Chrystal in the Mount Barker Hospital overnight and then try to get hold of Dr Downs and sort out the bed issue. He would see Chrystal the following day but he was of the view that she should not be staying in the Mount Barker Hospital for another week as that was not a suitable place for her to be.

[119] Transcript, page 697

8.4. Dr Sargeant made the following comment about his conversation with Chrystal which I accept as an accurate description of the conversation:

> 'I had a, quite a subtle conversation with Chrystal, leaving matters in Chrystal's hands, really, to then further discuss the following day, and if then Chrystal got wind that perhaps, you know, I, in private, had told everyone else 'Well, she's actually going home', then her trust that she had developed with me, and, would have been severely compromised.' [120]

8.5. He had not spoken to either Ms Byrne or Mr York before seeing Chrystal. After seeing Chrystal he then went to make a note in the nurses' station. It was then that he spoke to Ms Byrne. Ms Byrne asked him what was happening with Chrystal and he said that there was a problem with the bed at Rural and Remote and that it had something to do with Workcover. He told Ms Byrne that he had talked to Chrystal and that she could not guarantee her safety. He did not want her to stay in the Mount Barker Hospital. He said that he was also aware that he needed, in accordance with Dr Downs' recommendations, to increase Chrystal's fluvoxamine from 100mg to 150mg and he made a note to that effect. He said that he did not speak to Ms Byrne about a contract. He said that Ms Byrne got the impression that there was a possibility that Chrystal might be discharged and responded to Dr Sargeant that she should not be discharged and then '*went off in a huff*'[121]. Dr Sargeant said that he did not tell Ms Byrne that he was actually going to discharge Chrystal the following day[122].

8.6. After his conversation with Ms Byrne, Dr Sargeant said that he then encountered Peter York. He said he had quite a brief conversation with Mr York who was asking if there was anything he could do for Chrystal and Dr Sargeant told Mr York that he needed to work out what was happening with the bed and that he did not understand what had happened and then went on to add that in any event if Chrystal was going to be sent home what he needed to know from the Community Mental Health Team is what support they are willing to put in place for her if they were to decide that discharge was ultimately the best option for her[123]. He said that Mr York offered to see Chrystal and that was the end of the conversation.

8.7. Dr Sargeant was asked by Mr York's counsel if he might have told Mr York that Chrystal was probably going home the following day and he said he did not think he

[120] Transcript, page 701
[121] Transcript, page 700
[122] Transcript, page 765
[123] Transcript, page 702

had said that. He said that it would not be consistent with what he said to Mr York for Mr York to have subsequently told Chrystal that she would probably be discharged the following day[124].

8.8. Dr Sargeant said that he did not think that he would have discharged Chrystal at any time without her having another specialist assessment by which I took him to be referring to a further psychiatric assessment[125].

8.9. I find that Dr Sargeant never made a decision on the Monday that Chrystal was to be discharged the following day and that his attendance upon Chrystal that afternoon was not in order to tell her that she was to be discharged the following day. Instead it was to explain the need for him to explore why no Rural and Remote bed was being offered and to explore other options if such a bed remained unavailable and for Chrystal to consider overnight whether she could agree to a verbal contract if she was to be discharged into the community. I find that when Dr Sargeant left Chrystal on the Monday afternoon his plan was to return the following day and continue his discussion with her as to the options available to her. Furthermore, he was also intending to '*get to the bottom of*' whatever the problem was with a Rural and Remote bed. Dr Sargeant did not normally have patients booked in to see him on a Tuesday and accordingly he knew that he would have time on the following morning which was a Tuesday to deal with these issues. I also find on the basis of Dr Sargeant's evidence and that of Ms Thompkins that Chrystal was calm and not distressed or agitated after Dr Sargeant had spoken with her and further that Chrystal appeared to understand what Dr Sargeant had said and understand that he would return the following day to see her again. There was no reason for Dr Sargeant to think that Chrystal was at any imminent risk of self-harm notwithstanding her refusal to guarantee that she would not harm herself in the community. The risk in Dr Sargeant's mind was not a risk while she was in hospital, it was a risk that would arise if she were to be discharged into the community.

9. <u>Expert opinion - Dr Michael Clarke</u>

9.1. Dr Clarke provided an overview of Chrystal's case on behalf of the Court[126]. He said that the fundamental problem with Chrystal's management was that the Mount Barker Hospital was not an appropriate setting for the treatment of a patient with her complex

[124] Transcript, page 781
[125] Transcript, page 787
[126] Exhibit C29

set of problems. He acknowledged that there may have been some benefit to her initially being admitted to the Mount Barker Hospital, but said that once it was evident that she was not quickly improving he considered it important that she was transferred to a psychiatric setting. He noted that this was arranged after a week of Chrystal being in the hospital but that there followed a delay of five days and what Dr Clarke described as a series of distorted communications through the Rural and Remote Health Service and the Community Mental Health Team resulting in a belief that Chrystal no longer required transfer when a bed did become available.

