MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends, and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995

I, Robert Webster, Coroner, having investigated the death of CL.

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is CL

b) CL died as a result of hanging herself which was action taken by her alone, with the intention of ending her own life;

c) The cause of death was hanging; and

d) CL died between 4 and 5 May 2019 at Latrobe, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into CL's death. That evidence includes:

- the Police Report of Death for the Coroner;
- affidavits establishing identity and life extinct;
- affidavit of Dr Terence Brain, forensic pathologist;
- Forensic Science Service Tasmania – toxicological and analytical report;
- Ambulance Tasmania electronic patient care report;
- report of the coronial medical consultant Dr Anthony Bell MB BS MD FRACP FCICM;
- affidavit of NT, a very long time friend of CL;

- affidavit of RE, the mother of CL;
- affidavit of HJ, the father of CL;
- affidavit of LO, the ex-husband of CL;
- affidavit of AN, work colleague of CL;
- affidavit of BA the next-door neighbour of CL;
- affidavits of attending and investigating police officers namely First-Class Constable Peter Dabner; First-Class Constable Laura Windfeld – Petersen; Detective Sergeant Luke Bishop; Senior Constable Lloyd Goss; Constable Ebony Foster; and First-Class Constable Dean Wotherspoon;
- Medical reports and records from the Latrobe Family Medical Practice;
- Medical reports and records from the Tasmanian Health Service (THS);
- Forensic and photographic evidence; and
- Final root cause analysis report from the THS together with further information provided by the Executive Director, Medical Services, State-wide Mental Health Services (SMHS), Dr Ben Elijah.

Background

CL was born on 28 April 1986 at Hobart in Tasmania and she was 33 years of age at the date of her death. She was the only child of her parents RE and HJ. At the date of her death she lived by herself in Latrobe and she was employed as a casual disability carer.

CL attended Wesley Vale and Moriarty Primary Schools, Latrobe High School and Don College. She is described by her father as having a happy childhood with good friends who used to attend the family home to play. Just prior to her leaving school she obtained a part time job at Target which later became full-time. When CL was about 18 years of age one of her friends moved to Hobart so CL followed and commenced working at the Target store situated at Northgate in Glenorchy. Just prior to CL moving to Hobart she had an unplanned pregnancy and underwent a termination. After approximately 18 months in Hobart CL obtained a job as a support worker for Oakdale. Her parents sold their then property on the north-west coast and moved to Hobart as it appeared to them their daughter would remain in the south of the State.

CL met LO in 2009 and fell pregnant not long after. They moved into a house together in Brighton prior to their daughter, VR, being born in 2010. They married on New Year's Day in 2011. They then moved to a 50 acre property at Elderslie in or about 2013 at which time they had their second daughter EF. The marriage broke down in 2014 and CL moved with her children to her parents' home; they having returned to live in Latrobe. LO stayed in the Hobart area until the house sold and then he moved back to Latrobe in 2015 to be closer to his daughters. Less than 12 months after returning to Latrobe CL moved into her own home in Latrobe, before moving to East Devonport and then returning to her final home in Latrobe. CL shared custody of her 2 children with LO.

CL's Mental Health

CL endured a number of social stressors leading up to her death, many of which would have contributed to her declining mental health. I have therefore considered all the medical records obtained in this investigation very carefully.

The first relevant entry appears in the records of her general practitioner on 26 March 2001. The history is she was quite depressed about acne and missing school. A referral was made to a dermatologist. The next entry is for 27 June 2003. At that time the history is she was a very anxious and worried person. She was worried about her TAFE exams and was paranoid about other people whispering about her. She advised her general practitioner she had always been like this, that she was a little down but she still gets enjoyment out of things. The general practitioner considered CL was suffering from mild anxiety but she did not think CL needed an antidepressant. It was agreed she would attend counsellors at TAFE and if that did not assist or she felt worse then she was to return to her general practitioner for further assistance. The next relevant consultation occurred on 8 October 2007. The reason for her visit was that she was suffering from insomnia and she was not eating. The general practitioner determined, as a result of administering a psychological tool, that CL was suffering severe stress. He prepared a mental health plan and referred her to a psychologist. Although not in the notes, the mental health plan records a history of CL suffering from depression since the termination of her pregnancy which took place in May of that year. The general practitioner also prescribed temazepam.

