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 14th, 15th and 16th days of August 2019, the 19th, 20th, 21st, 22nd, 23rd and 26th days of October 2020 and the 17th day of June 2022 , by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Holly Alexandra Thredgold.

The said Court finds that Holly Alexandra Thredgold aged 42 years, late of 50 High Street, Kensington, South Australia died at Kensington, South Australia on the 28th day of August 2016 as a result of hanging. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for inquest

1.1. Holly Alexandra Thredgold died on 28 August 2016, aged 42 years. On that Sunday morning, Mrs Thredgold's[1] husband James Thredgold left the family home with their two children on a shopping errand, leaving her at home alone for about two hours. Upon returning, Mr Thredgold found his wife hanging in the carport. In taking her life, Mrs Thredgold lost a lifelong battle with depression which led to, and was compounded by, severe alcohol abuse.

1.2. On the morning of Friday, 26 August 2016 Holly Thredgold was admitted in crisis, severely intoxicated and with suicidal ideation, to the Royal Adelaide Hospital (RAH) Emergency Department (ED). There were several significant errors which attended the course of her treatment and contributed to her being inappropriately discharged on the evening of the same day. Those treating her in the ED were not aware that she was

[1] This is the manner in which Holly Thredgold has been referred to in this inquest by her family's legal representatives

under the care of a private psychiatrist. That psychiatrist was aware of the emergency admission but failed to take appropriate steps to ensure that the hospital knew that Mrs Thredgold was his patient. Neither did those at the hospital take proper steps to enquire and ascertain whether she was under the care of a private psychiatrist. Mrs Thredgold's psychiatrist had clinical information which should have been obtained and taken into account by the RAH clinicians. During her admission, Mrs Thredgold was not assessed by the RAH mental health care team. This was an error. Mrs Thredgold was discharged into the care of her husband, with a blood alcohol level which was still high at .2%, without adequate precautions in place to ensure that she would not take her own life, something which was, and which ought to have been understood to have been, a very high risk following her discharge.

1.3. This inquest has examined the circumstances of Mrs Thredgold's death, including her social, medical and psychiatric history, the events leading to her admission to the RAH, her treatment at the hospital and the failings of the hospital and individuals in that treatment. Systemic failings have been examined with a view to making recommendations to reduce the likelihood of other deaths in similar circumstances.

2. Cause of death

2.1. Dr Stephen Wills, a senior forensic pathologist employed at Forensic Science South Australia performed a post-mortem examination and confirmed that the cause of death was hanging. Samples taken during the post-mortem examination were analysed. There was a high level of alcohol, 0.25% detected in her blood, as well as 0.24 mg/L of sertraline, consistent with non-toxic concentration.[2]

3. Expert evidence of three psychiatrists

3.1. To assist the Court in its understanding and assessment of Mrs Thredgold's history and treatment by the various clinicians involved in her care before and at the RAH, evidence was received and heard from three psychiatrists[3] who were not personally involved in her care. They have given evidence of their expert opinions, which opinions I have considered and taken into account to the extent I consider appropriate, in drawing conclusions and making findings.

[2] Sertraline is an antidepressant, which was prescribed to Mrs Thredgold

[3] They will occasionally be referred to in this document as 'the three psychiatrists'

3.2. Dr Maria Naso was commissioned by the Court to provide an independent expert assessment and her opinion about the appropriateness or otherwise of the management of Mrs Thredgold, in particular on the presentation to the RAH and whether the ED should have attempted to obtain collateral information from Mrs Thredgold's private psychiatrist, Dr Koopowitz, and whether Mrs Thredgold should have been released without a psychiatric review from a mental health professional, and with her blood alcohol level still being high. Dr Naso's report was tendered and she gave oral evidence.[4]

3.3. Dr Naso has been a medical practitioner since 1992 and completed her specialty psychiatric training in 2002, since which she has worked predominantly as a psychiatrist in the public system but also in private practice. She works principally as Senior Staff Psychiatrist at the Modbury Hospital and regularly provides expert opinions in coronial matters, as well as for the Australian Health Practitioner Regulation Agency.

3.4. Dr Jonathan Symon provided a statement[5] in November 2019, at a time when he was the Acting Clinical Director, Mental Health Director, Central Adelaide Local Health Network (CALHN). In that position his duties included oversight of service provision, clinical governance and monitoring of Quality and Safety for the CALHN Psychiatric services at the RAH, the Queen Elizabeth Hospital and the Glenside Campus as well as the associated community mental health services. He has been a medical practitioner since 1993 and completed his specialty psychiatric training in 2003. By the time of giving evidence in October 2020 he was no longer in that position and had reverted to his usual role as a consultant liaison psychiatrist in the general part of the RAH.

3.5. Dr Michael Schirripa is a psychiatrist and psychotherapist who has practised as a medical practitioner since 2001 and commenced as a specialist psychiatrist in 2008. He has provided expert medical evidence in criminal and civil jurisdictions. He provided an expert report[6] at the request of Mr Thredgold's legal representatives and was called to give oral evidence.

3.6. In addition to the evidence and opinions of the three psychiatrists, the Court has had the benefit of Mrs Thredgold's previous psychiatry notes, including the notes of her treating psychiatrist Dr Koopowitz, and also the clinical assessments and opinions of

[4] Exhibit C20
[5] Exhibit C23
[6] Exhibit C21

Dr Koopowitz, who gave evidence during the inquest. Dr Koopowitz is himself a senior consultant psychiatrist of many years' experience in public and private practice, as well as in education in psychiatry. Dr Koopowitz has not sought to minimise or avoid findings as to his own role in this matter and, as will be seen, I regard his assessments and opinions as carrying significant weight.

4. Holly Thredgold's personal and clinical history

4.1. There is little controversy about the relevant medical history of Mrs Thredgold, or of the events in the weeks preceding her detention on 26 August 2016 pursuant to section 57 of the *Mental Health Act 2009* (SA).

4.2. Mrs Thredgold's biological family had a history of depressive and alcohol related issues. These predisposed her to the difficulties which subsequently presented in her life. Mrs Thredgold suffered from severe depression from a young age, which most likely led to an adult life of alcohol abuse.

4.3. Holly Thredgold was described as a strong, proud, determined and high functioning woman. She was also a perfectionist, a trait which developed in her childhood, but also came at a cost in her adulthood. She cared very much about her appearance and would punish herself if she did not meet her own high standards. With her perfectionist trait came self-punishment, discomfort, and dysphoria which left her chronically depressed. To escape her depression, she consumed alcohol in an effort to self-soothe. Her chronic depression and anxiety made her vulnerable to abusing alcohol.[7] The combination of pre-existing depression and alcohol abuse had devastating consequences for her and her family.

4.4. As Dr Naso explained, alcohol abuse by itself increases an individual's rate of developing depressive illness and suicidal ideation. In Mrs Thredgold's case the chronic depression and alcohol abuse together led to a complex presentation of comorbid mental illness and substance abuse.[8]

4.5. In September 1995, shortly after her 21st birthday, Mrs Thredgold (then Ms Slatter) was admitted to the RAH after she self-reported a suicide attempt with a large paracetamol overdose. She remained an inpatient for a fortnight under the care of Dr Peter Rofe,

[7] Transcript, page 758 (Dr Naso)
[8] Transcript, page 759 (Dr Naso)

psychiatrist, who continued to provide treatment after her discharge.[9] It appears this treatment was beneficial and seen by Mrs Thredgold as a positive experience in all the circumstances.

4.6. In March 2005 Mrs Thredgold married James Thredgold. Their first child Sophie was born in May 2007. Shortly beforehand Mrs Thredgold ceased work in the successful florist business she had established and operated for the preceding four years.

4.7. After the birth of her daughter, Mrs Thredgold developed depressive symptoms and ultimately came under the care of Dr Ivan Krell, who became the family general practitioner (GP) for Mr and Mrs Thredgold and their children.

4.8. Dr Krell prescribed the anti-depressant Zoloft[10] to Mrs Thredgold, and she remained on this medication for the balance of her life, except for the period when attempting to become pregnant again.

4.9. The Thredgolds' second child Angus was born in November 2010. Mrs Thredgold again developed depressive symptoms after the birth and resumed taking anti-depressant medication. Mrs Thredgold did not return to the paid workforce and remained at home caring for her two young children.

4.10. In about 2013 there were several stressors in her life, primarily related to difficulties around the home caused by renovations being undertaken and ultimately leading to the family moving to temporary accommodation. It was at around this time Mr Thredgold began to notice his wife consumed excessive amounts of wine on a daily basis.

4.11. Over the next few years Mrs Thredgold continued to consume alcohol excessively, becoming a high functioning alcoholic. In April 2016 Mrs Thredgold presented to the ED at the Wakefield Hospital following a fall at home. Blood tests revealed a blood alcohol reading of 0.33% and liver damage, indicating that she was chronically abusing alcohol.[11] It is not clear whether this attendance at the Wakefield Hospital was immediately reported to Dr Krell.

4.12. Mr Thredgold stated that by June 2016 when the family moved to a new home in Kensington, Mrs Thredgold was consuming about five bottles of wine a day.[12]

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[9] The relevant notes are in Exhibit C14 (Vol 1), commencing page 4
[10] Zoloft is a brand of sertraline
[11] Exhibit C12, page 12
[12] Transcript, page 28

5. July 2016 - The issue of alcohol abuse comes to a head - treatment begins

5.1. In July 2016 Mr Thredgold received a phone call advising that his two children were running down the street towards his shop. They had run from their home because they did not feel safe with their mother. The reasons included that she had been driving under the influence. Mr Thredgold found his children on The Parade in Norwood.

5.2. Mr Thredgold decided he could no longer stand by and watch the children witnessing their mother's drinking and left the home to stay at a hotel. His mother came to stay with him to help care for the children. Mrs Thredgold changed the locks on the house and burned Mr Thredgold's shirts. Her mother came from Melbourne to help.

5.3. Dr Naso expressed the opinion that Mrs Thredgold's behaviour was out of control and erratic and that Mr Thredgold's difficult decision of moving out would have consolidated her internal belief that she was a failure, both as an individual and potentially as a mother. Dr Naso considered the change of the locks as a demonstration of her perfectionist trait of trying to maintain some control in her life.[13]

5.4. Mr Thredgold did not abandon his wife and enlisted professional help, taking Dr Krell to see her at the Kensington home. There, Dr Krell became aware for the first time of the chronic alcohol abuse which Mrs Thredgold had carefully hidden from him and he persuaded her to seek specialist help. I note that Dr Naso expressed the opinion that the GP arriving at her door would have felt incredibly confronting and caused Mrs Thredgold to feel intense shame.

5.5. On the Monday, Dr Krell made an urgent referral to Dr Koopowitz, who first saw Mrs Thredgold in the company of her husband on Wednesday 27 July 2016. Dr Koopowitz took a very detailed history from Mrs Thredgold, who stated she had been dry for three days. Dr Koopowitz's plan was to continue to prescribe sertraline. He encouraged her to abstain from alcohol and ordered an MRI and blood tests. On this occasion Dr Koopowitz did not discuss suicidal ideation. He planned to continue to see Mrs Thredgold every two weeks and he expected a long and delicate treatment process.[14]

[13] Transcript, page 759
[14] Transcript, page 296

5.6. At the second consultation on 27 July 2016 Dr Koopowitz revealed to Mrs Thredgold the serious nature of the blood test results obtained in April 2016. Again, Dr Koopowitz did not discuss suicidal ideation. Dr Koopowitz's notes also reveal that Mrs Thredgold told him that her daughter Sophie was starting to not trust her.[15] In Dr Naso's opinion, this would have been absolutely devastating for Mrs Thredgold, as for any mother. Dr Naso stated otherwise that it was clear Mrs Thredgold was a doting, loving mother.[16]

5.7. Dr Koopowitz diagnosed Mrs Thredgold with severe depression and alcohol abuse. That combination increased her risk of suicidal ideation and suicide.[17] Dr Naso, Dr Symon and Dr Schirripa all agreed with Dr Koopowitz's diagnosis.

5.8. There was a further appointment made for Tuesday 23 August 2016, which was not kept by Mrs Thredgold, although she did ring to reschedule. Dr Koopowitz has identified the failure to keep this appointment, in the circumstances, to be a reason for concern.

5.9. On the basis of Dr Koopowitz's diagnosis, supported by the three psychiatrists, I can readily find that Mrs Thredgold suffered from severe depression and chronic alcohol abuse at the time she was admitted at the RAH ED on 26 August 2016.

