IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4890

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**NICOLE SUSAN EVANS**
Delivered on:	**28 July 2017**
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	2, 3 and 4 May 2016
Findings of:	**CORONER PETER WHITE**
Counsel assisting the Coroner:	Senior Constable Remo Antolini
Representation	Mr G Gilbert for J Williams Mr D Goldberg for Peninsula Health
Catchwords	Death caused by high risk activity after release from an Emergency Department following presentations on consecutive days in relation to an undiagnosed mental health condition

I, PETER CHARLES WHITE, Coroner,

having investigated the death of NICOLE SUSAN EVANS

and having held an inquest in relation to this death at Melbourne

on 2, 3 and 4 May 2016

find that the identity of the deceased was NICOLE SUSAN EVANS

born on 17 September 1980

and that the death occurred on 28 October 2013

at 32 Gairloch Drive, Frankston, Victoria

from:

I (a) BLUNT IMPACT INJURIES TO NECK AND CHEST

in the following circumstances:

BACKGROUND

1. Nicole Evans [hereinafter referred to as Nicole] was a 33-year old woman who lived in Frankston in a Department of Human Services transitional house with her three children. She had separated from her former partner in July 2013 and a Family Violence Intervention Order had been made against him. Despite the breakdown of that relationship, Nicole enjoyed the ongoing support of her former partner's aunt, Sharon Hawira [Auntie Sharon] and her partner who lived nearby, in addition to the support of her own family.
2. Nicole had a medical history of depression and anxiety secondary to an assault by a family member when she was a teenager and postnatal depression following the birth of her first child.[1] General Practitioner Dr Zdenek Dubrava saw her on four occasions in October 2013 and had prescribed an antidepressant, Zoloft. Nicole had declined a referral for psychological counselling.
3. The circumstances in which Nicole died will be discussed in some detail below. It is sufficient for present purposes to say that at about 1.45pm on 28 October 2013 Nicole was found by Tim Twining and Tonya Chique of Community Liaison Early Intervention Acute Recovery Service [CLEARS] lying face down in the front garden of her home, unresponsive. The emergency services were called and the attending paramedics confirmed that Nicole had died some time earlier.

[1] Exhibit 1.

4. An examination of the scene by one of the attending police members, Detective Senior Constable Francis Olle of Frankston Crime Investigation Unit [CIU], revealed no signs that a third party had been involved in Nicole's death or that the circumstances were otherwise suspicious. DSC Olle located an indentation in the grass next to where Nicole was found and an inspection of the outside of the house revealed scuff marks on a wooden fence, indentations in the galvanised steel of the carport roof and a handprint on roof tiles in this location. On the basis of these observations, DSC Olle formed the view that Nicole had climbed onto the roof of her home and had either jumped or fell onto the ground below.

CORONIAL INVESTIGATION – SOURCES OF EVIDENCE

5. This finding is based on the totality of the material the product of the coronial investigation of Nicole's death. That is, the brief of evidence compiled by DSC Francis Olle of Frankston CIU, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[2] In writing this finding I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation of a *reportable death* is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[4]

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[2] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.
[3] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.
[4] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

7. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[5] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[6] These are effectively the vehicles by which the prevention role may be advanced.[7]

8. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[8]

FINDINGS AS TO UNCONTENTIOUS MATTERS

9. In relation to Nicole's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Nicole's identity and the date and place of death were not at issue. I find, as a matter of formality, that Nicole Susan Evans, born on 17 September 1980, late of 32 Gairloch Drive in Frankston, Victoria, died at there on 28 October 2013, aged 33 years.

10. Nor was the cause of Nicole's death contentious. Forensic Pathologist Dr Jacqueline Lee of the Victorian Institute of Forensic Medicine reviewed the circumstance of the death as reported by the police to the coroner, available medical records, photographs of the scene, and post-mortem computerised tomography scans [PMCT] of the whole body, and performed an autopsy. Among Dr Lee's anatomical findings were superficial incised wounds to the neck upper limbs and left leg that may have been self-inflicted and blunt impact injuries involving fractures to the cervical spine and ribs and injuries to the brain, spinal cord and viscera.

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[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.
[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[7] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[8] Section 69(1).

11. Dr Lee commented that Nicole's blunt force injuries suggested a primary impact to the head, with subsequent injuries occurring to the spine and internal organs. She opined that Nicole's blunt force injuries were consistent with a drop from the roof of her home and that no autopsy findings were inconsistent with the scene findings. Dr Lee observed that her examination did not enable her to determine whether Nicole fell or jumped from the roof.

12. Dr Lee advised that the cause of Nicole's death was blunt impact injuries to neck and chest.

13. In accordance with Dr Lee's advice, I find, as a matter of formality, that Nicole died of blunt impact injuries to neck and chest.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

14. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Nicole's death was on the circumstances in which she died.

15. Nicole had several contacts with Peninsula Health clinicians in the two days prior to her death. She presented to Frankston Hospital by ambulance on 26 and 28 October 2013 and on each occasion was assessed in the Emergency Department [ED] by a Consultation Liaison Inpatient Psychiatry Service [CLIPS] clinician. She had telephone contact with the Community Liaison Early Intervention Acute and Recovery Service [CLEARS] on 26 October and there was an unsuccessful attempt to perform a home visit on the afternoon of 27 October 2013.