On 9 October 2007, the records disclose CL took an overdose of temazepam and she was transported by ambulance to the Mersey Community Hospital (MCH) and then to the Spencer Clinic at the North West Regional Hospital (NWRH) for psychiatric evaluation. CL complained of being sad and feeling guilty which had worsened over the past 3 months. She provided the history of undergoing the termination which she initially felt was the right decision but she felt guilty after a few weeks stating *"I hate myself I have killed my own child"*.

She was commenced on sertraline and was discharged on 13 October 2007 as she had set up a supportive network on discharge and had agreed to follow up with her general practitioner for a new prescription and for a referral to a psychologist. She attended her general practitioner on 18 October 2007 at which time the reason for the visit is recorded as major depression. A prescription for sertraline was provided but there appears to be no referral to a psychologist. There is then a gap in these records of almost 10 years. For the majority of that period the evidence discloses CL was living in southern Tasmania.

The next relevant entry is for 5 September 2017. The history provided on that day was CL was anxious, had a bad temper and was irritable even with minor things. But she said life was not too miserable in general. The notes recorded CL was a single parent who had 2 children and worked full-time. The previous overdose was mentioned but she denied suicidal ideation. The reason for the visit was recorded as depression. The same psychological tool, which was administered on 8 October 2007, was administered on this occasion and a score of 34/50 was returned.[1] A referral to a psychologist is again made, pathology tests were ordered and medication was prescribed. A letter from the psychology practice dated 31 January 2018 notes CL attended 3 sessions and in January of that year she was offered a further appointment but she declined on the basis that she was *"doing okay"*.

The records reveal that on 14 December 2018, CL was involved in a motor vehicle crash when she veered off the roadway and into a tree at approximately 80 km/h. She was transported by ambulance to the emergency department at the Launceston General Hospital (LGH) in the early hours of 15 December 2018. She was wearing a seatbelt. It was not known how long she had been in the vehicle however the bonnet was cold. She admitted to using alcohol and breaking up with her boyfriend that evening. Her partner was interviewed and advised CL told him *"she would go to gaol for Centrelink fraud"* and asked him *"to look after her daughters"*. She left his home *"to drop something off 4 doors down"* and never returned. She also left her bag behind which he described as out of character. CL admitted to deliberately driving into the tree and taking medication but was not specific as to what medication or how much was consumed. Later that day she was operated upon. A left intercostal chest tube was inserted and a laparotomy and repair of a perforated bowel was performed. She remained an inpatient of the LGH until she was transferred to the MCH on 24 December 2018. On 17 December 2018, the consultant psychiatric registrar was contacted via telephone by a general surgery intern. The advice of the psychiatric registrar was *"that given the client denied suicidal ideation and had alcohol and illicit substances on board, not for psyche review at this time, is likely just a motor vehicle accident"*. The plan was for social work involvement, referral to drug and alcohol services and a collateral history was to be obtained

[1] The previous result was 45/50.

from the family. CL was reviewed by a social worker the next day. CL said she had been under considerable stress and feeling depressed for some time but she denied active suicidal ideation and said she was relieved to have survived the accident. She was reviewed again by the social worker on 20 December 2018. She underwent foot surgery on the 21 December 2018. On 23 December 2018, nursing notes described her as *"being very upset and anxious"*. On 24 December 2018 at the social worker review, CL was emotional due to being away from her children. It appears her partner was present during the majority of her admissions to the LGH.