5.10. Dr Krell's case notes reveal contact from Mr Thredgold on 25 August 2016, the day before her admission to the RAH.[18] Dr Krell was informed Mrs Thredgold was drinking and it had got worse. Dr Krell was also informed that Mrs Thredgold had booked into a rehabilitation facility named The Sanctuary in New South Wales. The notes reveal that Dr Krell visited Dr Koopowitz and informed him of the plan for Mrs Thredgold to go to The Sanctuary. Dr Koopowitz was noted to agree it was a good plan.

5.11. It is therefore important to point out that the day before Mrs Thredgold's admission to the RAH, Dr Koopowitz was aware, firstly, that she had relapsed, which in his opinion meant she was at a heightened risk of suicide[19] and secondly, Mrs Thredgold was due to go to a rehabilitation facility on the following Tuesday, 30 August 2016.[20]

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[15] Exhibit C22d, page 1
[16] Transcript, page 761
[17] Transcript, page 354
[18] Exhibit C12, page 2
[19] Transcript, page 359
[20] Transcript, page 360

5.12. Mr Thredgold gave evidence that the decision to go to The Sanctuary was made by his wife. She had a long telephone conversation with the Director of The Sanctuary and was accepted. Mrs Thredgold had the means to pay the high cost of the rehabilitation program, so this was not a matter of concern for her.[21]

5.13. Dr Naso expressed the opinion that although The Sanctuary was a private facility which, on superficial appearance was an excellent fit for Mrs Thredgold in terms of maintaining her privacy, it would have been incredibly confronting for her to contemplate going into this facility for a number of weeks and then adding another layer of cover-up with a view to preventing her wider social community coming to learn of her alcoholism.[22]

6. The events of Friday 26 August 2016

6.1. At about 10am on Friday 26 August 2016 Mr Thredgold received a call from his wife, who sounded intoxicated. Mrs Thredgold told him '*Don't worry about me. I'll be fine, just make sure you look after the children*'. He understood this to be a repetition of similar things she had said for much of their relationship when her depression was too much for her and she wanted to run away. Although he acknowledges one interpretation of these words was consistent with his wife indicating an intention to self-harm, that was not how he interpreted it.[23] Mr Thredgold immediately went home and noticed his wife's car was missing, although her mobile phone was at home. He spent an hour and a half driving around looking for her. Shortly before noon he contacted Dr Krell, who advised him to call the police. Mr Thredgold did so and soon a male and female police officer were at his home. At about this time, Mr Thredgold telephoned Dr Koopowitz's rooms and left a message to the effect his wife could not be found and asking Dr Koopowitz to telephone him.[24]

6.2. Senior Constable Cassandra Ackarie and her colleague arrived at the Kensington address at about 12:10pm. Senior Constable Ackarie described Mr Thredgold as visibly upset and in a state of hopelessness. It was clear he had genuine and serious concerns for his wife's welfare. Constable Ackarie was also informed by Mr Thredgold that his wife had called him and said '*It's all too hard. The pain is too much. I can make it go*

[21] Transcript, page 40
[22] Transcript, page 762
[23] Transcript, pages 41 and 82
[24] Exhibit C22c, page 15

away'. The officer was also told Mrs Thredgold was receiving counselling, had attempted to self-harm in the past, and was booked into a rehab facility.

6.3. At about 1pm Senior Constable Ackarie observed Mrs Thredgold arrive home on foot. She was obviously drunk, stumbling on her feet, carrying a shoulder bag with multiple bottles of wine. She was upset and embarrassed at the police being at the house and repeatedly asked her husband '*Why, why did you call them? This is not necessary*'. Mrs Thredgold was slurred in her speech, easily moved to tears and making statements such as '*If I could end my life, I would…. I want my life to end*'.[25]

6.4. Section 57 of the Mental Health Act 2009 empowered Senior Constable Ackarie to detain Mrs Thredgold for the purpose of delivering her or arranging her delivery to a treatment centre[26] (in this case the RAH) if it appeared to Senior Constable Ackarie that Mrs Thredgold was suffering a mental illness, was at risk of self-harm and required medical examination. Senior Constable Ackarie correctly formed those opinions, lawfully detained Mrs Thredgold for that purpose and called for an ambulance. Mr Thredgold gave evidence that he did not hear his wife telling police she wanted to end her life, but Senior Constable Ackarie told him she had talked of self-harming, so he understood the reason for her detention.[27]

6.5. Dr Naso was of the opinion that although contacting the police was necessary at that stage for Mrs Thredgold, the presence of a marked police car and then the arrival of an ambulance outside her door was insult upon insult on her fragile personality.[28]

7. Communication between Dr Koopowitz and Mr Thredgold - Mr Thredgold as messenger

7.1. Mr Thredgold stated that Dr Koopowitz called him back after he had left the message at the clinic, whilst the police were in the front garden detaining Mrs Thredgold. Mr Thredgold described the phone call being very brief and occurring whilst there was '*a commotion*' in the garden.

7.2. Mr Thredgold gave evidence he had very little recollection of the contents of that phone call. However, he said he did not remember Dr Koopowitz telling him his wife was at

[25] Exhibit C6, page 3 (Senior Constable Ackarie)
[26] As defined in the Mental Health Act 2009
[27] Transcript, page 84
[28] Transcript, page 763

risk of suicide and he thought that if Dr Koopowitz had told him, he would remember that.[29]

7.3. In his evidence Dr Koopowitz stated that having received the message '*Holly was missing*' at his clinic, he became very concerned at the evolving situation and contacted Mr Thredgold.[30]

7.4. Dr Koopowitz stated he had no recollection of the conversation and relied on the clinic case notes and his police statement in December 2016 as to the contents of that conversation.[31] His note of the conversation is recorded as:

> 'I have spoken to James, Holly's husband. During the phone call, Holly arrived home, heavily intoxicated. The police are trying to settle her down and I have given James strong advice to get the police to take Holly to ED at the RAH as she is a high suicide risk. I have informed Dr Krell of the same.' [32]

7.5. Dr Koopowitz conceded he did not talk to the police and was unaware Mrs Thredgold had told the police she wanted to end her life.

7.6. Dr Koopowitz explained he wanted Mr Thredgold to convey to the hospital that he was her psychiatrist, he was worried she was suicidal and he would be available to be contacted.[33]

7.7. Mr Thredgold's recollection is Dr Koopowitz told him '*that once she's at the Emergency Department that someone should contact him; that he was her clinical psychiatrist.*'[34] There is nothing in the note by Dr Koopowitz about giving advice to Mr Thredgold to tell the ED staff to call Dr Koopowitz. Dr Koopowitz gave evidence that he was well known at the RAH ED and they knew how to contact him.

7.8. If Dr Koopowitz did tell Mr Thredgold on 26 April 2016 that Mrs Thredgold was a suicide risk, it unfortunately appears that, in all the commotion and emotion, this important message was not adequately conveyed to or understood by Mr Thredgold. Mr Thredgold says he remained unaware his wife's psychiatrist was of the opinion she was at risk of suicide and I accept this. It was not something Dr Koopowitz had ever

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[29] Transcript, pages 87-88
[30] Transcript, page 361
[31] Transcript, pages 298-299
[32] Exhibit C22c, page 2
[33] Transcript, pages 363-364
[34] Transcript, page 47 line 26

previously discussed with him. Mr Thredgold did not convey that message to the hospital.

7.9. However, it was certainly adequately conveyed to Mr Thredgold by Dr Koopowitz that he wanted the hospital to contact him. Mr Thredgold states he informed three hospital staff that Mrs Thredgold had her own psychiatrist. I have concluded that there is not sufficient evidence to identify with certainty any of those staff.

7.10. The three psychiatrists expressed the opinion that family members were not the appropriate persons to convey the private psychiatrist's message to a hospital ED. Dr Koopowitz also quite properly conceded that Mr Thredgold was not the right person to convey his messages to the hospital.[35]

7.11. The corollary of that is that Dr Koopowitz should himself have contacted the RAH ED. Unsurprisingly, each of the three psychiatrists expressed the opinion that he should have done so. To his credit, Dr Koopowitz did not challenge those opinions. He expressed genuine remorse and conveyed regret for not contacting the hospital personally, and felt guilty for letting down Mrs Thredgold, Mr Thredgold and their children. Dr Koopowitz said he was at a loss to explain to himself why he did not personally call the hospital. He said he no longer takes it for granted that his expectations will be met and either makes a phone call or writes a letter if he is aware that a patient of his is transported to the Royal Adelaide or any other emergency department.[36]

7.12. Dr Koopowitz accepted that if he had contacted the ED he could have provided collateral information about Mrs Thredgold, his opinion on her diagnosis and his opinion on her risk of suicide. He could have influenced her treatment. He could have participated in her discharge plan and he could have been involved in the continuity of care and transition to another facility. Dr Koopowitz agreed that his opinion, as a senior psychiatrist, would have carried some weight with the clinicians at the hospital.

7.13. Dr Koopowitz was an honest, contrite witness. He gave evidence openly and frankly. He accepted the opinions of Drs Symon, Naso and Shirripa that it would have been ideal or appropriate for him to have contacted the RAH if, as he expected, he knew that Mrs Thredgold was going to be taken to the hospital for assessment.[37] Dr Koopowitz

[35] Transcript, page 363
[36] Transcript, page 301
[37] Transcript, pages 300-301, 363, 367-368.

was visibly affected whilst giving evidence, and regretful, that he did not make contact.[38] He carefully listened to, and gave candid and considered answers to the questioning of the various counsel who appeared in this inquest.

7.14. I find that Dr Koopowitz should not have asked and expected Mr Thredgold to convey information on his behalf to the RAH and that he should have personally contacted the hospital to advise that he was Mrs Thredgold's psychiatrist, so that he could be consulted for collateral information.

7.15. Of course, Dr Koopowitz does not carry that burden alone. It was also incumbent on the RAH staff to investigate if Mrs Thredgold had been in previous contact with a mental health professional. It was a standard question which needed to be asked. Dr Naso said that a person presenting with suicidal ideation with a report of extreme alcohol ingestion should be asked questions beyond '*Who is your usual doctor?*' She said the patient should also be asked whether they are under specialist psychiatric treatment. She went further to refer to her supervision of fourth and sixth year medical students, and their psychiatry rotation, in which they are taught about taking a:

> '… psychiatric history in the emergency department, and part of that history is 'Who are the relevant people involved in your care?' So, not just GPs, but psychologists and psychiatrists, or any Anglicare services, counselling services.' [39]

7.16. I do accept that Dr Koopowitz expected to be contacted by the RAH. This is borne out in Dr Krell's notes in the entry for 26 August 2016 which states:

> 'Holly returned home voluntarily later in the day. Both husband and Dr Koopowitz informed me of this and Dr Koopowitz said he would arrange admission to private clinic once contacted by RAH. Was apparently very intoxicated. Was taken to RAH for admission. RAH to then contact Dr Koopowitz who would arrange private admission.' [40]

Dr Koopowitz gave evidence that this conversation with Dr Krell was with regard to the Fullarton Private Clinic and he envisaged making that arrangement.

8. <u>Mrs Thredgold is taken to the RAH</u>

8.1. South Australian Ambulance Service (SAAS) arrived at the home to take Mrs Thredgold hospital. In the meantime, Mr Thredgold enquired of the police how

[38] Transcript, page 301
[39] Transcript, page 785
[40] Exhibit C12, page 2

long his wife would be in hospital. Mr Thredgold considered it prudent to pack an overnight bag, which accompanied Mrs Thredgold to the RAH.

8.2. Shortly before 2pm Mrs Thredgold arrived at the RAH with SAAS personnel and the police officers. Mr Thredgold followed in his own vehicle.

8.3. The handover by police to the nursing staff at the RAH required the transfer of detention, so that Mrs Thredgold was then detained pursuant to section 56 of the Mental Health Act 2009. The handover was legally effective, with the reason for engaging section 56 of the Act being correctly recorded as '*suicidal ideation and history of depression*'.[41] This suggests the police officers accurately relayed the conversation Mr Thredgold reported his wife had with him earlier that day and the conversation Senior Constable Ackarie had with Mrs Thredgold in the driveway.

9. No pro forma or programmed question re current treating psychiatrist or psychologist

9.1. In addition to finding that Dr Koopowitz should have notified the RAH that he was Mrs Thredgold's treating psychiatrist, I readily conclude that the system of care at the RAH should have included, in the case of a mental health presentation, questions and/or enquiries requiring documentation, to ascertain whether the patient is or has recently been under the care of a mental health professional, particularly a psychiatrist.

