MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

FINDINGS, RECOMMENDATIONS and COMMENTS of Coroner Rod Chandler following the holding of an inquest under the *Coroners Act* 1995 (Tas) into the death of:

AH

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been partially de-identified at the request of family and by direction of the Coroner)

I, Rod Chandler, Coroner, have investigated the death of AH with an inquest held in Hobart on 6 June 2016 and 27, 28, 29 March 2017.

PREAMBLE

AH was the wife of RH. They had four children. The family lived on a farming property in Southern Tasmania. On 24 November 2013, AH took her own life. An inquest has been held concerning the death and these are my findings arising from it.

BACKGROUND

AH was born in 1976 and was raised on her parent's orchard property in Southern Tasmania. She attended school in Kingston and later attended the University of Tasmania where she graduated in 2000 as a Bachelor of Business Administration (Hospitality Management).

AH and RH married in 2002. Their first child was born the following year and thereafter their three sons were respectively born in 2004, 2007 and 2010. The evidence clearly shows that AH was a loving, devoted and most able mother and wife.

MEDICAL HISTORY

Prior to 2009 AH had enjoyed generally good health save for a childhood eating disorder and for a short-lived depressive condition which arose following her father's death in 1998. However, in 2009 she began to suffer from symptoms consistent with Crohn's disease. The diagnosis was made by 2010 and thereafter her condition progressively worsened with rashes on her legs, severe diarrhoea and stomach pain. All available pharmacological treatments were trialled but were unsuccessful. In 2012, the condition was treated surgically with a laparoscopic abdominoperineal resection, a procedure which entailed removal of the anus, rectum and part of the sigmoid colon and which necessitated a permanent end colostomy. AH then experienced difficulties with perineal wound healing which necessitated multiple

surgeries initially unsuccessfully tried on two occasions by her colorectal surgeon and then by a plastic surgeon who was able to achieve near total but not complete wound closure. This was in about mid-2013.

On 16 August 2013 AH consulted Dr Geoff Chapman, her general practitioner. He had been caring for AH since 2006 and had been assisting in the management of her Crohn's disease and its treatment. She reported that she was struggling to cope with her illness, the surgery and the possibility of further treatment and sought a referral to psychologist, Mr Andre Declerck. Dr Chapman agreed to the referral. (It was also supported by the colorectal surgeon). He prepared a Mental Health Treatment Plan, which he forwarded to Mr Declerck. It included a Depression Anxiety Stress Scale (DASS) which had been completed by AH. It showed scores of 21/42 for depression, 20/42 for anxiety and 25/42 for stress, which are suggestive of major depression. However, Dr Chapman did not consider her depression to be major but rather described it as *"borderline."*

AH saw Mr Declerck on 22 August. He utilised the appointment to obtain a psychological history and to provide supportive counselling. It was planned to put in place some psychological therapies and a further appointment was made for 10 September. However, AH later cancelled this appointment and she did not see Mr Declerck again.

CIRCUMSTANCES SURROUNDING THE DEATH

AC was a near neighbour and close friend of AH. They would speak to each other at least once every week. On Monday 18 November 2013 AH telephoned AC. She sought her help saying that *"she couldn't keep going on in life."* AC immediately drove to AH's home. Over about three hours, she talked with AH who was anxious and expressed feelings of helplessness. AC was concerned about AH's state of mind and feared that she may be planning to take her own life. They discussed seeking help and AH agreed to an appointment with Mr Declerck. AC telephoned his rooms and an appointment was made for that Wednesday.

On the Tuesday morning AH did some cooking with one of her sons. She also made some preparations for that evening's meal. At about 10:30am RH left the house with another of their sons, intending to attend to a chore on the farm. About one hour later he received a telephone call from his wife. She was *"in a real state, she was crying and said she didn't know what she was doing any more."* RH immediately called his brother JH and asked him to attend his wife. When JH arrived he found his sister-in-law lying on the ground next to the patio. She told him that she had tried to harm herself. When RH got back to the home he found his wife in a highly agitated state. He tried to calm her down but was not entirely successful. At one stage his wife grabbed a piece of cord and attempted to tie it around her neck. He

took it from her. Later she grabbed a can of fly spray and began spraying it into her mouth. RH took the can from his wife. An ambulance was called. AH was still distressed when it arrived at 2.18pm. A backup ambulance was summoned for support. After AH was placed inside the ambulance, she attempted to tie a blood pressure cuff around her neck and it had to be taken from her. RH travelled in the ambulance with his wife. He says that during the journey his wife appeared to wake up and *"snapped out of the trance."* The ambulance arrived at the Royal Hobart Hospital ('RHH') at 3.22pm. A copy of the Ambulance Tasmania (AT) Patient Care Report was left with the hospital. Its history includes reference to the incidents involving the fly spray and the blood pressure cuff but does not record AH's attempt to tie a piece of cord around her neck.