Day leave from the MCH was approved on 25 and 26 December 2018 before she was discharged on 27 December 2018. On her return from day leave on 25 December 2018, she requested a medical review due to anxiety. The history provided at that time was she had experienced intermittent panic attacks over the last 4 years on a background of stress caused by caring for her children as a single parent, the breakup of her marriage, her recent motor accident and not been able to see her children. She denied thoughts of self-harm and/or suicide and noted she had poor concentration, impaired sleep, a reduced interest in her hobbies, a persistent low mood, and a cycle of negative thought patterns. She thought she was depressed. The junior medical doctor's impression was CL was suffering from anxiety which had been exacerbated by the recent motor accident and that she was at risk of post-traumatic stress disorder if she was not treated. It was also thought she was suffering from mild depression. The plan was for her to be referred to a psychologist for cognitive behaviour therapy and ongoing mental health services. Prior to discharge on 27 December 2018, CL was reviewed by the social worker at which time CL indicated she had felt depressed and anxious over the last 4½ years since the separation from her daughters' father. However, she denied suicidal ideation, drug use, and binge drinking. It was noted she was working and that her new partner and mother were supportive. CL explained the motor accident as *"feeling funny while driving and next thing the car had crashed"*. She was encouraged to visit her general practitioner to discuss a mental health care plan and she was provided with information about a number of organisations which provide mental health assistance.

CL attended her general practitioner on 2 January 2019. Her presenting complaint was anxiety which she said she had been troubled by for many years and which commenced after she was repeatedly molested by a neighbour as a little girl. Her mood fluctuates and she was affected by insomnia and she drinks a bottle of wine every night to help her sleep. She drives when she is anxious in order to calm herself down and the recent motor accident occurred during an anxiety attack. CL denied self-harm or that the motor accident was a result of any tendency to self-harm. She said her partner was supportive and he attended this appointment. She accepted that she could not cope on her own and she requested

psychological assistance. Psychological testing was administered and this suggested extreme anxiety and stress, and moderate depression. There were no major issues with any of the physical injuries sustained in the motor accident. Alcohol and drug and mental health services were discussed, a mental health plan was prepared and a referral to a psychologist was made. Her general practitioner offered to talk to her further if required.

On 3 January 2019, CL presented to the emergency department of the MCH due to worsening depression and anxiety. She denied suicidal ideation, advised she was living with her partner, that she was the mother of 2 children and had a supportive friend. Her work and insomnia were noted and she denied intentionally crashing her car in December. On examination, her affect was sad and her mood depressed. She denied ever having suicidal thoughts, attempts or ideation or drug and alcohol problems. She was provided with a dose of temazepam, provided with a prescription and she was to continue regular follow ups with her GP and attend the psychology appointment which was coming up. She was discharged in the company of a friend.

The next morning she presented again to the emergency department of that hospital with suicidal ideation. She said the temazepam was ineffective, her general practitioner had not prescribed any medication and her psychology appointment was next week. CL said she cannot stop thinking about taking an overdose, being wrecked with guilt about the children, her behaviour and her inability to cope. She did not think she could continue without attempting to harm herself. CL repeatedly said if she was left to her own devices she would most likely self-harm. With her consent she was transferred to the NWRH for further assessment and potential admission.

On review by the crisis assessment and treatment team (CATT) at the NWRH, much of the previous history was repeated. In addition CL said she felt ashamed and embarrassed and wanted to take tablets in order to take the emotional pain away. She had experienced postnatal depression 5 years ago and was treated with Zoloft. She was ruminating on sexual abuse in the context of her daughter who was aged 8, CL having been abused at the same age. The plan was that she spend time with her partner and friend and engage in activities, mindfulness and self-care and to call CATT if she required support. The impression was she was suffering major depression with suicidal ideation. She was prescribed medication and advised to engage with Laurel House, a sexual assault service which provides counselling. She was to be reviewed at the CATT meeting on 7 January 2019 with the recommendation being she was to be reviewed by the community psychiatrist for assessment and medical management. She was discharged. The general practitioner also spoke to her on 4 January 2019 at which time CL is noted as not being suicidal and having no thoughts about harming herself or others. She was however very upset and said she was unable to cope.

There was further contact with, and assistance provided by, CATT on 5 and 6 January 2019. There was phone contact with CL's partner and in person contact with CL on 5 January at which time she denied self-harm and suicidal ideation. On 6 January when CL was spoken to via telephone, she sounded subdued and quietly spoken. She reported she slept well and expressed no suicidal ideation plan or intent. On 7 January 2019 at the review meeting, a doctor's appointment was arranged and CL was advised of that appointment via telephone. At that time she reported ongoing intrusive thoughts but said the increased medication dose had assisted her sleep. She was anxious about leaving her house and felt people were watching and judging her. Further medication by prescription was provided.