9.2. In documents completed upon Mrs Thredgold's admission on 26 August 2016, it was noted in the '*Emergency Department Record*'[42] and in '*Admission Details – MR 10*'[43] that she had had a prior admission for an overdose. In the latter document, the admission diagnosis is recorded as '*suicidal ideation*'. In Mrs Thredgold's inpatient progress notes a record is made of taking 'Care and Control' pursuant to section 56 of the Mental Health Act at 2:10pm, citing the risk of self-harm as being demonstrated by '*suicidal ideation and hx of depression*'.[44] These demonstrate the trite point that this was plainly a mental health presentation.

9.3. In the course of any hospital admission many forms are used, whether paper-based or electronic.[45] Despite the obvious importance of the question, not one of the forms used

[41] Exhibit C14 (Vol 2), page 29
[42] Exhibit C14 (Vol 2), page 18
[43] Exhibit C14 (Vol 2), page 21
[44] Hx = History and Exhibit C14 (Vol 2), page 29
[45] All of the paper forms used at the time of Mrs Thredgold's additions are now electronic

at the RAH on the occasion of Mrs Thredgold's admission in August 2016 provided for or prompted a question to be asked whether the patient was presently or recently under psychiatric care or being treated by a psychologist, not even the form then completed by Dr Breslin headed '*Medical Assessment of Patients with Psychiatric Presentation*'.[46] There is an exception in the case of a patient referred to the hospital by a specialist psychiatrist, in which case that would be shown in the '*Admission Details – MR10*' form in the box headed '*Referring Doctor/Specialist Name and Address*'.[47] Mrs Thredgold, however, was not referred to the RAH by Dr Koopowitz.

9.4. Dr Julianne Schliebs, Emergency Department Consultant proffered her opinion[48] that the appropriate place to require pro forma questioning in relation to the treating psychiatrist would be in the electronic version of the Medical Assessment of Patients with Psychiatric Presentation form, by adding it to the relevant acronym expansion in the new computer-based record-keeping system (now known as Sunrise EMRPAS).[49]

10. Mr Thredgold tells hospital staff of the involvement of Dr Koopowitz

10.1. Mr Thredgold's evidence was that he told three people at the hospital that Dr Koopowitz was Mrs Thredgold's treating psychiatrist and that the hospital should contact him. Firstly, he told a nurse who was dealing with the police shortly after Mrs Thredgold's arrival at the hospital; secondly, he told a man of Asian appearance in green scrubs who came out of Mrs Thredgold's cubicle: to him Mr Thredgold reiterated that someone needed to contact Dr Koopowitz, her clinical psychiatrist; and, thirdly, he told an administrative staff member just before he left to collect the children, between 3pm and 3:10pm.[50] On the evening following Mrs Thredgold's death, he sent a text message to Dr Koopowitz:

> 'I told them 3 times the (sic) had to consult you and she was in your care. I am gutted. She was such a beautiful soul.'

10.2. At the time of Mrs Thredgold's admission, an electronic patient activity tracking system known as HASS was in use in the RAH ED. It is no longer in use. A copy of the relevant records was received in evidence.[51]

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[46] Exhibit C14 (Vol 2), page 41
[47] Exhibit C14 (Vol 2), page 21
[48] Transcript, page 273
[49] See Dr Symon, Exhibit C23, page 10
[50] Transcript, pages 51-52
[51] Exhibit C23b

10.3. At 2:50pm on 26 August 2016 a HASS entry was made noting an arrangement for security for Mrs Thredgold because Mr Thredgold needed to collect the children from school.

10.4. At 2:51pm, Dr JC Lee, Dr Breslin's supervising consultant, logged into HASS.[52] Dr Breslin gave evidence that it is common practice for the supervising consultant to put their name against a patient as supervising consultant, to go into the cubicle and lay eyes on the patient and then wait for a more junior doctor to go and see the patient and present a more detailed assessment.[53]

10.5. At 3pm a HASS entry was made noting that security was unable to provide a guard. The entry described Mrs Thredgold as 'high absconding risk'.[54] It was shortly after that that Mr Thredgold left, having the conversation with the man in green scrubs who came out of Mrs Thredgold's cubicle.

10.6. There is no doubt in my mind that Mr Thredgold did convey this information as he stated. I agree with the submission of counsel assisting, Mr Kalali that there is insufficient evidence before the Court to enable the recipients of the information to be identified. It is clear that Dr Ryan Breslin was not one of them.

10.7. There is evidence, to which I will come later, that Mr Thredgold must also have told Dr Van Meer.

11. Dr Breslin and his assessment of Mrs Thredgold

11.1. Dr Breslin was on duty as a Resident Medical Officer (RMO) in the RAH from 8am until 6pm on 26 August 2016.[55] At the time he had been a legally qualified medical practitioner for about two years and had recently arrived from the United Kingdom to take up a position at the RAH. His postgraduate experience in emergency medicine was limited. In his second post-graduate year he undertook a four-month rotation as an RMO at The Harbour, an inpatient mental health facility in Blackpool, UK. He had some experience there of patients presenting with comorbid conditions, for example a drug or alcohol intoxication issue and a mental health issue.[56] His work there included the assessment of patients detained by police and brought in for physical and psychiatric

[52] Exhibit C23b, page 3
[53] Transcript, page 689
[54] Exhibit C23b, page 2
[55] Exhibit C24
[56] Transcript, page 679

assessment pursuant to mental health legislation comparable to the Mental Health Act 2009. Dr Breslin's induction to the RAH ED included being shown documentation concerning the detention provisions of the Mental Health Act. He was told that when assessing acute mental health patients he was to assess their mental health and consider whether any organic cause was contributing to their presentation.[57]

11.2. Dr Breslin gave evidence at the inquest. I found him to be an impressive witness. He said he did not have an independent recollection of his examination and assessment of Mrs Thredgold. Nevertheless, the notes which he made at 3:55pm of his examination and assessment, which commenced at approximately 3:15pm are detailed and thorough. Together with Dr Breslin's evidence of his clinical practices, they enable me to make findings as to the examination and assessment which occurred. As to the role of Dr Breslin in the circumstances, Dr Symon gave evidence that the role of the emergency physician is to provide a primary assessment of a patient to determine whether or not more expert opinion is required at that point in time.[58] The evidence satisfies me that Dr Breslin met that expectation. However, as will be seen, he did so without ascertaining that Mrs Thredgold was under treatment by a private psychiatrist.

11.3. Dr Breslin logged onto HASS at 3:12pm.[59] Having regard to what he said was his inevitable practice, it is likely he then reviewed the SAAS case card, the triage notes and Mrs Thredgold's observations and then opened the OACIS electronic record-keeping system, before going to see Mrs Thredgold.[60]

11.4. Dr Breslin stated that he conducted his examination between 3:15pm and 3:55pm. These were the times recorded as the taking of an alcohol reading of 0.399% by a nurse, and the time Dr Breslin commenced his notes after the examination.[61] I accept Dr Breslin's evidence as to timing. He carried out a medical examination and a mental state examination. He recorded details of Mrs Thredgold's presenting complaint, including the call to Mr Thredgold, which Dr Breslin interpreted as a threat to kill herself.[62] He recorded that Mrs Thredgold denied harming herself in any way but stated she was still thinking of killing herself, although she denied an active plan. He recorded a past medical history of depression leading to one previous suicide attempt 20 years

[57] Exhibit C24, paragraph 9
[58] Transcript, page 419
[59] Exhibit C23b, page 2
[60] Transcript, page 695
[61] ExhibitC14 (Vol 2), pages 41-42
[62] Exhibit C14 (Vol 2), page 42

ago and Gilbert's Syndrome. He recorded that she was taking sertraline, an antidepressant. Under the heading '*alcohol use*' he noted 'EtOH +++' [63] and that an alcohol withdrawal chart was required. He conducted a physical examination revealing normal observations. He conducted and noted a mental state examination, noting that Mrs Thredgold was cooperative, but agitated, suspicious and anxious. He noted that her speech and thought form was rapid and tangential. He noted that her thought content was '*suicidal*' and that she had no abnormal perceptual disturbance and a normal cognitive assessment. He noted that her insight was poor and her judgement impaired. Her alcohol level was recorded at 4pm as 0.39%.

11.5. Dr Breslin came to the working diagnosis of '*Depression. EtOH influence. ? features of emotionally unstable personality disorder*'. In the Suicide/Violence risk assessment tool Dr Breslin assessed Mrs Thredgold at '*Level 1, Security guard required*', circling from the available reasons[64] in the tool, '*Attempts to inflict injury on self*'. He explained his reasoning for this choice, that he had interpreted Mrs Thredgold's disappearance as a possible intent or attempt to kill herself. Dr Symon, however, stated[65] that he thought Mrs Thredgold's presentation warranted a finding in the tool of Level 2[66] risk, a moderate risk of self-harm, leading, according to the tool, to a requirement for Mrs Thredgold to be kept under observation in a clinical area.

11.6. Little turns on a determination of whether Dr Breslin's assessment of risk at that time was correct, or whether, on the basis of the information available to Dr Breslin, a better assessment would have been Level 2 as advocated by Dr Symon. Mrs Thredgold was under detention pursuant to section 56 of the Mental Health Act and it was a requirement, according to hospital policy, for her to have a security guard, regardless of Dr Breslin's risk assessment. Nevertheless, I consider that it was open to Dr Breslin to infer that the circumstances of Mrs Thredgold's disappearance were indicative of a person going beyond merely expressing suicidal ideation and for him to determine that she was at high risk of self-harm. Regardless, the fact that she was determined to be at

[63] Alcohol
[64] The Level 1 reasons available to be circled are 'Heated verbal encounters/Threats; Attempts to inflict injury on self/Others; Past history of severe violence/Alert screen on Hass; high lethality suicide attempt; severe psychosis present; severely altered mental state'
[65] Transcript, page 445
[66] The Level 2 reasons available to be circled are 'Suicide attempt/Ideation; Features of severe depression; Psychosis minimal/absent

high risk was available to be seen in Dr Breslin's notes by the doctor who later discharged her. More of that shortly.

11.7. Dr Breslin proposed in the notes, as a result of his assessment, a Management Plan:

> '1) IV fluids to facilitate EtOH clearance
> 2) AWS & PRN diazepam
> 3) IV thiamine
> 4) Psych referral' [67]

11.8. In conclusion of his assessment, Dr Breslin was required to state whether Mrs Thredgold was medically fit for admission to a psychiatric unit, which he said she was, and have his assessment cleared by his consultant, Dr JC Lee. Dr Breslin gave evidence[68] that Dr Lee (as his consultant) would have been the person with whom he discussed all of the history, examination and investigation findings as well as all his decision-making processes, and the Management Plan and that Dr Lee would have signed off on those decisions. The medical assessment bears Dr Breslin's signature, recorded as having been applied at 4pm. Then it appears to have been signed by Dr JC Lee, whose signature Dr Breslin identified.

11.9. It is recorded that diazepam and thiamine were administered to Mrs Thredgold at 4:10pm, by someone other than Dr Breslin, presumably a nurse.[69] An Infusion Therapy Record records that intravenous rehydration therapy was also commenced at 4:10pm.[70] Dr Breslin's evidence was that this would have occurred as he was seeing Mr Howard, the mental health nurse, for the purpose of referring Mrs Thredgold for psychiatric assessment.[71]

12. Did Dr Breslin ascertain if Mrs Thredgold had a treating psychiatrist?

12.1. I have accepted that Dr Breslin had no actual memory of the consultation with Mrs Thredgold. He stated if he had become aware of Dr Koopowitz his normal practice would have been to document it.[72] As to whether Dr Breslin enquired of Mrs Thredgold whether she had contact with a psychiatrist, Dr Breslin pointed out he was aware that

[67] Exhibit C14 (Vol 2), page 42
[68] Transcript, page 689
[69] Exhibit C14 (Vol 2), page 37
[70] Exhibit C14 (Vol 2), page 39
[71] Transcript, page 710
[72] Transcript, page 693

she was being prescribed sertraline, and that might have indicated other health practitioners. He stated:

> 'So the fact that she was on sertraline would indicate someone needed to prescribe that. In terms of what conversation I had with her about who was prescribing that for her, I don't remember that conversation. It would be normal for me to try and explore that and find out who was looking after that aspect of her health.' [73]

12.2. However, I heard from Dr Symon and Dr Naso and see from the documentation that sertraline can be and is prescribed by GPs. In Mrs Thredgold's case, Dr Krell had been prescribing sertraline for a long time. Dr Koopowitz had only managed her sertraline over two appointments. I was told that if it is known that sertraline has been prescribed by a GP, this would not usually result in follow-up contact with the GP to obtain collateral information.