16. The adequacy of the clinical management provided by Peninsula Health between 26 and 28 October 2013 was the focus of my investigation and the inquest into Nicole's death.

26 OCTOBER 2013: CLIPS ASSESSMENT #1 AND CLEARS TELEPHONE FOLLOW-UP

17. On 26 October 2013 Nicole was transported by ambulance to Frankston Hospital ED with her two sons aged 12 and 2 years. Nicole was referred to CLIPS and was assessed

by Registered Psychiatric Nurse 4 Joanne Gaffy[9] at about 9.30am.[10] This was Nicole's first known contact with Victorian public psychiatry.

CLIPS Assessment #1

18. Nicole presented as overwhelmed and reported deterioration in her mental state over the previous four months in the context of the recent breakdown of a relationship and the termination of a pregnancy. She said that she was not coping, reported scattered thoughts and concern that her daughter had been recently molested by a male family member. She also reported an inability to sleep, low mood, periods of anxiety, poor appetite and weight loss.

19. Nicole said that she had recently been prescribed an antidepressant for low mood and anxiety. She also reported a history of marijuana use, stating that she had stopped using it for several weeks but had smoked the drug on the previous evening.

20. As part of her psychiatric assessment Nurse Gaffy noted Nicole's distress, *poor concentration* and *poor memory* and psychotic symptoms,[11] including *hearing voices of her ex-partners family.* Nicole *denied commands to harm self or others* [and] *said the voices told her to delete all her phone numbers yesterday, which she did.* She said she could *hear voices when the radio is on. Thinks the home may be bugged by her ex, fears she may lose the children, tearful. Requesting help...* Nurse Gaffy also noted that Nicole *knew that something wasn't right... she was distressed by it and she wanted to get that fixed.*[12]

21. When undertaking a risk assessment, Nurse Gaffy considered Nicole's distressed state, her denial of suicidal thoughts and the absence of a similar family history. She also considered Nicole's denial of current or previous self-harm ideation and that she was not aware of any previous history of psychosis. Nicole, *believed the hearing of voices telling her to do specific things was a new issue for her ... and part of her further deterioration.*[13] Nurse Gaffy observed when giving evidence at the inquest that, *the*

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[9] Registered Psychiatric Nurse 4 Joanne Gaffy was employed as a clinician within the psychiatric unit attached to CLIPS, at Frankston Hospital.

[10] Statement of J Gaffy exhibit 2 page 1. See. She interviewed Nicole and later completed the risk assessment and registration documentation after receiving the print out from ambulance officers, which itself was a thorough documentation of their findings. See the clinical record of her assessment at Exhibit 2(b), Exhibit 2(a) from page 10 of the medical records and transcript 45-6, 53 and 62.

[11] Exhibit 2(b).

[12] Transcript 36, (and exhibit 2(b) pages 14 and 15) plus transcript 64 and 66.

[13] Transcript 50-51.

other thing that was significant for me was that she was help-seeking and...that when I saw her she said I to me, 'I need your help'.[14]

22. Nurse Gaffy considered that Nicole was at, *a low risk of suicide and self-harm and at medium risk for psychosocial -environmental factors and harm from others arising out of her history of emotional and physical abuse, as well as her current AVO*[15] *and circumstances.*[16] She further characterized Nicole's help-seeking as an indication of a protective nature.[17] She gave her a triage rating of C, which was a suggested level of post-triage follow up response time of within 8 hours.[18]

23. Nurse Gaffy testified at inquest that she was not concerned enough to believe Nicole should be made an involuntary patient... *but, you know, I believed she was in crisis.* [19] Instead, she formulated a follow up plan for Nicole involving a referral to the hospital's psychiatric unit, Community Liaison Early Intervention Acute and Recovery Service [CLEARS]. CLEARS would initiate contact that evening and arrange to visit Nicole at home on 27 October 2013.[20] Nurse Gaffy rationalised her plan in the following way: *I referred her to acute because I wanted a longitudinal assessment and diagnostic clarification, because it is not my role to diagnose.*[21]

24. Nurse Gaffy also anticipated and informed Nicole that she would see a psychiatrist, *(for diagnostic clarification).*[22]

25. Ms Gaffy gave evidence that Nicole was agreeable with the plan for follow-up by CLEARS. Arrangements were also made for Auntie Sharon to collect Nicole and her two sons from the ED and stay with the family overnight. DHS were informed of the

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[14] Transcript 40

[15] AVO is an abbreviation of 'Apprehended Violence Order' a phrase used to describe an Intervention Order [IVO] in other jurisdictions.

[16] Ibid. The IVO was not discussed in detail due to the presence of Nicole's children. See also further discussion of *psycho-social/environmental factors,* at transcript 54. (These included financial stress, estrangement from her mother, concerns about the molestation of her daughter and the absence of a network of friends due to the attitude towards same by her ex-partner).

[17] Transcript 56.

[18] Transcript 41 and Screening Register exhibit 2(b) at records page 11. I note here that that this level of urgency code was not intended to apply to other than Nicole's presentation on this particular morning, (i.e.26 October). It was also meant to convey that someone would see her within 8 hours of arrival which I note ultimately did occur.

[19] Transcript 50-51

[20] Nurse Gaffy gave further evidence concerning the positive aspects of a *longitudinal* home assessment by a CLEARS clinician, at transcript 72-3

[21] Transcript 75-76. There was also a complete absence of a history indicating a similar pattern of behaviour which again made a longitudinally based diagnosis important. Transcript 84.