On 10 January 2019, CL was reviewed by a psychiatrist. The history provided was the motor accident was not a deliberate act, she had been feeling anxious for the last several months, was very distressed and lost control. She was taking tramadol medication and drank 4-5 alcoholic drinks most days. Postnatal depression and sexual abuse were noted. Guilt and shame relating to that abuse remained. She lived with her partner and was working but she was fearful of losing shared custody of her children. After conducting a mental state examination, the psychiatrist's impression was CL was suffering from recurrent major depressive disorder with prominent anxiety. Treatment options were discussed. Sertraline was recommenced, quetiapine continued, there was to be a referral to a psychologist for sexual abuse counselling, CATT assistance was to continue providing support and she was to be reviewed in 4 to 6 weeks' time.

CL was discussed at the clinical review meeting on 11 January 2019 at which time it was agreed there would be contact over the weekend and a follow-up psychiatrist appointment was to be made.

Telephone contact was made on 12 January 2019. However CL was too busy to talk. Further telephone contact was made the next day at which time CL spoke about her embarrassment, guilt and anger with respect to her behaviour. She believed people were judging and talking about her. Her anxiety had reduced but her sleep was erratic. Her ex-husband had changed access to the children to weekends only during the day for up to 12 hours. She was advised to seek legal advice. Her GP was to arrange a psychology appointment. She denied thoughts of suicide or self-harm.

On 14 January 2019, CL's case was discussed at a review meeting and it was determined she would be contacted second daily and a home visit would be conducted mid next week. A psychiatrist review was booked for 23 January 2019. Telephone contact on that day revealed CL's visit with her children was good but she reported ongoing distress and embarrassment. She and her ex-husband had booked mediation at Relationships Australia and CL was

informed and agreed to the further appointment with the psychiatrist, the home visit and second daily telephone contact.

Contact was made with CL by her general practitioner by telephone on 14 and 15 January 2019.

On 16 January 2019 CL reported she was improving. She denied any thoughts of self-harm or suicide.

The home visit on 17 January 2019 revealed CL's home was untidy and the curtains were all drawn. However, she indicated she planned to perform housework that day. The clinician described CL presenting as *"hopeless"* and she reported her ex-husband planned to have the children for 12 months. They had engaged with Relationships Australia, she was still waiting for an appointment with a psychologist and she said her parents were supportive. She denied suicidal ideation or thoughts of self-harm.

At the next telephone contact on 19 January 2019, it is reported CL sounded more reactive and she said her children had visited the previous evening for a meal. She spoke of her supportive parents and that she was doing housework and playing with her dog. She denied suicidal ideation and said the medication was effective.

CL was discussed at the next clinical review meeting of CATT and the decision was made to wait for the psychiatrist's review. However, CL did not attend that appointment on 23 January 2019. She was contacted about that on 25 January 2019 and said she did not attend because she had other commitments. She said her general practitioner was monitoring her medications and a mental health care plan had been completed. She refused a follow-up appointment with the psychiatrist because she believed the situation had improved and she was attending Relationships Australia. She was advised she would remain a client of the CATT until her situation was reviewed. That review took place at a meeting on 29 January 2019 and because of her refusal to attend the appointment with the psychiatrist she was discharged and both CL and her general practitioner were advised by letter. In addition, she did not attend her orthopaedic outpatient appointment on 4 February 2019 but she did attend on 25 February 2019 and after that review she was discharged.

At a consultation with her general practitioner on 2 February 2019, CL indicated she had some financial difficulties in relation to paying her rent. She could not work, was waiting to see a counsellor, had a supporting partner but the father of her children had taken them away. There were no suicidal thoughts or plans and she was not sleeping well. Her medication was continued and she was provided advice. She next attended a general practitioner on 12 February 2019 where her financial difficulties were again highlighted as

was her poor sleep and low self-esteem. She was anxious. There were no suicidal thoughts, she was taking her medication, seeing a psychologist and she was doing well. She wanted to return to work however she was unfit to perform the duties of her employment. CL saw her general practitioner again on 15 February 2019 at which time she indicated her mood was okay and she had no suicidal ideation. She said it was stupid to attempt suicide. In that regard she can only be referring to the motor accident. There was an upcoming appointment with a psychologist and although she wished to return to work, the general practitioner advised her she needed to see her psychologist and orthopaedic specialist first before the general practitioner would fully clear her to return to work.