9.2. It was Dr Clarke's opinion that Chrystal's death would have been very much less likely to have occurred if she had been transferred earlier to an appropriate psychiatric setting, in other words to the Glenside Rural and Remote Unit[127].

9.3. Dr Clarke noted that Chrystal's mental health problems pre-existed her wrist injury and they made it more difficult for her to deal with that wrist injury. He noted that there were difficulties with Workcover which he did not find supportive of her need for treatment. He believed that she needed psychiatric help and that Workcover was resistant to this because of the pre-existing problems. He did note the involvement of psychologists prior to January 2015, but commented that psychologists are not always fully skilled in the sorts of problems that Chrystal had. He commented that she had good basic care but he did not describe it as optimum care. This was largely based on her underlying borderline personality traits. In that respect Dr Clarke noted that Chrystal had a reasonably good relationship with her partner over a good number of years which was a factor weighing against the notion that she had full borderline personality disorder. Nevertheless there were traits there including her unstable affect, rapid mood swings, fragile sense of herself in respect of her body image, a possible eating disorder and misuse of substances.

9.4. Dr Clarke said that Dr Sargeant's treatment was reasonable for a general practitioner and that he had used appropriate medication and referred her to psychologists. Dr Clarke thought that Dr Sargeant's decision to admit Chrystal took place at an appropriate time.

9.5. Dr Clarke said that telepsychiatry is a useful tool when face to face consultations cannot occur, but agreed that it was not ideal. He thought that Dr Downs' involvement was

[127] Exhibit C29

appropriate and he made no criticism of anything that Dr Downs did. He thought that Ms O'Neill-Ferrie's work was thorough and that she appreciated the problems.

9.6. Notably Dr Clarke made the following comment about whether it would have been desirable on 15 or 16 January 2015 when no bed had become available to press for a bed. He said:

> 'I would presume only contacting them again and saying 'We have this patient here, this is not the best place for them, can we move things along'. I imagine that everyone is *so defeated by the way the bed flow works* is that they just accept that this is what occurs and it's probably pointless to be ringing up or making demands because they won't get very far.' [128]

That passage of evidence is very significant. It reflects accurately in my opinion the current state of the mental health system in this State.

10. <u>The current state of the mental health system in South Australia</u>

10.1. Those who work within it are indeed defeated not only by the way 'the bed flow works', to quote Dr Clarke, but by the lack of appropriate mental health beds which is really just another way of saying the same thing. For example, it was repeatedly said by members of the Community Mental Health Team that they had no role in relation to inpatients at the Mount Barker Hospital. This was subject to the exception of the liaison role played by Ms O'Neill-Ferrie, but that role only existed in relation to her. When she went away on leave the role ceased to exist and the function ceased to exist so far as the Community Mental Health Team was concerned.

10.2. Yet as a matter of fact the team still continued to have an involvement, albeit an unhelpful one. When Ms Browne from the Rural and Remote Health Service needed to talk about Chrystal's status and what she thought Dr Downs had told her about Chrystal's need for a bed or otherwise, Ms Browne contacted the Community Mental Health Team. She did not contact the hospital. This is inconsistent with the notion that there was no role for the Community Mental Health Team to play for an inpatient at the Mount Barker Hospital. Nevertheless the call was made and it was taken and then acted upon by Mr York who then played a further active role on the Monday morning. That role was to inform the caller from the Rural and Remote Health Service, who was then offering a bed for Chrystal, that the Rural and Remote Health Service had advised the

[128] Transcript, page 826

previous Friday that she no longer required such a bed. In doing that he did a grave disservice to Chrystal, but he undoubtedly accepted a role in relation to an inpatient at the Mount Barker Hospital.

10.3. Thus on the one hand the Community Mental Health Team would have it that the primary responsibility for the patient in the hospital was for the hospital staff to accept, but on the other hand they would nevertheless come in and out of the matter as it suited them, or in response to calls from the Rural and Remote Health Service.

10.4. By contrast, when on 16 January 2015 a person from the Mount Barker Hospital called the Community Mental Health Team to ask if somebody could come over and see Chrystal, they were told there was no capacity for the team to offer that assistance. Effectively the role that the team played on the Friday and the Monday was administrative only in relation to taking information about Chrystal's need for a bed and then acting on that information without any clinical assessment of Chrystal's mental state or her general wellbeing.