[22] Transcript 71

plan to have the aunt attend to assist with the children; Nicole also took a positive view of this involvement.[23]

CLEARS Telephone Follow-up

26. At approximately 7.30pm on 26 October 2013, CLEARS clinician Tim Twining[24] received a verbal handover about Nicole from Nurse Gaffy. He accessed her medical record, which included the Screening Register prepared by Nurse Gaffy before telephoning Nicole later that evening.

27. The clinical notes of Mr Twining's telephone conversation with Nicole were recorded at 8pm and state, in part, that:

> *Nicole had self-presented due to anxiety and concern that she may be experiencing symptoms of psychosis... Her concerns round psychotic symptoms were not strongly supported on assessment and it was felt that she presented with difficulty adjusting to recent stressors on a background of drugs* [my emphasis].[25]

28. When asked by my Assistant why he had characterised the report of psychotic symptoms as not being *strongly* supported on assessment, Mr Twining replied that the evidence was not clear as to whether Nicole's behaviour was stress-related, or psychosis-related.[26] He stated the documentation pointed quite clearly towards psychosis not necessarily as the only thing going on and that, *there were just question marks more around the psychosis*.[27]

29. Mr Twining's notes continued:

> *given that Nicole is unknown to PHCMHS[28] and that several dependent children remain in her care, she was referred to acute FLU for diagnostic clarification, longitudinal examination and medical review.*

30. He testified about the importance of *sticking to the plan* made by Nurse Gaffy. He recalled that, *it was always drummed into us quite early, that not having seen the person directly, that we rely on the assessment and the judgement of the people in the ED, to*

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[23] Transcript 57 See also Nurse Gaffy's observations concerning Nicole's positive role as a mother. Transcript 74.
[24] Mr Twining holds a Batchelor of Psychology (Hons) and a Masters of Social Work and was employed within the Psychiatric Unit at Frankston Hospital.
[25] Exhibit 9.
[26] Ibid.
[27] See paragraph 24 above and Transcript 91.
[28] Peninsula Health Community Mental Health Service.

formulate a plan so we stuck to that one.[29] During the hearing I indicated my own view that, *I should not rely too heavily on a psychiatric assessment that was undertaken over the telephone.*[30]

31. Mr Twining gave evidence that he and Nicole discussed her stressors,[31] the prescription and use of an antidepressant over the previous three weeks and smoking two to three cones of cannabis the night before her ED presentation to assist with sleep.[32] He documented that Nicole was:

> *able to reflect on her stressors and demonstrated clear thinking and rational thought processes. Nicole thought her symptoms were actually caused by her THC* [marijuana] *use the previous evening and that this had now resolved. Nicole had appropriate support for herself and her children. A home visit was organised for 27 October 2013.*[33]

32. On the basis of their telephone interaction, Mr Twining assessed Nicole as, *far more settled in her mental state since her presentation at* the ED, and in particular that:

> *Nicole reported a significant decrease in anxiety after having time with Frankston ED staff and was looking forward to a good night's sleep. Nicole's speech was fluent and of normal V, R, T*[34] *and her thinking clear and linear. She did not present any bizarre or delusional material and denied any perception disturbances since previous evening. Nicole noted ongoing issues with her mood but denied any SI plan or intent. She felt comfortable with care of children and reiterated that she could adequately care for them... Nicole agreeable to acute H/V (home visit) at approximately 3 pm, and happy to call for triage if required in the interim.*[35]

27 OCTOBER 2013: ATTEMPTED HOME VISIT BY CLEARS & LATER AMBULANCE ATTENDANCE

33. A little after 7am on 27 October 2013, Michelle Smith [Michelle] received a telephone call from her daughter, Nicole, from whom she had been estranged. Nicole was crying, confused and very frightened by the *voices in her head* that were *telling her to do bad*

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[29] Transcript 95.
[30] Transcript 92.
[31] Such as being in a transitional house, struggling with a young family and fleeing from domestic violence
[32] Transcript page 89.
[33] Statement at exhibit 3 page 1.
[34] Abbreviations of Volume, Rate and Tone.
[35] Medical Records Exhibit 9 page 5. See also Mr Twining's supporting evidence at transcript 96.

things.[36] She told Michelle that she had been to the Frankston Hospital the day before, *but they didn't help*.[37]

34. Michelle calmed Nicole and established that the children were safe. She learned that although Auntie Sharon had stayed with them for some time after Nicole was discharged from the ED, she had left in the early hours of the morning. Michelle said she would get to Nicole's house as soon as possible, but had to travel from her home in Bacchus Marsh.