On 8 March 2019, she was certified fit to return to work on reduced hours with some restrictions namely weight bearing on the left foot. At that appointment she insisted she was well physically and mentally. At her next appointment which took place on 22 March 2019, it was noted she was doing some voluntary work with her employer who was happy to give CL further paid work. She had missed her psychologist's appointment. She was told she needed to attend those sessions and that the general practitioner could not help her unless she adhered to the recommendations provided. The next appointment of note occurred on 5 April 2019 at which time she indicated she felt guilty about the accident and her mood was low. She reported she was sad about her kids being away and her ex-husband was not willing to share custody. She had got her house back and saw a psychologist on 28 March 2019. She was comfortable at work and was working 20 hours per week. She was certified fit for 30 hours per week. The final appointment took place on 12 April 2019. She had spent 3 hours with her children on the previous Sunday. She was worried about losing custody as her ex-husband was making threats about not letting her have custody because of the motor accident. She was seeing her children every second weekend, was working 30 hours per week and visiting her psychologist.

It appears from the further records from the psychologist which are on file CL did not attend an appointment until 7 March 2019 at which time she was diagnosed with a major depressive disorder and severe anxious distress. It appears she did not attend her appointments on 21 March and 10 April but she did attend a further appointment on 14 March 2019.

Circumstances of death

On Sunday 28 April 2019, CL had her children at her parent's home for her birthday.

On Tuesday 30 April 2019 she spent time with NT who took her to PQ's house in East Devonport where they stayed for about 2 hours. NT says that CL and PQ were talking about commencing a relationship. CL had dinner at NT's home that evening. NT says CL

was on edge and she was chain smoking. CL had spoken to NT about attending the Spencer Clinic. NT offered to take her but she refused and said she would see how she was in a couple of days.

On Wednesday 1 May 2019, NT visited CL after NT had dropped her children off at school. She found CL drinking alcohol. CL offered NT a drink which she accepted because she thought that would be one less for CL to consume. NT noted there was no food in the fridge but there were 2 full bottles of wine on the bench. CL told NT she had found out from a neighbour that her ex-boyfriend, GI, had been sending rude photos to them. She also advised NT she had been molested when she was little. Even though NT had known CL all her life this was the first time she had heard anything about this. They both left CL's home in their respective cars at about the same time. NT knew CL hated being in the house on her own and that she had made an offer for CL to stay with her but she would not accept that offer.

On Thursday, 2 May 2019 CL was meant to attend NT's home for dinner however CL called NT advising that she would not be coming as she had been sleeping.

On Friday 3 May 2019, NT attended CL's home and found CL had vomited over the floor from drinking the night before. They discussed the upcoming appointment with the psychologist on 15 May 2019. CL told NT how she had *"fucked up"* and that she was an embarrassment to her parents. She promised NT she *"wouldn't do something stupid"*. They both departed CL's home. This was the last time NT either spoke to or saw CL.

On 3 May 2019, just prior to 7.00pm, CL's neighbour, VT, found CL in her motor vehicle attempting to gas herself with carbon monoxide. Police and ambulance personnel attended and CL was transported by ambulance to the NWRH. She was assessed in the emergency department at which time she admitted the suicide attempt was intentional. The history she provided was she had had an argument with her parents over dinner and had consumed one bottle of wine prior to the suicide attempt. She was medically examined 48 minutes after providing the initial history at 8.28pm. She was assessed by nurses 30 minutes later. CL expressed remorse, that she was flat and down but wanting to be alive. Her breath analysis reading was .00. Just before 11.00pm, a referral was made to the on-call psychiatric team with that review taking place at 11.30pm. The history provided included the argument with her parents who criticised her parenting skills, the fear of losing her children, her poor sleep pattern and low mood over the last month, her anxiety and how drinking a bottle of wine each night helps, her heavy smoking and past history of THC use. She denied planning this suicide attempt and any past attempts. She admitted past thoughts about overdosing. She said her grandmother had died by suicide. She denied any financial difficulties. A mental state