10.5. This dysfunction is likely to be found in a system where there is a scarcity of mental health beds. All of the participants in such a system are 'defeated' by the very system they work in. They know that the one thing that the patient needs, namely a bed, is not within their power to provide. Thus they try to deal with the matter as best they can with the inevitable unsatisfactory outcomes exemplified by this case.

10.6. Another example of this phenomenon was the role played by Dr Downs. I do not criticise Dr Downs in saying this, but his role as described by him and as established by the system was to act as a consultant without ongoing responsibility for the patient. Thus he saw Chrystal via video link for an hour to make his initial assessment on 9 January 2015. He had a further involvement at the behest of Ms O'Neill-Ferrie on the Wednesday 14 January 2015 when she was concerned that Chrystal was not improving and that Chrystal required a bed in the Rural and Remote Service at Glenside. Dr Downs agreed with that course of action. In that respect he was once again performing a consultant advisory role. However, when he was called again on 16 January 2015 by Ms Browne to ask whether Chrystal still required a bed, he was not performing the role of a consultant called in to assess a patient. Instead he was participating in administrative decisions relating to the way in which the patient would be handled within the mental health service as a whole. I do not criticise him for doing this because it is obviously expected he must do so as part of his job. However if his

job truly is to act as a consultant, then one must ask why he is being asked whether a patient who he has not seen for a week requires a bed or not. It would beggar belief that a consultant in another medical field, for example orthopaedic surgery, would be called upon by a member of the nursing staff to engage in a discussion about whether there was a need for a bed for a patient whom the consultant had not seen for a week. In my view this reflects the lack of proper respect for psychiatrists within South Australia's mental health system.

10.7. The culmination of the dysfunction is seen when on Monday 19 January 2015 a person who had had no involvement whatsoever in Chrystal's case, namely Mr York, took it upon himself to take steps to ensure that she was discharged from the Mount Barker Hospital as soon as possible. His first step was to carry forward the wrong information that had been given to Ms Dunn the previous Friday by telling the caller that morning that the offered bed was no longer required. He managed to glean from the duty log that there was a reference to borderline personality disorder. He did not bother to read any of the relevant reports or to acquaint himself thoroughly with Chrystal's case. His role was really an administrative role. It certainly could not be described as clinical. Without discussing the matter properly with Dr Sargeant (I do not regard the fleeting interaction between Dr Sargeant and Mr York in the nurses' station as a proper discussion) nor with Dr Downs who was the consultant psychiatrist, nor with Ms O'Neill-Ferrie, nor any of the nursing staff at Mount Barker Hospital he hurried to convey to Chrystal that she was to be discharged the following day. The fact is that at that point the only person who could make a decision to discharge her was Dr Sargeant. Dr Sargeant was the person who at that stage had the least information in relation to what was going on. Mr York himself was armed with better information than Dr Sargeant. Crucially, Mr York knew that there was a bed available and that it had been offered. Had he imparted that piece of information to Dr Sargeant the result would of course have been entirely different and Chrystal's death at that time almost certainly prevented.

10.8. Another instance of this dysfunction was the conversation between Dr Downs and Ms Browne. With great respect to Dr Downs it is my opinion that he completely overestimated Ms Browne's ability to absorb what he was saying at an intellectual level. Furthermore he overestimated her ability to listen to what he was saying and make an

accurate record of it. He treated her as if he was speaking to a clinician operating at a similar level of function as he himself.

10.9. In doing that he was merely acting in the manner that the system expected him to act. The mental health system in this State is not hierarchical. It does not regard psychiatrists as being at the top of the hierarchical ladder. Generally the system operates as some kind of workers' collective in which no-one has overall responsibility for any clinical decision.

10.10. Such a system is bewildering for people who do not generally work within it. An example of such a person is Dr Sargeant. He was bewildered by the fact that his patient had been taken off a bed list without his knowledge and without his permission. Such a thing would not happen in any other medical setting apart from South Australia's mental health system. By contrast, Dr Downs did work within the mental health system and was familiar with its operation. Thus when he spoke to Ms Browne he spoke to her as if to a clinician with a similar level of professional responsibility and interest in the patient's welfare that he himself exhibited. He completely overestimated Ms Browne's ability or willingness to reciprocate. Thus she only heard what she wanted to hear: that there was an option in which Chrystal would not be admitted to the Rural and Remote Health Service. As he said, Dr Downs gave equal prominence to the other option, namely that she be admitted and emphasised that he had not seen the patient for a week. From Ms Browne's point of view however, he had opened the door to an option that within the mental health system was only too tempting, namely to rid itself of the need to find a bed for a patient in a system where beds are as rare as hen's teeth.