12.3. Dr Breslin later again acknowledged a possibility that he did not ask Mrs Thredgold whether she had a treating psychiatrist and regarded it as possible but unlikely that he did ask her or was otherwise told by Mrs Thredgold of Dr Koopowitz's involvement but did not make a note.[74] He acknowledged the importance of obtaining collateral information particularly for mental health patients and that Dr Koopowitz would have been an important source of collateral information.

12.4. I conclude and find that Dr Breslin did not ask or otherwise ascertain that Mrs Thredgold was under the care of psychiatrist Dr Koopowitz.

12.5. Dr Breslin did not seek to excuse himself from any obligation to ascertain that Mrs Thredgold was under the care of psychiatrist. However, it is clear that he concluded upon completion of his examination that she should be referred for psychiatric assessment, and that plan was approved by his consultant. His failure to ascertain that she was under the care of Dr Koopowitz must be assessed in the context of his expectation that she would be assessed by the mental health team, in which case it would have been hard for him to conceive of that assessment not involving the ascertainment of her present psychiatric treatment and the collection of collateral history from the psychiatrist.[75]

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[73] Transcript, page 699
[74] Transcript, page 741
[75] Dr Breslin's evidence, Transcript page 700

12.6. However, he noted in the progress notes at 4:24pm (after the refusal of the mental health team referral):

> 'Consultant (Dr Lee) aware – advised admit EECU for IVI and to be reassessed when sober.' [76]

and in the Treatment Order instruction his fourth point was:

> 'When sober to be reassessed – if psych input still needed for referral then as per their advice.' [77]

12.7. So, the issue of diagnosis and decision-making as to referral to the mental health team was, on the face of the documentation, left by him for the next shift, in circumstances where he could no longer expect collateral history to be assembled by the mental health team.

13. No inpatient treatment order

13.1. Dr Breslin stated in evidence that there was insufficient evidence upon which to place Mrs Thredgold under an inpatient treatment order (ITO). Dr Naso and Dr Symon agreed that there was insufficient evidence to support the imposition of an ITO at that stage. Dr Schirripa also stated that it would have been premature.[78] Later I shall refer to evidence that there may well have been a sufficient basis to impose an ITO if contact had been made with Dr Koopowitz.

14. Dr Breslin refers Mrs Thredgold for psychiatric assessment

14.1. As described by Dr Symon, in 2016 the Emergency Consultation Liaison Service (by which name it was not widely known)[79] was a mental health service embedded within the ED at the RAH with the role of providing advice or assessment of patients who were referred to the service and presenting with a psychiatric complaint.[80] Dr Symon gave examples of when a referral would be delayed by the service, including:

> 'if a patient was intoxicated with any substance and, on account of the intoxication the patient was unable to be assessed at that time'

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[76] Exhibit C14 (Vol 2), page 29
[77] Exhibit C14 (Vol 2), page 35
[78] Transcript, page 652
[79] Dr Symon said it was known as the mental health service or team
[80] Exhibit C23, page 2

and:

> 'if a patient had a comorbid medical condition and was too unwell as a result of that condition to participate in an assessment'. [81]

14.2. Dr Breslin described in his statement that, after obtaining and recording Dr Lee's approval of his plan for Mrs Thredgold, he walked to a small office outside the resuscitation rooms in the ED where the mental health liaison nurse was located and spoke to a nurse he did not know, who gave his name as Reece (sic). He had a conversation the effect of which was that he wanted the mental health service to accept his referral to have Mrs Thredgold assessed, and that the nurse declined to accept the referral because Mrs Thredgold's alcohol breath level was high and she needed time to sober up, following which a referral could be made if it was still considered necessary.[82] He asked the nurse for his surname so that he could document the discussion but the nurse declined to give it to him.

14.3. Dr Breslin made a record in HASS at 4:21pm:

> 'A/w [awaiting] bloods. When normal, for transfer to EECU to continue IVI. AWS monitoring and to sober up. Needs reassessed by us when sober before mental health will accept referral. Ryan.' [83]

14.4. Dr Breslin made a note in the progress notes at 4:24pm which he described as the normal course of events when there is disagreement, for which purpose he said he would ordinarily wish to record the full name of the person with whom the disagreement had occurred:

> 'DW [discussed with] mental health nurse (Reece) (sic) who advised not accepting referral at present – to be reassessed by ED when sober then referred if still appropriate. Reece (sic) declined to give me his surname when asked for purpose of documenting his professional advice.
>
> Consultant (Dr Lee) aware – advised admit EECU for IVI and to be reassessed when sober.' [84]

14.5. Rhys Howard gave evidence at the inquest. He is an experienced registered mental health nurse, having completed an undergraduate degree in 2005 and then, after five years working as a general nurse, a postgraduate Diploma in Mental Health and, in

[81] Exhibit C23, pages 2-3
[82] Exhibit C24, paragraph 39
[83] Exhibit C23b, page 2
[84] Exhibit C14 (Vol 2), page 29

2012, a Master of Nursing Science with a mental health specialty. He started working at the RAH as a mental health nurse in 2010 and at the time of giving evidence was working as a clinical mental health nurse with the Psychiatric Consultant Liaison Service, a service covering all the hospital wards. He gave evidence that in 2016, at the old RAH there was a four bed Psychiatric Extended Care Unit (PECU) situated near the ED.[85] It was staffed by four registered mental health nurses, two of whom were stationed in a nearby office within the ED, and medical staff, including a consultant psychiatrist, physically present from 9am until 5pm and on call after hours.

14.6. Mr Howard gave evidence that he was approached by Dr Breslin, with whom he had a discussion about his patient with suicidal ideation and an alcohol reading of .39%, who was under section 56 of the Mental Health Act.[86] He said they talked about the risk of such a person suffering severe alcohol withdrawal. In addition, it was discussed that because it was difficult, if not impossible in a person with that level of intoxication, to distinguish between clinical symptoms related to alcohol intoxication and those relating to underlying mental illness, it was not possible to provide an accurate psychiatric assessment at that time. He said that for those two reasons it was agreed that the most appropriate clinical pathway was not psychiatry but to remain under the care of the ED, with which the ED consultant agreed and that there was then the option to refer back to psychiatry if deemed necessary when the patient was able to be assessed accurately from a psychiatric point of view. He said his practice as a nurse would be to assess someone with an alcohol reading of .05%.[87] He said at that level '*you can be fairly confident that the clinical presentations of a mental state are related to a potential underlying mental illness rather than acute alcohol intoxication*'. He said this could vary from case to case citing a circumstance of a person having a high tolerance to alcohol, but he would deem that beyond his scope of practice as a nurse to make a decision about and would refer it to a doctor.[88] He said there would never be a time when he would deem it appropriate to assess a person with a blood alcohol reading of .39% but there was not a policy which prohibited him from doing so. He maintained that he and Dr Breslin agreed after discussion that psychiatric assessment at that time was not the appropriate clinical pathway and that Mrs Thredgold was not referred.[89] He

[85] With capacity to flex to five beds
[86] Transcript, page 121 – 122
[87] Transcript, page 123-4
[88] Transcript, page 124
[89] Transcript, pages 125-127

said that if the referral had not been withdrawn, Mrs Thredgold would have remained on a list of potential patients for whom extra resources could be allocated, for example by seeking collateral information.[90] Mr Howard said he was not told that Mrs Thredgold had a private psychiatrist and if he had been, he would have highlighted the importance of contacting the private psychiatrist or would have contacted the private psychiatrist himself to gain collateral information and gain his opinion[91], although it was clear from his evidence that as there was no referral he was not saying he would have done so in this instance. Mr Howard suggested that Dr Breslin's documented Management Plan of IV fluids to facilitate alcohol clearance, diazepam treatment, intravenous thiamine and then psychiatric referral was agreed between Dr Lee after Dr Breslin had withdrawn the referral.[92] He argued that this must have been so, as it was clear that that part of the plan had been implemented in the ED.

14.7. Dr Breslin was referred by his counsel, Mr Homburg, to the evidence of Mr Howard and took limited exception to it. Firstly, he did not agree that he withdrew the referral and said he could not force Mr Howard to accept it. They already had a plan for keeping Mrs Thredgold safe in the interim period.[93] Secondly, he did not agree that she could not be assessed to some degree at that point, or at least be '*put on their books to come and see her later on*'.[94] Thirdly, he was asked about Mr Howard's response to Dr Naso's report in which Dr Naso said:

> 'Dr Breslin adequately assessed Mrs Thredgold and discussed the case with the on-site senior. He tried to refer Mrs Thredgold to the psychiatric team and was met with some resistance.' [95]

Dr Breslin made the point that if by '*resistance*' Dr Naso meant something unprofessional or outside what you could reasonably expect, he could not say that. He said it was resisted, only in as much as it was declined.[96] Fourthly, Dr Breslin disagreed that a risk of Mrs Thredgold going into acute alcohol withdrawals and needing acute medical intervention was a justification for not undertaking the assessment. He had already put her on an alcohol withdrawal scale in order to safeguard against the risk of alcohol withdrawal, had concluded that she was medically fit for admission to the

[90] Transcript, page 125
[91] Transcript, page 128
[92] Transcript , page 129
[93] Transcript, page 713
[94] Transcript, page 714
[95] Exhibit C20, page 7
[96] Transcript, page 714

psychiatric unit and felt that alcohol withdrawal scale and PRN diazepam would be within the realms of what could be managed by the mental health team.[97] On this point, he accepted this was very likely one of Mr Howard's concerns about accepting the referral, but he felt the risk was small enough or manageable enough that she could still be referred to mental health.

14.8. Mr Howard's assertion that Dr Breslin's Management Plan was conceived by Dr Breslin and Dr Lee after Dr Breslin's conversation with Mr Howard is contrary to the evidence given by Dr Breslin. It is also inconsistent with the commencement of intravenous therapy and the administration of thiamine and diazepam, all recorded at 4:10pm. In my opinion, Mr Howard was speculating, based on what he read in the notes. One of his assumptions was that Mrs Thredgold was in the EECU (Extended Emergency Care Unit) at the time these therapies commenced. That speculation is contrary to the record made by Dr Breslin in HASS at 4:21pm which anticipated subsequent transfer to EECU.[98] It is also inconsistent with Dr Breslin's treatment order at 4:27pm which recorded an order/instruction to nursing staff to move Mrs Thredgold to EECU, give intravenous infusion as prescribed, continue alcohol withdrawal scale monitoring and PRN diazepam and, finally, the new instruction following Dr Breslin's failed referral '*when sober to be reassessed – if psych input still needed for referral then as per their advice*'.[99]

14.9. I accept the evidence of Dr Breslin and find that his Management Plan[100] was prepared and signed off by Dr Lee before Dr Breslin spoke to Mr Howard and that by the time he spoke to Mr Howard, the plan was in the process of being implemented with administration of the prescribed medications and intravenous infusion. I also find that Dr Breslin did not withdraw his oral referral and that it was effectively rejected. I note that this is inconsistent with the opinion of Dr Symon expressed in his statement[101], namely that the referral was delayed and this was appropriate but Dr Symon in evidence, having read the transcript and other material, changed his opinion and agreed that the referral had been rejected. I also find that Mr Howard's rejection of the referral

[97] Transcript, page 716
[98] Exhibit C23b, page 2
[99] Exhibit C14 (Vol 2), page 35
[100] Exhibit C14 (Vol 2), page 42
[101] Exhibit C23, paragraphs 17-26

was solely on the basis of Mrs Thredgold's high alcohol level and his belief that at that level no effective mental health assessment could be made. In rejecting the referral, he did not consult any other clinician.

15. Could Mrs Thredgold be psychiatrically assessed?

15.1. Mr Howard rejected Mrs Thredgold's referral purely based on her alcohol level. Dr Symon's view was that not conducting a mental state examination on Mrs Thredgold when her BAL was .39% was reasonable and appropriate. Dr Symon gave evidence that Mrs Thredgold's presentation (high alcohol consumption with suicidal ideation) was a common one, but rejection of a referral by a mental health team was rare. Dr Symon stated:

> 'I'd honestly say that we reject very few referrals, because you don't know that often unless you actually do see the patient.' [102]

15.2. Dr Symon expressed confidence that Mrs Thredgold's alcohol level was in fact too high to allow assessment. He said:

> 'I stick to my feeling though that the level of intoxication meant seeing the patient at that point was not going to give any meaningful psychiatric assessment.' [103]

15.3. These statements were made in the context of the model of care which prevailed at the time which, he pointed out, had changed. I shall return to that shortly.