examination was conducted and it was noted her affect was flat and restricted and she looked objectively depressed. She denied current suicidal thoughts or plan. She identified her children as her protective factor. There was no evidence of psychosis. It was considered she was a low risk to herself. The impression of the on call psychiatrist was that this was an impulsive suicide attempt on a background of major depressive disorder, social stress and alcohol abuse. The management plan which was discussed with the on-call consultant psychiatrist was to discharge her the following morning, to continue sertraline, with a referral to CATT accompanied with a request that they follow her up over the weekend and conduct a face-to-face review next week, and for CL to contact alcohol and drug services. She was then admitted to the emergency medicine unit at 11.44pm but it seems from the notes that admission only occurred due to the time of night and the fact CL lived in Latrobe and was unable to organise transport home.

On 4 May 2019 CL was medically assessed prior to discharge and a referral to the social worker was made at 9.31am. The notes indicate CL was discharged from the unit in the company of a friend however that cannot be so because PQ says she picked CL up from outside the front of the hospital.

At 8.10am on 4 May 2020, the transfer of CL's care was received by CATT and a member of that team telephoned CL at 12.27pm on 5 May 2019 but she did not answer.

CL spoke to her work colleague, AN, on a couple of occasions and he believes he sent her a text on 4 May 2019. He kept in regular contact with her after the motor accident with the intention of helping her get back to what he calls *"the normal or the old CL"*. He says she did not appear to be the same after the crash and she told him the only way she could kill the pain of missing her children was by consuming alcohol. A couple of weeks prior to the motor accident he says she told him about being sexually abused as a child. AN says he saw her a few days prior to that crash but he thought she appeared happy. On 4 May 2019 CL told him she had been to the Burnie hospital because she needed someone to talk to at the Spencer Clinic. She told him she had been provided some strong medication but she said little else.

On 5 May 2019, CL did not attend work and could not be raised by phone. NT was advised of this by way of a call from a work colleague of CL. NT and her mother, MR, attended CL's house and located her in one of the bedrooms. An electrical cord had been wrapped around the curtain rod a number of times, a slipknot had been tied into the electrical cord and this was around CL's neck so that she was hanging from the curtain rod. She was deceased. Police, Ambulance Tasmania and CL were contacted and they attended CL's home.

Investigation

CL was formally identified at the scene by her LO. She was then taken to the LGH where Dr Terrence Brain, a very experienced forensic pathologist, performed an autopsy. Dr Brain expressed the opinion, which I accept, that the cause of CL's death was hanging. Toxicological analysis of her blood sample identified no alcohol or illicit drugs. Prescription drugs were present in the blood sample.

A full police investigation into her death was subsequently conducted. The police officers who attended CL's home, including forensics and a CIB officer, were of the opinion there were no suspicious circumstances at the scene indicating the involvement of any other person in CL's death. I accept that opinion.

A suicide note was located in the kitchen of CL's home. The note says, amongst other things, she had lost her children because of her stupidity, she had made a fool of herself and she was a failure as a daughter, and she never feels good enough in herself.

The coronial medical consultant Dr Anthony Bell examined the medical records and in his report noted the history set out above. He provides some general information with respect to suicide. First he notes suicidal ideation can be passive whereby the person is thinking for example that life is not worth living or it might be active where the person, for example, wants to die; in the latter category the person is severely ill. The risk of suicide increases where pervasive hopelessness is present and the conclusion reached that suicide is the only option in order to escape the ongoing and intense pain being experienced. A prior history of attempted suicide is the strongest single factor of a subsequent successful attempt. Following an attempt the risk of a completed suicide is greatest in patients with schizophrenia, bipolar disorder and/or major depression as was the case here. The risk of suicide is also greater in adults who suffer childhood abuse, live alone, have lost a loved one or have experienced a failed relationship. The evaluation of the patient who may be suicidal includes an assessment of ideation, method, plan and intent. Dr Bell acknowledges the limited ability of a medical practitioner to predict who will suicide and who will not. Similarly among those patients who have presented to an emergency department after an episode of self-harm it is difficult to predict who will repeat self-harm. He goes on to say however *"[p]sychiatric inpatient hospitalisation for further evaluation and initiation of therapy is nearly always indicated for patients with recent suicidal behaviour (suicide attempt) or imminent high risk of suicide (e.g. patients with moderate to severe suicidal ideation that includes a plan and intent)"*. He says anxiety disorder increases the risk and he notes major depressive disorder is associated with a rate of suicide 27 times greater than in patients without that condition. Dr Bell says in this case CL had a history of major depression with anxiety, previous suicide attempts and a history of

helplessness and child sexual abuse. In those circumstances he says inpatient treatment was warranted.