35. When she arrived around 10am, Auntie Sharon was there looking after the children. Nicole burst into tears when she opened the door and appeared pale, thin and frightened. She told Michelle that she feared a male relative who, *had stayed for a weekend a few weeks earlier and that she believed he had sexually assaulted her daughter.* Nicole said that voices were talking to her, *because of all the lies she'd told* to and about Michelle, *and because of an abortion she had had earlier in the year.* She said the voices *were telling her she was bad, a bad mother and daughter, and she had to die.* Michelle told Nicole that, *she was very ill and that she was very ill because it wasn't true.* Nicole seemed to understand that she was ill and needed professional help in order to get better for her kids. Michelle assured her that she would look after the children while Nicole was in hospital.[38]

36. At around 11.15am, Michelle suggested that they visit her terminally ill husband (Nicole's stepfather) at the Cabrini Hospital, in part because she did not want to leave Nicole alone now that she appeared more settled. Although the children were happy, the trip was hard: *Nicole started hitting her head with her hand quite hard and telling 'them' (the voices) to shut up*. Michelle told Nicole to stop hitting herself, *but she said the voices wouldn't stop. Nicole said that the voices kept telling her she had to die*[39] [my emphasis]. Michelle told her to *try and ignore them.* When Nicole saw her stepfather she was shocked at how sick he was and sat on the bed crying and holding his hand.[40]

37. After lunch in the hospital cafeteria, Nicole, Michelle and the children began their return journey to Frankston. Michelle was conscious of the time, as she had to *get them home in time for her meeting with the* CLEARS team. About half an hour before the

[36] Exhibit 1.
[37] Exhibit 1 page 2.
[38] Exhibit 1 page 2.
[39] Exhibit 1.
[40] Ibid page 3.

scheduled appointment time, when they were about ten minutes from the house, Nicole received a telephone call from Mr Twining querying her whereabouts.

Attempted Home Visit

38. Michelle overheard the conversation and recalled that Mr Twining *was speaking loudly because I could hear most of the conversation quite clearly... He raised his voice and growled at her saying that she should have been home. They couldn't wait and had to go to another appointment.* Nicole had an appointment card which Michelle thought set the meeting for *3.30pm.* Nicole was very upset and burst into tears while Michelle was *upset for her but angry as well.*[41]

39. Mr Twining's colleague, Tonya Chique made the following note of this conversation:

> *27 Oct 14.45, H/V to Nicole's house with Tim Twining as previously arranged. Nicole not at home* ... [Phone call to Nicole who apologised for not being home] ... *Was unsure on what time she will return home ... Informed her that we would call back later on today to arrange another time for a H/V ... Nicole agreeable to this.*[42]

40. When questioned about this home visit at the inquest, Mr Twining confirmed that he called Nicole at 2.45pm, some 15 minutes before the agreed time, and was told they would be home, *sometime shortly thereafter.* He could not recall the precise time she said they would return; he thought, *it was, you know, 15- 20 minutes.* When asked how he responded, Mr Twining recalled *well, the response at the time was that we would like to try and see some of the other people that we were working with at the time and come back and try and see Nicole later on that evening* [my emphasis].[43] Mr Twining was asked whether he would have waited the extra few minutes if they had actually arrived at 3pm.[44] He responded: *waiting five minutes seems reasonable... and again in hindsight, you know, these are some of the questions that have plagued me and Tonya since but ... but if we had have* [arrived] *later, would things be different? No, I'm not sure what the answer is there.*[45]

41. Anticipating that the CLEARS team would in fact return, Michelle remained with Nicole at her home until 5.10pm. During this period Nicole spoke positively about her future

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[41] Ibid page 4. Later according to Michelle, they arrived home and spoke with the two aunties, who were not aware of any visitors arriving, while they had been there.
[42] Ibid, page 2-5.
[43] Transcript 96-7.
[44] See paragraph 30 as to the earlier arrangement made with Nicole.
[45] Transcript 97-8.

plans to re-involve herself with her family, which gave Michelle a sense of confidence about Nicole and her future.

42. At 6.30pm, a CLEARS clinician tried unsuccessfully to reach Nicole by telephone. A further attempt was made to reach Nicole at 8pm and, this time, was successful. An appointment for a home visit was made for 1.30pm the following day, 28 October 2013.[46]

Ambulance Attendance

43. Just before 10.50pm on 27 October 2013, Nicole called the emergency services. When Ambulance Victoria [AV] paramedic Trevor Clancy arrived a little more than 10 minutes later, police were already present. Nicole was sitting cross-legged on the kitchen floor with a knife next to her and approximately three superficial lacerations to each wrist. She reported hearing voices telling her that she was *worthless and not taking care of the children properly and that she should kill herself.* She reported using the knife to cut her wrists while waiting for the ambulance.[47]

44. Paramedics disarmed Nicole and tried to ease her anxiety and paranoia. They cleaned and dressed her wounds, sat with her and made her an Ovaltine drink but she refused to drink it, believing it had been poisoned. It was evident that Nicole required transport to hospital for psychiatric assessment.[48] Police contacted Michelle to advise her that Nicole was a *very sick girl* and would be taken to hospital. Her children were in the care of Auntie Sharon.[49]

45. On arrival at Frankston Hospital ED just before midnight, paramedics explained Nicole's presentation to the triage nurse and waited with her until an examination cubicle became available. Nicole was transferred to a cubicle at 12.20am on 28 October 2013 at which point paramedics handed over her care to the ED nurse.[50]

46. Significantly, part of the handover provided by AV was its Patient Care Report [PCR], outlining the history obtained by paramedics along with their observations and the nature of any interventions. This document was printed at 12.40am and apparently placed in a

[46] Medical records, page 5.
[47] Exhibit 4.
[48] Exhibit 4 page 1.
[49] Exhibit 1.
[50] Exhibit 4 page 2.

plastic folder with similar documents in the ED in accordance with usual practice.[51] Nicole's PCR contained the following information:

> *Case Given As PSYCH, THREATENING SUICIDE ... patient on floor in kitchen with knife next to her ... stated she has been hearing voices telling her that she is worthless ... and she should kill herself ... used knife to scratch across both wrists ...behaviour agitated and bizarre; speech content bizarre; auditory hallucinations; thought content delusional and suicidal; concentration poor ability to organise thoughts & lack of insight ... Patient Outcome no change (Observed).*[52]

28 OCTOBER 2013 – CLIPS ASSESSMENT #2 AND DISCHARGE FROM THE ED

47. Around 1am on 28 October 2013, Nicole was reviewed by CLIPS clinician Jennifer Williams.[53] Nicole presented as tearful and upset and was initially difficult to understand and engage.[54] Ms Williams spent about 20 minutes just speaking with Nicole and trying to calm her down.[55]

48. At the end of that period she had stopped crying and was more relaxed and logical.[56] Ms Williams performed a mental state examination and risk assessment, as required during all face-to-face assessments.[57]

Clips Assessment #2

49. At the time Ms Williams first spoke to Nicole, she had reviewed the notes of the assessment performed by Nurse Gaffey about 40 hours earlier, including the Screening Register. She was also aware that Nicole had reported auditory (command) hallucinations on that occasion, in relation to deleting phone messages, and that she had complied with that direction.[58]

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[51] Transcript 134-5.
[52] See patient care report at exhibit 4(a) and discussion at transcript page 129 where he states, *this person puts alarm bells into me to say yes she is psychotic and definitely needs to be transported to hospital for further attention.*
[53] Ms Williams' qualifications include a Bachelor's degree in Social Work and a Post Graduate Certificate in Developmental Psychiatry. She had been employed in mental health and clinical roles since 1997.
[54] Exhibit 6.
[55] Ibid.
[56] Transcript page 208.
[57] Transcript page 219 where Ms Williams states, *I'm required as a mental health practitioner each time I undertake a face to face assessment to complete-undertake a risk assessment and then complete the documentation relevant to that risk assessment, and you can see there are prompts on the right hand side... that inform us about some of the things that we should explore...*
[58] Transcript pages 207-8.

50. Ms Williams testified that she was not aware that an incident of self-harm had precipitated her current ED presentation, she was only told by an ED nurse that Nicole was, '*tearful and distressed*'.[59]

51. I note however that the ED's clinical record of the admission – ED Adult Guideline [60] – described Nicole as a, *re-present* with *auditory hallucinations*, *superficial lacerations on left and right wrists* and that these injuries were characterised as *self-harm,* but that it is not clear whether the Ms Williams reviewed this document or made any effort to do so. Similarly Ms Williams did not review the paramedics' PCR [61] and also denied seeing any bandages on Nicole's wrists.[62]

52. Ms Williams further stated that she unaware that Nicole had reunited with her mother on 27 October 2013, and that they had spent much of the day together.[63] It follows that if Ms Williams was indeed unaware of the fact that Nicole and her mother had spent the day together that she would not know of Nicole's behaviour while she and her mother travelled to the Cabrini Hospital by car,[64] and that the only corroborative history available, was that provided by Auntie Sharon and her partner who, in Ms Williams' words, though, *compassionate in the way that they spoke about Nicole … expressed their irritation and frustration with* her and that they were *exhausted* by the situation.[65]

53. Ms Williams' clinical notes state in part:

> *Nicole B/B via ambulance 0.05, (28 October 2013), reporting an increase in auditory hallucinations, expressing suicidal ideation with no plan or intent... very tearful at assessment, stating she has done and said some things to her mother and other people, denying drug or alcohol use today, states she has not told the truth about things, stating that she deserves to be punished and should die. Unable to clearly ascertain from Nicole, triggers for her current distress* [my emphasis].[66]

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[59] Transcript page 230.
[60] Medical Record page 72.
[61] Transcript page 221-222, where Ms Williams agreed that she was not saying that the Ambulance officer PCR exhibit 4(a), was not available to her on the DMR, or in a file kept by the triage nurses station, *but that, it wasn't verbally handed over to me that she had self-harmed.*
[62] Transcript page 220. Ms Williams denied seeing any injuries to Nicole's wrists during their interactions. See Transcript page 284 where she stated, *I'm not saying they didn't exist, because we know they did exist. They were not visible to me at all.*
[63] Transcript page 244.
[64] See transcript 244, where she states in response to a question from Michelle, *I do not recall absolutely that she did mention it, that you had been to see your (step) father in hospital together*, and later that Nicole spoke about their previously difficult relationship (but), *She didn't make it clear that she had been to hospital with yourself that day.*
[65] Transcript page 218.
[66] Exhibit 9, Medical records at page 16A.

54. According to Ms Williams she endeavoured to obtain a full understanding of Nicole's risk and social situation and events leading up to her presentation at the ED. Ms Williams stated that Michelle's contact details were not in the medical record [67] and she did not want to ask Nicole for them because, *she had expressed existing conflict with her mother.*[68] So, around 2am Ms Williams telephoned and spoke to Auntie Sharon and her partner who reported Nicole had, *mentally deteriorated* since a relationship breakdown and that she had, *fought with her mother on 27 October 2013 and that the CAT [69] team was supposed to attend but had not.*[70]

55. Ms Williams noted in the Assessment Details document:

> Nicole *has not slept well for days, denying drug use today, reporting increase in auditory hallucination* [and] *increased anxiety ... Denies intent to act on these voices* [telling her that she is worthless and should die]. *After approximately 20 minutes was calm no longer tearful and requesting to go home, although stating she is not sure if she could manage in the house alone. Reports some ideas of self-harm which escalate if home alone and unable to cope. States she was to see Frankston Acute today who were unable to* attend [my emphasis].[71]

56. In her evidence at inquest, Ms Williams was questioned about Nurse Gaffy's earlier reference to auditory hallucinations of which she was aware.[72] It was also clear from her evidence that Ms Williams was concerned that Nicole had, *a fluctuating underlying psychosis*. She further commented that, *I am not a psychiatrist so it is not within the scope of my practice to make that diagnosis.*[73]

57. Ms Williams reportedly questioned Nicole closely about suicidality. She noted that Nicole expressed, *vague suicidal thoughts* but had no suicidal intent and denied having any plan. Nicole denied having a stockpile of medications at home and denied any past history or intent to harm herself.[74] Although Nicole's deterioration in mental health with

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[67] This statement does not appear to be accurate as Ms Smith's name, relationship and phone number appear on documents generated on 26 October 2013 in Nicole's medical record, though I am unable to say whether the contact details were correct. See Medical Records Exhibit 9 at page 97.
[68] Exhibit 6.
[69] CAT is the acronym of Crisis Assessment and Treatment used to describe psychiatric teams that respond to acutely psychiatrically unwell individuals in the community.
[70] Exhibit 6 where Ms Williams refers *to existing conflict* between Nicole and her mother and her earlier clinical note of this understanding, where she refers to Nicole feeling, *guilt* about her relationship with her mother. Exhibit 9 page 71. See also footnote 64 above, which sets out her response to a question from Michelle, concerning this matter.
[71] Medical Records Exhibit 9 page 76.
[72] Transcript page 207-208.
[73] Transcript page 237. See Nurse Gaffy's similar view discussed at paragraph 23 above.
[74] Exhibit 6. Ms Williams' statement had read *'I now understand that she attempted self-harm when being bought in by ambulance, however there was no evidence of trauma and this wasn't reported to me as significant'*. When read into evidence at the inquest Ms Williams asked that the statement be amended to remove the phrase 'as significant' as she

suicidal ideation for the past one day was noted as an identified risk, and without apparent reference to Nurse Gaffy's earlier assessment or to the threats implicit in her own interview with Nicole, Ms Williams assessed Nicole as at low risk of suicide. She further assessed her risk of self-harm as very low, conceding at inquest that had she been aware of the self-harm incident that prompted her presentation to the ED, she would have assessed this risk as low or medium.[75]

58. Ms Williams noted:

> *OUTCOME nil acute risk identified, Nicole is vague about ongoing suicidal ideation stating that she wants to go home but is feeling unsafe at home alone. Nil psychotic symptoms noted at assessment* [my emphasis].[76]
>
> *PLAN stay in ED overnight due to inability to cope at home alone and containment. For brief risk [assessment] by CLIPS in a.m. and follow-up by Frankston acute [CLEARS].*[77]

59. As the last note demonstrates, a plan was formulated for Nicole to remain in the ED overnight and for CLIPS to review her prior to discharge in the morning. Given that Nicole was distressed and had identified an inability to cope by herself at home Ms Williams thought that an overnight stay in the ED would, *assist in providing reassurance and allow* Nicole *time to settle* and *would reduce the time gap between discharge from the* ED *and acute follow up* [with CLEARS] *the next day.*[78] Nicole agreed with Ms Williams' plan.[79]

60. Despite concern about her own ability to cope at home alone, Nicole reportedly told Ms Williams that she, *felt better* and wanted to leave within a short time of their meeting.[80] In response, Ms Williams was able to persuade Nicole to remain at the hospital, all the while mindful that no beds were available in the emergency short stay unit more conducive to rest and that Nicole's cubicle was in a high traffic area in the bright and noisy ED. In evidence she further stated that she was not surprised that Nicole appeared unable to relax in that environment – a not uncommon phenomenon apparently – and anticipated that Nicole would ultimately want to go home.[81]

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denied *receive a hand over (see* Transcript page 206).*I now understand that she attempted self-harm when being bought in by ambulance, however there was no evidence of trauma and this wasn't reported to me*

[75] Exhibit 6.
[76] Exhibit 9, Screening register detail 28 April, at page 1 of 4.
[77] Medical Records pages 77-78.
[78] Exhibit 6.
[79] Medical Records pages 77-78
[80] Transcript 209-213.
[81] Transcript page 213.

61. At about 3am, Ms Williams had passed Nicole's on several occasions and checked on her. She initially stated, that she, *had seen Nicole a number of times between my assessment and Tony's phone call,* but in her later testimony informed that, *she had sat with her and re-assessed her* [my emphasis].[82] I further note that no notes were made of these meetings and deal with this matter at paragraph 64 below.

62. According to Ms Williams, Nicole was apparently more relaxed and reiterated her desire to go home, explaining that she wanted to go there and sleep and be able to take her children to school in the morning. Ms Williams suggested to Nicole that it, *would be best* [83] to go home to the Aunties' place where the children were but she was resistant to this idea, concerned they would be cross with her because she had caused, *enough trouble for one night.*[84]

Discharge

63. Around 3.30am on 28 October 2013, Nicole informed ED staff that she wanted to leave the hospital. Nurse Unit Manager [NUM] of the ED, Tony Hilary, telephoned Ms Williams and Nicole was psychiatrically cleared for discharge. Ms Williams explained her decision to clear Nicole for discharge in the following way:

> *On the second time that I spoke to her after I had spoken to her aunties ... My concern was similar to Ms Gaffy's that if she was expressing thoughts about being worthless and deserving to die, was she receiving any messages to act on that. Which wasn't the case... She was requesting again to go home, and settled considerably, was open, was polite, was appreciative ...*
>
> *She is speaking to me openly. She's identified the children as protective factors. She is acknowledging and agreeing to see the CLEARS team. She is speaking to me in a rational and clear manner. She was quite logical in what she was talking about.* [85]
>
> *Advised by NUM Tony, Nicole requesting to leave as overnight stay was primarily psychosocial and Nicole advising she did not feel safe at home alone. Nil acute risk at this time, not meeting criteria for involuntary treatment under Sect 8 of MHA, discharge home at own risk for follow up by Frankston Acute...*[86]

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[82] See statement at exhibit 6 paragraph 23 and later testimony at 213-14.
[83] Transcript page 214.
[84] Ibid.
[85] Transcript pages 230-31.
[86] Medical Records page 16b and Transcript page 233. I note that A/Prof Jespersen's assessment of the manner of Nicole's discharge was that she was cleared for discharge, not that she was discharged 'at her own risk' or against medical advice: Transcript page 184.

64. At inquest, Ms Williams agreed with the evidence of Clinical Director of Peninsula Health's Mental Health Service, Associate Professor Sean Jespersen, that a change of plan – say from remaining in the ED overnight to discharging a patient home – should involve a reassessment of risks performed face-to-face to ensure that the new plan is safe.[87] While Ms Williams confirmed that she did not have a face-to-face meeting with Nicole after being contacted by the NUM, she stated that she had seen her about half an hour earlier and considered this to be a re-assessment.[88]

65. I also note A/Prof Jespersen's evidence that in his view how a plan thought to be inappropriate at one point (going home alone) had suddenly become appropriate at a later point in time remained, *unexplained.*[89] He opined that, *Nicole appeared persuadable* and so, at the point at when she changed her mind about the plan and wanted to go home, it *was reasonable to expect a reassessment* and *exploration of that* change in more detail. Indeed, *she may well have been persuaded to stay until morning* when review by a psychiatry registrar or consultant could have occurred.[90]

66. Ms Williams testified she was aware that Nicole had presented to the ED more than once within 72 hours and conceded that re-presentation may *indicate increase risk, but not in every case.*[91] She stated that she was not aware of a provision of Peninsula Health's Mental Health Clinical Guideline [PH Guideline][92] which among other things, required that any patient presenting to the ED consecutively within 72 hours be discussed with the Psychiatry Registrar prior to the second discharge from the ED. Ms Williams did not discuss Nicole's presentation with the Psychiatric Registrar.[93]

67. Nicole's nominated next-of-kin was not informed of her impending discharge nor of her destination contrary to the PH Guideline applicable to CLIPS clinicians at the time. According to A/Prof Jespersen, Ms Williams had explained her failure to do this by reference to the lateness of the hour of discharge,[94] however at inquest, she suggested the

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[87] Transcript pages 155, 174 (Jespersen) and 234 (Williams).
[88] Transcript page 234. As above I note that there was no recording of any such attendance or assessment (and also Ms Williams own evidence concerning the importance of standard form risk assessment documentation, at transcript 219). In the absence of any clinical record or documentation of such assessment(s) I direct myself to attach little weight to her evidence concerning this matter.
[89] Transcript page 173.
[90] Transcript page 178.
[91] Ibid.
[92] Peninsula Health Clinical Practice Guideline – Mental Health: Consultation Liaison Inpatient Psychiatry Service [CLIPS] in the Emergency Department (03/2013), "Clients who present frequently", Coronial Brief at page 142.
[93] Ms Williams also confirmed in evidence that she had not contacted a Consultant psychiatrist about Nicole's management or discharge, *because there were no clinical indicators* to do so (Transcript page 234-5).
[94] Exhibit 5.

Aunties', *irritation and frustration* with Nicole played a role in her decision not to contact them again.[95] She conceded, with hindsight, that A/Prof Jespersen's view that subject to the patient's wishes, his or her nominated contact person should be informed of discharge irrespective of the time, was good practice.[96]

68. Nicole left the ED by taxi after Nurse Rencey Ramadevi had confirmed with the NUM that she had been medically and psychiatrically cleared for discharge between 3.30 and 4am on 28 October 2013.[97]

Follow-up by CLEARS and Michelle

69. At around 11am Mr Twining, having been informed of Nicole's overnight presentation to and discharge from the ED, tried to call her to confirm the scheduled home visit. Nicole did not answer.

70. Michelle also tried repeatedly to reach her daughter by telephone on the morning of 28 October 2013 and was unsuccessful. She eventually called Frankston Hospital and was informed that Nicole had been discharged around 3.30am and was very concerned to learn that no-one had collected her from the ED, rather, that she had been put in a taxi.[98]

71. At approximately 1.45pm, Mr Twining and Ms Chique attended Nicole's address. They found Nicole unresponsive, lying face down in the front garden and called the emergency services. Later that afternoon, Michelle learned that Nicole had died.

72. Three weeks after Nicole's death, Michelle and Nicole's half-sister, Renee, attended a meeting with Ms Susan O'Keefe at Frankston Hospital to discuss Michelle's concerns about the adequacy of the care her daughter received proximate to her death.[99]

CONCLUSIONS

73. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[100] Having applied the applicable standard to the available evidence I find that:

[95] Transcript page 218.
[96] Transcript page 236 and Exhibit 5.
[97] See Coronial Brief exhibit 8 at page 185.
[98] Exhibit 1.
[99] Ibid.

a. Nicole's mental health had been deteriorating for a period of about four months prior to her death. She was concerned about her own mental health and engaged in help-seeking behaviours;

b. Nurse Gaffy's clinical management of Nicole when she presented to the ED on 26 October 2013 was reasonable and, in particular, that Nicole's discharge into the care of Auntie Sharon and the plan for follow-up by CLEARS for diagnostic clarification given concerns about the emergence of psychotic symptoms, was necessary and appropriate in the circumstances;

c. CLEARS clinicians' telephone contact with Nicole following her discharge from the ED on 26 October 2013 was timely and I am satisfied that notwithstanding the limitations of *telephone assessments*, the interaction provided a reasonable basis for scheduling a home visit in the afternoon of the following day;

d. Nicole's interactions with her mother throughout 27 October 2013 suggest psychotic symptoms such as auditory hallucinations;

e. The CLEARS clinicians arrived at Nicole's home before they were expected and left without seeing Nicole. It is unfortunate that the clinicians did not remain at Nicole's home at least until the appointed time for the home visit, or later return as was suggested might occur, but I do not conclude that their failure to do so was causally related to Nicole's death;

f. Ms Williams' clinical management of Nicole upon her presentation to the ED in the early hours of 28 October 2013 was suboptimal in that she:

    i. Failed to review documents such as the PCR and clinical (physical health/triage) ED records, which contained pertinent information about circumstances precipitating Nicole's presentation and were particularly relevant to assessment of her mental state including the progress of psychosis and risks of suicide and self-harm;

    ii. Missed an opportunity to obtain a corroborative history from Michelle, which was temporally relevant and, unlike that provided by Auntie Sharon

[100] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

and her partner, was likely to have confirmed the emergence of psychotic symptoms rather than situational crisis;

iii. Accorded insufficient consideration to the fact that Nicole had not been psychiatrically assessed by a CLEARS clinician as planned by RPN Gaffy, (between Nicole's ED presentations);[101]

iv. Failed to formally re-assess Nicole when informed by the NUM of her request to be discharged, or explore the reasons for Nicole's apparent change of heart about complying with the agreed management plan; and

v. Failed to ascertain the risks associated with discharge home at that juncture or otherwise endeavour to persuade Nicole to remain in the ED until morning;

g. Ms Williams' failure to comply with PH Guidelines[102] relevant to re-presentations by mental health patients to the ED within a 72-hour period was also suboptimal as was the general failure to notify that Nicole was to be discharged home alone in the early hours of the morning, (which decision I find difficult to understand at any level);

h. I find then that the decision to agree to release Nicole in the early hours of 28 October from the Frankston ED without an attempt being made to persuade her to stay and (if then needed) without reference of the matter to an on call Psychiatric Registrar or Consultant was suboptimal and finally cost both Nicole and her family the best chance she had of receiving protection from self-harming behaviour;

i. Nicole climbed onto the roof of her home herself, without third party involvement, sometime after her discharge from the ED on 28 October 2013;

j. I am satisfied that when Nicole climbed onto the roof she was mentally unwell with an undiagnosed condition suggestive of intermittent psychosis involving auditory command hallucinations and in consequence I am unable to ascertain with certainty whether she intended to harm herself by doing so;

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[101] The result was that by the time Ms Williams was later called upon to respond to Nicole's wish to leave Frankston Hospital, that no one had assessed Nicole's possible psychosis in any meaningful way, or could therefore assess whether upon release any such condition was likely to impact upon her potential to self-harm.
[102] Exhibit 8 page 142.

k. I am unable to determine at what time of day this occurred and whether Nicole fell or jumped from the roof her home and so make no finding as to the manner of her death.

74. I note the practise changes that have occurred at Frankston Hospital since Nicole's death and the protocols previously put in place by the Department of Health and Human Services. The appropriateness or otherwise of these initiatives has not been examined and for this reason I have determined not to make recommendations. Instead I refer interested parties to those changes and to the relevant Departmental protocols and have nothing to add.[103]

75. I also extend my sincere condolences to Nicole's family and friends. Despite the difficulties she faced, it is apparent that until the end Nicole maintained a strong commitment to do her best to protect her children and that it was this commitment that guided her efforts to seek medical assistance.

Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

Ms Michelle Smith
Ms Mia Janssen, Peninsula Health
Chief Executive, Frankston Hospital
CLIPS Jennifer Williams
Joanne Gaffy
CLEARS Tim Twining
Tonya Chique,
NUM Tony Hillary
Office of the Chief Psychiatrist
Senior Constable Francis Olle, Frankston Police
Coroners Prevention Unit, Mental Health Investigator

[103] See Mental Health Care Framework for Emergency Department services published by The Dep of Human Services in August 2007; Mental Health Reponses in Emergency Departments, published by the Department of Human Services in February 2008; and Emergency departments-principles of care for people with mental illness, published by the Department of Health and Human Services in June 2017.

Signature:

Peter Charles White
CORONER
Date: 28 July 2018.