FINDINGS and RECOMMENDATIONS of Coroner McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Edward Paisley Peck

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Edward Paisley Peck with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

10, 11, and 12 December 2018, 7 February 2019, final written submissions received on 29 July 2019

Representation

Counsel Assisting the Coroner: M Allen

Counsel for Tasmania Health Service: J Rudolf

Introduction

1. Edward Paisley Peck ("Edward") was born in Hobart on 20 August 1991 and was aged 23 years at the time of his death. He was single and unemployed. Edward's parents are Malcolm Peck ("Mr Peck") and Michelle Peck ("Mrs Peck"). Edward grew up and spent most of his life in the Howrah area with his parents and older sister, Stephanie Lee Smith.

2. The evidence in the inquest allows me to find that, tragically, Edward died as a result of the consequences of jumping from the Tasman Bridge on Monday 10 August 2015 just hours after he was discharged from the Royal Hobart Hospital ("RHH") from an emergency admission for a mental health crisis. Unfortunately, Edward's body has never been recovered.

3. For a relatively young man, Edward had a long and complex medical history, much of it related to his ongoing issues with his mental health and his battle against drug addiction. In the days immediately before his death, Edward's mental health was in a particularly fragile state. He had sought professional help due to his increased use of illicit drugs, and

apparently escalating suicidal ideation. This period of crisis led to two admissions to the RHH; one on the evening of 7 August 2015 arising from an overdose of prescribed and non-prescribed drugs, and the second on 9 August after he had seriously cut his arm with a razor blade.

4. During his second admission to the RHH, Edward was assessed by a medical practitioner, psychiatrist Dr David Lang, under the provisions of the *Mental Health Act 2013* ("the MHA"), to determine whether he should receive medical treatment for a mental illness, and if so, whether he met the criteria under that Act for involuntary detention of Edward for that purpose.

5. Dr Lang determined that Edward had the necessary capacity to make the decision for himself about whether or not he should receive medical treatment. Purportedly having that capacity, Edward elected not to be treated. Edward was therefore discharged from the RHH.

6. The primary issue examined during the inquest was the assessment and determination by Dr Lang in respect of Edward at the RHH on 10 August 2015, and in particular, whether Edward ought to have been made the subject of an involuntary order under the provisions of the MHA.

7. A related matter examined at inquest was whether there were, or are currently, any systemic deficits related to the assessment, treatment and discharge of patients, including Edward, under the MHA at the RHH.

Background and Medical History

8. The evidence of Mr and Mrs Peck and Ms Smith, both in their affidavits and at inquest, provided significant insight into Edward's struggles with his mental and physical health. Their deep care and concern for him over many years was obvious in their evidence and in their participation in the whole inquest process. Their evidence regarding Edward's background and the issues he was dealing with leading up to the events a few days prior to his death went unchallenged and was corroborated by other witnesses and records tendered at inquest. The following narrative comprises mostly evidence from these members of Edward's family, whose evidence I accept.

9. As a young child, Edward enjoyed being outside engaging in physical activities as well as playing a variety of sports. He had a difficult time at school from an early age. Struggling with his fine motor skills, he came under the guidance of an occupational therapist and tutor to assist in the development of these skills. Despite the extra support provided by

his parents and professionals, Edward's confidence became damaged and he did not enjoy school.

10. Edward's mental health first came into question in grade 8 when he began saying that he wanted to kill himself. It was at this time that Mr and Mrs Peck engaged a child psychiatrist to work with Edward. Despite all efforts by mental health professionals, his mental health difficulties persisted throughout high school.

11. Mr and Mrs Peck separated in 2003, when Edward was 12 years of age. Edward continued living with his mother, and spent regular time with his father. Both Mr and Mrs Peck remained in a close and amicable relationship, and both continued to play a very active and caring role in Edward's physical and mental health until his death. In 2006 Edward was formally diagnosed with depression. During this year he engaged in self-harm by cutting his arms. Subsequently, he had a number of further deliberate self-harm episodes and suicide attempts.

12. In grade 10, whilst at Clarence High School, Edward began a welding traineeship at INCAT. During this traineeship, at the age of 16 years, he sustained a lower back injury that caused him ongoing pain for the remainder of his life. This injury not only caused ongoing physical pain and discomfort, but was also a possible contributing factor to his depression as it resulted in him being unable to maintain employment.

13. In about 2009 Edward began heavy episodes of alcohol consumption and smoking cannabis. His drug use developed over time to also include the use of MDMA ("ecstasy"), amphetamines, and opiates. In her affidavit, Mrs Peck indicated that she was aware of Edward's recreational drug use, although it seems open on the evidence that she did not appreciate the true extent of his addiction. Nevertheless, throughout this period, she and Mr Peck continued their extensive efforts to ensure that he received the treatment and care he needed.

14. There followed a series of hospital admissions with Edward in crisis. These are set out below.

15. On 28 July 2009, when Edward was 17 years of age, he took an overdose of approximately twenty five Paroxetine tablets, and was admitted to the RHH.

16. On 10 August 2009, Edward had the first of 13 admissions to the Hobart Clinic, a mental health facility in Rokeby, after a self-harm incident.

17. On 10 September 2009 police officers removed Edward from the railings of the Tasman Bridge after he threatened to jump whilst under the influence of alcohol. He was

admitted to the Psychiatric Intensive Care Unit ("PICU") in the RHH.

18. On 5 October 2009 Edward stabbed himself in the abdomen with a knife, causing an approximately two centimetre deep wound. He was admitted to the RHH.

19. On 5 October 2010 Edward inflicted a laceration on his left wrist using a broken porcelain plate after consuming alcohol and was transported to the RHH.

20. In January 2011 Edward took an overdose of approximately sixty Seroquel 100mg tablets.

21. On 29 August 2011 Edward was located by police with multiple self-inflicted cuts to his arms and was transported to the RHH.

22. At 18 years of age, Edward moved in with his father before moving into his own flat in Howrah.

23. At the age of 19 years, Edward was re-admitted to the Hobart Clinic. From this time onwards, Edward was admitted to the Hobart Clinic for two or three stays per year upon referral from his general practitioner at the time. During his stay at the Hobart Clinic, the evidence indicates that he received comprehensive treatment including numerous prescription psychotropic medications and psychotherapy. The medical records indicate that Edward's attendance at medical appointments was generally erratic and he was not always compliant with medication.

24. In December 2013, on Edward's seventh admission to the Hobart Clinic, he began being treated by Dr Nicolle Ait Khelifa, a consultant psychiatrist and addiction medicine specialist. In her evidence at inquest, Dr Ait Khelifa stated that she confirmed Edward's past and current diagnoses as being bipolar affective disorder, polysubstance use disorder (amphetamine, cannabis, alcohol, cocaine, opioids and MDMA) and borderline personality traits. She also noted that he had a history of chronic pain and multiple somatic complaints. She further said that Edward's borderline personality construct with significant emotional and psychological delay was evident by his anger and fluctuating mood, irritability and frustration, poor coping mechanisms, difficult interpersonal relationships, frequent thoughts of self-harm, self-sabotage and abuse of substances. Dr Ait Khelifa commented in her evidence:

> "For as long as I had dealings with Edward he described to me having suicidal ideas and, in particular ideas of jumping from the Tasman Bridge. However, he explained to me that he was stopped from suiciding by the thought of the impact on his

parents. His parents were very supportive".[1]

25. Edward suffered numerous ongoing aches and pains during his adult life and at the time of his death was being treated by specialists for rheumatoid arthritis and ongoing stomach and bowel troubles. In the twelve months before his death, he experienced multiple health concerns, including weakness in one side of his body, urinary tract issues, increased generalised pain, and stomach and bowel problems.

26. In the months leading up to his death, Edward had been speaking with Dr Ait Khelifa and his family about attending a facility on the mainland that would give him the opportunity for detoxification from illegal substances and to work on improving his mental health without having the ability to leave the centre (a service that the Hobart Clinic is unable to provide).

27. Edward received treatment from a number of health care professionals throughout his life. At the time of his death, he was under the care of the following medical professionals:

- Dr Nicolle Ait Khelifa - consultant psychiatrist and addiction medicine specialist at the Hobart Clinic. As discussed, Dr Ait Khelifa began treating Edward when he was admitted to the Hobart Clinic for his seventh stay. She continued to be heavily involved in Edward's treatment until the day of his death.

- Dr Sally Chapman – general practitioner at the Clarence GP Super Clinic. Dr Chapman was Edward's general practitioner from May 2013 until his final appointment on 8 July 2015. She treated Edward for a number of his health complaints.

- Dr Joanne Hunter – clinical psychologist. Dr Hunter first saw Edward in December 2010 and continued to assist him until his death as a consequence of referrals from varying healthcare professionals. His final appointment with Dr Hunter was on 29 July 2015, with a further appointment scheduled for 12 August 2015 (two days after his death).

- Dr Jane Zochling – rheumatologist. Edward started to see Dr Zochling on 2 August 2014 for ongoing management of rheumatoid arthritis and he continued to see her until the time of his death.

[1] C49 – Affidavit of Dr Ait Khelifa, at [15].

- Russell Little – community mental health nurse and clinical nurse with the Hobart Clinic. Mr Little knew Edward well and maintained a good relationship with him, being involved in most of his admissions to the Hobart Clinic. Mr Little liaised regularly with Edward and his family during the days leading to Edward's death.

- Dr William Osler – gastroenterologist. Dr Osler was treating Edward in relation to a lazy colon. At the time of his death, Edward had been referred to a specialist in Melbourne for further treatment.

28. At the time of his death, Edward was prescribed various medications for his conditions. These medications included olanzapine, lamotrigine, lithium carbonate and melatonin for his mental health conditions.

Edward's Last Days

29. On Tuesday 4 August 2015, Edward was admitted to the Hobart Clinic for the thirteenth time. Medical notes from the Clinic record that Edward *"requested re-admission as quickly reported relapsing to opiate use with escalating suicidal thoughts*". He was placed on an Observation Three category, being grounding (not to leave the premises) by agreement, with one hourly observations. On this date, Edward stated to staff at the Clinic that he would like to cease drugs and that he wanted to get himself "sorted out".

30. On Friday 7 August 2015 Edward sent a message to his brother-in-law, Mr Beau Smith, stating that he was *"deep into addiction"* and that it was physically killing him, like a *"ticking time bomb"*. Mr Smith responded to Edward stating that he (Edward) needed to make some big changes in his life and start taking some responsibility, to which Edward responded that it hurt and that he wished he could change.

31. On this same date, Edward left the Hobart Clinic, without a psychiatrist's permission and without warning, contrary to his agreement for admission. Mrs Peck said in her affidavit that the Clinic informed her that Mr Peck had signed Edward out to go fishing but informed Mr Peck that Edward had signed himself out at 3.00pm for an appointment. I need make no finding concerning this matter.

32. At this point, I briefly note that the coronial investigation focused, initially and in some depth, upon the circumstances of Edward leaving the Hobart Clinic and any deficits in the Clinic's supervision of him and its procedures. Numerous affidavits from Clinic staff, supervisors and clinic records were obtained in the investigation. However, once the scope of the inquest was considered in detail, I determined that it was neither necessary nor appropriate to further investigate the circumstances of Edward's admission to and

departure from the Clinic. In determining how Edward's death occurred, it was apparent that any practices of the Clinic resulting in Edward leaving by himself, not accompanied or on the agreed terms, played no part in his death. Further, the Clinic at no time had any legal power to detain Edward.

33. After Edward left the Hobart Clinic on 7 August 2015, Mrs Peck received a call from the Clinic looking for him. Mrs Peck went to Edward's unit. There, she found Edward lying face down on the floor, unconscious. Edward had been consuming alcohol and had taken an overdose of drugs (believed to have been Lyrica, Tramadol, Diazepam, ethanol, and cannabis). He was transported to the RHH by ambulance. At the time of transport he regained a level of consciousness but was unable to walk or speak coherently. He was admitted at the RHH for the duration of the night.

34. At 10.30am the following day, Saturday 8 August 2015, Mrs Peck telephoned the RHH and was informed by staff that there had been no change in Edward's condition, and that it was possible that there would continue to be no change until Monday 10 August 2015. Mrs Peck asked that she be telephoned if there were any change in Edward's condition.

35. Approximately four hours later, at about 2.30pm, Mrs Peck received a phone call from staff at the RHH stating that Edward had got up to go to the toilet and had left the hospital when a guard was not looking. Edward then made three calls to his mother and father from a pay phone in the Hobart CBD asking for help. Mr Peck immediately drove to the CBD to locate Edward whom he found in the mall, confused and disoriented. During this time Mrs Peck attended Edward's unit and removed all sharp objects, illegal substances, and most prescription medications to reduce accessibility to potential means of suicide. In oral evidence, Mr and Mrs Peck emphasised that their actions at this time were driven by their strong concern that Edward was at risk of death, either intentionally or accidentally.

36. Mr Peck stated in his affidavit that when he located Edward in the CBD, Edward refused to go back to the RHH as he did not want to be admitted to PICU. Mr Peck explained that Edward had a strong preference to go home to his unit. Mr Peck spoke with Mr Russell Little, mental health nurse, on the telephone and the decision was made to take Edward back to his unit to rest and recover. Mr and Mrs Peck settled Edward into his unit, remained with him for some hours and then, at about 5.00pm, they left him sleeping in his unit.

37. Later that same evening, Edward went to his mother's house at 6 Yani Court, Howrah and spoke with her partner, asking him for the property that he believed his mother had taken from his unit earlier in the day. Mrs Peck was not home. Mr Peck came to collect Edward and drove him back to his unit and then left. Mr Peck said that Edward appeared

to be in a stable state of mind.

38. On Sunday 9 August 2015 Mr and Mrs Peck went to Edward's unit to clean the unit and spend time with Edward. As pre-arranged by Mrs Peck, Mr Little and his colleague from the Community Assessment Team attended the unit and spoke with Edward. Edward agreed to Mr Little's proposal of speaking with his private psychiatrist, Dr Ait Khelifa, on Monday 10 August 2015 to arrange a meeting with all involved in Edward's care. Before leaving the unit, Mr Little told Mr Peck that he had never previously seen Edward in such a condition, that he was clearly in trouble, and that Mr Peck should call him if there was anything further he could do before concluding at 8.00pm that night. Mr Little's statement is corroborated by Mr and Mrs Peck. I find that, at that time, Edward was suffering a severe mental health crisis.

39. Mr Peck gave evidence regarding Edward calling him shortly after 5.00pm that day to tell him that he had badly cut himself, that he had stopped the bleeding, and that he had called an ambulance. Mr Peck drove immediately to his son's unit where he saw the serious aftermath of Edward's self-harm. Ambulance officers were in attendance. Mrs Peck also arrived.

40. Paramedics placed Edward in an ambulance and transported him to the RHH where he was again admitted, with a deep horizontal seven centimetre long laceration to his left forearm. Mr Little stated in his affidavit that he telephoned the RHH and spoke with a nurse caring for Edward and then spoke with Mrs Peck, asking both to ensure that Edward be put on a Mental Health Order at the RHH. The records indicate that, upon admission at 6.00pm, Edward was subject to an initial involuntary protective custody order for a two-hour period.

41. Edward's arm was assessed by a medical team after which a doctor from the surgical team spoke with Edward and explained the need for surgery to rectify the damage incurred. The surgery was proposed for the following day. No further involuntary order was applied for during that evening as Edward had agreed to move to the surgical ward voluntarily. Mrs Peck stated that the doctor told her that Edward would be assessed by the psychiatric team before being discharged from the surgical ward. Mrs Peck left the hospital at 9.00pm that evening. Her concern for Edward's welfare at this time was extreme.

42. Edward remained at the RHH for the duration of that night. During the following morning, being Monday 10 August 2015, he rang Mrs Peck before his operation telling her that he was feeling anxious and wanted her to be at the hospital with him. Mrs Peck gave evidence that this request was unusual for Edward as he typically did not want people to be around him when he was having difficulties with his mental health. Mrs

Peck attended the surgical ward and waited with Edward until he was taken for surgery.

43. Mrs Peck again spoke with Mr Little, who again stressed to her the need for Edward to be detained involuntarily on a Mental Health Order. Mr Little told Mrs Peck that the hospital would let Edward go and that she would need "to beg" to have Edward detained. Mr Little also told Mrs Peck to ask the assessing psychiatrist to speak with Edward's private psychiatrist, Dr Ait Khelifa, prior to the assessment.

44. At 10.30am Edward was taken for surgery. Mrs Peck remained waiting at the RHH. She gave evidence that before and during Edward's surgery she regularly spoke with a number of surgical ward staff at the nurses' station as well as the surgical registrar, Dr Patrick. Mrs Peck repeatedly asked when the psychiatric team would arrive to assess Edward, however, no indication of a time frame was given. Mrs Peck repeatedly asked the same staff to pass a message on to the psychiatric team to let them know that they needed to speak with Dr Ait Khelifa and herself prior to assessing Edward.

45. During the morning Dr Ait Khelifa telephoned Dr Daya Sadiq. Dr Sadiq was (then) a fourth year psychiatry registrar working under Dr Lang with the Psychiatry Consultation Liaison Team at the RHH. Dr Ait Khelifa stated that the conversation involved her advising Dr Sadiq of Edward's past and current history, expressing her concerns for Edward's safety, and requesting that he remain at RHH for further psychiatric assessment.

46. Mrs Peck continually reminded staff that Edward had made two attempts at suicide that weekend alone and that he needed to be kept in hospital to prevent any further attempts. Mrs Peck also repeatedly stressed to staff that Edward would try to leave the hospital as soon as he awoke from surgery, telling them that 'it would not be pretty' and asking if security was available to assist in keeping Edward at the hospital post-surgery.

47. When Edward returned to the ward after his surgery at approximately 2.00pm, he was highly agitated and wanted to leave the hospital. Edward was informed by nursing staff that he would need half hourly observations for four hours before being discharged. Edward informed nursing staff that he would not stay at the hospital, continually showing signs of agitation including pacing back and forth.

48. Mrs Peck again attended the nurses' station, repeating the same questions and statements, even stating that if Edward was let out of the hospital that day, he would kill himself. Mrs Peck sat at the nurses' station to ensure that she would not miss the psychiatric team when they arrived to assess Edward. After some time, two males walked past Mrs Peck which prompted her to ask nursing staff if they were part of the psychiatric team. She was advised that they were. Mrs Peck said that she raced to catch

up with the two males but they were already speaking with Edward when she reached them. The evidence of Dr Lang was that he was accompanied in his assessment by a medical student. Mrs Peck waited outside the room, listening to how Edward was answering the assessment questions as she strongly suspected that he would provide false answers in order to not be detained involuntarily.

49. Approximately fifty minutes later Dr Lang, opened the door to where Mrs Peck was standing and waiting. He informed Mrs Peck that Edward had been assessed but that he did not wish for any information to be passed on to his parents and that due to confidentiality reasons, they could not discuss Edward's assessment with her. Dr Lang then informed Mrs Peck that Edward was free to be discharged.

50. Mrs Peck said that she was shocked that Edward was not to be detained on a Mental Health Order and explained to Dr Lang that Edward had attempted suicide twice already that weekend. Dr Lang simply replied that he could not discuss the matter with her. Whilst Mrs Peck was trying to speak with Dr Lang, he began to walk away, although Mrs Peck attempted to continue the conversation. Mrs Peck asked Dr Lang if he had spoken with Dr Ait Khelifa, to which he replied "*I am calling her now*" whilst using his mobile phone and walking away. During this discussion, Edward walked up behind Dr Lang and said "*What are you talking about? I'm not going to PICU or DEM*."

51. Dr Lang's conclusion, as he noted in the medical record, was that "*while risk undoubtedly persists to a degree, he is denying ongoing suicidal intent and declines the offer of hospitalisation. Not for detention under the Mental Health Act*". Dr Lang sent an email to Dr Ait Khelifa and other relevant parties at 4.50pm outlining the findings of his assessment. Dr Lang stated in the email that Edward seemed euthymic (in a positive, happy mood) and spoke of sensible future plans including day programmes at the Hobart Clinic and participating in an information technology course at university or TAFE. Dr Lang further stated that Edward was not risk-free but he could not see any grounds to detain Edward under the MHA despite this being displeasing to Mrs Peck. Dr Lang requested that the CAT team contact Edward in 24-48 hours. He also documented that he was aware that Edward's mother and treating psychiatrist were aware of the decision.

52. I should note that Mr Peck's evidence at inquest was that he did not like being in the hospital due to claustrophobia, and preferred to be outside. He therefore did not have direct contact with Edward inside the hospital or those within the hospital responsible for his care.

53. Mrs Peck gave evidence that at 4.00pm Edward was still very agitated, continuing to pace back and forth. He asked a nurse if he could be discharged and she stated that he

could be released at 4.30pm.

54. At approximately 4.00pm Edward went outside the hospital temporarily for a cigarette, and spoke with Mr Peck. During this time Edward mentioned to his father that he (Edward) needed to grow up and that the events on the Friday had occurred because of the extreme pain he was suffering. Edward did not specify whether the pain he was referring to was mental or physical. Edward was discharged at 4.30pm and left the RHH at 4.45pm in the company of his father.

55. Mr Peck stated in his affidavit that Edward was insistent on collecting his vehicle, a white Toyota Corolla registration FH4314, from his grandparents' house in Howrah and would meet Mr Peck at his house at 3 Skillion Road, Howrah. Edward attended his father's address for a very short time and left again, passing his father on the road. Edward then went to his own unit where Mrs Peck and a carpet cleaner were present to clean blood from the floors after Edward had cut his arm. She noted that he was angry, and wanted some medication that he claimed had not been given to him at the RHH. Edward collected his medication and returned to his father's address. Mr Peck was, by then, home. Edward did not stay long at his father's address, collecting a bag belonging to him and leaving again. Mr Peck saw that Edward was very agitated and angry. This was the last time that Mr Peck saw Edward. Edward returned to his own unit, having purchased a bottle of Captain Morgan Rum and a bottle of Coke. Edward drank a small amount of alcohol from the bottle and then poured a small amount into a glass mixed with Coke and sat on the floor with his phone and the drink.

56. From this time onward, it is apparent that Edward's mood and behaviour changed markedly from his presentation at the hospital. Mrs Peck's evidence was that, at this point in time, Edward was angry, aggressive and uncommunicative.

57. As stated in Mrs Peck's affidavit, a short time later Edward got up and slammed his unit door on Mrs Peck who was standing outside speaking with the carpet cleaner. Edward then began throwing things around his unit causing items to smash. Mrs Peck opened the unit door and saw Edward come towards her in anger and again slammed the door.

58. A short time later, at approximately 6.30pm, Edward exited the unit, jumped the fence, walked down his driveway, entered his vehicle and drove away. Mrs Peck advised Mr Peck who called the police radio room to advise of this concerning event. This was the last time that Mrs Peck saw her son alive.

Police notification, search and investigation

59. At 6.40pm on Monday 10 August 2015 Police Radio Dispatch Services received a call from a member of the public who stated that he had just seen a male person travelling across the Tasman Bridge from east to west, park his car and jump off the bridge.

60. Police Radio Dispatch Services tasked Constable Kate Nichols and Constable Anthony Marr to the bridge in relation to the report. Sergeant Kim Parish also immediately drove to the bridge and located an abandoned vehicle, registration FH4314. Sergeant Parish located witnesses to the event standing just to the east of the crest of the bridge on the southern side.

61. One of the witnesses was an off duty police officer, Detective Senior Sergeant Natasha Leaman. In her affidavit for the investigation, Detective Senior Sergeant Leaman stated that she had been travelling in her vehicle towards Hobart when she observed a white hatch-back stop abruptly ahead of her on the crest of the bridge in the far left hand lane. She observed the hazard lights flashing and a male exit the vehicle hastily. Concerned for the male's welfare, she pulled over approximately 20 metres in front of the vehicle. She observed the male climb over the inner railing of the pedestrian walkway. Detective Senior Sergeant Leaman exited her vehicle, ran towards the inner railing and climbed under to gain access to the walkway. By this time the male had climbed up over the second (outer) railing. As she was getting up from the walkway she looked up and observed the male leap off the bridge into the water below.

62. The attending officers then instituted traffic control measures on the bridge and took details from the civilian witnesses at the scene. They began searching the water below the bridge, illuminating the water with torches from the jump point. Two members of the public also assisted in searching with their own torches.

63. Additional officers were tasked to search by foot the western shoreline under and near the bridge. This search was undertaken but the officers were unable to locate the male person.

64. At 6.43pm officers from Marine and Rescue Services were notified and immediately activated a search for the male using the police vessel, "Dauntless", having formulated a search plan based upon the tidal and weather conditions.

65. A registration check of the abandoned vehicle revealed that the registered owner was Edward. A driver's licence and other personal papers in his name were found in the vehicle by police. There were no other items of assistance to police in the vehicle, and specifically no suicide note located there. Bellerive officers then attended 9 Yani Court

Howrah to notify Edward's parents.

66. Marine and Rescue officers continued to search as far south as the Wrest Point Casino with the search pattern concluding on a line from the casino through to the southern edge of Kangaroo Bluff on the eastern shore. It was the officers' belief that Edward could not be located further south under the prevailing conditions.

67. Before concluding the search, the Marine and Rescue officers again searched the shoreline on the eastern shore and the vicinity of the bridge. The search was concluded at approximately 9.30pm with Edward not being found.

68. Police attended the RHH Department of Emergency Management (DEM) at 9.05pm in an attempt to gather more intelligence on Edward's movements prior to his death.

69. Police also attempted to gain footage of Edward jumping from the Tasman Bridge but there was no suitable footage available.

70. Early in the morning on Tuesday 11 August 2015 police officers searched the western shore along Nutgrove Beach and Long Beach in Sandy Bay. At the same time police officers searched on the eastern shore, checking Bellerive Beach, Little Howrah Beach and Howrah Beach. Searches on both sides of the river were unsuccessful.

71. At approximately 7.25am officers on Dauntless conducted a water search along the western shoreline as far south as Piersons Point whilst a second police vessel searched the eastern shoreline. Edward's body was not located.

72. On 7 December 2015 Mrs Peck informed police that Mr Peck had located a suicide note at Edward's address not long after his death. The suicide note was seized as an exhibit, and delivered to the Coroner's Office. Mrs Peck also provided a copy of her translation of the suicide note. It is very difficult to read and was covered in blood. It is likely that it was written on 9 August at the time he cut himself.

73. The note reads:
"9/[illegible date] I am sorry [illegible] this hurt to [sic] much now I'll [illegible and crossed out] at rest happy I am not suffering any more this isn't your fault it's mine [illegible] now I am please [illegible] life without me [illegible] love you all xo".

74. There has been no evidence since this time of any activity indicating that Edward is alive including on his phone, bank accounts, Medicare, Centrelink or with any airline.

75. I am satisfied that Edward is deceased. Upon all of the evidence, I find that the person that was seen jumping from the Tasman Bridge was Edward and, further, that this was an intentional act on his part to bring about his own death.

The meaning of 'decision-making capacity' under the *Mental Health Act* 2013

76. The central question in this inquest is whether Edward should have been subject to an involuntary order under the MHA requiring him to remain in the RHH for further assessment and/or treatment, rather than allowing him to leave the hospital with a potentially high risk of suicide.

77. Most relevant to Edward's situation was the decision regarding whether or not Edward should have been subject to an Assessment Order under Division 1 of Part 3 of the MHA after his consultation with, and assessment by, Dr Lang. An Assessment Order compels assessment but not treatment to a maximum duration of 4 days.[2] A treatment order under Division 2 allows treatment without informed consent to be administered.[3] A treatment order is of the duration specified in the order, but is not to exceed six months.[4] In respect of both categories of order, there is a requirement that the person does not have decision-making capacity.[5]

78. In the case of an assessment order, section 25 of the MHA prescribes the criteria for satisfaction as follows:

> *"(a) the person has, or appears to have, a mental illness that requires or is likely to require treatment for –*
> *(i) the person's health or safety; or*
> *(ii) the safety of other persons; and*
> *(b) the person cannot be properly assessed with regard to the mental illness or the making of a treatment order except under the authority of the assessment order; and*
> ***(c) the person does not have decision-making capacity*** *(my emphasis)."*

79. Section 7 of the MHA defines decision-making capacity as follows:

> *"7. Capacity of adults and children to make decisions about their own assessment and treatment*

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[2] Sections 30, 32 and 34 of the *Mental Health Act* 2013
[3] Section 42.
[4] Section 44.
[5] Section 25, 40.

*(1) For the purposes of this Act, an adult is taken to have the capacity to make a decision about his or her own assessment or treatment (**decision-making capacity**) unless it is established, on the balance of probabilities, that –*

(a) he or she is unable to make the decision because of an impairment of, or disturbance in, the functioning of the mind or brain; and

(b) he or she is unable to –

(i) understand information relevant to the decision; or

(ii) retain information relevant to the decision; or

(iii) use or weigh information relevant to the decision; or

(iv) communicate the decision (whether by speech, gesture or other means).

(2)…omitted (child)

(3) For the purposes of this section –

(a) an adult or child may be taken to understand information relevant to a decision if it reasonably appears that he or she is able to understand an explanation of the nature and consequences of the decision given in a way that is appropriate to his or her circumstances (whether by words, signs or other means); and

(b) an adult or child may be taken to be able to retain information relevant to a decision even if he or she may only be able to retain the information briefly.

(4) In this section –

***information** relevant to a decision includes information on the consequences of –*

(a) making the decision one way or the other; and

(b) deferring the making of the decision; and

(c) failing to make the decision."

80. The current test for determining capacity contained in section 25 of the MHA departs from that of the previous (now repealed) *Mental Health Act* 1996 (Tas), in which the determination of capacity was instead focused upon the risk of the individual to themselves and the community. The relevant provision was section 24, which stated:

"24. Criteria for detention as involuntary patient

A person may be detained as an involuntary patient in an approved hospital if –

(a) the person appears to have a mental illness; and

(b) there is, in consequence, a significant risk of harm to the person or others; and

(c) the detention of the person as an involuntary patient is necessary to protect the person or others; and

(d) the approved hospital is properly equipped and staffed for the care or treatment of the person."[6]

[6] *Mental Health Act 1996* (Tas) s24.

81. The Second Reading Speech delivered on the *Mental Health Bill 2012* (Tas) identifies that the current legislation was intended to recognise *"the ability of individuals with capacity to make their own treatment choices; while enabling treatment to be provided to persons lacking capacity where this is necessary for the person's own health and safety or the safety of others"*.[7] It expresses that the legislation was intended to be "rights focused", creating a *"substitute decision making framework for persons with a mental illness who, because of their illness lack decision making capacity and cannot make their own assessment and treatment decisions, and for whom treatment is needed to prevent harm to that person's health or safety, or the safety of others"*.[8] It also confirms that decision-making capacity was introduced into the legislation as a "*threshold test for determining whether or not people with a mental illness can be involuntarily treated*".[9]

82. The Clinical Guideline issued by the Chief Civil Psychiatrist and Chief Forensic Psychiatrist under section151 of the MHA in effect from 17 February 2014 applied at the time of Edward's assessment in 2015. The Guideline was updated in 2017. Both Guidelines were tendered as exhibits on the inquest. Amongst other things, the Guideline covers the following issues in respect of capacity:

    (a) The definition of capacity;
    (b) Capacity assessment principles;
    (c) Ways to enhance decision making capacity;
    (d) When capacity should be assessed; and
    (e) Determining whether the criteria (in the Act) are met.

83. Generally, the Guideline (both original and current) highlights that an adult with capacity has the right to refuse medical treatment, even if such decision might be viewed by others as wrong, or illogical or ill-considered, and even if such refusal of treatment may have the effect of leading to serious injury or death.

84. This principle has long been part of the common law. In *Schloendorff v Society of New York Hospital*, Cardozo J stated that: "…every human being of adult years and sound mind has a right to determine what shall be done with his own body".[10] This statement continues to be cited and applied in many cases. For example, in *Malette v Shulman* Robins JA stated that:

> *"A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as*

[7] Second Reading Speech of the *Mental Health Bill 2012* (Tas), page 1.
[8] Ibid page 2.
[9] Ibid page 3.
[10] (1914) 211 NY 125 at 129.

death and may appear mistaken in the eyes of the medical profession or of the community".[11]

85. The authorities recognise the potentially conflicting principles of a competent adult's right of self-determination and to control his or her own body on the one hand, and the interest of the state in protecting and preserving the lives and health of its citizens on the other. This conflict was recognised by Lord Donaldson in *Re T* where His Lordship observed that, at least when other factors did not tip the balance one way or the other, the individual patient's right was paramount.[12]

86. Further, in *Airedale NHS Trust v Bland*, Lord Keith stated at 859, that the State's interest is not absolute, and does not compel treatment of a patient contrary to the patient's express wishes.[13] In the same case, Lord Goff said at 864, that:

"…it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so. ... [t]o this extent, the principle of the sanctity of human life must yield to the principle of self-determination..."[14]

87. It has been held that recognition of the right to reject medical treatment does not depreciate the value of life, for example in *Malette v Shulman Robins* JA stated that:

"Individual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, not enhance, the value of life".[15]

88. Where a patient is competent, their consent, or lack thereof, must be followed even if it means they will die.[16]

89. Regarding the issue of capacity, an adult "is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted".[17]

90. In Australia, in *Hunter and New England Area Health Services v A,* McDougall J considered that there is not a dichotomy between 'capacity' on one hand and 'lack of capacity' on

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[11] *Malette v Shulman* (1990) 67 DLR (4th) at 328.
[12] *Re T* [1992] EWCA Civ 18; [1993] Fam 95 at 26.
[13] [1992] UKHL 5; [1993] AC 789 at 859.
[14] Ibid at 864.
[15] *Malette v Shulman* (1990) 67 DLR (4th) at 334.
[16] *Re B* [2002] 2 All ER 449 at 20, citing *Re MB (Medical Treatment)* [1997] 2 FLR 426 at 17.
[17] *Re MB (Medical Treatment)* [1997] 2 FLR 426 at 30.

the other, rather that capacity is a scale.[18] His Honour went on to say that the issue of capacity is relative to the transaction in question and that an assessment of an individual's capacity must be issue, or 'transaction' specific, as an individual may be capable of making some simpler decisions that arise from a situation, but not more complex ones.[19]

91. In *Re MB,* Butler-Sloss LJ held that, in deciding whether a person has capacity to make a particular decision, the ultimate question is whether that person suffers from some impairment or disturbance of mental functioning so as to render him or her incapable of making the decision.[20] That will occur if the person is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; or is unable to use and weigh the information as part of the process of making the decision.[21]

92. If a patient understands their condition, and the consequences of refusing treatment, the reasons for refusing that decision – whether they be irrational, rational, unknown or non-existent – are irrelevant.[22]

93. In a decision of the Supreme Court of Victoria, *PBU & NJE v Mental Health Tribunal*[23]*,* Bell J summarised the principles applicable to the test of decision-making capacity in respect of the relevant section of the Victorian Act being almost identical to that of the MHA.[24] His Honour, in that case, stated that the "interpretation and application of these provisions are informed by well-accepted principles of both the common law and human rights regarding capacity".[25] There follows a detailed examination of these principles relating to assessing capacity to give informed consent. His Honour's summary at [206] is reproduced here:

> *"The abovementioned principles relating to assessing capacity to give informed consent under s68(1)–(2) of the Mental Health Act may be summarised as follows:*
>
> *1. The primary purpose of the Mental Health Act is to ensure that people with mental illness, including those lacking the capacity to give informed consent, receive treatment for that illness (s 1(a); see also ss 10(a), 10(f), 11 and especially 72). But the legislative intention is that this is to be done in a manner that affords equal respect for*

[18] [2009] NSWSC 761 at [24].
[19] Ibid.
[20] *Re MB (Medical Treatment)* [1997] 2 FLR 426 at 30.
[21] Ibid.
[22] *Re T* [1992] 4 All ER 649 at 662.
[23] [2018] VSC 564.
[24] See, in particular, *Mental Health Act 2014* (Vic) s68(1).
[25] [2018] VSC 564 at [136].

their human rights and particularly their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, as recognised in the Charter.

2. *Consistently with affording that respect and the position at common law for people generally, there is a (rebuttable) presumption that people with mental illness (as for people without that illness) have the capacity to give informed consent (s 70(2)). Capacity to give informed consent is issue-specific (s 68(2)(a)), can fluctuate (s 68(2)(b)) and may be enhanced with support, all of which may have significant implications for the capacity-assessing process and the ultimate determination.*

3. *Reflecting the common law, the test of capacity in s 68(1) is primarily a functional one in which the question is whether the person has the ability to remember and use or weigh relevant information and communicate a decision, not whether the person has actually done so (paras (b), (c) and (d)). The purpose of the functional test (as distinct from a status or outcome-based test) is to ensure that, in relation to capacity to give informed consent, people with mental illness are afforded the same respect for their inherent dignity and autonomy-space as people not having that illness. In relation to s 68(1)(a), the question is whether the person understands the information.*

4. *The capacity test must be applied in a non-discriminatory manner so as to ensure that people with mental illness are not deprived of their equal right to exercise legal capacity upon the basis of contestable value-judgments relating to their illness, decisions or behaviour, rather than upon the basis of the neutral application of the statutory criteria (s 68(2)(c)). In short, the test is not to be applied so as to produce social conformity at the expense of personal autonomy.*

5. *A person with mental illness is not to be found lacking the capacity to give informed consent simply by reason of making a decision that could be considered unwise (s 68(2)(d)), which recognises that self-determination is important for both dignity and health and that people with mental illness should have the same dignity of risk in relation to personal healthcare decision-making as other people. This reflects the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and personal health and wellbeing on the other.*

6. *Reflecting human rights considerations, the Mental Health Act rejects the best-interests paradigm for healthcare decision-making. Those assessing capacity under s 68(1)–(2) must vigilantly ensure that the assessment is evidence-based, patient-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon identification of a so-called objectively reasonable outcome.*

7. *The threshold of capacity in s 68(1)(a)–(d) is relatively low and requires only that the person understands and is able to remember and use or weigh the relevant information and communicate a decision in terms of the general nature, purpose and effect of the treatment. The threshold is not that the person understands the information sufficiently to make a rational or well-considered decision, is able make such a decision or has actually done so. The person does not need to have an understanding and possess those abilities in terms of the actual details of the proposed treatment but only the salient features.*

8. *Acceptance of, belief in and insight into the diagnosis of illness and need for treatment varies significantly depending upon the person and the situation. It is not a normative criterion in s 68(1)(a)–(b). Depending upon the facts of the case, a person with mental illness may lack that insight or otherwise not accept or believe that the person has a mental illness or needs treatment yet may have the capacity to give informed consent when assessed under the statutory test. The opposite may be so.*

9. *Lack of the capacity to give informed consent must be established according to the Briginshaw standard.*

10. *The provisions of the Mental Health Act are predicated upon the central purpose of ensuring that persons with mental illness have access to and receive medical treatment, consistently with the person's right to health. Where, consistently with the above principles, it is established that the patient does not have the capacity to give informed consent and there is no less restrictive way for the patient to be treated, VCAT must grant an application for ECT (s 96(1)(a)) because, under the legislative scheme and subject to its safeguards, this is a necessary means of ensuring that the patient is given that treatment."*[26]

94. The principles outlined above by Bell J are consistent with the MHA generally and its objects (section12) and principles (section15 and Schedule 1), and accord with the Second Reading Speech for the *Mental Health Bill 2012* (Tas). They inform the correct approach to determining whether a person does or does not have capacity as defined in sections 7 of the MHA.

Dr Lang's Assessment of Edward

95. The inquest focused in detail upon Dr Lang's assessment that Edward did have decision-making capacity and whether he was correct in that assessment. As discussed above, any

[26] [2018] VSC 564 at [206].

decision that Edward did not have capacity was required to be made by Dr Lang in accordance with the high standard of proof set out in *Briginshaw v Briginshaw,* holding that the task of deciding whether a serious allegation is proved must be approached with great caution.[27]

96. Dr Lang was questioned at length in his evidence at inquest and was the author of a report tendered in evidence. He presented as having sound knowledge in his specialty and as a medical practitioner who cared for his patients. The evidence of the facts and circumstances surrounding his assessment of Edward were not challenged or open to question.

97. Initially, Dr Lang gave evidence about how he approached the task of assessing capacity in patients under the MHA. In answer, he stated:

> "Okay, well I guess the first thing is the (*sic*) decision making capacity is assessed in the context of an interview with the patient. So it's very, very rare just to sit down and go *I'm here to assess your capacity*, so it will involve the usual sort of you know introducing [indistinct word(s)] getting a sense of who the person is, why they're in hospital, what their understanding of why they're in hospital is. Often rather than a formal process of saying you know – providing them with health care information and asking them to regurgitate it as it were it's based on sort of the interview conveying or not conveying you know an understanding and appreciation of what the key issues are. If someone is declining for example – I guess we see people under the Act but we also see people who might be sort of subject to a guardianship sort of applications, so you get a sense of do they understand what's it about, what the pros and cons of what they're being offered are you know their ability to express themselves clearly because you know I might see patients who are physically confused, have had strokes, things like that".[28]

98. Dr Lang was then asked specifically about his recollection of his assessment of Edward on 10 August 2015. He responded that he recalled the event "somewhat hazily but yes".[29] He recalled in "general terms" being told by Dr Sadiq of the phone call she received from Dr Ait Khelifa. He confirmed at this point that he did not dispute Dr Ait Khelifa's evidence about this call which I will discuss further on.

99. Dr Lang explained that his usual practice immediately before assessing a patient was to access the medical record, consider the important areas (such as recent history, psychiatric discharges and medication charts) and have discussions with relevant nursing

[27] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[28] Transcript of inquest proceedings, p119.
[29] Ibid p121.

staff to gain their general impression of the patient. He could not recall whether he was aware that Edward's mother wished to speak to him before he assessed Edward.

100. Dr Lang made what I consider to be detailed notes of his 50-minute consultation with Edward. In his evidence, Dr Lang was asked to read and explain those notes in their entirety. His notes provide important guidance as to how his assessment took place and his reasoning processes. I now set out, from the court transcript, Dr Lang's interpretation of and comments upon his notes:

> "Injury to left arm yesterday. Cut self and wanted to change how I was feeling. Didn't expect blood plus plus – that just means lots of blood. Relieved at lack of serious injury. Pain okay now. Adamant – which I have underlined – that this did not represent a suicide attempt and there is no intention to repeat. [indistinct word(s)] as similar to past cutting behaviour to regulate emotions slash dispel numbing [indistinct word(s)]. Attributes current exacerbation of distress to firstly a lack of meaningful work and study. Secondly, to reducing his polysubstance use – and I've commented there *previously THC*, which is shorthand for cannabis stimulants and opiates. Since he'd admitted his high level of substance use to his family Edward had experienced his family as increasingly controlling – I just want to emphasise the word *experienced* there, not – this isn't saying this is what anybody was doing, this is just how he related this in his interview.
>
> He reported that his mood was up and down and that this was chronic or longstanding and present since his teens. Today he said that his mood was actually pretty good. He outlined what I thought were sensible plans for the future, to persisting with the Hobart Clinic day program, visiting friends, starting Uni or TAFE to do an IT course, and the intention to maintain sobriety as much as was possible. I made a note there that he declines to permit me to discuss his care other than the basic outcome with either of his parents. Shorthand there refers [indistinct word(s)] past psychiatric history with a diagnosis of bipolar two disorder, largely treated with lithium and lamotrigine. He described approximately a decade of low and unstable mood complicated by substance abuse – or in the setting of as well – substance abuse, some what I described as minor [indistinct word(s)] problems, deliberate self-harm and overdoses, and conflict with his parents. He told me that people wouldn't generally be able to spot the mania and that his mood would be good and he might spend more money than would be usual – and I've made a note there *query context of comorbid stimulant use*, that it's often difficult to ascertain you know whether someone is suffering from a mood disorder in a primary sense, so they've got a psychiatric disorder, or whether their mood is elevated secondary to stimulant use.
>
> He recently impulsively discharged himself from the Hobart Clinic and took an overdose of alcohol, [indistinct word(s)], and tramadol and diazepam. And I've

quoted him as saying that this was because he just wanted to get high. He denied experiencing any significant childhood trauma. He reported that he had an allergy to nuts that led to angioedema, so a severe nut allergy. And then there's my – what's called my mental state examination. This is the psychiatric equivalent of a physical examination. And in that I found that he was solidly built young man. I found him engageable. I found him capable of asserting himself. I didn't notice any abnormal movements. I did not note that he was sedated or inattentive suggesting that there was a confusion or a marked intoxication. I found that his speech was spontaneous and not pressured – pressured speech is a sign of mania.
I found his affect, which is the – the – how people look, how they convey emotion through their face and movements to be reactive in the sense that he responded appropriately during conversation. And that – and congruent, so the way – the things that he was talking about fitted his facial expressions. He reported what we call euphomania, which is being in a good mood. He didn't demonstrate any formal thought disorder. So there was no sort of disorganisation of thought as evidenced by disorganisation of sort of speech content. That's relevant again. That can be abnormal in situations of marked intoxication or in mood disorder. And Edward adamantly denied ongoing suicidal sort of ideas. And he denied any psychotic symptoms. My overall summary was that the current situation appeared to relate more to stress and personality vulnerabilities rather than an acute presentation of a bipolar disorder. So my next comment is that while risk undoubtedly persists to a degree his denying ongoing suicidal intent and he declined the offer of hospitalisation to the Department of Psychiatry. So he was certainly offered some voluntary sort of psychiatric hospitalisation at that point. And then a plan, not for detention under the Mental Health Act, Dr Khelifa aware, mother aware if displeased, and a referral was made for the crisis assessment team to follow him up until he could re-engage with his usual care. That's basically [indistinct word(s)].[30]

101. Dr Lang concluded that Edward had decision-making capacity, giving the following evidence:

"He certainly seemed able to comprehend the information put to him, he was clearly able to retain it and he was able to tell me about the - you know the things that had been offered to him, and he was able to communicate his decision making, he wasn't – his speech wasn't garbled, he wasn't you know he was sort of able to speak freely. I deemed that the – the care that he was proposing to engage with and the activities he was proposing to engage with you know sobriety, good social activities, training

[30] Ibid p124-6.

and education, and ongoing sort of psychiatric treatment implied that he understood that he had these difficulties that were best managed in this way."[31]

102. An issue arose regarding the extent to which Dr Lang should have sought "collateral information" to aid him in the assessment of Edward. Collateral information in this context included information from other reliable sources, including Dr Ait Khelifa and Edward's parents, who may have been able to provide insight into Edward's current condition and decision-making capacity.

103. Dr Lang was asked if he could recall any reason why he did not speak to Dr Ait Khelifa before he finalised his decision about Edward's decision making capacity. While he could not recall his "exact thinking at the time" he explained, somewhat non-responsively, that "it's not unusual to discuss the outcome of an assessment once it has been performed". He acknowledged receiving the information prior to his assessment that Dr Ait Khelifa was very concerned about Edward and his risk as manifested by his behaviour in the previous week. He agreed that information from a patient's treating practitioner before making the decision could be sought where it might be relevant and practical. He conceded that information from Dr Ait Khelifa may have assisted, although as discussed below, it was apparent that Dr Lang had formed the view (based upon his interview with Edward) that additional information would not have changed his decision.

104. Dr Lang also gave evidence in respect of his telephone conversation with Dr Ait Khelifa, which occurred after his assessment of Edward and after his decision not to place him on an involuntary order. He said that he spoke to her about the reasons why he was impressed with Edward's ability to reflect on the past and anticipate the future. In evidence, he emphasised that he was in a situation where Edward was ready for discharge in the surgical ward and he had to make a decision in limited time. He said that he was aware that Dr Ait Khelifa was unhappy with his decision to discharge Edward but, at the same time, it was clear in his mind at that point in time, that Edward had capacity to make decisions about his treatment.

105. Dr Lang was questioned at inquest about whether he was aware of the possibility of Edward manipulating him to ensure he was not detained. He gave evidence that he was aware of such a possibility with any patient but also distinguished that situation from those times when patients plead their case and make an argument without them necessarily attempting to deceive him. This is a relevant observation in Edward's case.

[31] Ibid p127.

106. Dr Lang also gave evidence about not obtaining information from Mrs Peck to assist him in his assessment. He said that, in retrospect, he wished that he had taken a more "sophisticated approach" to being able to engage with Edward's family in this situation.

107. He gave evidence about his recall of his encounter with Mrs Peck following his assessment of Edward as follows:

> "In all honesty very little (recall). And time is a factor. My recollection is of talking to Dr Ait Khelifa on the phone and encountering Mrs Peck and being unable to do the two tasks sort of at the same time…I think you know my – I usually try reasonably hard not to be sort of abrupt and certainly not physically sort of aggressive in my manner. The - you know my recollection is of you know coming out into a narrow corridor which is filled with hospital paraphernalia and people moving past, Mrs Peck approaching me, and talking on the phone at the same time.
>
> [Why didn't you just listen to her?] The – I guess the first thing I'd say is in retrospect I wish that I had gone to the effort of finding the appropriate time and space to do so…I think since having reflected a great deal upon all this the – I think I'd allow that my approach to understanding confidentiality and patient's requests to maintain confidentiality has become – has been more nuanced. And I think while it's often physically and practically a difficult thing to do I now see it as being worth the time and effort to make the [indistinct word(s)] – absolutely worthwhile, usually a very important thing to do.[32]

108. Dr Lang specifically did not dispute Mrs Peck's recall of those events, and when asked if his apparent refusal to talk to Mrs Peck in the circumstances was unjustified, he said "it's certainly something I regret very much". He gave evidence that he now realises that it would not have breached Edward's confidentiality to receive information from his mother. He also said that to have such discussions are an important part of the information-gathering process. Importantly, he said that to have had an open conversation was the "human thing to have done".

109. He was asked whether he was open to the possibility that what he was told by the family at that time might have changed his decision, he suggested that it was possible but that it "would have to be pretty extraordinary information".

110. Dr Lang explained that he accepted Edward's request for confidentiality, but did not properly understand at the time that this request did not prevent him from talking to Mrs Peck for the purpose of receiving information about his situation. He explained

[32] Ibid p133-4.

that "it certainly has become my understanding more recently" but at the time it was likely that he believed he was prevented from talking to family members by reason of confidentiality.[33]

111. Finally, Dr Lang was questioned about the content of an email he sent following his assessment to a number of relevant stakeholders. He commented in that email that he couldn't see any grounds to detain him under the Mental Health Act which displeased his mother, I don't think that he's risk free, I don't think that the Mental Health Act would be lawful either." Asked to expand on the opinion that Edward was not "risk free", Dr Lang gave the following evidence:

> "Edward was clearly a young man who engaged in a lot of risky sort of activities, and I suspect for a lot of different reasons. Our ability to predict, for example, suicide is actually quite poor you know someone having made suicide attempts, self-harm attempts you know they certainly are at an elevated risk you know for months to years afterwards in fact of further such events. So – yeah so I think you know I certainly wouldn't say that he you know had minimal risk. There are a lot of people who do live with a significant amount of risk and hospitalisation is not necessarily an appropriate way to manage that risk, sometimes it actually makes things worse, there's a degree of literature that suggests that people's suicide risk actually marginally elevates in hospital, so it's a very vexed and complicated issue. Other than to say that we tend – particularly when people have long term sort of features of sort of impulsivity, substance use problems and what not that that risk is likely to remain elevated for a long time and is not easily reduced".[34]

112. I find therefore that Dr Lang was aware that Edward was at risk of self-harm, but was confident in his assessment that Edward possessed capacity to make decisions as to his treatment. With the benefit of hindsight he accepted that this was a case that justified him obtaining information from Dr Ait Khelifa and Edward's parents, although he was confident that his assessment would not have changed.

Other Expert Evidence Regarding Assessment of Edward

113. Expert evidence in the inquest was sought from Dr Lennie Woo. Dr Woo is a consultant psychiatrist based at the RHH. He has been a consultant psychiatrist for approximately 20 years and is currently Head of Department, Adult Mental Health Services, Tasmanian Health Service (THS) South.

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[33] Ibid p173.
[34] Ibid p136.

114. The affidavits, reports and oral evidence from Dr Ait Khelifa and Dr Woo, both experienced psychiatrists, was helpful and instructive in assessing the concepts of capacity and risk from the point of view of an assessing psychiatrist, and in understanding how the capacity test under the MHA is to be correctly applied.

115. In his most comprehensive submissions, Mr Allen accurately summarised the evidence of Dr Ait Khelifa and Dr Woo. He also set out extensively the particularly relevant passages of their evidence from the transcript. Mr and Mrs Peck were present in court to hear their evidence and also had the opportunity to consider the transcript of their evidence and consider Mr Allen's submissions. In these circumstances, it is appropriate to deal in a briefer form with their evidence that touches upon the issues in the inquest.

Dr Lennie Woo

116. Dr Woo has occupied his position as Head of Department, Adult Mental Health Service at Tasmania Health Service South since August 2018, after he returned to the RHH in 2017. He had previously worked in private practice and had been the Director of Medical Services at St Helens Private Hospital in Hobart. He therefore had no involvement in Edward's treatment and care in 2015. The intention of calling Dr Woo was to provide expert evidence upon aspects of assessment under the MHA and procedures at the RHH. It was not to comment directly upon whether Dr Lang was correct in his decision. In fact, both Dr Woo and Dr Ait Khelifa were both careful to say that Dr Lang was the only psychiatrist to see Edward at that particular point in time and was therefore in the best position to assess his level of capacity and risk as those matters then presented. Dr Woo also gave evidence, which I accept, that the usual standards and procedures were followed in Edward's general management during his admission.

117. Dr Woo's oral evidence concerning the interpretation of the provisions of the MHA regarding assessment of capacity was similar to that of Dr Lang. He said that this task of exploring capacity is a discrete one under the MHA. He commented that a person's ability to understand, retain, communicate and weigh the information can be determined "quite quickly" upon assessment, particularly if the person is conversant and a relationship with them exists such that it is clearly apparent that they understand the negative aspects of not accepting the recommended treatment. He described that, particularly in some cases of obvious perceptual disturbances (such as occurring in schizophrenia) it is very clear that a patient does not have the requisite capacity.

118. However, Dr Woo also said that the ability to determine capacity can be more difficult in cases where the patient retains the ability to communicate is not suffering any obvious perceptual disturbance. Dr Woo agreed in evidence that, for example, a person suffering a panic attack at the time of an assessment might not have decision-making capacity. Dr Woo also said that the effects of medication or drugs may impact on a person's capacity. Nevertheless, he gave evidence of the importance of the assessor assuming that capacity exists as a starting point.

119. Relevantly to Edward, Dr Woo was asked about a scenario where a patient being assessed was motivated to decline treatment due to an overriding desire to leave the hospital in order to seek drugs. Dr Woo explained in response:

> "So we are taught and it's been written that we should not determine capacity on the type of decision that people make, so therefore it may be seen as irrational, it may not be sensible, but if that's the decision they make if they have capacity that's the decision we respect…I think it's a very complicated thing when you talk about rational or irrational or sensible or not sensible, you have to think about it in terms of also that person's usual make-up and what you know about the person and whether that's consistent with what they might say. So if they, you know, lived for years in a hermit existence and you think they were saying things like *I want to go into the crowd and do certain things* you would certainly question that as well".[35]

120. Thus Dr Woo, in evidence, showed a clear understanding of the MHA and acknowledged the distinction between capacity to make decisions and the type of decision actually made by a patient, which may or may not be objectively rational or wise. He also conveyed an understanding that a person who is expressing thoughts and ideas very differently from his or her normal character may not, at that time, have decision making capacity. He said that, in these cases, other relevant information, (collateral information) is likely to be a particularly useful to guide the assessment.

121. During his evidence at inquest, he was asked whether it was his expectation or his practice that communication between a private referring clinician and the assessing clinician at the RHH will occur before the decision as to assessment. Dr Woo said that he would certainly expect the assessing psychiatrist to speak to a patient's private psychiatrist where that private psychiatrist refers a patient for assessment pursuant to the MHA. He commented that this is important because the private psychiatrist is transferring a patient he/she considers to be at risk.

122. Dr Ait Khelifa, in the situation concerning Edward, was not formally handing Edward over from her care for an assessment, as he was not under her care at that time.

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[35] Transcript of inquest proceedings p24.

Nevertheless, Dr Woo expressed the view that he would expect a practitioner conducting an assessment to contact the patient's private psychiatrist prior to making a final decision upon the assessment if that person had requested to be contacted.

123. Dr Woo also gave evidence that, as a primary position, he would speak to concerned family members before making a decision. However, he indicated that in certain circumstances he may not do so – for example, if the patient felt very strongly about him not seeing those family members and that to do so would impact upon the therapeutic relationship with the patient and the patient's ongoing management. He said that the obligation was to do the best for the patient but described the difficult balancing between being able to obtain relevant information from family members and not compromising the subsequent care of the patient.

124. Dr Woo agreed that there is nothing, ethically, to prevent a doctor from receiving collateral information in relation to a patient, even in a circumstance where the patient does not want the doctor to speak with a particular person or disclose medical information. Whilst Dr Woo indicated that, in listening and obtaining important information from others, there is no need to disclose confidential patient information. He indicated that it was a matter of careful judgement as to whether the taking of such information might potentially undermine a therapeutic relationship with the patient. He gave evidence that the impact upon such relationship was a prime consideration, even where the patient was at high risk of self-harm or suicide.

125. In respect of the length of time it took Dr Lang to assess Edward, Dr Woo indicated a period of 45-50 minutes was a fairly standard period for a psychiatric assessment consultation.

126. On the issue of a patient's self-report, Dr Woo agreed that there were circumstances where a patient's self-report about the circumstances of their behaviour may be something about which care should be taken before accepting. He indicated that it can be very difficult to always know whether a self-report is accurate and that self-reports may point in different directions depending on all of the circumstances. Dr Woo said in response to the factual scenario of Edward's two incidents of self-harm that they may well have indicated the actions of a person who is highly agitated and self-destructive without suicidal intent.

Dr Nicolle Ait Khelifa

127. Dr Ait Khelifa, as Edward's private treating psychiatrist, was closely involved in his treatment in the days before his death.

128. Dr Ait Khelifa saw Edward on 6 August 2015, and did not feel at that time that there was any increased risk of self-harm as he had attended a scheduled group program before his appointment with her, was starting to talk about his next step for change, and did not present as an increased risk at that point.

129. When Edward left the Hobart Clinic on 7 August, 2015 of his own accord, Dr Ait Khelifa was informed and became concerned at this time as it was contrary to their "agreed management plan". She was later advised that Edward had been found unconscious in his flat and an ambulance was attending to him.

130. On Saturday 8 August 2015 Dr Ait Khelifa spoke with RHH psychiatry registrar, Dr Liz Walker, about Edward for the purpose of providing an "appropriate handover and to work out a joint management plan". It was later that afternoon that Edward absconded from the RHH. Dr Ait Khelifa indicated that she had advised Mrs Peck that Edward was welcome to come back to the Hobart Clinic if he chose to do so.

131. At about 6.30pm on 9 August 2015 Mr Little, in his capacity as a member of the Community Assessment Team, telephoned Dr Ait Khelifa to say that Edward had cut himself and he was on the way back to the RHH. Upon being advised about Edward's self-harm, Dr Khelifa felt compelled to ring the duty psychiatrist at the RHH, to relay her level of concern. Dr Ait Khelifa therefore telephoned psychiatric registrar, Dr Vanaja Yogendran, to advise of her concerns about Edward. In her affidavit she records telling Dr Yogendran that, in her opinion, Edward "was now high risk and needed a period of in-patient assessment". In oral evidence, Dr Ait Khelifa explained that she was of this opinion because the degree of self-harm was not behaviour that she had seen from Edward, particularly referring to the extent of the cutting injury. She also said that he needed to stay in hospital until his level of sedation from the drug overdose had been reduced.

132. As previously discussed, Dr Khelifa remained concerned about Edward and, during the morning of 10 August, contacted the RHH, speaking with then psychiatry registrar, Dr Daya Sadiq. She explained to Dr Sadiq her concerns regarding Edward's change in presentation and her concern around his level of risk. She explained that she felt unable to adequately manage Edward in a voluntary capacity and that he needed to be admitted at the RHH. Dr Sadiq advised Dr Khelifa that she would pass her concerns on to the whole liaison team and that Edward would be assessed by the team.

133. Dr Khelifa did not specifically request that she be contacted in relation to the decision-making around Edward until "further down the track in respect of discharge planning". In response to a question about this she said that she believed that the assessing psychiatrist would "take on" her concerns, assumed that he would be

admitted (I infer involuntarily) and that she would not need to have further involvement around the decision-making.

134. In the afternoon of 10 August, Dr Ait Khelifa received the telephone call from Dr Lang who advised her that he was discharging Edward because he had decision-making capacity under the MHA. Dr Ait Khelifa's recollection of the conversation was that she expressed to Dr Lang that Edward was at risk, that she did not feel that she had control of him, and that he was deteriorating. She recalled that Dr Lang clearly said to her that it would be unlawful to detain Edward under the MHA as a result of him having the requisite capacity. She said that she emphasised Edward's level of risk but he was firm in his decision that an in voluntary admission would not be possible due to the "legalities". Dr Ait Khelifa told Dr Lang that she would not make the same decision, because his risk was high taking into account a longitudinal view of his history. Dr Ait Khelifa said that she did not make a request of Dr Lang to start a fresh assessment with the benefit of her input because she did not believe that he was open to this course. She was aware from Dr Lang that Edward had been offered voluntary admission to the RHH and follow-up from the Community Assessment Team had been arranged.

135. Dr Ait Khelifa gave evidence that receiving collateral information is an integral part of an assessment process for a patient, stating "you don't get the full picture potentially from the patient. So it's about gaining a better understanding of what's happening for them from others' perspective as well".

136. Dr Ait Khelifa gave evidence concerning Edward's self-report of the reasons for his self-harm leading to the two admissions to the RHH prior to his death. She said that, if she had been in place of Dr Lang, she would have challenged Edward more vigorously in light of the serious harm and the conflicting evidence of intent. In this regard the ambulance report of 9 August indicated that, on arrival, Edward told paramedics that he had felt suicidal and that he had self-harmed (by cutting his arm) instead.

137. Dr Ait Khelifa also considered Edward's drug use and/or addiction impacted on his ability to make decisions about his treatment and care in that he would impulsively discharge himself driven by the desire to use drugs. In evidence, she said that Edward was not ready to be properly treated for his drug addiction, still being in the pre-contemplative phase.

138. It was apparent by her evidence that Dr Ait Khelifa's approach to assessment of capacity under the MHA was guided primarily by the level of risk to the patient. In evidence, she explained that her work involves mainly treating patients on a voluntary basis outside the hospital setting, although in the course of that work she indicated

that it is necessary for her to assess capacity by considering the patient's understanding of the information she provides, their ability to retain that information and to weigh the benefits and negatives of the proposed treatment.

139. It had been her experience that in this context some patients are able to provide coherent answers, or what appear to be coherent answers, but this did not necessarily lead to a conclusion of capacity. She explained that, in some of these cases, patients are not using or weighing the information provided due to their mental health condition significantly influencing their ability to judge and make an informed decision. She said that, in making the decision, it is important to compare and consider the patient's past history and manner of decision-making. She quite appropriately observed that, when a patient's risk is elevated in a mental health crisis, this may also be an indicator of a lack of decision-making capacity.

140. Dr Ait Khelifa also conceded that her view of the primacy of risk in assessing capacity might explain why she had a different view than Dr Lang about Edward's capacity when she spoke with him on 10 August. Dr Ait Khelifa said she found it difficult to express her contrary view because, in light of his very firm view that Edward's detention would have been unlawful, she was not as familiar with the MHA and she had not seen Edward at that point in time. I note that Dr Ait Khelifa was trained in the United Kingdom and the evidence suggested that her training may have been based upon a different test of capacity. She agreed in evidence that the test in the MHA emphasised the concept of self-determination.

Discussion of Issues

Decision not to detain Edward involuntarily

141. I am satisfied that Dr Lang assessed Edward appropriately and in accordance with proper procedure. His assessment was not rushed and he gave adequate time and consideration to conducting it. He took detailed notes. I fully accept his evidence of his observations of Edward's mood, rational manner of response and well-articulated plans for the future. He recorded his firm view of Edward's decision-making capacity before the tragedy of Edward's death.

142. I find that Dr Lang assessed Edward's capacity in accordance with the correct test under the MHA. Whilst he recognised that Edward was at risk, he properly formed the view that the issue of risk was a secondary statutory consideration, with the matter of decision-making capacity being the initial threshold test for the imposition of an involuntary order. Dr Woo's approach accorded with the approach of Dr Lang.

143. It is understandable that Dr Ait Khelifa was extremely concerned about Edward's heightened risk. That concern was fully justified. Her role as his treating psychiatrist for three years allowed her to understand the degree to which his condition had escalated in the several days before his death. Her representations to Dr Yogendran and Dr Sadiq are evidence of this concern and represent a most diligent approach to Edward's welfare. The concerns were notified in general terms to Dr Lang, through Dr Sadiq.

144. I accept, as expressed by Dr Ait Khelifa and Dr Woo, that the degree to which a patient departs from his or her normal views or character can indicate a change in ability to understand, use or weigh information. Therefore collateral information obtained regarding the patient's history and normal character and behaviour may indicate a significant contrast with the patient's behaviour and character at assessment. This, in turn, may signify diminished decision-making capacity.

145. If Dr Lang had had discussions with Mrs Peck, or direct discussions with Dr Ait Khelifa, before making his decision, he would have been told of Edward's unprecedented level of distress and suicidal/self-destructive behaviour. Mrs Peck would also have advised him that Edward was capable of manipulation in assessment interviews. In such case, Dr Lang may have pressed Edward to a greater degree regarding his intentions in the two self-harm incidents. However, I am in little doubt that Edward would have still articulately maintained to Dr Lang that such behaviour arose out of distress rather than any intention to end his life. As submitted by Mr Allen, it cannot be concluded that the explanations provided by Edward for his behaviour were not, at least in his mind, true; none of Dr Lang's medical notes or oral accounts of the consultation given by Dr Lang, or other evidence, supports a finding that Edward did try and deceive him.

146. As I have discussed above, all three psychiatrists gave evidence regarding the difficulty of accurately determining intent in such circumstances. Even if Edward had told Dr Lang that these incidents represented suicide attempts, Dr Lang would have been bound to decide capacity as the sole threshold issue for involuntary detention. His conclusion would have remained unchanged given his assessment of Edward's lucid presentation at that time.

147. I find that it would have been desirable and best practice for Dr Lang to have made direct contact with Dr Ait Khelifa before his assessment of Edward, particularly given her concern that had already been notified to him. As Mr Allen submitted, it would have been a prudent step to take given the obvious level of risk surrounding Edward. Even though it is highly unlikely that such a discussion would have caused Dr Lang to change his opinion regarding capacity, it would have left open the possibility of

obtaining useful information for a more coordinated discussion around the management of Edward's risk in the community. I acknowledge that, in his discussion with Dr Ait Khelifa after the assessment, Dr Lang advised that he had offered Edward the option of a voluntary admission as well as arranged for follow up with him after discharge by the Community Assessment Team.

148. In evidence, Dr Lang impressed me as an experienced and conscientious psychiatrist. Edward declined his offer of voluntary admission to the RHH and Dr Lang put in place follow-up support. Dr Lang was in the best position to assess Edward. As demonstrated by the transcript passage relating to his notes, he was vigilant to look for signs of perceptual disturbance, and alcohol or drug intoxication. He saw none. Dr Lang's assessment gave effect to Edward's decision not to be treated as a psychiatric inpatient. Edward's choice may have appeared unwise, irrational or unreasonable to others. As Mr Allen submits, Dr Lang's decision also incorporates the principle that any decision that a person does not have capacity require strong proof. Dr Lang's decision was sound.

149. With the benefit of reflection upon the circumstances of this case, Dr Lang nevertheless gave evidence that he would have done things differently in several respects. Most notably, he would have spoken with Mrs Peck about his assessment and received information from her about Edward. In fairness to Dr Lang, his failure to speak with Mrs Peck was tied substantially to the request of his patient that he not do so, and not for any other reason that would leave him open to criticism. As is documented clearly in his medical notes, Dr Lang was attempting to give effect to Edward's wish on the basis that he was ethically bound to do so.

150. It should not be overlooked that the concerns of Mr and Mrs Peck were always about the welfare of their son, and were not confined to the issue of his capacity. The conclusion that Edward had capacity was only one aspect of a discussion that might have been had about the best way to assist him, and the information they had about their son was relevant to this broader question. While it could have been anticipated that Mr and Mrs Peck would be displeased that Edward was not to be involuntarily detained, it is this very conclusion that demanded Dr Lang did communicate with them, as their input into the plan to adequately treat him and manage the risk to his safety in the community ought to have been at the forefront of Dr Lang's mind as a consequence of his assessment. Dr Lang properly conceded that this was the appropriate course to take in the circumstances, and he expressed sincere regret directly to Mr and Mrs Peck during oral evidence about the manner of his interaction and his sadness upon Edward's death.

151. Dr Lang was also asked to explain the ways in which this incident and his involvement in it has impacted on his current practice. Dr Lang answered that, having reflected upon the events, he now works harder to engage families, something he described as a positive development.

152. Dr Lang also gave evidence that he had reviewed his ethical obligations regarding confidentiality and acknowledges that there was nothing preventing him from receiving information from Mrs Peck that may have been relevant, whilst maintaining the confidential information received from Edward. He has since changed his practice accordingly to receive such information, where appropriate, and in circumstances that do not jeopardise his patients' management or treatment.

Training in the capacity test

153. Dr Lang was asked about the training he received around the provisions of the new MHA, particularly pertaining to assessment of capacity. He explained that he had received formal and informal training and, in conjunction with the head of the department and a clinical director, had had considerable discussions about the new MHA and the responsibility of a psychiatrist under relevant provisions. Having regard to his correct understanding of the MHA and the similarly correct understanding of Dr Woo, there is no formal comment or recommendation to be made relating to improvement in training.

Bed availability

154. Both Dr Lang and Dr Woo were asked about the relevance of the availability of a bed in the designated psychiatric section of the hospital on the assessment of a person under the MHA. Both gave very firm evidence that if a person required detention and treatment under the MHA, that that person would be admitted, notwithstanding the unavailability of a bed in that section. They said that other arrangements would be made to accommodate that person safely. I fully accept that evidence.

155. I add that the evidence at inquest regarding Edward's admission did not in any way suggest that there was a lack of beds. The bed occupancy data tendered in evidence also does not indicate that there was any shortage of beds in the event that Edward was detained as an involuntary patient. Even if there had been a shortage of beds, this factor played no part in Dr Lang's decision-making.

Resourcing of the Consultation Liaison Service

156. Dr Woo explained that the Consultation Liaison Service (CLS) at the Hospital consisted of a psychiatrist and one or two doctors in training who have the responsibility of managing patients throughout the whole hospital, other than those within the Department of Psychiatry itself or those in DEM who have psychiatric issues.

157. To his credit, at no time during his evidence did Dr Lang volunteer that there was inadequate resourcing of the Consultation Liaison Service. However, towards the conclusion of his evidence, and only upon my questioning him, he gave evidence to the effect that the service is significantly under-resourced. He indicated that he was confident that this fact did not curtail his assessments or treatments of patients. I accept that this was the case with Edward's assessment, although the degree to which Dr Lang felt pressed in his work may well have been reflected in the fact he did not speak to Dr Ait Khelifa or utilise a more sophisticated approach with Edward's family. As this inquest reveals, the work of the assessing psychiatrist is significant and is not limited to simply an interview of the patient.

158. Dr Lang indicated that the CLS at the time he gave the evidence, comprised one psychiatrist (himself) and 1.5 registrars. He said that, at times, the team are assisted by one psychiatric emergency nurse. He compared that level of resourcing to the position statement by the British Royal College of Physicians and the Royal College of Psychiatrists. For a catchment area the same size as Hobart, the recommended composition of the team would be 1 to 2 consultants, 1 to 2 registrars, 5 psychiatric nurses, an administrative assistant and a social worker (or psychologist). His evidence was credible and compelling. The fact that he is required to perform his valuable public service in such drastically inadequate conditions signifies his dedication. Dr Lang gave evidence that there had been originally more consultants, nurses, administrative and allied health positions in the team but they had all been removed a number of years ago.

159. Dr Lang gave evidence that, if the CLS was properly funded with an administrative assistant, that person would retain and collate information for the psychiatrists and nurses and keep current information on scheduling and cases and any new communication in respect of a patient. He said, at the time he gave evidence, that administrative assistance may be forthcoming.

160. In relation to nursing positions, Dr Lang indicated that if the necessary number of psychiatric nurses were recruited, their role would include seeing the patients, engaging with other relevant nursing staff and conducting family interviews. I can well understand that the recruitment of psychiatric nurses would alleviate a significant

burden.

161. Properly funding this critical service would go much of the way to addressing the concerns raised by the evidence in respect of the issue of the timely transfer and recording of communications in respect of a patient to their medical file, particularly from treating medical practitioners in the private system wishing to pass information on or formally hand over care of a patient to the RHH. Dr Lang indicated that since this incident, a "rolling handover" system had been implemented to improve communications in this regard.

162. Dr Lang said that the consultation-liaison team model of which he is a member is a well-recognised part of larger hospitals and the evidence he has seen particularly from the United Kingdom suggests that it is effective in improving patient outcomes and hospital expenditure".

Implementation of recommendations from reviews

163. After Edward's death, the Tasmanian Health Service (THS) conducted an internal review. The document was tendered in evidence. It was not dated or signed, nor was the identity of the author apparent from the face of the document. However, it appears to be factually accurate and represents a considered review of the issues arising from the hospital's perspective. The review identified several issues and areas for practice improvement. These related to deficiencies in alerts for Edward's opioid dependence and suicide risk; lack of coordinated care between the public and private sectors, with no liaison/sharing of information between services; the issue of capacity under the MHA; and the role of confidentiality and consent.

164. The recommendations arising from the review were as follows:

- Closer liaison between public and private psychiatric services for high risk clients which should include the primary care provider. The primary care provider be responsible for a management plan that can be used by other services to ensure continuity of care.

- Clarification of the definition of capacity within the MHA, clarification to include the presence of fluctuating capacity which increases risk.

- Education for staff in regard to confidentiality and consent, particularly in relation to voluntary patients. This should particularly concentrate on strategies to obtain information from parents/carers whilst maintaining the patients' confidentiality.

- One Information Technology system across the THS be implemented to ensure effective patient care across services based on the patient's journey.

- Education in regard to the importance of all doctors interacting with parents/carers, while keeping in mind confidentiality issues, to ensure that corroborative history is gathered and that parental concerns are validated.

165. Dr Woo was unsure of what, if any, action had been taken by the RHH, to implement the above recommendations. I have, however, received evidence at inquest from the Acting Nurse Director of the Quality and Patient Safety Service of the THS regarding the THS policy concerning how safety events are reported, investigated and how the recommendations are implemented and the lessons disseminated.

166. The THS has developed a protocol for a consistent process across all health services in the management and coordination of recommendations from safety events. Within the protocol is included a directive that recommendations from investigations and reviews of patient safety events are to be implemented. The Acting Nurse Director advises that the Safety Reporting and Learning System (SLRS) is an electronic tool used by all staff across the THS, Department of Health, Ambulance Tasmania and Communities Tasmania to report, manage and learn from safety events and record recommendations.

167. The evidence indicates that the system has been improved so that the recommendations are added to the system as "action items" for completion within a particular time frame. If the person responsible for completing a particular recommendation does not mark it in the system as complete, the system will send out reminders until that person completes the task.

168. The Acting Nurse Director further reported that the THS Quality and Patient Safety Service produces reports to track and monitor recommendations (including Coronial recommendations) through the various THS Quality and Patient Safety Committees. In addition, she advises that the Critical Incident Review Committee conducts a clinical overview of all serious safety events and in its regular meetings tracks and monitors recommendations based upon a report extracted from SLRS.

169. For Coronial recommendations, the THS has established a working group to develop a state-wide Coroners' Case Policy, intended to incorporate Coronial recommendations specific to the THS into the SLRS system for tracking and implementing.

170. The Tasmanian health sector, including the THS, also participates on the interagency Coronial Recommendation Working Group through Department of Health representation. This interagency working group, established to monitor and implement coronial recommendations across government, is a most positive initiative by the Department of Premier and Cabinet.

171. The ongoing work by THS on the SLRS system and on current projects in respect of coronial recommendations will hopefully promote the efficient recording of the recommendations, their implementation and dissemination of learnings to relevant areas and personnel in a consistent way, the ultimate goal being to improve the health and safety of those using the THS services.

Implementation of recommendations relating to suicide prevention on the Tasman Bridge

172. Edward was able to end his life easily by climbing the low railings of the Tasman Bridge. In her affidavit, Detective Senior Sergeant Leaman said that she exited her vehicle when she saw Edward climb over the inner railing of the pedestrian walkway of the bridge. Although she did everything she could to stop Edward, he was able to effect his purpose very quickly.

173. In my finding Deaths from a Public Place 2016 TASCD 385-390 I observed that the current outer railing of the bridge is 1.59 metres in height. This is relatively easy to scale and provides a direct drop into the river at a height that will almost always cause death. Further, maintenance and lighting gantries and electrical connection boxes are installed at regular intervals along the inside of the fence. These provide an opportunity for footholds for those intending to effect suicide. The evidence does not permit me to find whether Edward used one of these installations as a foothold – only that he was able to scale the railing quickly, making it impossible to save him.

174. The tragedy of Edward's death was only heightened for his family and friends by his body never having been found. In many cases of suicide from the Tasman Bridge, the family members are unable to bury their loved one and must live with the unresolved grief of this situation.

175. In that finding I made a recommendation that the government formulates a plan for the implementation of structural modifications to the Tasman Bridge with the aim of eliminating the bridge as a method of suicide.

176. Other recommendations included installing effective cameras, installing and monitoring life line phones and signage, and establishing a Suicide Register to inform suicide

prevention strategies.

177. For this finding, I received recent written information, tendered as evidence, about the progress of the recommendations from the Cross Agency Working Group ("CAWG"), established by the Tasmanian government to progress the issues of suicide prevention on the bridge. The CAWG is chaired by the Chief Psychiatrist, Dr Aaron Groves, and is administered by the Department of Health. Members are from Lifeline Tasmania, the Magistrate's Court (Coronial Division), and the Departments of State Growth, Health, and Police and Emergency Management. The CAWG continues to meet regularly and monitors the status of all recommendations and supports their implementation.

178. The CAWG advises that the Department of State Growth has engaged consulting engineers and an urban designer to undertake investigations into options for structural modifications, including barriers. The options need to take into account the significant complexities of the structure, user access and safety, wind loading, and maintenance structural capacity. The CAWG advises that, while it was previously recognised that there may be structural challenges in implementing infrastructure changes to the bridge, the current investigations have found the structural issues to be even more complex and difficult to resolve than anticipated. It is expected that the options project will be largely completed by the end of this year, after which the government should be in a position to make an informed decision regarding appropriate upgrades.

179. I am further advised by the CAWG that a number of improvements in line with the coronial recommendations have already been implemented to help reduce the potential for using the bridge as a means of suicide. I set out below the developments as they have been provided to me by the CAWG.

180. The Tasmanian Government has successfully secured Federal Government funding to remove and/or relocate electrical distribution boxes located at regular intervals along the length of the bridge railing which represent significant hand and footholds for those considering suicide. This work will take place during 2019/20.

181. There are six blue Lifeline phones installed on the Tasman Bridge that are linked directly to Lifeline Crisis Support and ten signs that promote the crisis telephone number. The technical operation of each phone is checked by Department of State Growth contractors on a weekly basis. The CAWG, through the Tasmanian Department of Health, receives a quarterly report from Lifeline Australia which provides data on the use of the telephones and whether an emergency intervention was initiated, as per agreed protocols. I am advised that the phones have been regularly used by persons in distress in the three years of their operation. Installation

of the phones may well have had a positive impact upon decisions of individuals in crisis on the bridge. I note that it is the intention of the Department of Health to undertake an evaluation of the usage of the phones.

182. The Tasmanian Suicide Register (TSR) was established within the Coronial Division of the Magistrates Court of Tasmania in November 2017. Suicide data from 2012 until 2016 has now been coded. The first TSR biannual report will be completed in the coming months. The Research Officer employed to operate the TSR is now able to provide reports to coroners to inform effective prevention strategies.

183. The CAWG has advised that the cameras installed on the bridge now cover 99% of the pedestrian pathways. Since March 2019 Tasmania Police Radio Dispatch Services (RDS) has had the ability to view the footage from the bridge cameras. The cameras are not actively monitored by RDS but remain fully operational 24 hours a day. Tasmania Police officers have been made aware of the existence of this footage and the process for obtaining it.

184. The CAWG has been very effective in progressing some of the complex issues associated with suicide prevention on the Tasman Bridge. Its ongoing work is to be commended. Of fundamental concern is the issue of the physical barriers to mitigate suicide from the bridge. All other improvements are secondary to that principal issue. At its most basic, only the erection of appropriate physical barriers can prevent suicide by persons jumping from the rails of the Tasman Bridge**. I comment** that in my respectful opinion the finalisation of this project is a matter of genuine urgency. Until it is complete more people will end their lives from the Tasman Bridge.

Summary of key findings

185. *The findings required by section 28(1) of the Coroners Act 1995:*

a) The identity of the deceased is Edward Paisley Peck, born 20 August 1991;
b) Edward died in the circumstances set out in this finding as a result of jumping from the Tasman Bridge with the intention of ending his life.
c) The cause of Edward's death was injuries sustained in the fall from the Tasman Bridge and/or drowning after being submerged in the water below; and
d) Edward died on 10 August 2015 at Hobart in Tasmania.

186. *Other important findings*

a) The evidence does not support a finding that, when assessed at the RHH by Consultation-Liaison Psychiatrist Dr David Lang on 10 August 2015, Edward did not have decision-making capacity within the meaning of section 7 of the Mental Health Act 2013.
b) The decision by psychiatrist, Dr David Lang, not to place Edward on an involuntary order under the Mental Health Act 2013 did not contribute to Edward's death;
c) Dr Lang assessed Edward's decision-making capacity in accordance with the correct interpretation of that concept as required by the Mental Health Act 2013 and in accordance with the current Clinical Guideline issued by the Chief Civil Psychiatrist and Chief Forensic Psychiatrist under that Act.
d) Dr Lang should, as a matter of best practice, have made contact with Edward's treating psychiatrist, Dr Ait Khelifa, before his final decision on assessment of Edward.
e) Dr Lang should have developed a considered approach to communicating with and obtaining relevant information from Mrs Peck without breaching Edward's confidentiality. However, any information provided by Mrs Peck would not have changed his decision at the time of the assessment.
f) The Consultation Liaison Service of which Dr Lang is a member is a valuable service in the hospital. However, it is not resourced with sufficient psychiatrists, psychiatric nurses and administrative personnel for the demand upon the Service. The inadequate staffing did not change the decision in respect of Edward, but it may have resulted in a more comprehensive and coordinated approach to obtaining information to inform the assessment and treatment of Edward, and in communicating with his psychiatrist and family. Adequate staffing of the service is also necessary for its operation and proper functioning on an ongoing basis.

Recommendations

187. I **recommend** that the Tasmanian Department of Health undertake a review of the medical, nursing and administrative staffing requirements for the proper operation of the Consultation Liaison Psychiatry Service at the Royal Hobart Hospital and, informed by the results of this review, provide further resourcing to this service as required.

Final Comments

188. The role taken by Edward's family in this inquest must be recognised. Despite their grief, the Peck family have made every effort to contribute fully to the investigation and to assist the Court to properly determine the circumstances of Edward's death and to make the necessary findings and recommendations based upon all the evidence. Their collective efforts as a family in these extremely difficult circumstances have been commendable.

189. I am grateful to Dr Woo for providing valuable expert assistance and to the RHH for making him available.

190. I extend my appreciation to both counsel for their assistance and, in particular, to Mr Allen for his support of Mr and Mrs Peck during the process and his high quality submissions. I thank Sergeant Anthony Peters, coroner's associate, for his work in preparation of the inquest and also Constable Kate Nichols, investigating officer, for her comprehensive investigation and report.

Dated: 26 September 2019 at Hobart in the State of Tasmania

Olivia McTaggart

Coroner