Further Investigation

A request was made by the Coronial Division of the Magistrates Court of THS as to whether that organisation had undertaken a Root Cause Analysis (RCA) with respect to the medical treatment provided to CL. A report detailing that analysis has been provided. The investigation noted the following matters should be considered:

- The psychiatry medical officer, in making his decision to discharge CL to her home, did not appear to take into account important historical and clinical history in his assessment of the severity of suicide risk and may not have conveyed this accurately to the consultant on-call in his formulation of the case. This may have led to the consultant on-call agreeing with the decision of the psychiatry medical officer to discharge CL from the emergency department and not admit her;
- The assessment of risk is both longitudinal (past) and cross-sectional (current);
- Despite repeated denials of suicidal ideation, plan and intent, CL eventually acknowledged the overdose and motor vehicle crash were suicide attempts;
- Her grandmother had committed suicide;
- Alcohol was a major factor in her presentations. This appeared to be a harmful if not dependent pattern of use. Alcohol, by its very nature, is disinhibiting and it is not uncommon for patients who use alcohol to present with suicidality;
- The severity of CL's ongoing alcohol use could have been better managed as an admitted patient with a well-established medicated detoxification program together with monitoring;
- CL appeared to suffer from undertreated major depression and anxiety;
- The attempted suicide by carbon monoxide poisoning required some planning in its execution and could not strictly be described as impulsive;
- The method of attempted suicide in this case is considered highly lethal and is generally more common in males than females. Accordingly, in this patient, given she was female it should have been viewed as a significant qualitative change of means and therefore a concerning increase in the risk of completing suicide. Immediate risk factors included carbon monoxide poisoning;
- The ongoing psychological stressors in CL's life were ongoing perpetuating contributors to the elevation of her suicide risk;

- The nature of the discussion between the chief medical officer and the patient's friend into whose company she was discharged is not clear from the doctor's documentation. The reason for this is that CL's friend, as mentioned above, picked her up from outside the hospital. That is, CL was not in the company of anybody when she was discharged; and
- The doctor's decision to discharge CL was not fully informed by the longitudinal (past) and cross-sectional (current) history of risk and the associated complicating factors such as alcohol consumption and ongoing clinical evidence of major depressive symptoms.

The panel members who conducted the RCA considered the protocol which applies in the Royal Brisbane Hospital Psychiatric Emergency Centre, and after the panel's investigation of this death, the panel concluded it was probable CL's death could have been prevented if she had been admitted rather than discharged. In my view given Dr Bell's advice and the dot points set out above, CL should have been admitted as an inpatient. If she had been, her suicide between 4 and 5 May 2019 would have been prevented.

The RCA made several recommendations including:

- Junior psychiatric medical officers receive mandated, regular clinical suicide risk assessment training and that psychiatry Heads of Department ensure this training has occurred and is documented;
- Supervising Consultant Psychiatrists should be encouraged to ensure that the assessment, risk, formulation and management of patients discussed with them by on call junior clinicians, who present as suicidal, is thorough and includes all pertinent information to arrive at a safe decision for each suicidal patient seen;
- Heads of Departments are to institute a monitoring protocol (criteria) and ensure the risk assessment sections of all the required documentation of the management of suicidal patients presenting post attempt or as suicidal are completed. After an agreed period of time, there could be an audit of this and review of clinical practice as required; and
- Where consent is provided, the patient and his family or friends should be educated on the management and/or safety plan. The management/safety plan should include the identified risk(s) and the mitigating strategies, as well as identifying who to contact for further support. This needs to be clearly documented in the patient's notes.