11. <u>The response of Country Health SA</u>

11.1. An affidavit of Dr McKenny who is the Clinical Director of Mental Health, Country Health SA Local Health Network was tendered to the Court[129]. Appropriately Dr McKenny acknowledged that expected service standards were not met after Chrystal was placed on the Rural and Remote Health Service inpatient bed waiting list and Ms O'Neill-Ferrie commenced her leave on 14 January 2015. In particular he noted that ongoing support by the Community Team to Chrystal and her general practitioner did not continue, the Community Team did not refer the hospital nursing staff to

[129] Exhibit C30

Dr Sargeant or the Emergency Triage and Liaison Service when they were unable to respond to a request by hospital nursing staff to review Chrystal on 16 January 2015, that the Community Mental Health Team did not perform a mental health state assessment on Chrystal on 19 January 2015 when such an assessment had been requested and noted on the previous Friday's daily log and, finally, that the team was involved in removing Chrystal's name from the inpatient bed waiting list without first consulting Dr Sargeant or Dr Downs. I note that Dr McKenny offered an apology to Chrystal's family and friends on behalf of Country Health SA[130].

11.2. Dr McKenny noted that certain measures have been put in place since Chrystal's death. He annexed to his affidavit several documents evidencing these changes. One of them is entitled 'Clinical Pathways for People from Country SA to Mental Health Inpatient Treatment Centres'. He pointed out that pursuant to that document it is now Country Health SA policy that no person's name will be removed from the inpatient bed waiting list unless that decision has been reviewed by the Country Health SA psychiatrist who requested the bed and if that psychiatrist is not available, by the Emergency Triage and Liaison Service consultant or by the Clinical Director[131].

11.3. Dr McKenny also made reference to another procedural document entitled 'Transfer Between Mental Health Beds and General Beds in Country Hospitals' and a document entitled 'Country Health SA Community Mental Health Model of Care and Operational Pathways'[132].

12. <u>Commentary upon Country Health SA's response</u>

12.1. While I am sure that all of these documents have been prepared with good intentions, I regret to say that with the exception of the clear rule that no patient can be removed from the inpatient bed waiting list without the approval of one of the three categories of psychiatrists mentioned above, I do not believe that these documents alone will improve the systemic problems that I have referred to above, which are more a function of the State's mental health system generally than of the Country Health SA subcategory of the mental health system. It would not be necessary to have such a plethora of policy and procedure documents if there were an ample sufficiency of mental health beds in this State. Furthermore, to run a mental health system with an

[130] Exhibit C30, paragraph 36
[131] Exhibit C30, paragraph 19
[132] Exhibit C30, paragraph 25

insufficiency of inpatient beds requires that every person involved in the decision making process will have the ability to comply with the plethora of policy and procedure documents and to act in a generally professional manner. As has been seen in this case, it is not possible to be confident that complex conversations such as that which Dr Downs had with Ms Browne on 16 January 2015 will be properly understood or even recorded. No amount of guidelines, policies and procedures can prevent a human error from occurring, and incompetent people with guidelines, plans, policies and procedures are still incompetent people.

13. Recommendations

13.1. 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.

13.2. Apart from the burning issue of the need for more mental health beds in this State, Mr Collett, counsel for Chrystal's mother, asked that I say something about funding for families for legal representation in Inquests. Mr Collett has had a long and distinguished association with this jurisdiction. He was involved on behalf of families in the Royal Commission into Aboriginal Deaths in Custody, and has appeared on behalf of families in Inquests over the years since then. Although he did not say so, there is no question that such work, while undoubtedly professionally fulfilling, involves a sacrifice on the part of the practitioners who give of their time to provide representation in these matters, often pro bono. There is no doubt that their contribution provides invaluable assistance to the Court. The Royal Commission into Aboriginal Deaths in Custody recommended that the Government pay for the representation of families in Inquests into deaths in custody[133]. For the same reasons I am of the opinion that Government assistance should be available, through the Legal Services Commission, in all Inquests.

13.3. I recommend that the number of mental health beds in this State be radically increased. At a minimum the number should increase four fold. I direct this recommendation to the Minister for Health and Wellbeing.

[133] See Recommendation 23

13.4. I recommend that the Government provide, through the Legal Services Commission, funding to enable families to be legally represented in Inquests, for deaths in custody, and generally. I direct this recommendation to the Attorney-General.

Key Words: Hospital Treatment; Psychiatric/Mental Illness; Suicide; Hanging

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 19th day of July, 2018.

State Coroner