In the Emergency Department ('ED') AH was assessed by Dr Ruyare Nyakunu, the on-call psychiatric registrar. AH reported difficulty coping and complained of low concentration, poor appetite and low energy. She expressed guilt for being a poor mother and had anhedonia (an incapacity to feel normal happiness). She also reported disturbed sleep and intrusive thoughts of suicide. It was Dr Nyakunu's impression that AH was suffering from depression with suicidal ideation along with anxiety and panic attacks upon a background of Crohn's disease. He arranged for her admission to the psychiatric ward and prescribed diazepam 5-10 mg prn (when required) for her anxiety. One dose was administered that night.

The following morning AH was assessed by consultant psychiatrist Dr Anila Rao along with psychiatric registrars, Drs Imran and Johnson. She repeated her concerns related to her care of her children, affected sleep and reduced appetite and concentration. She reported thoughts of self-harm the previous day and a desire to end it all. She rated her mood at 2/10. She reported an aunt having suicided.

Notes of the consultation were made by Dr Johnson. They include these entries: *"Dr Rao states AH has been anxious with depression…give it a few days here and could consider anti-depressants. She has been struggling for a while with basic stuff"* and *"Take break few days here and monitor mood."* AH was prescribed Escitalopram 10 mg to be taken each morning and she agreed to a plan for her to remain in hospital for several days. During the day she was given leave from the ward for two hours when her sister was visiting. In this time they went to a supermarket to buy some food.

On 20 November, AH had two doses of diazepam, the first at 6.05am and the second at 9.15pm. On that day RH described his wife as having *"calmed right down."*

At 10.30am on 21 November 2013 Dr Rao and Dr Imran reviewed AH. Dr Rao assessed her to be *"significantly brighter."* It was recorded: *"Patient is satisfied to continue Escitalopram…."* and *"Patient is keen for discharge home today."* It was

agreed that she could be discharged with follow up by Dr Chapman and a psychologist. For a reason that could not be explained, reference in the notes to the involvement of the Crisis Assessment and Treatment Team (CAT team) in AH's treatment plan was crossed out. The notes do record Dr Rao's impression of the diagnosis at this time to be major depressive episode with suicidal ideation and panic attacks.

Later that morning RH arrived at the RHH. His wife had texted him beforehand to say that she was being discharged home. This came as a surprise to him as he had expected that his wife's illness would require a longer admission. When he arrived at the hospital his wife was dressed, her bag was packed and she was being briefed by a staff member on her discharge. RH noted his wife to be *"calm"* and *"thinking clearly."* Nevertheless, he informed nursing staff of his reservations concerning the proposed discharge including the fact that their home was an hour's drive from the hospital and that they had four children to care for. It was agreed for RH to speak to Dr Imran.

The records show that RH spoke with Dr Imran at 12.55pm. His wife was also present. RH reported his concerns around the proposed discharge. Dr Imran advised of the treating team's view that AH's mood had improved, that she no longer felt suicidal, that she had displayed very good insight into her illness and that she was keen to be followed up by her own psychologist and general practitioner. RH was also informed that it may take four to six weeks before the full therapeutic effects of the antidepressants could be seen. He was advised of the support mechanisms that had been put in place and which could be utilised post-discharge. Specific to the intention to involve the CAT team Dr Imran recorded that *"RH and AH are satisfied with this."*

AH saw a hospital psychologist, Ms Pip Cannan at 3.00pm. It was recorded by Ms Cannan that: *"AH quiet, reported wanting discharge home – acknowledged the importance of follow up and the need to address the mood symptoms….."* She also recorded having linked *"AH in with a private psychologist (not Mr Declerck) via MHCP (Mental Health Care Plan)* for her to *"follow up with next week"."* After that she was discharged home. An appointment had been pre-arranged for her to see Dr Chapman the following day. She also had in place an appointment with Mr Declerck on 9 January 2014. The hospital provided pamphlets showing contact numbers if an emergency arose. It was also intended for a Transfer of Care form to be provided to the district CAT team with the expectation that it would make contact with AH within 48 hours of her discharge. However, this document was not promptly dispatched with the result that the CAT team did not become aware of the transfer until after AH had taken her own life. This is a matter which I will address in more detail later.

On Friday 22 November RH described his wife as being *"just a bit fragile."* Late that afternoon they both attended Dr Chapman. He had not received any material from the RHH and was unaware of AH's admission. He described her as being calm but vague. He was given a general outline of the events the previous Tuesday. He understood that she had been prescribed an antidepressant and counselled AH on the possible side-effects. In particular, he explained to them both that it may take seven days or longer for the medication to be effective and that it was important for her to be in a safe environment until her mood improved.

On the Saturday, RH felt that his wife had *"gone downhill"* and that she had *"hit the wall a little bit."* He spent much of the day counselling and re-assuring her. He was concerned by the advice given by Dr Chapman and the need to keep her safe. However, she resisted his suggestion that she return to hospital. He resolved that he would consider returning his wife to hospital the next day when the family travelled to Hobart to return their daughter to school.

RH and AH retired to bed at about 9.00pm on the Saturday night. RH woke at about 3.00am. He realised that his wife was not in the bed. He immediately searched the house but could not find her. He dressed and went outside. He found his wife had taken her own life. He noted that she was not breathing and he was unable to find a pulse. He called 000 and requested an ambulance. He began CPR. He had previously called his brother JH and he arrived shortly afterwards and assisted with the CPR. The ambulance arrived after about 45 minutes. It was apparent to the paramedics that AH was deceased.

POST- MORTEM EXAMINATION

This was carried out by forensic pathologist Dr Donald Ritchey. He confirms the cause of death to be asphyxia due to hanging. He cites significant contributing factors to be depression and chronic ulcerative colitis.

ISSUES

The circumstances surrounding AH's death have given rise to two principal issues which require my consideration. They concern:

1. The decision to discharge AH from the RHH on 21 November 2013.
2. The referral to the CAT team.

I will deal with each in turn.

THE HOSPITAL DISCHARGE

When Dr Rao initially assessed AH it was her expectation that she would remain in hospital for a *"few days."* However, the following morning she authorised AH's discharge. That decision enabled AH to take her own life less than three days later and it is in that circumstance that the appropriateness of the discharge needs to be considered. This subject along with other issues concerning AH's hospital care were reviewed by consultant psychiatrists, Dr Ian Sale and Dr Michael Evenhuis and by Professor of Psychiatry, Matthew Large, each of whom provided helpful expert opinion.

The decision to discharge was made at around 10.30am on 21 November. According to Dr Rao it came about in these circumstances:

> *"…… initially before the patient came into the room the nurse who'd been looking after her said that she was feeling much better and was wanting to go home and then she was brought in and then we had a talk about how she was feeling and at that point she said that she was feeling much better, had kind of come to realise what her issues were and that she would really prefer to be at home because she found being in hospital to be quite sort of traumatic for her given her previous hospitalisations and that she wanted to be at home with her children who she was missing while she was in hospital and I guess she presented as being quiet ……..and settled, there'd been no sort of concerns about her behaviour over the last couple of days and she was willing to engage with all of the follow-up that we suggested."*

And:

> *"We suggested to her that, that there was a possibility that she could stay, I guess we didn't give her a time for how many days but that yes, that she'd improved quite quickly but that she'd benefit from another couple of days in hospital but she was quite adamant that she felt that she'd be more comfortable at home because she didn't like the environment on the psychiatric ward."*

I acknowledge that consideration of AH's discharge arose upon her own initiative and was not prompted by Dr Rao whom I accept favoured her remaining in hospital a little longer. The question is whether in the circumstances it was appropriate for Dr Rao to accede to her patient's wish to be discharged home.

The first point to be made in considering this issue is that machinery exists courtesy of the *Mental Health Act 2013* whereby a person can be legally detained against

their will if they have or appear to have a mental illness that requires treatment for the person's health or safety or the safety of others. Whilst it is clear that in this case AH did suffer a mental illness in the form either of an adjustment disorder as diagnosed by Dr Rao or major depression as opined by Drs Sale and Evenhuis, it was not the opinion of Dr Rao or any of the reviewing psychiatrists that a legal basis existed for her involuntary detention. This leads me to conclude that it was not open to Dr Rao to retain AH in the hospital against her will. This brings me to the next issue; that is, whether more should reasonably have been done to persuade AH to remain in hospital as a voluntary patient? In this context I note RH's evidence that his wife would *"absolutely"* have accepted a direction from the medical staff to remain in hospital.

It was Dr Sale's conclusion, *"reluctantly reached,"* that the decision to discharge AH was *"premature and unfortunate."* Dr Evenhuis considered the decision to discharge was within the bounds of competent psychiatric practice but with this rider: *"It is possible that Dr Rao may have come to a different opinion about AH's level of risk if she had obtained further history regarding AH's recent suicidal behaviour."* In this context Dr Evenhuis said that in "*ideal"* circumstances further enquiry of RH, Dr Chapman and Mr Declerk may have helped to inform the discharge decision. Professor Large also expressed the view that the decision to discharge was within the bounds of competent psychiatric practice having particular regard to AH's clinical improvement, her agreement to ongoing treatment and her desire to leave the hospital. He said further that in his view *"few competent psychiatrists would have insisted that AH remain in hospital."*

Several issues have arisen surrounding the decision to discharge AH which require comment. They follow:

1. <u>The Diagnosis of AH's Illness.</u>

The first psychiatrist to assess AH was Dr Nyakunu. In his view her mental state required her admission to the psychiatric ward along with medication to manage her apparent anxiety. Understandably, he did not at that time proceed to make a formal diagnosis. However, as I have already noted it was his impression that AH was suffering from depression with suicidal ideation along with anxiety and panic attacks upon a background of Crohn's disease. The first comprehensive assessment of AH was carried out by Dr Rao the following morning. The notes made by a Dr Johnson at this time do not record a diagnosis. However, in a report provided to the coroner and dated 3 December 2013, Dr Rao has stated that at the time of her first consultation she assessed AH as having an *"Adjustment Disorder with depressed mood and anxiety, occurring in the context of difficulty adjusting to the impact of chronic illness on her health and functional ability….."* This is contradicted in a later report dated 14 January 2014, also provided to the coroner, where Dr Rao indicates

the diagnosis to be *"a depressive episode with co-morbid anxiety and panic attacks…."* .

In her oral testimony Dr Rao explained that the report dated 14 January 2014 was an initial draft report and that the reference to a diagnosis of depression was an error. It was her firm view, she said, that AH's presentation better fitted with a diagnosis of an adjustment disorder rather than a major depressive episode with suicidal ideation. Dr Rao further said that the written record made by Dr Imran of her last consultation with AH on the morning of her discharge where he noted: *"IMP-*Major depressive episode with suicidal ideation"* did not accurately state her view of the correct diagnosis for AH.

I am prepared to accept that it was Dr Rao's opinion that the correct diagnosis for AH was an adjustment disorder and not a major depressive episode with suicidal ideation. It is pertinent for me to note that despite this opinion the Discharge Summary which was completed by Dr Johnson cites AH's principal diagnosis to *be "Depression, Suicide Ideation."*

Does Dr Rao's opinion upon the correct diagnosis coincide with other expert evidence?

In Dr Sale's opinion, AH was suffering from major depression, a condition which had slowly evolved over the preceding months and significantly escalated in the days immediately preceding her hospitalisation. Symptoms consistent with this diagnosis were fatigue, feelings of guilt, intrusive thoughts of suicide, an inability to experience pleasure (noted by Dr Nyakunu but not by Dr Rao), and feelings of lack of self-worth, anxiety and agitation. However, Dr Sale acknowledged that chronic adjustment disorder with mixed anxious and depressed mood was a reasonable differential diagnosis. He also acknowledged that it may not have been possible for Dr Rao to make a definitive diagnosis and distinguish between the two main options at the time of her initial assessment and this was a reason why further time with AH was required.

In Dr Evenhuis' opinion, a diagnosis of a major depressive episode was warranted, based upon AH's entire pre-hospitalisation history. However, it was his further view that Dr Rao's formulation of an adjustment disorder was reasonable having regard to the material available to her. Professor Large considered AH to be suffering from a depressive condition but her presentation did not permit that condition to be classified as either an adjustment disorder or a major depression.

I acknowledge that Dr Rao was the senior clinician involved in AH's care. I acknowledge too that she, unlike Drs Sale and Evenhuis and Professor Large, had the advantage of a face-to-face assessment of AH. Too, I need to be mindful that Drs Sale and Evenhuis and Professor Large, in forming their opinions, have been

benefited by hindsight. Keeping these matters in mind I have come to the view that the weight of evidence favours a finding that AH's presentation at the RHH warranted a diagnosis of major depression rather than an adjustment disorder. This conclusion accords with the impression of Dr Nyakunu and the opinions of Drs Sale and Evenhuis. It is also consistent with the understanding of AH's condition as recorded by Drs Imran and Johnson. Finally, it also accords with the initial draft report prepared by Dr Rao herself. This finding raises the question whether a diagnosis of major depression, if it had been made by Dr Rao, mandated her adopting a different treatment strategy to that put in place by her for an adjustment disorder including permission for AH's discharge.

When AH was initially admitted her treatment plan involved the administration of anti-depressants with hospitalisation planned for several days. Medical opinion is unanimous that the use of antidepressants was appropriate irrespective of the categorisation of AH's depressive condition. However, does a diagnosis of major depression warrant a longer period of hospitalisation, more so than an adjustment disorder? This question raises the issue of risk and whether a patient diagnosed with major depression should, for their own safety, be hospitalised for a longer period than a patient diagnosed with an adjustment disorder.

Dr Sale gave evidence that major depression does not *"remit overnight"* and that a patient diagnosed with the condition is 25 times more likely to commit suicide than the general population. However, upon the rate of suicide for a person with major depression compared to a person suffering from an adjustment disorder, Professor Large opined: *"….. the rates of suicide among people with lesser forms of depression, such as an adjustment disorder,……..are very similar to those with major depression. There may – in some studies the odds of – the odds of suicide are a little higher associated with major depression than – than – than adjustment disorder, but that absolute risk is very minimally different."*

The foregoing leads me to conclude that had Dr Rao diagnosed AH to be suffering from major depression such diagnosis should have been a factor which weighed to a modest extent against discharge on 21 November because of the slightly greater risk of suicide than attached to a diagnosis of an adjustment disorder.

2. Further Background Information

Pertinent to Dr Sale's view that AH's discharge was premature was the failure on the part of Dr Rao to better inform herself before acquiescing to her patient's request to go home. The decision to discharge was made at around 10.30am on 21 November. At that time AH had been in the hospital just a little more than 1.5 days. No background information had been sought from Dr Chapman. Both Drs Sale and Evenhuis opined that this would have been helpful. Dr Evenhuis also considered that it would have been appropriate for background information to have been sought

from Mr Declerck. Drs Sale and Evenhuis along with Professor Large agreed that it would have been appropriate for RH to have been interviewed alone and for a separate history to have been obtained from him. Dr Rao accepted that her failure to do this was a missed opportunity.

I accept that in an ideal world it would have been preferable for background information to have been sought from AH's general practitioner and psychologist before determining whether she should be discharged. In Dr Chapman's case he would have been able to report upon the DASS and his related consultation with AH at that time. However, this was approximately three months prior to her hospital admission and the assessment results, at least in the opinion of Dr Evenhuis, would have been of modest benefit only. As to Mr Declerck it is evident from Dr Nyakunu's notes that the hospital was aware of his one consultation with AH and her disengagement. This again was around three months beforehand and Mr Declerck certainly would not have had any contemporary information, which may have assisted Dr Rao in her decision. Overall, it is in my view most doubtful that neither Dr Chapman nor Mr Declerck, if contacted, would have been able to provide any additional information, which would have significantly assisted in deciding upon AH's discharge apart perhaps from lending some insight into the possible chronicity of her mental illness.

What of RH? In my view, it was an error on Dr Rao's part for her to make the decision to discharge without first seeking input from him. He was the person best able to provide an account of the events which immediately led to his wife's hospitalisation including the incidents of apparent attempted self-harm which preceded the fly spray incident. It would, in my view, have been pertinent for Dr Rao to have had a full understanding of RH's reservations concerning an early discharge, particularly in the context of his capacity to care for and secure his wife's safety when at the same time he was responsible for the care of their four children and also had his farm to manage. Too, it would have been beneficial for Dr Rao to have a full appreciation of the isolation of the family home and the attendant difficulty in obtaining prompt assistance in the event of an emergency. Finally, an interview with RH would have enabled him to respond to his wife's apparent wish to go home and perhaps for him to suggest some strategies, most particularly around the children and which could have addressed her desire to see them (which could have been away from the hospital) and which in turn may have made it easier for AH to be persuaded that her ongoing hospitalisation was in her best interests. I am mindful that RH did have the opportunity to vent his reservations upon the discharge at the meeting with Dr Imran. However, two points need to be made. Firstly, by the time of this meeting the decision to discharge had been made and Dr Imran's role, impliedly at least, was to explain and justify that decision rather than entertain RH's reservations with an open mind. Secondly, AH was also present at this meeting, a

fact which, in all likelihood, had a moderating effect upon RH's insistence that his wife remain hospitalised. After all, as Professor Large explained, a psychiatric ward is not a pleasant place and it is not in the interests of a husband/wife relationship for one partner to argue that the other remain confined to such a place.

3. Matters Concerning Medication

In a document provided to the inquest RH expressed his understanding that a side-effect of the antidepressant Escitalopram was to *"increase suicidal tendencies or feelings in the person taking it."* Obviously if this side-effect does exist then this was a most relevant factor to be taken into account, both with respect to whether AH should have been discharged and if so, with respect to the level of supervision to be put in place to secure her safety.

It was the evidence of toxicologist, Ms Miriam Connor, that an enhanced risk of suicidal thoughts and behaviours does exist in children and adolescents using antidepressants but there was no increased risk for adults. This was largely consistent with other medical evidence although Dr Evenhuis did observe that antidepressants can cause some people to *"become energised and agitated after starting antidepressants, and theoretically, that could lead to an increase in suicidal behaviour and completed suicide."*

In my view, the evidence supports the conclusion that there is not an established connection between antidepressant use in adults and the increased risk of suicide. More important, in my view, is the need to be aware that antidepressants are not immediately effective and that there is an extended interval before their full therapeutic benefit is achieved. Dr Sale says this interval can be as long as two weeks and, although he did not contend that a patient should remain in hospital for this full period, it was his evidence that it is necessary before a patient is discharged for the drug's use to be 'bedded down' and for *"good follow-up arrangements (to be) in place."* He advised as an option commonly used during this 'bedding down' phase was for a patient to go home overnight and for them to report back the next day upon how the drug was being tolerated.

CONCLUSION UPON THE DECISION TO DISCHARGE

There is a natural temptation, when a patient takes their own life shortly after discharge from a psychiatric facility, to assume that the decision to discharge was wrong and should not have been made. It is of course necessary for me to resist that temptation and instead to assess the appropriateness of the decision having regard to the relevant evidence.

It is clear that AH was seriously ill with a depressive condition at the time of her admission to the Department on 19 November. I have found that condition to have

been major depression. I have found too that in assessing AH's suitability for discharge a diagnosis of major depression attracted a slightly greater risk of suicide than a diagnosis of an adjustment disorder and hence warranted a greater level of care in assessing the risk of self-harm.

I have come to the conclusion, although not easily, that the decision to discharge AH less than two days after her admission was too hastily made and should have been better informed before it was taken. Dr Rao was aware that the family resided at an isolated address. She was aware too that AH had four young children to care for. Too, she was of course aware that there would be a prolonged period, perhaps as much as two weeks, before the full therapeutic effect of the antidepressant was achieved. These circumstances, in my view, mandated some input from RH upon the decision to discharge before that decision was taken, given that he was the person principally responsible for his wife's care and safety. It was only after an evaluation of RH's contribution could a proper assessment of the risk be made. It is therefore my view that Dr Rao should not have agreed to AH's request for discharge when it was made in the mid-morning of 21 November but instead should have delayed that decision until there was first a meeting with RH. Such a meeting would have been an opportunity for AH's treaters to better inform themselves of the history related to her admission, to learn of her husband's misgivings related to a possible discharge and to assess his capacity to provide the level of support for his wife that her condition required.

It is not possible for me to predict the outcome of such a meeting. It may be that the decision would have been made for the discharge to take place with the same care plan being put in place, which in fact did eventuate. However, it may also have led to AH agreeing upon a plan which incorporated strategies, which made her hospitalisation more palatable and hence prolonged her stay. In that circumstance her tragic death on 23 November may have been avoided.

REFERRAL TO THE CAT TEAM

The CAT team is a community based mental health service staffed by personnel trained to provide treatment and support to persons resident in the community who suffer from mental illness. It operates state-wide and comprises multiple, geographically based teams. One of these is the Glenorchy and Northern team which services the area north of Hobart extending from Moonah to the Midlands region and incorporating the district where the family resided.

I have noted earlier that the plan put in place at the time of AH's hospital discharge included the transfer of her care from the RHH's Department of Psychiatry (the Department) to the Glenorchy and Northern CAT team.

It was the evidence of Ms Debra Solomon, the Nurse Unit Manager at the Department, that in November 2013 Mental Health Services (MHS) had in place a documented procedure (entitled 'MHS Transfer of Care Procedure') to affect the transfer of patients to another body including the CAT team. According to Ms Solomon that procedure, coupled with staff practices which had evolved, should have ensured that the following occurred at the time of AH's discharge:

- The completion of a formal Transfer of Care form by a nurse involved in the patient's care.
- Making of a telephone call to the CAT team advising it that the Transfer of Care form was oncoming.
- Delivery of the Transfer of Care form to the CAT team by fax within 24 hours of the patient's discharge. Whilst this was the stipulated time period it was Ms Solomon's evidence that in practice the form was usually faxed at the time of discharge or within 2 hours of the patient leaving the ward.
- Faxing of a copy of the Transfer of Care form to the Mental Health Helpline, a telephone service which maintains a database of all persons who come into contact with Mental Health Services.
- Notification to the patient's family or carer of the transfer of care.

Ms Solomon explained that there has not been any material change to the patient transfer procedure since November 2013 save that it is now the practice, within seven days of discharge, for a discharge notification form to be emailed to the patient's general practitioner.

It is relevant for me to note that the MHS transfer document specifically provides that in those instances where a patient's care is being transferred to the CAT team that the team shall ensure, whenever possible, that the patient receive a face-to-face assessment/review within 48 hours of the transfer. In practice this ordinarily means that the CAT team will make contact with the patient on the same day it receives the transfer document with a view to organising a convenient time for the face-to-face meeting to take place within the 48 hour timeframe.

The evidence concerning the completion and handling of the Transfer of Care form was confusing and contradictory. However, I can glean these matters. Firstly, the Department contends that responsibility for sending the form to the CAT team lies with the nurse caring for the patient. Despite this assertion the situation existed in 2013 when, on occasions, the task was assigned to a ward clerk. During AH's last day in hospital her nurse was Ms Clarita Price. She partially completed the transfer form but it had not been completed when her shift finished that afternoon. It was therefore not dispatched by her to the CAT team. It has not been possible to identify the nurse who assumed responsibility for AH's care following the change of shift. Further, it is not clear from the evidence whether that person would have undertaken

the task of faxing the transfer document or whether he/she would have assumed it to be a job for a ward clerk. The form was to be sent by fax machine but the machine used by the Department did not have the capacity to record the time of sending. Further, by using a fax machine there was not any means of recording whether and when the form was received. Compounding these shortcomings the Department did not have in place a procedure requiring staff to record the time the form was sent and identifying the sender. Although it seems that there existed a requirement that a telephone call be made to the CAT team advising it of the patient transfer there was again no procedure in place requiring the person making the call to record its occurrence. In her evidence, Ms Solomon acknowledged that AH's case was not a unique event and that there had been other instances where a Transfer of Care form had not been sent or received. She said that a procedure was in place now requiring a monthly audit of a sample of cases to monitor how well the transfer process was working.

The evidence shows that in AH's case the following occurred:

I. The CAT team did not receive telephone notice of the proposed transfer of care.
II. Although the Transfer of Care form was completed there is not any evidence of it either being dispatched or received by the CAT team. I am satisfied that it in fact was not sent.
III. A copy of the Transfer of Care form was faxed to the Mental Health Helpline by an unidentifiable member of the RHH staff. It seems that in the morning of 24 November 2013 a member of the Helpline staff became aware that there was not a record of AH on the CAT team database. This led to the discovery that the CAT team had not in fact been sent the Transfer of Care form following AH's discharge.
IV. Sometime in the morning of 24 November the Transfer of Care form was sent to the CAT team. A member of the team then very promptly telephoned the family residence with the intention of organising a time for a home visit. The team member was then advised of AH's death.
V. A discharge notification was completed and signed by Dr Johnson and was forwarded by email to Dr Chapman. It is dated 25 November 2013 and was hence unavailable to him when he saw AH three days previously.

It is trite for me to say it but the proper transfer of a psychiatric patient's care from one provider to another is critical to the safety and medical management of that patient. Fundamental to a proper transfer is delivery and receipt of the transfer documentation. It thus behoves the body transferring the care to ensure that it has in place a process to guarantee such delivery and receipt. Regrettably such process did not exist in 2013 as illustrated in AH's case and surprisingly remains deficient to the present day as acknowledged by Ms Solomon. It beggars belief that in this age

the Department has not been able to put in place a process that ensures, firstly, that a Transfer of Care document is dispatched to the CAT team with the times of its sending and receipt being recorded and, secondly, that a cross-check is in place to ensure that the process has not been overlooked before the patient exits the Department. These circumstances lead me to **recommend** that the Department, as a matter of urgency, undertake a review of its processes with the aim of implementing a new process which guarantees the timely delivery of transfer of care documentation to the CAT team and its receipt.

I have noted earlier that the Department now has in place a practice whereby it requires its discharge notification form to be emailed to the patient's general practitioner within seven days of discharge. It is my further **recommendation** that the rules around this practice be re-assessed with a view to them being modified to ensure that the general practitioner has had delivered to him/her a copy of the discharge notification, either prior to their next consultation with the patient or within seven days of discharge, whichever is the earlier. In AH's case such a requirement would have ensured that Dr Chapman had access to her discharge notification form on the day following her hospital discharge when it would have been of maximal benefit to him.

As has been noted AH's post-discharge treatment plan incorporated the transfer of her care to the CAT team. This was clearly in the expectation that it would be available to provide ongoing support to her away from the Department. An important component of that support was the expectation that a member of the team would, in all likelihood, have a face-to-face meeting with her within 48 hours of her hospital discharge. Such meeting did not occur because of the team's ignorance of the transfer of her care. This state of affairs gives rise to the obvious question; that is would the outcome for AH have been different if the CAT team had received timely notice of her care transfer?

I am confident that if the CAT team had been notified of AH's transfer of care on the day of her discharge then it is most likely that either on that day or the following day a member of the team would have made contact with her and in all likelihood arranged to meet with her on 23 November and hence within the team's 48 hour operating timeframe. The evidence from RH is that by that day his wife had *"gone downhill"* to the extent that he was considering returning her to hospital the following day. A meeting with AH on 23 November would have presented an opportunity for the CAT team to re-assess her psychiatric state and to learn of RH's increased concerns. It is impossible to predict the outcome of such a meeting and in particular whether it would have led to AH's re-hospitalisation or other strategy being implemented which may have avoided her death. Nevertheless, I am satisfied that because of the non-involvement of the CAT team at this critical time AH was denied

the benefit of its professional assistance and hence was in turn denied a greater prospect of surviving her illness.

FINDINGS PURSUANT TO S28 OF THE *CORONERS ACT 1995*

The evidence permits me to make these formal findings:

a) The identity of the deceased is AH;
b) AH's death occurred in the circumstances described in these findings;
c) The cause of AH's death was asphyxia due to hanging;
d) AH died on 24 November 2013 in Southern Tasmania.

I am also satisfied, and find, that the hanging was a voluntary act carried out by AH with the intention of taking her own life.

I extend to RH and to his family my sincere condolences for his wife's death. I acknowledge and regret the delay in bringing this matter to a conclusion. Nevertheless, I trust that the coronial process has been of some benefit to him and his family in coping with this tragedy that has befallen them.

Finally, I record my thanks to counsel assisting, Ms Allison Shand and to coroner's associate, Ms Katie Luck for their excellent work, both in its preparation and during the course of the inquest.

Dated: 22nd day of August 2017 at Hobart in the State of Tasmania.

Rod Chandler
Coroner