Because my view is CL should have been admitted as an inpatient and if she had been her suicide would have been prevented, procedural fairness dictates a copy of my draft decision

be forwarded to the SMHS for comment. My draft was forwarded to the SMHS on 11 March 2022 and the Executive Director of that service, Dr Ben Elijah, responded by letter dated 14 April 2022. I have taken all of his comments into account however the following is worth noting. He quite rightly points out the SMHS is governed by, amongst other things, the *Mental Health Act* 2013. As part of an assessment, a doctor must consider a person's capacity to make decisions about his or her assessment and treatment and that assessment and treatment is to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare.[2] In addition s15 of the *Mental Health Act* 2013 provides that where responsibilities are exercised under this Act, then regard is to be given to the mental health service delivery principles set out in Schedule 1 to that Act. There are 17 such principles set out in the schedule. It appears to me that the 15 principles which follow the first 2 either support or extend the first 2 principles which are:

- to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness; and
- to interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service.

Dr E Elijah goes on to say the following:

> *"It is within this statutory context, that the State-wide Mental Health Service's treatment of* CL*, and in particular the criticisms in connection with the failure to admit her, must be viewed. Bearing in mind the express legal constraints within which medical professionals must operate, my view is that in most cases, apart from immediately after the car crash in December 2018,* CL *would not have met the requisite test of capacity and therefore could not have been lawfully detained under the Mental Health Act.*
>
> *A further issue that arises is whether* CL *would have agreed to voluntary admission, despite her attendances to the emergency departments. The medical records demonstrated in all cases* CL *settled in ED, most likely as a result of the passage of time and her blood alcohol level (and attending dysphoria and depressed mood with attendant cognitions) settling."*

In so far as these comments are concerned I note Dr Elijah does not say in all cases apart from immediately after the car crash in December 2018 she would have met the test for capacity; he says in most cases. In any event the psychiatric assessment made within 2 days

[2] See ss7 and 12(d) and Part 3 of the *Mental Health Act* 2013.

of the car crash is contrary to Dr Elijah's view. The psychiatric registrar at that time said *"given the client denied suicidal ideation and had alcohol and illicit substances on board, not for psyche review at this time, is likely just a motor vehicle accident"*. This assessment was also incorrect given CL's subsequent admission the motor accident was a suicide attempt. Self-evidently it is very difficult to determine now whether or not CL had capacity on 3 and/or 4 May 2019 by reference only to the hospital notes; that is without actually examining and assessing her. With respect to the point Dr E Elijah raises about whether or not CL would have agreed to a voluntary admission sadly we will never know. She was not offered that alternative as the decision was made to discharge her. If, on the assumption CL had capacity, then if she had been offered admission and had refused and had acknowledged in writing she was being discharged against medical advice then there could be no criticism of the SMHS. Unfortunately this did not occur because the RCA found the doctor's decision to discharge CL was not fully informed by the longitudinal (past) and cross-sectional (current) history of risk and the associated complicating factors such as alcohol consumption and ongoing clinical evidence of major depressive symptoms.

Comments and Recommendations

CL was conveyed to hospital after a suicide attempt. The medical officer who assessed and made the decision to discharge her did not take into account important historical and clinical history in assessing her suicide risk and accordingly an accurate picture of her condition and suicide risk was not presented to the consultant on call. This led to the consultant on call agreeing with the medical officer's decision to discharge CL. CL's death was entirely avoidable. It occurred because of a substandard assessment of her suicide risk which led to the decision to discharge her rather than admit her for treatment. On discharge she was then left to her own devices.

I am satisfied with the extent of the RCA and strongly support the implementation of the recommendations. I have been advised that all but the last recommendation referred to in the second dot point at the top of page 15 have been implemented. I **recommend** that if the decision is made to discharge a psychiatric patient then that only occur if the patient is discharged into the care of a family member or friend so that person can be fully appraised of the patient's condition. That discussion is to be fully documented in the patient's notes. I acknowledge this can only occur with the permission of the patient. If that permission is not forthcoming then that fact should be clearly documented in the patient's notes.

I am satisfied CL took the action of hanging herself with the express intention of ending her own life. I am unable to specifically determine why she took this course of action however

she had a large number of social stressors in her life that made her feel she had failed both as a parent and a daughter.

The circumstances of CL's death are not such as to require me to make any further recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of CL.

Dated: 1 July 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner