IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006415

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF SARAH LOUISE SKILLINGTON

Findings of:	Coroner David Ryan
Delivered on:	18 June 2025
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	17-21 February 2025
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Jarvis Johnson & Peter Skillington:	Patrick Over of counsel Instructed by Maurice Blackburn
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Mitcham Private Hospital (Ramsay Health Care):	Paul Halley of counsel Instructed by MinterEllison
Dr Philippa Costley:	Peter Harris of counsel Instructed by Avant Law
Dr Ruvanya Illesinghe:	Sebastian Reid of counsel Instructed by Wotton Kearney

Danielle Dillon:	Diana Price of counsel Instructed by Gordon Legal
Dorota Dudek:	Laila Hamzi of counsel
WorkSafe Victoria:	Jayr Teng of counsel
Keywords:	Postpartum psychosis – in-patient medical treatment – ligature point - risk assessment - observation – communication – training - staffing

INTRODUCTION

1. On 19 November 2023, Sarah Louise Skillington (**Sarah**) was 33 years old when she passed away at Mitcham Private Hospital (**MPH**). MPH is operated by Ramsay Health Care.

2. Sarah was born on 26 January 1990. She is deeply mourned by her loving family which includes her husband, Jarvis Johnson, her daughter, Lily, her parents, Peter and Karen Skillington, and her siblings, Robert and Laura Skillington.

3. In moving Coronial Impact Statements delivered to the Court, Sarah's family conveyed with warmth and affection their experience and memory of Sarah, and their grief, devastation and loss at her passing. They painted a vibrant and affectionate picture of a remarkable woman who embraced life and was dearly loved by those around her.

BACKGROUND

4. Sarah was employed as an architect, and she was very well regarded by her clients and colleagues.

5. Sarah's medical history included disordered eating and health anxiety. She had a number of appointments with a psychologist in 2022 where she reported that *"her anxiety was precipitated by experiencing a physical symptom and catastrophizing about her physical symptoms becoming a chronic issue"*. Further, she reported that during periods of severe health anxiety, she had experienced *"fleeting suicidal ideation"*. She also reported that her paternal grandmother had been diagnosed with bipolar disorder. Sarah was treated with psycho-education, Cognitive Behaviour Therapy and mindfulness-based skills training. Her last session was on 5 July 2022, and it was reported that she engaged well with therapy, achieving positive results and that she would be in contact with her psychologist if she required further support.[1]

[1] CB19-1-2.

6. On 6 November 2023, Sarah gave birth to Lily at Frances Perry House.[2] Lily was Sarah and Jarvis's first child and was delivered by obstetrician and gynaecologist, Dr Philippa Costley. Dr Costley stated that Sarah's pregnancy had been uncomplicated and she had *"appeared excited about the baby"*.[3]

7. Sarah had a difficult birth which required a vacuum assisted delivery and an episiotomy. Throughout her hospital stay, Jarvis was observed to be very attentive and supportive to both Sarah and Lily. Karen also visited to provide assistance and guidance.

8. On 9 November 2023, during her postnatal stay in hospital, Sarah began to experience rapidly increasing anxiety in the context of breastfeeding difficulties and lack of sleep, and was observed to become overwhelmed and hypervigilant of her daughter. She also experienced racing thoughts. Dr Costley was concerned about Sarah's anxiety and arranged for her stay in hospital to be extended by a further day and temazepam was prescribed to assist with her sleep. Although she was concerned, Dr Costley stated in evidence that a presentation of anxiety by a mother in the three to five day postnatal period is extremely common.[4]

9. On 10 November 2023, Dr Costley recommended that Sarah cease breastfeeding as it continued to be a source of ongoing anxiety for her. Dr Costley remained concerned about Sarah and considered that her anxiety was "*more intense than general anxiety following a birth"* and she mentioned to Sarah the risk that it could develop into postpartum psychosis.[5] Further, Dr Costley discussed the possibility of a referral to a psychiatrist and an admission to the perinatal unit of MPH for additional support.[6]

10. On 11 November 2023, as it was the weekend and Dr Costley was not at work, Sarah was reviewed by her colleague, Dr Kym Jansen. Dr Costley had discussed her concerns with Dr Jansen. Dr Jansen prescribed olanzapine[7] to assist with Sarah's anxiety and insomnia

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[2] Frances Perry House is a private maternity hospital also operated by Ramsay Health Care.
[3] CB17-2.
[4] T39.
[5] T20; Postpartum psychosis is a rare but serious mental illness that can affect women within the first few weeks of giving birth. There is an increased risk in women with a family history of bipolar disorder.
[6] T20-T21; CB17-3.
[7] There is no evidence that Sarah took any olanzapine.

and she was discharged from Frances Perry House and advised to contact Dr Jansen or Dr Costley if she had any concerns. A discharge summary was sent to her regular General Practitioner (**GP**) at South Yarra Medical.