15.4. Dr Naso and Dr Schirripa, in their evidence, specifically stressed the importance of seeing the patient before making that decision. Dr Schirripa stated he had assessed patients with high alcohol levels and had regarded them as reliable.[104]

15.5. Dr Naso gave extensive evidence on this topic. Dr Naso went further to make it plain that a mental state examination conducted at a high alcohol level may enhance conclusions from a later examination. She stated:

> 'The idea is the mental state examination is a point in time examination. It's, in effect, in psychiatry the closest equivalent to the physical examination that physicians would use in

[102] Transcript, page 399.30
[103] Transcript, pages 551-552
[104] Transcript, pages 602-605

> medical patients. So, add a few mental state examinations together over a period of time, it provides a longitudinal picture rather than a cross-sectional picture.' [105]

15.6. Dr Naso was of the opinion the alcohol level should not be considered before an assessment and went on to say that it would be a dangerous assertion to base it on a level.[106] She said that the public health service has really struggled with the concept of assessability and blood alcohol levels. In the 1990s when she started in psychiatry she was told not to assess unless the alcohol level is down to .05%. She said that psychiatrists came to realise that might not be correct and it got changed to .1%, and later back to .05%. She said this demonstrated the confusion.[107]

15.7. Dr Naso stated:

> 'The current thinking is, and should be, is that it should be based on an individual assessment and it should be done in parallel. So it's actually okay to say "you know what, at a BAL of .399 I might not get the most clear of mental state examinations', but that doesn't preclude me from doing an initial mental state and then going back and working in conjunction with the medical team.' [108]

15.8. Dr Naso made the point that the proper rationale to be applied in assessing patients with high levels of alcohol is no different to the rationale to be applied in relation to benzodiazepine, a drug which works in a similar way as alcohol. Dr Naso stated the only way to decide whether a person, overdosed on benzodiazepine, can be assessed is to see the patient and make the assessment.[109]

15.9. She suggested that rigid views about assessability of mental state, dependent on alcohol levels, encourages inappropriate decisions to alleviate the pressure of work in very busy ED's. She said:

> 'Now the other issue that I've also come across is that I have seen in practice the RMO has come to the door or the consultant has come to the door from the emergency department and they say 'Look we've got a patient, she or he is got a BAL of .2 or .3' and the nurse will say 'Well I'm not touching it'. That's what I want to stop from happening is that because it's busy and it gives you a reprieve, and I've seen that happening.' [110]

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[105] Transcript page 770.11
[106] Transcript, page 770
[107] Transcript, page 771
[108] Transcript, page 771
[109] Transcript, page 771
[110] Transcript, page 771

15.10. Dr Naso provided another reason for conducting an earlier assessment to operate as a baseline, being:

> 'An experienced psychiatrist, mental health worker or practitioner, would also need to be aware that as a person sobers up – this is where personality comes into it – as a person sobers up, it might not be the most reliable assessment around risk.' [111]

In other words, she agreed, the patient may be more truthful at a high level than when sober.

15.11. Consistently with the evidence of Dr Naso and Dr Schirripa, clinical guidance documents from other States contain warnings not to assume that a person cannot be given a mental state assessment due to intoxication.

15.12. Tendered in evidence was a 2009 publication of the New South Wales Department of Health, entitled '*NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings*'.[112] At page 8, under the heading '*Misconceptions about working with clients who have a comorbid mental and substance use disorder*' appears the following 'misconception':

> '**A Mental Status Exam (MSE) cannot be conducted on a client when they are intoxicated**
> A Mental Status Examination may be conducted on anyone who is conscious including those who are intoxicated. The state of intoxication is likely to influence the outcomes of exam and should be noted. The practitioner should remain cognisant of the fact that the outcomes of the exam will change when it is repeated at a time when the client is not intoxicated.'

15.13. This document is referred to in an SA Health document, published in 2020, which Dr Naso obtained from the SA Health website in October 2020, entitled '*CHALLENGING BEHAVIOUR TOOLKIT – TOOL 4 – Clinical guidelines and additional resources*'.[113] It is not clear whether this document, containing its reference to the 2009 NSW health document, existed and was published by SA Health at the time of Mrs Thredgold's admission. However, Dr Naso stated in October 2020 that she had '*seen it before and not recently so it's been there for a number of years*'.

15.14. Also tendered were four pages from the website of the Victorian Department of Health and Human Services, last reviewed on 23 September 2015 and headed , '*Assessment of*

[111] Transcript, page 775
[112] Exhibit C23f
[113] Exhibit C20b

intoxicated persons'.[114] Under the heading '*Background*' it is reported that coronial findings have emphasised the importance of mental state assessment in the presence of alcohol or drug intoxication. Under the heading, '*Implications for mental health service staff*' the following is stated:

> 'The presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated. When a request for assessment is received, it is not appropriate to insist that the person be free from the effects of alcohol and/or drugs.'

15.15. Dr Schliebs gave evidence that in 2016 there were no clear policies or procedures in the ED for interaction between the mental health teams or the ED staff as to at what level of patient was able to be adequately assessed. It was her own experience that the mental health staff would require a patient's alcohol level to be down to .05% before they would review a patient. Dr Schliebs said this was contentious. The effect of her evidence was that she and others considered the .05% limit to be arbitrary and incorrect.[115]

15.16. Having regard to the evidence of Dr Naso and Dr Schirripa, as well as the publications referred to, which support that their opinions are in accordance with prevailing expert opinion both at the time of Mrs Thredgold's admission and currently, I conclude that it was not appropriate for Mr Howard to reject the referral of Mrs Thredgold for psychiatric assessment solely on the ground of her alcohol level.

15.17. However, in making that finding I make no criticism of Mr Howard, as there were no policies or guidelines to this effect applicable to the RAH. Mr Howard was permitted to make a clinical judgment as to assessability like all other mental health workers. Mr Howard's working level was .05%. Dr Symon's was .1%. According to Dr Naso, such strict formulations are based in old teachings which, I accept, should be regarded as redundant and wrong. Mr Howard viewed Mrs Thredgold's alcohol level of .39% to be too high to assess and sufficient for him to reject the referral. Dr Symon gave evidence that he agreed with that decision. The evidence has shown that for a decision to be made on a proper basis, it would have been necessary for the decision maker to see Mrs Thredgold. Having regard to Dr Breslin's assessment, and the evidence of Dr Naso, in my view it is likely that some sort of useful assessment could have been

[114] Exhibit C23d
[115] Transcript, pages 232-235

made, with a further assessment inevitably to have followed. An early assessment made at or close to the time of referral might have assisted a clinician (in this case Dr Van Meer) in making a later decision as to whether Mrs Thredgold's assertion that suicidal ideation had passed was likely to be truthful.

15.18. Having said all that, once the referral had been rejected, Dr Breslin had every reason to expect that Mrs Thredgold was safe and would still receive appropriate care. As Dr Naso observed, Mrs Thredgold was under a section 56 order, she was not being discharged and he believed that she would at some point have a mental health assessment.[116] His consultant was informed and he agreed that Mrs Thredgold could enter the EECU, receive fluids, be given thiamine and diazepam, having her physical state looked after, pending reassessment. Dr Naso regarded it as still a reasonable plan to observe her and treat her as described, with the understanding that there would be a review later on.

16. The consequences of rejecting the referral - the RAH model of care in 2016

16.1. The consequences of rejecting the referral are uncontentious. The primary responsibility remained with the ED to obtain collateral information and to later reconsider referral to the mental health team. So, the primary responsibility fell again on an ED medical team to monitor and manage her alcohol withdrawal and continue to assess Mrs Thredgold's level of sobriety, and to decide at a later stage whether or not psychiatric assessment is required.[117] Hand-in-hand with that goes the proposition that if it were later to be decided that psychiatric assessment is not required, that would involve a diagnosis excluding a comorbid mental health presentation. In Mrs Thredgold's case, that is exactly what occurred, and that subsequent diagnosis by another ED doctor was erroneous, which led to her discharge without an adequate assessment of her mental health.

16.2. Dr Breslin stated that Mrs Thredgold's case provided an opportunity for the mental health team to work in parallel with the medical team.[118] He thought what probably would have happened, had the referral been accepted, is that Mrs Thredgold would have been allowed to sober up in the EECU, that she would have been kept safe there and

[116] Transcript, page 776
[117] See, for example, Dr Symon at Transcript, page 553
[118] Transcript, page 749

that the mental health team would have come to view her once she was more sober, with the teams working in parallel.

16.3. Dr Schliebs gave evidence that the physical management of Mrs Thredgold could have co-existed with a mental health team referral. Dr Schliebs stated:

> 'Particularly with patients who have significant alcohol use in the past we would expect them to go through a potential alcohol withdrawal pathway before they are safe to move to a psychiatric unit which doesn't have acute medical care. As is – as was the time in 2016, there was never those beds immediately available so patients would always remain in the emergency department for some time so had concurrent medical care and psychiatric assessment and care whether they had been cleared for transfer or not.' [119]

16.4. Dr Symon agreed that the teams of different disciplines could work in parallel.[120] Dr Symon also gave evidence of the differences between the Psychiatric Consultant Liaison Service now existing in the new RAH and that which existed in the old RAH: Firstly, the service is no longer embedded in the ED but is about 50 metres from the ED so the mental health team staff come to the ED to see patients. Secondly, the team is substantially larger than it was in 2016 when there was one consultant psychiatrist, three registrars and three or four nurses. Now there are two and sometimes three psychiatrists, four registrars and three nurses as well as a nurse practitioner with an extended scope of practice. Thirdly, there is a different referral system, now undertaken through the Sunrise Emergency Medical Record Patient Activity System (Sunrise EMRPAS). A referral is made electronically, accompanied by a phone call to ensure it is not missed or delayed, following which the patient must be seen by someone from the Psychiatric Consultant Liaison Service within one hour. The expectation is that a nurse would then go and do the primary assessment, seeking initial biographical data and some collateral information. If a doctor is available within the hour then the assessment would take place. If the patient is not seen within an hour, the patient is then bed-carded to psychiatry, with responsibility for the patient transferring from the ED. [121]

16.5. Under the new system, Mrs Thredgold could not have been discharged from the ED without being assessed by the mental health team.

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[119] Transcript, page 261
[120] Transcript, page 541
[121] Transcript, pages 430-435

17. Continuation of care for Mrs Thredgold after rejection of the referral

17.1. The hospital notes reflect that Dr Breslin continued to have and exercise responsibility for the care of Mrs Thredgold until, as recorded in HASS[122] he handed over to Dr Oene Van Meer at 5:41pm on 26 August 2016.

17.2. Dr Van Meer provided a Coroner's investigator (by Skype) a four-page statement dated 22 February 2017.[123] By that time he had left Australia (in October 2016) and was residing in the Netherlands. Other than by providing that statement, he has declined to participate in these proceedings; in particular the Court endeavoured to have him make himself available to give evidence, either in person or by video link and he declined to do so.

17.3. He was notified that adverse findings might be made against him and he was provided, through his local legal representative, Ms Cliff, copies of written submissions made by the various counsel who appeared in the inquest. Although Ms Cliff did not appear as counsel at the inquest, I permitted her client, through her, to make written submissions as to the findings which might be made. As an introduction to the content of those submissions, I can say that Dr Van Meer concedes that various adverse findings may properly be made against him. He has been afforded procedural fairness.

17.4. Dr Van Meer's statement reveals that in the Netherlands he obtained a degree in medicine in 2000 and thereafter completed further training, specialising in emergency medicine. At the time of making his statement he had worked in hospitals in South Africa and the Netherlands and had completed half of his training to become a surgeon. He commenced working in the RAH ED in February 2015. On 26 August 2016, he was involved in the treatment of Mrs Thredgold and, for the purposes of refreshing his memory before making his statement, was provided with copies of medical notes relating to his dealings with her. It is worth noting that even though Dr Van Meer was not available for questioning during the inquest to test the accuracy of his statement, at least it was provided within six months of Mrs Thredgold's death, at a time when it is reasonable to expect that he had a recollection of his interaction with her.

17.5. In August 2016, Dr Schliebs was Dr Van Meer's supervising consultant. She relied on the medical notes, asserting no independent recollection of any interaction with

[122] Exhibit 23b, page 3
[123] Exhibit C4

Mrs Thredgold or with Dr Van Meer about her. She gave further information about Dr Van Meer that he was a senior registrar in the ED and that she regarded him as quite competent to make an assessment of Mrs Thredgold at 6:30pm, as it is recorded in the progress notes that he did.[124] She pointed out that Dr Van Meer, as with all the registrars, was relied upon to run the ED overnight from midnight to 8am when there was no consultant present and to make senior clinical decisions and, if they were uncomfortable with those, they could call the consultant or defer the decision to the morning. She said that as the consultants delegate responsibility for those decisions to the registrars overnight, they therefore feel that they are able to make those decisions during the day as well.

17.6. It is likely that Dr Schliebs had at least some awareness of Mrs Thredgold before Dr Breslin handed over to Dr Van Meer because Dr Schliebs recorded in HASS at 5:20pm '*waiting to sober up. May not require psych when sober. Bloods all back so can go to SS EECU*'.[125] Dr Breslin gave evidence this is likely to indicate Dr Schliebs taking over Dr Lee's role as consultant, although he could not say because the consultants would normally hand over between themselves without involving the junior doctors.[126] Dr Schliebs was not asked about this entry because the HASS documents had not been produced to the Court at the time she gave evidence.

17.7. As I have mentioned, Dr Breslin handed over responsibility of Mrs Thredgold to Dr Van Meer at 5:41pm, as recorded in HASS. There is a note made in HASS six minutes earlier at 5:35pm:

> 'PMHx depression. Now EtOH intox and suicidal ideation. BAL 0.39. Now denying suicidal ideation. Bloods: normal CBE, MBA 20, bHCG and pcm. Medically cleared. On section 56. Plan: sober up, reassess and probably referred to MH (oene).'

17.8. It is perhaps not clear on its face whether Dr Breslin or Dr Van Meer made this note. As Dr Symon pointed out, Dr Van Meer's name 'oene' could indicate that the note was written by him or that it was referring to him. However, Dr Breslin said it was an entry made by Dr Van Meer and noted it was consistent with having been made at the time of handover.[127] I accept his evidence. I find that Dr Van Meer made this note at

[124] Exhibit C14 (Vol 2), page 30
[125] Exhibit C23b - Dr Schliebs was not asked about this entry because the record was not produced and tendered until after she had given evidence
[126] Transcript, page 723
[127] Transcript, page 727

handover and, accordingly, it was at that time within his contemplation that he would '*reassess and probably refer to MH*'.[128]

17.9. Dr Van Meer recorded in Mrs Thredgold's Progress Notes the following:

> 'Oene Van Meer
> reassessed
> Hist.: Drank EtOH today.
> Expressed suicidal thoughts to her husband, who requested SAPol – >presented to ED RAH.
> Not suicidal at this moment.
> 30.8.16 she is going to private rehab to end her EtOH dependency.
> Coll. Hist. (husband): She never expressed any suicidal thoughts before.
> He is happy and not concerned about her well-being when she will be discharged.
> BAL 0.20
> Bloods NAD
> (indecipherable) 129 episode of suicidal ideation after EtOH
> Plan D/W J Schliebs: discharged in company of husband and two children' [130]

18. Dr Van Meer's statement

18.1. In his statement Dr Van Meer said he spoke with Mrs Thredgold extensively about her situation, her alcohol dependency, the burden of life for her and about how she was trying and that she was a bit of a perfectionist and her personality.[131] There is no reason to doubt what he said; aspects of his account are consistent with Dr Naso's assessment of Mrs Thredgold's personality and concerns she would likely have expressed. Dr Van Meer also said that they spoke about a suicide attempt 20 years ago. He does not say whether he attempted to access any records about this, but it is reasonable to assume that he did not. He explained that a person who is a chronic alcoholic and drinks a lot can tolerate much higher levels of alcohol before judgement is impaired and that Mrs Thredgold gave him the impression not to be under the influence of alcohol at that moment and that her judgement was fine and her state of mind could be properly assessed. He said:

> 'I determined that Holly had the capacity to make her own decisions and that her judgement was sound at that time. On further discussion with Holly and her husband we made an assessment together that she was not a threat to herself anymore.'

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[128] Mental Health
[129] But presumably indicating 'diagnosis'
[130] Exhibit C14 (Vol 2), page 30
[131] Exhibit C4

He says that he noted her alcohol level had dropped to .2%. He said that prior to discharging her he discussed her case with his supervisor, Dr Schliebs and she agreed with his assessment and suggestion of discharging her.

18.2. Dr Van Meer said that when he discharged Mrs Thredgold she was in the company of her husband who was '*able and eager to keep an eye on her*' and that he (Dr Van Meer) did not '*know whether she was seeing a private psychiatrist or her GP but someone was already in the role of taking care of her.*'[132] Dr Van Meer said that Mrs Thredgold had expressed to him that she had her kids and that they were something to live for.

18.3. Dr Van Meer states that he was asked by the police officer taking his statement whether Mr Thredgold mentioned that she was under the care of a psychiatrist by the name of Dr Koopowitz. He states he cannot remember if that was mentioned or not, but it could have been. Dr Van Meer continued:

> 'We do sometimes contact a patient's psychiatrist but not often because an assessment is an assessment at that point. We would do that if we are unclear or if we are uncertain about the background or the bigger picture. Or if there are still some unsolved issues then I would consult someone to get more information. In the case in discussion, my assessment was that there was not an immediate threat so she did not need immediate admission to a hospital or to the care of her private psychiatrist.'

18.4. Dr Van Meer went on to express confidence in his own ability to make a mental health assessment, saying:

> 'I have been trained in the assessment of patients with mental health issues, as doctors we assess mental health patients quite often. I've spoken with mental health nursing staff multiple times and they say they are also convinced that their assessment is just as good as my assessment. If a patient states that he is not suicidal, he's not suicidal with them either. So that is the opinion of our colleagues from Mental Health and I'd completely agree with that and that we are able to make an assessment.'[133]

18.5. Mr Crocker of counsel for Mr Thredgold submitted that Dr Van Meer's statement should be approached with caution, in two respects in particular, given that Dr Van Meer declined to present himself for questioning at this inquest to allow his assertions to be tested. Dr Van Meer asserted firstly that he had a three-way conversation with Mr and Mrs Thredgold. This, Mr Thredgold denies. Secondly, Mr Crocker submits it is unsatisfactory that Dr Van Meer makes no explanation as to why he made no enquiry whether she had a treating specialist. As to that second matter, Dr Van Meer did not

[132] Exhibit C4
[133] Exhibit C4, page 4

specifically say he made no enquiry; he said, '*I don't know whether she was seeing a private psychiatrist or her GP but someone was already in the role of taking care of her*'. As to whether her husband mentioned she was under the care of a psychiatrist by the name of Dr Koopowitz, Dr Van Meer said, '*I cannot remember if that was mentioned to me at that time or not, it was four months ago now. It could have been mentioned but I cannot recall*'. As I shall explain in a moment, it is my view that Dr Van Meer knew, at least by the time he discharged her, that Mrs Thredgold had a treating psychiatrist.

19. Mr Thredgold's account of dealing with Dr Van Meer

19.1. Mr Thredgold said he rang the ED after he returned home having collected the children from school and was told his wife had '*been given fluids and that she was waiting on a psych consult*'.[134]

19.2. Mr Thredgold gave unchallenged evidence that a doctor who, in my opinion, could only be Dr Van Meer, rang him twice at home. In the first call, the doctor asked Mr Thredgold how his marriage was and whether he would '*be able to look after Holly if she was released*'. Mr Thredgold told the doctor he would of course be able to look after his wife. Mr Thredgold said he asked the doctor '*whether anyone had contacted Dr Koopowitz*'. The response was, '*that she either had or was waiting for a psych consult*'.[135] The telephone call was left on the basis that the doctor '*was going back to his superiors to talk to his superiors about what was going to happen and that he would call me back very soon*'.[136]

19.3. The second call was about 10 minutes later in which Mr Thredgold said he was never asked, rather he:

> '.. was told that Holly was to be discharged and it had to be into the care of an adult which was me being her husband ... there was never anything talked about concerns, or anything else like that.' [137]

Mr Thredgold gave evidence that this doctor:

> 'Didn't ask me whether I was happy or content about her coming home, he was telling me that she was to be discharged into my care.' [138]

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[134] Transcript, page 56
[135] Transcript, page 57
[136] Transcript, pages 56-57
[137] Transcript, page 76
[138] Transcript, page 93

Mr Thredgold described this second phone call as '*being told what I had to do*'[139] and agreed with the suggestion that the second phone call '*was just a matter of the logistics of time to collect her*'.[140]

19.4. I have previously mentioned the three occasions upon which Mr Thredgold stated he told staff at the RAH that Dr Koopowitz was Mrs Thredgold's treating psychiatrist and that he should be contacted. This did not come to the attention of Dr Breslin, who did not ask. Mr Thredgold said that in his first telephone conversation with the doctor, who was undoubtedly Dr Van Meer, he asked whether anyone had contacted Dr Koopowitz and got a response which was not directly in answer to the question, but asserted that she will receive, or has received, a psychiatric consult. Mr Thredgold did not question that further. It is too much to expect of him that he should have, for the same reasons that it was inappropriate for Dr Koopowitz to expect Mr Thredgold to be his messenger, and the perfect advocate for Mrs Thredgold. It was the job of Dr Koopowitz to inform clinicians at the hospital and it was the job of clinicians at the hospital to make the enquiry and then to act upon the answer by ensuring that Dr Koopowitz was spoken with to obtain the expert collateral history which was available.

19.5. There is another piece of evidence indicating that Dr Van Meer knew of Dr Koopowitz's involvement with Mrs Thredgold, namely Mr Thredgold's evidence that when he came to collect his wife, Dr Van Meer handed him two hand-addressed envelopes, one to Dr Krell and one to Dr Koopowitz.[141] Dr Van Meer told Mr Thredgold that they were for the doctors, when he saw them, and that they were about the diagnosis of suicidal ideation due to alcohol. Mr Thredgold said that he took them home unopened and that they were both opened by police when they attended after Mrs Thredgold's death on the following Sunday 28 August 2016. Mr Thredgold kept one letter, which was received as an exhibit after he produced it at the inquest.[142] This is a letter to Dr Krell, identical to a copy of the discharge letter from Dr Van Meer to Dr Krell, in the hospital notes.[143] Also produced at the inquest was a copy of a police field receipt which stated that, among other things, a copy of a letter from the RAH ED dated 26 August 2016 addressed to 'Krell, Ivan', was seized. This could not be produced, as the only item of property seized by police which Mr Thredgold collected

[139] Transcript, page 95
[140] Transcript, page 96
[141] Transcript,pages 58-60
[142] Exhibit C17
[143] Exhibit C14 (Vol 2), page 20

when he eventually attended the police station, was Mrs Thredgold's phone and he asked police to destroy the rest. So, the letter seized by the police could not be produced.

19.6. Mr Thredgold's evidence that he was given envelopes addressed to Dr Koopowitz and Dr Krell is therefore supported. Also, it was unchallenged. It is quite clear that he was given two letters and, although he could not produce the envelopes because he disposed of them, I accept his evidence.

19.7. It is clear therefore, and I find, that Dr Van Meer knew that Dr Koopowitz was treating Mrs Thredgold. If Dr Van Meer did not know that Dr Koopowitz was a psychiatrist, despite Dr Koopowitz being well-known at the Royal Adelaide Hospital, then he ought to have enquired. This is particularly so, as he should earlier have enquired of Mrs Thredgold whether she had a private psychiatrist. I regard it as likely that Dr Van Meer learned that Dr Koopowitz was treating Mrs Thredgold after his assessment of her. I find, therefore:

- Firstly that Mr Thredgold told four people at the RAH of Dr Koopowitz's involvement with Mrs Thredgold, three whose identities have not been established and one of whom was Dr Van Meer;
- Secondly, that not one of them recorded that in the hospital notes; and
- Thirdly, that Dr Van Meer, despite knowing that Mrs Thredgold was being treated by Dr Koopowitz, did not contact Dr Koopowitz by telephone to obtain collateral information from the one person who would likely have persuaded him that Mrs Thredgold's suicidal ideation was likely not solely as a result of her intoxication.

20. <u>Dr Schliebs' oversight of Dr Van Meer's plan to discharge Mrs Thredgold</u>

20.1. Relying on Dr Van Meer's note in the progress notes, Dr Schliebs agreed that Dr Van Meer discussed with her his plan to discharge Mrs Thredgold into the care of her husband. She said she did not see Mrs Thredgold and she had no recollection of any discussion with Dr Van Meer, but she could say it would have been based on information he gave her around whether he felt that Mrs Thredgold was safe and appropriate for discharge, based on his assessment. He would not necessarily have been asking permission, but just advising her that this was his plan. Dr Schliebs said that she

must have not had concerns about his plans for discharge and therefore did not think that she needed to see Mrs Thredgold beforehand.[144]

20.2. Early in her evidence, Dr Schliebs expressed her opinion that the plan to discharge Mrs Thredgold was an appropriate plan at that time. She gave reasons. Dr Van Meer had been back to reassess her. She noted his assessment that Mrs Thredgold was safe and not expressing suicidal thoughts, had positive plans to book into private rehabilitation, was going home with her husband who would care for her and that her children were a positive thing for her to look forward to in terms of being with them.[145] In expressing this opinion she took into account not only Dr Van Meer's notes set out in the progress notes,[146] but also the more extensive information referred to by Dr Van Meer in his statement.[147] She said that the extent of information in this statement compared to the fairly scanty notes demonstrated that his documentation should have been improved, but she had no criticism of what he did. However, by the end of her evidence it was clear that she did not regard Dr Van Meer's assessment as complete.

20.3. During questioning by Mr Kalali, counsel assisting, Dr Schliebs agreed that ED staff, at least in an assessment process, should ask whether a patient has a private psychiatrist, particularly if the patient had presented to the hospital with suicidal ideation.[148]

20.4. Dr Schliebs stated that if Dr Van Meer did know about Dr Koopowitz, as Mrs Thredgold's treating psychiatrist, and chose not to contact him or was not able to contact him and get that information, then she would say his assessment was incomplete.[149] She also agreed that in that event, the assessment was superficial.[150]

20.5. Dr Schliebs was also referred to Dr Naso's opinion, agreed with by Dr Schirripa, that Dr Van Meer only conducted a cross-sectional assessment of Mrs Thredgold.[151] Dr Schliebs said that was not a commonly used term in the ED, but she knew it to mean, essentially, a '*here and now assessment*'.

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[144] Transcript, pages 207-208
[145] Transcript, page 209
[146] Exhibit C14 (Vol 2), page 30
[147] Exhibit C4
[148] Transcript, page 253
[149] Transcript, page 265
[150] Transcript, page 265
[151] Exhibit C20, page 8

20.6. Dr Schirripa's criticism, to which Dr Schliebs was referred, defines '*cross-sectional assessment*' for present purposes:

> 'I agree with Dr Naso's statement that Mrs Thredgold received a 'cross-sectional assessment' while she was at the RAH and that this was 'ultimately inadequate'. A cross-sectional assessment is a superficial, 'point in time' assessment of a patient that focuses significantly on the 'here and now' symptoms and mental state and does not take into account the longitudinal, background history. I agree that Mrs Thredgold should have had a thorough, longitudinal mental health assessment undertaken.' [152]

20.7. Dr Schliebs agreed that a longitudinal assessment should have been made of Mrs Thredgold, whether or not Dr Van Meer knew of her private psychiatrist. She assumed that Dr Van Meer had done so and that the assessment he made was a longitudinal one, taking in all the information that he had available to him, including her history and including, if he was aware, information from her private psychiatrist.[153]

20.8. It is clear then that Dr Van Meer's choice to discuss with his consultant, Dr Schliebs, his plan to discharge Mrs Thredgold, added little or nothing to the value of his own assessment and decision, because Dr Schliebs trusted him to have done those things which she has agreed he ought to have done, but which, it is certainly now clear, he did not do.

20.9. Having made that observation, I acknowledge that Dr Van Meer was entitled to assess and discharge Mrs Thredgold without reference to his consultant. That being so, it is not reasonable to expect Dr Schliebs to have required Dr Van Meer to give a full account of all the detail of his approach and his assessment. Furthermore, without reliable evidence of the conversation and without knowing whether Dr Schliebs was shown Dr Van Meer's notes, there is no evidence upon which I could conclude that Dr Schliebs ought to have realised in this instance that Dr Van Meer was about to discharge Mrs Thredgold in circumstances where an assessment ought to have been undertaken by the mental health team. It appears that Dr Schliebs relied on assumptions that Dr Van Meer had done his job in the manner she expected, and upon his advice of the protective factors that were in place.

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[152] Exhibit C21, page 3
[153] Transcript, page 269

21. The expert evidence as to Dr Van Meer's assessment

21.1. Dr Naso did not criticise Dr Van Meer's judgment that he was able to assess Mrs Thredgold, despite her then alcohol level of .2%. She was, however, critical of Dr Van Meer only doing a cross-sectional assessment, rather than the longitudinal assessment which was required and she was critical of his failure to contact Dr Koopowitz to obtain collateral information about his patient. Implicit in that was that Dr Van Meer should have asked Mrs Thredgold whether she had a treating psychiatrist.

21.2. Ultimately, Dr Naso expressed the view that Mrs Thredgold ought not to have been discharged without an expert mental health examination. I have already referred to Dr Naso's evidence that Mrs Thredgold ought to have been assessed by a mental health worker after she saw Dr Breslin and that this examination could then have formed part of the longitudinal information available during a later examination. This would have allowed proper consideration of whether she was later being untruthful, in saying she was no longer suicidal, for the purpose of securing her release from hospital.

21.3. Dr Naso said Dr Van Meer's assessment of Mrs Thredgold and the protective factors was superficial. He made assumptions about her children, marriage and relationship and the plan to go to The Sanctuary being protective, without knowing enough information to make those assumptions.[154] An experienced clinician would realise she was going to present herself in the best possible light; that given her personality and her sense of shame she would present herself as having these protective factors, but without the collateral information about her chronic alcohol abuse and chronic dependence, and the likely strain placed by those factors upon her marriage, it could readily be seen that these factors were in fact not protective.[155]

21.4. Dr Naso said that an experienced ED doctor should at least identify that this was a challenging area and that they may not necessarily have the answer or be able to diagnose.

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[154] Transcript, page 779
[155] Transcript, page 778

21.5. Dr Naso criticised Dr Van Meer's assertions in his statement:

> 'I have been trained in the assessment of patients with mental health issues, as doctors we assess mental health patients quite often. I've spoken with mental health nursing staff multiple times and they say they are also convinced that their assessment is just as good as my assessment. If a patient states that he is not suicidal, he is not suicidal with them either. So that is the opinion of our colleagues from mental health and I'd completely agree with that and we are able to make an assessment.' [156]

Dr Naso gave a practical example of how the differences in expertise between Dr Van Meer and a trained mental health professional might emerge in practice. Dr Naso said:

> 'I would not, for instance, have taken at face value what Mrs Thredgold had said about suicide. I would not have taken at face value that they were all protective factors. I would have gained collateral, I would have spoken to Mr Thredgold separately. I would have interviewed Mrs Thredgold differently. It would not have been a superficial assessment at all. It would have been a somewhat kind but confronting assessment around 'Look, what's actually changed for you? You were suicidal before, your life look looks like it's in a mess; what's actually changed?' Nothing had actually changed at that point in time. So to say that the expertise is the same, I do not agree with.' [157]

21.6. To the same end, Dr Schirripa explained that whereas it appeared Dr Van Meer's assessment was in the vicinity of 15 to 20 minutes, an experienced consultant psychiatrist would have spent at least 60 minutes. Dr Schirripa was not prepared to accept that the busy workload of an ED could be any excuse for an inadequate assessment.[158]

21.7. Dr Naso also explained, as mentioned in her report, that there were mandatory requirements which needed to be explored with Mrs Thredgold and there was no evidence that they were. She referred to medical practitioners' obligations to notify Child Protection Services if there were risks to children and it was not clear that this was addressed by Dr Van Meer. She referred to her obligation to notify the Registrar of Motor Vehicles if she believed that a patient was drinking and driving, because it places the community at risk and the fact that there was no indication that Dr Van Meer addressed this with Mrs Thredgold.

21.8. Dr Naso said it was not open to Dr Van Meer to make the diagnosis that Mrs Thredgold's was an alcohol induced suicidal ideation. She said Dr Van Meer did not have enough information to make any adequate dispositional management plan or to

[156] Exhibit C4, page 4
[157] Transcript, page 780
[158] Transcript, page 629

make a decision about discharge, admission, ITO or referral to a mental health team. It was a very superficial look at things:

> 'It's "she is no longer suicidal, she has protective factors, husband happy to take her home and she is going to The Sanctuary", that's it.' [159]

21.9. Dr Schirripa agreed with Dr Naso that Dr Van Meer undertook an inadequate, cross-sectional assessment and that Mrs Thredgold should have had a thorough, longitudinal mental health assessment.

21.10. Dr Symon, in his statement, based his criticism of Dr Van Meer's assessment upon the decision to assess Mrs Thredgold at an alcohol level of 0.2% which, as discussed earlier, he considered to be a level at which a mental health assessment could not be undertaken. Despite this, Dr Symon went on in his statement to deal uncritically with the assessment Dr Van Meer did undertake, referring to him obtaining collateral history from Mr Thredgold that Mrs Thredgold had never expressed any suicidal thoughts before and that he made sure she was safe by ensuring she went home to the care of her husband and children.[160] Dr Symon went on to refer to his expectation that Dr Van Meer's decision-making as an ED doctor was not about comprehensive management but to determine whether Mrs Thredgold required further acute care in the ED as well as further psychiatric assessment.[161]

21.11. When asked about this in evidence, Dr Symon framed the question for the emergency physician as:

> 'What is the immediate care required for this patient to keep this patient safe? What further input do I need to seek from further decision-makers and experts?' Or, 'Am I satisfied at this point in time that we don't need that and this patient can now return to a primary care of private practice setting?' [162]

21.12. Dr Symon confirmed that he would have been reluctant to discharge Mrs Thredgold at an alcohol level of .2%. He then discussed the need as much as possible to take people at face value and assume that they are generally telling the truth, which leads to the need to rely on collateral information. In this context, Dr Symon referred to a cross-sectional versus a longitudinal assessment, acknowledging that information from Dr Koopowitz would be important to take into account.

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[159] Transcript, page 783
[160] Exhibit C23, pages 7-8
[161] Exhibit C23, page 8
[162] Transcript, page 420

21.13. It is this acknowledgement from Dr Symon which demonstrates the error made throughout Mrs Thredgold's treatment at the RAH, namely the failure of clinicians to make of Mrs Thredgold, what I have heard is that most basic of enquiries, namely whether she was under the treatment of a psychiatrist, and thereafter to obtain collateral information from that psychiatrist.

21.14. Dr Symon also agreed that, even putting aside Dr Koopowitz, Dr Van Meer should have made a referral to the psychiatric unit. He said Dr Van Meer's assessment that Mrs Thredgold's was an alcohol induced problem was wrong, and it was more complex than that. There was still a differential diagnosis which had not been properly clarified. It was inappropriate to discharge her.[163]

21.15. In written submissions made by his legal representative Ms Cliff, after Dr Van Meer was given notice at the end of the inquest of criticisms made of him by counsel assisting and other counsel appearing at the inquest, Dr Van Meer accepted that his assessment:

- Was not adequately noted in the medical record;
- Was superficial, in particular in that he did not obtain collateral information;
- Allocated to much weight to what he considered to be protective factors; and did not provide him with enough information to make the decision to discharge her.

21.16. In summary, Dr Van Meer made the following omissions and errors:

- He failed to contact Dr Koopowitz to obtain collateral information about Mrs Thredgold;
- He failed to refer Mrs Thredgold for specialist mental health assessment; and
- He conducted a superficial cross-sectional assessment which did not properly test Mrs Thredgold's assertion that she was not suicidal; and
- He assumed that discharge into the care of her husband and family, and the impending admission to The Sanctuary, were protective factors; and
- He discharged Mrs Thredgold which, in the light of the aforementioned omissions and errors, he should not have.

[163] Transcript, pages 567-568

22. Events after Mrs Thredgold's discharge

22.1. Mrs Thredgold was discharged into the care of her husband. Upon arrival home, Mrs Thredgold went straight to bed.

22.2. The next morning Mr Thredgold took their daughter Sophie to a tennis lesson at about 9:45am, leaving Mrs Thredgold in bed watching television. She told Mr Thredgold she was sorry and it would not happen again. By the time he got home at about 11:30am, Mr Thredgold noted that his wife had started drinking. She said it was alright as she would not get drunk. The rest of the day was spent around the house. Later that evening she telephoned her sister and told her about the rehabilitation plan. She tried to contact her mother, who was travelling in Greenland, to tell her about the plan but was unable to contact her. She felt her mother would be proud of her for making the decision to get help. Towards the end of the day Mr Thredgold noticed that Mrs Thredgold had started to get drunk. He put his wife to bed.

22.3. The next day, Sunday 28 August 2016, Mr Thredgold took Mrs Thredgold a cup of tea in bed and at about 8am she got up and they started booking flights. Mrs Thredgold seemed upbeat and positive about going to The Sanctuary. They explained to the children that their mother was going away, telling Sophie it was to help her stop drinking but telling Angus, due to his age, that she was going to London to visit her auntie.

22.4. Mrs Thredgold asked Mr Thredgold to get her a new DVD player for the trip, to replace a broken one. She also asked him to get a mulcher for the garden. Mrs Thredgold asked him to take the children to use some vouchers they had for the Smiggle store. Mr Thredgold asked Mrs Thredgold if she would like to come, but she said she wanted to finish watching television and tend to the roses.

22.5. Mr Thredgold and the children left the house at about 11am and returned at about 1pm, noticing that a car which had been in the garage had been reversed out into the driveway. The children entered the house, but as he walked in Mr Thredgold saw his wife hanging in the garage. There was an old rope from the garage suspended from a rafter and wound around Mrs Thredgold's neck with some track pants under it. A stepladder was lying nearby. Mr Thredgold did everything he could to help his wife. A neighbour responded to his calls for help and ushered the children back inside when they came out. Mr Thredgold rang for an ambulance and while he waited for a call

back for CPR instructions, he used Mrs Thredgold's phone to call his sister-in-law Megan, and found next to it a note written in Texta saying '*Sorry XX*'. A partly empty wine bottle indicated Mrs Thredgold had been drinking.

22.6. An ambulance attended and attempts to revive Mrs Thredgold were unsuccessful. Holly Thredgold was certified deceased at 2:05pm on Sunday 28 August 2016.

23. Was Mrs Thredgold's death preventable?

23.1. Mrs Thredgold took her own life at the first opportunity, less than 40 hours following her discharge from hospital. The evidence received at this inquest satisfies me that Mrs Thredgold was discharged when she remained at an acute risk of suicide. She ought not to have been discharged. The temporal connection between her discharge whilst at acute risk, and the act of taking her own life, cannot be ignored.

23.2. Dr Naso's opinion was that Mrs Thredgold's risk of suicide was, if anything, heightened at the time she was discharged.[164] As has been referred to, Dr Naso did not regard as protective the factors relied upon at the time of discharge, and considered there had been an escalation of insults and shame to her psyche. As Dr Naso put it:

> 'I don't believe there was any change. The depression was still there, the alcohol dependence was still there, the shame was still there, The Sanctuary was getting closer and closer. So I don't believe there had been any diminishing of her suicidal ideation or self-harming thoughts.'

23.3. Dr Schirripa agreed, for similar reasons, that when discharged Mrs Thredgold was at acute risk of suicide.

23.4. I approach the question of whether her death was preventable as a question to be answered by reference to the short term, and particularly whether she could be safely delivered to her planned rehabilitation at The Sanctuary, hopefully to lay a foundation for the years of treatment which Dr Koopowitz foresaw as being necessary. He anticipated a lengthy and difficult therapeutic relationship, with numerous crises.[165] Dr Koopowitz assessed, undoubtedly correctly, that Mrs Thredgold's chronic comorbid mental illness and substance abuse rendered her at chronic risk of suicide.

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[164] Transcript, page 793

[165] Exhibit C22a, page 5; Transcript, pages 332-333

23.5. There are two avenues to consider on the question of preventability. Firstly, could Mrs Thredgold's death been prevented without any communication between Dr Koopowitz and the RAH? Secondly, could her death have been prevented in the event of communication between Dr Koopowitz and the RAH?

23.6. As to the first question, the evidence seems to suggest it would have been possible for a mental health team assessment to be cognisant of Mrs Thredgold's playing down of her suicidal ideation if the mental health team had conducted an initial assessment and a subsequent assessment when sober.[166] However, I accept the opinion of Dr Naso, with which none of the psychiatrists has disagreed, that '*In the absence of collateral information from Dr Koopowitz an ITO would not have been confirmed*'.[167] In other words, relying on Mrs Thredgold's presentation at the time she was assessed by Dr Van Meer and without the collateral information which could have been provided by Dr Koopowitz, there could have been no basis for continuing to hold Mrs Thredgold involuntarily for the purpose of providing further treatment.

23.7. Would the situation have been different if Dr Koopowitz and the Royal Adelaide had communicated? The evidence overwhelmingly suggests a Level 1 ITO, providing for Mrs Thredgold's detention and treatment, would have been instigated and confirmed the following day.[168] Dr Symon considered that if Dr Koopowitz had spoken with Dr Van Meer and expressed that Mrs Thredgold was at high risk of suicide, an ITO would very likely have been imposed, instigating a psychiatric referral and Mrs Thredgold being seen by a psychiatrist within 24 hours. Dr Symon considered that, based on the further information which Dr Koopowitz had, it would have been clarified that the events of Friday 26 August 2016 were a sentinel event for Mrs Thredgold, leading to a high level of humiliation and shame, that the high risk of suicide would be clear and the ITO would be confirmed.

23.8. It is also clear that the RAH medical team and mental health team could have collaborated with Dr Koopowitz. If an ITO had been imposed and confirmed, Mrs Thredgold would have had to stay in the RAH, an approved treatment centre under the Mental Health Act, for as long as the ITO remained in place. However, as Dr Symon pointed out, there would be scope for revoking the ITO in order to facilitate

[166] Transcript, pages 781-784
[167] Transcript, page 797
[168] Transcript, pages 568-569

Mrs Thredgold's move to the Fullarton Private Hospital if, following discussion with Dr Koopowitz, Mrs Thredgold was willing to commit to voluntary admission to that private hospital under Dr Koopowitz's care.[169]

23.9. Even if Mrs Thredgold was still in the RAH, under an ITO, on Monday night, there could have been arrangements put in place for Mrs Thredgold's transition to The Sanctuary in New South Wales, setting the scene for revocation of the ITO for that purpose.[170]

23.10. Dr Naso, too, was of the opinion that on balance an ITO would have been confirmed, even in light of the adverse mental effects it would have had on Mrs Thredgold. Dr Naso too considered that an ITO may have been used as a vehicle to transition her to The Sanctuary.

23.11. Accordingly, I find that Mrs Thredgold's death was preventable. What was required was communication between Mrs Thredgold's private psychiatrist and clinicians at the RAH, initiated by either, in order for the RAH clinicians to have the collateral information required to understand that Mrs Thredgold was at acute risk of suicide, and later remained so despite reduction in her alcohol level and her own statements that she was no longer suicidal. It is likely then that she would have been detained and kept safe pending a period of rehabilitation at The Sanctuary

23.12. If there had been communication between Dr Koopowitz and the RAH clinicians, then even in the unlikely event that Mrs Thredgold was not detained on an ITO, Dr Koopowitz could have collaborated with the RAH clinicians and formulated a plan to safeguard Mrs Thredgold during the period before she left for The Sanctuary to commence intensive rehabilitation.[171]

24. <u>Conclusions</u>

24.1. Dr Koopowitz did not communicate, as he ought to have, with the RAH to advise that he was Mrs Thredgold's psychiatrist and to provide collateral information relevant to her proper assessment and diagnosis.

[169] Transcript, page 570
[170] Transcript, page 569
[171] Transcript, page 600

24.2. Dr Breslin did not enquire of Mrs Thredgold, or Mr Thredgold, as to whether she was under psychiatric treatment or other mental health treatment. He ought to have so enquired.

24.3. None of the three unidentified people told by Mr Thredgold that Mrs Thredgold was being treated by Dr Koopowitz conveyed that information to Dr Breslin, as each of them should have.

24.4. If Dr Koopowitz had communicated with the hospital, or if Dr Breslin enquired as to arrangements in place for the management of Mrs Thredgold's mental health, the refusal of Dr Breslin's referral to the mental health team is unlikely to have occurred.

24.5. The Court received documents providing guidance to clinicians in New South Wales,[172] Victoria[173] and the ACT[174] relating to the mental health assessment of intoxicated patients. Having regard to those documents and expert opinion received in this inquest, it is clear that the question of assessability of a person's mental health cannot be considered merely by reference to a quantified level of intoxication, and that the contrary view is historical and outmoded.

24.6. Dr Breslin's referral of Mrs Thredgold for mental health assessment was wrongly refused, on the basis of her alcohol level alone.

24.7. The model of care affecting the working relationship of the old RAH ED and the mental health team in August 2016 was flawed, not effectively providing for parallel management by emergency and mental health teams of patients presenting with the comorbidities of alcohol intoxication and mental illness.

24.8. In the new RAH the model of care has changed; in particular, an assessment by the mental health team is now assured once an ED doctor makes a referral.

24.9. If Dr Van Meer did not enquire before he assessed her whether Mrs Thredgold was under psychiatric treatment or other mental health treatment, he ought to have. It may be that Dr Van Meer only ascertained after that assessment that Mrs Thredgold was under treatment by Dr Koopowitz. Either way, he ought to have spoken with Dr Koopowitz and obtained collateral information as to Mrs Thredgold's history,

[172] Exhibit 23f
[173] Exhibit 23d
[174] Exhibit 23e

diagnosis and treatment. His failure to do so was a serious error. If he had, it is likely that Mrs Thredgold would have received a mental health assessment and would not have been discharged.

24.10. Dr Van Meer's diagnosis of an episode of alcohol induced suicidal ideation was reached after a superficial cross-sectional assessment, which fell short of the longitudinal assessment which was required. It was an erroneous diagnosis and involved unjustified rejection of Dr Breslin's insightful and accurate assessment and working diagnosis.

24.11. Clinicians at the RAH failed to provide a comprehensive discharge plan which transitioned the care of Mrs Thredgold safely to the private rehabilitation facility which she had arranged to attend.

25. Recommendations

25.1. Pursuant to Section 25(2) of the Coroners 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.

25.2. The Court therefore makes the following recommendations directed to the attention of the Minister for Health and Wellbeing and the Chief Executive of SA Health.

1) That the pro-forma document in Sunrise EMRPAS which succeeds the paper document 'Medical Assessment of Patients with Psychiatric Presentation'[175] be amended to include provision for recording the answer to a question as to whether a person is or has recently been under treatment by a psychiatrist or psychologist, and provision for recording that that psychiatrist or psychologist has been contacted to obtain relevant collateral information.

2) That guidelines be prepared and issued 'For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings'.[176] Consideration may be given to achieving this by amendment of the South Australian Guidelines for 'Working with the Suicidal Person'. The guidelines should acknowledge and state, in particular, a) that the provision of mental health services

[175] Exhibit C14 (Vol2), pages 41 and 42
[176] see Exhibit 23f, NSW Clinical Guidelines

is not dependent on sobriety, and is not restricted to situations in which there is a perceived risk of suicide[177] and b) that the presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated. When a request for assessment is received, it is not appropriate to insist that the person be free from the effects of alcohol and/or drugs.[178]

3) That clinicians practising in hospital emergency departments should assess with a critical mind a patient's denials of current suicidal intent and should consider the possibility that denials of important and critical circumstances may be engendered by a desire to be discharged from the hospital. In particular, denials of suicidal ideation should be evaluated against the patient's documented medical history and collateral history, including collateral history obtained from the persons treating psychiatrist or psychologist.

4) That the extent of availability at public hospitals of after-hours contact details for private psychiatrists be investigated, with a view to then considering the feasibility of establishing a register of such details. This recommendation is made because the Court heard evidence from Dr Schirripa that on a number of occasions as a private psychiatrist he has not been contacted about one of his patients who was admitted to a public emergency department. The suggestion was made that private psychiatrists' after-hours contact details may not be available in emergency departments but this was not explored in this inquest.

Key Words: Intentional self-harm; hanging; psychiatric/mental illness; alcohol abuse

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 17th day of June, 2022.

State Coroner

[177] see Exhibit 23d, Assessment of intoxicated persons – Health, Vic. page 1
[178] see Exhibit 23d, Assessment of intoxicated persons – Health, Vic. page 2