11. On 12 November 2023, Sarah consulted Dr Keating Vuong from the Allegiance Medical Centre, who was not her regular GP. She reported worsening anxiety, insomnia, and occasional thoughts of self-harm. It was recorded by Dr Vuong that Dr Costley had told Sarah that she was *"at risk of psychosis if she does not sleep"*.[8] Sarah sought Dr Vuong's assistance in obtaining a referral to MPH, and he prescribed temazepam and diazepam to assist with her sleep, to be taken as needed. On the referral form, Dr Vuong recorded that Sarah had *"very bad anxiety"* and required a *"priority"* referral.[9]

12. After her appointment with Dr Vuong, Sarah contacted Dr Costley and advised that she had obtained a referral to MPH from a GP and that she was experiencing constipation. Dr Costley encouraged her to take the diazepam prescribed by Dr Vuong to assist with her escalating anxiety and Sarah declined an offer for a review the following day.[10]

13. Later on 12 November 2023, Jarvis contacted MPH advising that Sarah was seeking an admission. Staff recorded the information provided by Jarvis in a *Mental Health Triage Patient Information Checklist*. It was recorded that Sarah had a history of health anxiety, had been experiencing high anxiety after giving birth to Lily and was preoccupied with the thought of her insomnia developing into psychosis as mentioned by her obstetrician. Further, it was recorded that she had been experiencing fleeting suicidal thoughts with no plan or intent.[11]

14. On 13 November 2023, an experienced midwife from Dr Costley's rooms contacted MPH to confirm that they had received Dr Vuong's referral and inquired whether they needed any further information from Dr Costley. MPH advised that they did not need anything

[8] CB23-1.
[9] CB24-66.
[10] T23-T24.
[11] CB24-67-CB24-68.

further at that stage and the referral was accepted that day with a planned admission on 15 November 2023.[12]

15. Later that day, Dr Costley sent a text message to Sarah to see how she was feeling. Sarah called her and reported that she was still feeling constipated and Dr Costley prescribed an enema. Dr Costley remained concerned about Sarah and as a *"backup plan"* made inquiries with a perinatal psychiatrist who advised that she would be able to see Sarah the following week if necessary.[13]

16. On 14 November 2023, Sarah attended Dr Costley's rooms for a review. She was accompanied by Jarvis and Lily. Dr Costley noted that Sarah appeared *"flat and slightly distracted"* and *"slightly dishevelled"*. Sarah advised that she had arranged an admission to MPH the following day. Dr Costley did not find any evidence of constipation and was concerned that her fixation on constipation may be psychiatric. She also noted that while Sarah's perineum was healing well, it was not being well managed and Dr Costley was concerned about Sarah's ability to care for herself so she prescribed prophylactic antibiotics. Sarah assured Dr Costley that she felt safe at home and Dr Costley encouraged her to present to MPH as had been arranged and that she was welcome to contact her if needed. Dr Costley was reassured that Sarah would be receiving psychiatric care in an inpatient facility.[14]

17. On 15 November 2023, Registered Nurse Karen Lowry at MPH spoke with Sarah and Jarvis on the telephone and discussed Sarah's ambivalence about her planned admission. Ms Lowry provided reassurance and the admission was postponed to the following day.

[12] T24-T25; CB24-68.
[13] T37.
[14] CB17-4-CB17-5; T31.

CORONIAL INVESTIGATION

Jurisdiction

18. Sarah's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

19. The Coroners Court of Victoria (**the Court**) is an inquisitorial court.[15] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

20. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

21. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

22. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

23. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[16]

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[17] and

[15] Section 89(4) of the Act.
[16] Section 72(1) of the Act.
[17] Section 67(2) of the Act.

(c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[18]

24. These powers are the vehicles by which the prevention role may be advanced.

25. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[19] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[20]

26. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[21]

27. It was not mandatory under the Act for an inquest to be held into Sarah's death. However, in separate applications, Karen and Jarvis submitted requests to the Court pursuant to section 52(3) of the Act seeking that an inquest be held into Sarah's death. At a mention hearing on 21 June 2024, I advised the interested parties that I had determined to hold an inquest in the exercise of my discretion pursuant to section 52(1) of the Act. The inquest occurred between 17 and 21 February 2025.

28. A number of factual disputes arose from the evidence given at the inquest. Many of these disputes were exposed by the questioning of counsel for the interested parties in the reasonable pursuit of their clients' interests. However, it has not been necessary to resolve all of those disputes in order to make the findings necessary under section 67 of the Act.

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[18] Section 72(2) of the Act.
[19] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[20] *Keown v Khan* (1999) 1 VR 69.
[21] (1938) 60 CLR 336.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

29. On 16 November 2023 at around 10:30am, Sarah attended MPH and was admitted with Lily on a voluntary basis to the Perinatal Mental Health Unit (**the Unit**). She was admitted to Room 230 and she was accompanied and supported by Jarvis.

30. Sarah was admitted by Ms Lowry who partially completed a number of admission forms while speaking with Sarah and Jarvis. In the *Nursing Admission Form*, it was recorded that Sarah did not have a history of self-harm but the section in relation to any recent thoughts of self-harm was not completed.[22] It was also recorded that Sarah remained ambivalent about admission but that she was aware that she needed support, acknowledging that she was exhausted and struggling to care for Lily.

31. In the *Mental Health Risk Assessment*, Ms Lowry recorded that Sarah did not have a family history of suicide and that she had no or few suicidal thoughts with no plan.[23] Her overall risk of suicide/self-harm was assessed as *"moderate"* and Ms Lowry placed her on an observation regime which required that she be sighted every half hour (Category 3). Ms Lowry stated in evidence that all patients on the Unit were initially admitted under a Category 3 observation regime until they were assessed by a psychiatrist.[24] Further, she stated that she did not consider that Sarah's handbag was a *"risk item"* that needed to be removed.[25]

32. In relation to the forms only being partially completed, Ms Lowry stated in evidence that Sarah was *"very distressed"* and she was hoping to persuade her to proceed with the admission by making her feel comfortable and more settled with only *"gentle enquiries"* at that stage. She stated that often the forms may not be fully completed on admission but would be followed up by staff on the next shift by reference to the *Perinatal Mental Health Unit Admission Checklist*. There is no evidence that any incomplete sections of the

[22] CB24-12
[23] Ms Lowry also recorded in the progress notes on Sarah's medical file that Sarah had denied thoughts of self-harm; CB24-45.
[24] See also CB13-32.
[25] T96; T78.

admission forms were followed up subsequent to Ms Lowry's entries.[26]

33. During the day on 16 November 2023, Sarah telephoned Dr Costley and stated that she did not want to be at MPH but did not expand on the reasons why. Dr Costley encouraged her to trust the treatment offered and reiterated that she was not well and needed inpatient management. Dr Costley recalled that Sarah seemed to accept this advice. Sarah also asked for the details of the psychiatrist that Dr Costley had been liaising with but Dr Costley encouraged her to put her trust in the treatment offered at MPH as introducing another psychiatrist to the dynamic at that stage would be confusing.

34. Sarah was assessed by Consultant Psychiatrist Dr Ruvanya Illesinghe at around 3.00pm. Dr Illesinghe practised in perinatal mental health in various public and private hospital settings including MPH. Her assessment took about 90 minutes. Jarvis and Lily were also present. Dr Illesinghe had access to the *Mental Health Triage Patient Information Checklist* but did not recall if she reviewed the *Nursing Admission Form*. On assessment, Sarah was observed to be anxious and tearful but did not express any thoughts of self-harm or suicide and appeared ambivalent about her admission.

35. Sarah was not forthcoming during the assessment and did not disclose any family history of bipolar disorder or suicide. Dr Illesinghe did not recall if she directly asked Sarah whether she was experiencing thoughts of self-harm but did recall that she was future focussed.[27] She recorded her assessment in *Psychiatric Examination* and *Psychiatric Risk Assessment* forms. Dr Illesinghe recorded a diagnosis of *"moderate to severe post-natal anxiety"* and assessed Sarah's overall risk as *"low"*, whereby she was suitable for unescorted leave and subject to standard 2-hourly visual observations (Category 1).[28]

36. Dr Illesinghe prescribed a low dose of quetiapine *extended release* (in the morning and evening) with *immediate release* as required. She also prescribed zopiclone (in the evening)

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[26] T58-T59. However, the reference to Sarah's fleeting suicidal ideation recorded in the *Mental Health Triage Patient Information Checklist* appears to have been carried over to a handover sheet used by nursing staff during her admission, see CB36-1.

[27] T157-T159.

[28] CB13-30; Notwithstanding the observation regime that applied to a Category 1 rating, it was standard practice at MPH for all patients to be observed hourly overnight.

to help with sleep with the prescribing of an antidepressant to be considered the following week. Further, she recommended that Sarah attend the group sessions offered at MPH and referred her to one of the psychologists who attended the Unit on Fridays and Mondays. Dr Illesinghe stated in evidence that her treatment plan at that stage was to promote sleep restoration for Sarah with the support of inpatient care. Dr Illesinghe planned to review Sarah three times a week, with the next review on 20 November 2023.[29] Given her presentation, Dr Illesinghe did not consider that Sarah was suffering from postpartum psychosis, but she was aware of the risk that it may emerge during her admission. If she considered that Sarah had been suffering from postpartum psychosis, Dr Illesinghe stated in evidence that she would have had a *"fairly low threshold to be organising transfer to the public system"* and possibly as a compulsory patient. [30]

37. In the afternoon and evening on 16 November 2023, it was recorded that Sarah had a number of interactions with nursing staff and she remained ambivalent about her stay but was hoping to get some sleep. She did not attend any groups that day. Sarah was administered zopiclone that evening and Lily was cared for overnight in another room by night staff. Jarvis went home to get some sleep, returning to support his family the following day.

38. On 17 November 2023, Sarah was recorded to have slept well overnight and was administered her morning dose of quetiapine, keeping a *"low profile"* on the ward. The progress notes record that nursing staff regularly engaged with Sarah and she remained ambivalent about admission and expressed guilt and inadequacy about *"not feeling bonded with Lily"*. She did not disclose any suicidal ideation to staff.[31] Ms Lowry recalled in evidence that Sarah did not see a psychologist that day as planned as she had been sleeping, and the plan was for her to be seen the following week.[32]

39. That day, Dr Illesinghe had been in contact by telephone with nursing staff about another

[29] T134.
[30] T132;T149.
[31] CB24-47-24-48.
[32] T66

patient and she was advised that Sarah remained ambivalent about her admission.[33]

40. In the afternoon, Karen visited for a few hours and observed that Sarah was *"so down"* and recalled that Sarah told her that she *"felt like killing herself"*.[34] Karen stated that she had an interaction with a nurse that afternoon (most likely Ms Lowry), and recalled telling her that Sarah *"felt terrible"*.[35] Ms Lowry recalled having a discussion with Karen about the facilities in the room but did not recall being told that Sarah *"felt terrible"*. Ms Lowry recalled that Sarah appeared to be more settled that afternoon and she stated that she would have contacted Dr Illesinghe if any suicidal thoughts had been disclosed. Sarah attended a group session held later that afternoon.[36]

41. Before leaving the hospital, Karen accompanied Sarah, Jarvis and Lily for a walk to the supermarket. She recalled that Sarah was teary and she reassured her that she was loved.[37]

42. In the evening, Sarah did not take her prescribed dose of quetiapine as she reported feeling too sedated but she was administered zopiclone to assist with sleep. Lily was again cared for overnight in another room by night staff with Jarvis going home to get some sleep, returning to support his family again the following day.

43. In the morning of 18 November 2023, it was reported that Sarah had slept well but she again refused her prescribed dose of quetiapine but planned to take it that evening. Nursing staff advised Dr Illesinghe by text message who stated in evidence that she was not significantly concerned as no signs of a deterioration in Sarah's mental state had been reported and the option of *immediate release* quetiapine was available if required.[38]

44. That morning, Sarah had a medical examination by a doctor. He noted that her episiotomy wound was healing well. Nursing staff recorded that Sarah's mood had improved and that she was *"gradually gaining more confidence"* and she was observed to be *"warmly*

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[33] T172-T173.
[34] CB7-10
[35] CB7-11.
[36] T100-T101; CB19B-4.
[37] CB7-12.
[38] T142.

interacting with Lily". Further, it was recorded that there was no suicidal ideation. [39]

45. Registered Nurse Dorota Dudek was rostered to work that afternoon on the Unit between 2.15pm and 10.00pm. She had a Diploma in mental health from Deakin University and had experience in working in mental health. She engaged with Sarah, who appeared to have settled, and assisted her to care for Lily. She recalled in evidence that Sarah appeared *"very attentive to the baby"* and she was observed to be engaging effectively, although she expressed concern about Lily's nappy rash. Sarah attended a group run by Ms Dudek that afternoon and went for a walk in the evening.[40] She also spoke on the telephone with her friend, Eloise Stark. After their conversation, Eloise was concerned that Sarah was suicidal and she sent a message to Jarvis expressing her concern that Sarah should remain in hospital where she would be safe.[41]

46. Ms Dudek provided Sarah with her prescribed dose of quetiapine at around 8.00pm. Later that evening, she provided a handover in the nurses' office to the night staff, Registered Nurse Danielle Dillon, who had commenced her shift at 9.30pm. Ms Dillon had also worked on the Unit the previous night. Ms Dudek introduced Ms Dillon to Sarah and Jarvis before finishing her shift at 10.00pm. Ms Dillon recalled giving Sarah her zopiclone dose that evening which was recorded as being given at 10.00pm.

47. Jarvis had planned to remain with Sarah and Lily that evening but he subsequently decided to return home as some furniture had been delivered and left on their doorstep. At around 10.27pm, Jarvis left Sarah's room with Lily and handed over her care to Ms Dillon.[42] He did not believe that Sarah was suicidal.[43] Ms Dillon was the only staff member on the Unit overnight although there was an Afterhours Nurse Coordinator who was also on site at MPH who was available to be called for support if required. The Unit was at full capacity with six mothers and five babies, with two of the babies (including Lily) being cared for by Ms Dillon. All of the mothers were required to be the subject of regular observations by

[39] CB24-19-CB24-20;CB24-49.
[40] T255-T256;T279; CB24-50.
[41] CB6-1.
[42] CB31 - CCTV.
[43] CB4-3.

staff.

48. Ms Dillon recorded that she conducted observations of Sarah overnight on an hourly basis from 10.00pm on 18 November to 6.00am on 19 November 2023.[44] The instructions on the *Category Sighting Chart* require staff to *"Sight patient…, if asleep, check for signs of life (eg rise and fall chest, respiration rate)"*. Further, in relation to visual observations, the Ramsay Health Care *Risk Assessment & Category Observation* policy provided that *"Staff must physically sight the patient and observe the patient's mental/physical presentation. Staff must have a clear visual view of the patient with nothing obscuring the observation, for example, door with viewing window, bedside curtain, or blanket. If sleeping, patient should be observed breathing with respiratory rate within normal range"*.[45]

49. Ms Dillon did not in fact conduct any observations of Sarah overnight on 18/19 November 2023. She gave evidence that her rationale for this decision was that she knew that Sarah had been assessed as a low risk and had wanted to prioritise her sleep. She wanted to avoid disturbing Sarah while she cared for Lily in another room. Further, she thought that she would be able to hear Sarah if she got out of bed.[46]

50. Ms Dudek arrived at MPH for her morning shift on 19 November 2023 at around 7.00am. When she arrived, she had a discussion with the Afterhours Nurse Coordinator Registered Nurse Karelle Kunst. Ms Kunst advised Ms Dudek that she would be working alone on the Unit after Ms Dillon's departure until around 9.00am as another staff member had called in sick. She said that Nurse Coordinator Registered Nurse, Suzanne Smith would be available to assist if necessary. Ms Dudek stated in evidence that she voiced her concern to Ms Kunst that it was not safe to be on the Unit by herself.[47] Ms Kunst could not recall Ms Dudek voicing these concerns but I am satisfied that she did, given that a few days after the incident, Ms Kunst and Ms Dudek had an exchange by text message which corroborated Ms Dudek's recollection. In that exchange, Ms Kunst acknowledged that there needed to

[44] CB24-71
[45] CB13-31.
[46] T199.
[47] T263.

have been two staff in the Unit.[48]

51. Ms Dudek had a handover with Ms Dillon when she arrived on the Unit. She recalled from the handover that Sarah was *"settled"*, *"fine and asleep"*.[49] Ms Dudek recorded in the *Category Sighting Chart* that she conducted observations of Sarah at 7.00am and 8.00am, and that she was asleep. The CCTV did not record Ms Dudek conducting any observations at these times. However, there was no CCTV recorded between 7.01am and 7.16am.

52. Ms Dillon left the Unit at 7.23am and Ms Dudek stated in evidence that prior to that time, she and Ms Dillon went to Sarah's room and observed her through the observation window to be sleeping in bed. Ms Dudek stated that they did not open Sarah's door to check for signs of life. This observation is not referred to in Ms Dudek's statement and Ms Dillon gave evidence that she did not conduct any observation of Sarah that morning. It is possible that Ms Dudek conducted this observation between 7.01am and 7.16am, when there was no CCTV recording, however, I am satisfied that it did not occur with Ms Dillon. Further, I am not satisfied that it can be concluded from Ms Dudek's evidence that Sarah was in bed and alive at this time. Ms Dudek conceded that what she thought to be Sarah could have in fact been rumpled bedclothes.[50]

53. At around 8.23am, the CCTV recorded that Ms Dudek opened the door to Sarah's room and leaned her head in to conduct an observation. She then left the room, closed the door and carried on with other duties. This observation is not referred to in her statement. She stated in evidence that *"it still appeared that someone was in bed"* and she gently called out to Sarah that it was time for her medication and breakfast. However, she was *"not sure"* that what she had perceived in the bed to be Sarah sleeping could actually have been rumpled bedclothes.[51] She also did not recall seeing the bathroom light on at that stage although she conceded that she could not in fact see the bathroom door from her position when she leaned into the room through the doorway. Further, she stated that the bathroom

[48] CB34-1-34-2.
[49] T265.
[50] T267.
[51] T270-T271.

light is also not visible from that position.[52]

54. Between 8.40am and 8.56am, Ms Smith and Ms Dudek conducted a handover in the nurses' office. Ms Smith then left the Unit and it was planned for Registered Nurse Joanna Clough to join Ms Dudek shortly after 9.00am.

55. At 8.57am, the CCTV recorded that Ms Dudek entered Sarah's room for about 30 seconds before coming out again. She went in and out of the room a number of times in quick succession and then telephoned Ms Smith and requested her to return to the Unit. At around 8.59am, after calling Ms Smith, Ms Dudek returned to Sarah's room, turned on the light and activated the Code Blue[53] alarm.

56. Ms Dudek stated in evidence that she located Sarah hanging from the bathroom door when she entered her room at 8.57am. She initially thought that what she saw was a coat hanging on the door but then she realized that it was Sarah. She stated that she *"just couldn't believe what I was seeing"* and *"went into shock"*.[54]

57. Soon after the incident, Ms Dudek recounted to an attending police officer that when she had entered the room *"the bed was open"* and she had thought that Sarah was in the bathroom as the light was on in there. She stated that she returned a few minutes later and then realized that what she had thought was a jacket hanging on the door was in fact Sarah. It is clear from the police officer's Body Worn Camera (**BWC**) footage that Ms Dudek was shocked, traumatised and devastated by the incident.[55]

58. Ms Smith arrived back on the Unit at around 9.00am and she and Ms Dudek lifted Sarah off the bathroom door with the aid of a chair. The bathroom door opened as they lowered her to the ground. Sarah had used her handbag strap as a ligature by placing the bag over the top of the bathroom door and jamming it shut. The end of the cot had been removed and was found in the alcove leading to the bathroom. Sarah may have used the end of the cot to climb onto the door. The strap was removed from Sarah's neck and later placed on

[52] T312-T313.
[53] A Code Blue signifies a medical emergency that requires an immediate response.
[54] T274.
[55] CB33 - BWC.

the bed. Ms Smith then commenced cardiopulmonary resuscitation (**CPR**) while Ms Dudek went to collect the crash cart.[56]

59. Ms Clough responded to the Code Blue and entered Sarah's room as she was being lowered to the ground. She used Ms Smith's phone to contact emergency services. Ambulance Victoria paramedics arrived a short time later and took over the emergency response, however they were unable to revive Sarah and pronounced her deceased at 9.25am.

60. It was later suggested that Sarah may have placed a number of pillows under the blankets on her bed which gave the impression that a person was sleeping in the bed. The source of this suggestion was not able to be identified and there is no evidence from first responders that Sarah's bed had been staged to create the impression that a person was sleeping in it. I am satisfied that it did not occur, although the silhouette of the rumpled bedclothes on the empty bed may have created a similar effect in the darkened room.

61. A note written by Sarah was located at her home in which she expressed her love for Lily and Jarvis and her regret at not being able to see a way through her predicament. Its contents were consistent with an intention to take her life. It is clear from a review of her mobile phone that this note had been written by 17 November 2023 and had likely been completed at home before she was admitted to MPH.

OTHER INVESTIGATIONS

62. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

63. MPH conducted a SAPSE Review[57] in relation to Sarah's death which resulted in the following relevant findings:

[56] A crash cart is a mobile trolley that contains emergency medical equipment necessary for resuscitation and life support.
[57] Serious Adverse Safety Event Review as defined in s3(1) of the *Health Services Act 1988*.

(a) Sarah's admission to MPH was appropriate and the risk assessment completed did not warrant an involuntary admission under the *Mental Health and Wellbeing Act 2022* (**MHWB Act**).

(b) In hindsight, Sarah's ambivalence and two out of three risk factors being identified as *"moderate"* and strengthened inter-hospital communication could have triggered a higher risk score for the first 24 hours of admission.

(c) Sarah experienced a rapid and significant deterioration in her mental health, which was not detected by staff at MPH. This resulted in Sarah's risk assessment being classified low, and her category of observations being at the lowest level (every two hours). This therefore increased the likelihood that Sarah could plan and complete suicide.

(d) Sarah's admission mental health risk assessment, the general mental health risk assessment and the treatment and care plan were only partially completed. This increased the likelihood that important information pertaining to Sarah's risk was neither recognised nor communicated, increasing the likelihood that Sarah was classified as a low risk, resulting in low category observations.

(e) The physical layout of Sarah's bedroom, the presence of potential anchor points, and the location of the bathroom door increased the likelihood that a high risk patient could complete suicide by hanging.

(f) The absence of regular formal environmental risk assessments resulted in potential anchor points not being identified or removed, increasing the likelihood that a high risk patient could complete suicide by hanging.

(g) The screening questions in the *Mental Health Triage Information Checklist* do not adequately address aspects of risk to identify patients for an urgent admission, or a referral to a crisis team. This increases the likelihood that high risk patients are not identified prior to their admission.

(h) There is no scheduled education and training program for night duty staff, which decreases the likelihood that permanent night duty staff are exposed to current best practice changes or competency assessment. Additionally, night duty staff are rostered on their own, decreasing their exposure to other mental health colleagues.

(i) There is no formal clinical supervision in place in the Unit. This decreases the opportunity for mental health nurses to further develop enhanced reflective skills that are essential to continued advancing practice and to contribute to improvements in the safety of their nursing interventions.

(j) Bedside handover does not consistently occur at each shift change, which decreases the likelihood that staff review a patient together and assess and confirm a patient's risk level. When a bedside handover does not occur, there is no formal process to ensure that on every shift at least two staff members review a patient's level of risk together.

(k) There is limited understanding of the mental health services available for obstetric patients while inpatients, or post discharge, nor is there structured maternal wellbeing education, resources and tools for midwives to access. This decreases the likelihood that timely initiation of appropriate treatment and support pathways during an admission or post discharge occur to proactively prevent patient deterioration.

(l) There is no structured process for midwives to reliably receive adequate antenatal information concerning patients, prior to their admission to hospital – this decreases the likelihood that a patient's mental health status or risk factors are communicated and/or identified. The panel noted that Ramsay Health Care was working to improve the data collected in relation to patients' current and prior mental health conditions as an ongoing initiative.

64. The SAPSE panel made the following relevant recommendations:

(a) A review of MPH's care and planning documentation take place to ensure that the frequency of risk assessment and associated documentation are included. MPH has

since introduced monthly care planning documentation audits and monthly admission checklist audits.

(b) The establishment of an *Admission Checklist Audit* to be completed regularly for every new admission file. MPH has since introduced monthly admission checklist audits.

(c) MPH undertake an environmental assessment of Room 230 to identify all anchor points and the top of bathroom doors (even those doors which can be visualised from the bedroom door) be cut down at an angle to remove the opportunity for the door to be used as an anchor point. MPH has advised that bathroom doors have been cut down.

(d) MPH develop and implement a schedule for routine audits for anchor points and hazardous items which should include the requirement for a rapid audit and review to be initiated in the presence of high risk patients. MPH has advised that environmental risk audits are now required to be conducted every six months at MPH (with the audit tool being reviewed annually)[58];

(e) MPH review an alternate for the current metal cots which present a risk as they can be used as an anchor point. MPH advised that inquiries to source a suitable alternative were ongoing noting that safety standards for hospital cots had not been recently updated.

(f) MPH review the *Mental Health Triage Information Checklist* screening questions and update the form to include comprehensive risk screening questions. MPH has advised that the review is complete and that the mental health triaging questions now comply with Ramsay Health Care policy, with a standardised digital intake questionnaire.

(g) MPH identify permanent night duty staff and develop an education schedule to ensure that they are included in ongoing training and development opportunities,

[58] Submissions on behalf of Mitcham Private Hospital dated 20 May 2025, [24].

that they receive competency assessment, and clinical supervision is initiated. MPH have advised that all permanent staff have since received education regarding visual observations and a new Mental Health Clinical Nurse Educator has been appointed to develop an education calendar. MPH has advised that a comprehensive peri-natal mental health package was released to staff in January 2025 (including of online e-learning inclusive of postnatal psychosis). A specific training package was also mandated in October 2024 that included risk assessment and category observation policy.[59]

(h) MPH develop and implement a plan for the introduction of routine clinical supervision. MPH have advised that they have introduced monthly group sessions by way of clinical supervision. The sessions are voluntary.

(i) Education and training be provided to staff regarding consistency in safety huddles and bedside handover for the reduction of risk with MPH to develop and implement an audit schedule of bedside handover and the implementation of safety huddles. MPH advised that bedside handover education had been provided to nursing staff with an audit schedule to be implemented by May 2024. Further, a policy and guideline has been developed to formalise a requirement for staff to conduct bedside clinical handover at the change of shift.[60]

(j) MPH implement a requirement for the afterhours hospital manager (**AHM**) to conduct one set of category observations overnight alongside the rostered night duty staff member. MPH advised that all AHMs are now aware of this requirement with education provided.

(k) The Ramsay National Clinical Governance Unit review processes for overnight category observations and implement a plan for strengthening processes. MPH advised that an additional training package was mandated in October 2024 that included risk assessment and category observation policy. Further, an education

[59] Submissions on behalf of Mitcham Private Hospital dated 20 May 2025, [29]-[33].
[60] Submissions on behalf of Mitcham Private Hospital dated 20 May 2025, [33].

schedule of perinatal night duty staff has been developed detailing training competency assessments.[61]

(l) Ramsay Health Care implement a *Ramsay Edinburgh Depression Scale* for use during postnatal admission, and when appropriate or required within the patient journey, on all maternity units nationally; to ensure clear escalation processes are embedded in the tool, based on the patient's risk level assessed, actions will be scheduled for nursing staff to follow. Ramsay Health Care has advised it is now a mandatory requirement for all patients to be assessed under the *Edinburgh Postnatal Depression Scale* in its Early Parenting Centres, peri-natal Mental health Units and Maternity Units.[62]

65. Ramsay Health Care has confirmed that it will, subject to an appropriate risk assessment process, implement any outstanding training and supervision recommendations identified in the SAPSE Review in full.[63]

SOURCES OF EVIDENCE

66. Victoria Police assigned Senior Constable Billy Elliot to be the Coronial Investigator for the investigation into Sarah's death. The Coronial Investigator conducted inquiries on my behalf and prepared a Coronial Brief including statements from the forensic pathologist, various medical practitioners and staff who treated and cared for Sarah, relevant medical records, CCTV and BWC footage. It also includes reports from a number of independent experts obtained by the Court and the interested parties.

Expert reports

67. The Court obtained an expert report from Professor Anne Buist, a psychiatrist with perinatal expertise, dated 6 January 2025. She made the following relevant comments in relation to Sarah's care and treatment at MPH:

[61] Submissions on behalf of Mitcham Private Hospital dated 20 May 2025, [33],[36].
[62] Submissions on behalf of Mitcham Private Hospital dated 20 May 2025, [28].
[63] Submissions on behalf of Mitcham Private Hospital dated 20 May 2025, [31].

(a) An in-patient admission for Sarah was appropriate but it is unlikely that she would have met the criteria for compulsory admission under the MHWB Act. A compulsory admission would have required transfer to a public facility.

(b) The assessment of Dr Illesinghe was sufficient to conclude that Sarah had a provisional diagnosis of anxiety, although postnatal depression and postpartum psychosis could not be ruled out.

(c) The risk assessment conducted by Dr Illesinghe was reasonable but she failed to get a full family history (bipolar disorder and suicide) which led to a plan that did not alert staff to *"keep a specific eye to the risk of postpartum psychosis"*. However, the assessment and observation level was reasonable in absence of knowledge of history of bipolar.

(d) The prescription of quetiapine was appropriate.

(e) There was a clear dereliction of duty with respect to nursing staff signing off on observations that were not in fact performed.

(f) Staffing level on the Unit was inadequate and unsafe.

(g) The decision by the obstetrician/gynaecologist to prescribe olanzapine was appropriate and the critical information was conveyed by them and the GP.

(h) It is unsafe to have an inpatient mental health ward without a minimum of two nursing staff at all times (one of which needs to have a mental health nursing qualification and experience).

(i) It is likely that Sarah had postpartum psychosis.

68. Dr Illesinghe obtained expert reports from Dr Scott Hall, Consultant Psychiatrist, dated 22 July 2024 and 14 January 2025. He made the following relevant comments in relation to Sarah's care and treatment by Dr Illesinghe:

(a) Patients deemed a high risk or who require compulsory treatment under the MHWB Act are treated in the public system.

(b) The GP referral and MPH triage process was appropriate and included sufficient information to deem Sarah suitable for admission.

(c) It is not usual practice for an admitting psychiatrist at a private hospital to contact a patient's obstetrician or GP unless there as concerning information in the GP referral or triage notes regarding symptomatology or risk.

(d) Dr Illesinghe's Mental State Examination of Sarah was reasonable.

(e) If a psychiatrist considers a patient to be low risk, obtaining collateral information can be deferred to subsequent reviews. Dr Illesinghe elicited Sarah's past psychiatric history appropriately.

(f) As Jarvis was present during the assessment, Dr Illesinghe was not required to obtain further collateral history, perhaps until the following week in a family meeting.

(g) Dr Illesinghe's diagnosis of anxious premorbid personality and postnatal anxiety, moderate to severe was reasonable but it would have also been appropriate to consider a differential diagnosis of affective psychosis.

(h) An average peer psychiatrist would not have considered Sarah to be a high risk of suicide and in the absence of specific suicide concerns, 2-hourly nursing observations were appropriate.

(i) Private hospitals do not employ junior doctors to work over weekends. Nursing staff appropriately contacted Dr Illesinghe when Sarah refused doses of quetiapine.

(j) It was appropriate for Sarah to remain in hospital, receiving regular observations and engagement which would detect significant changes in her mental state.

(k) Dr Illesinghe's plan to review Sarah on 20 November 2023 was reasonable. There was no clinical indication for a further face-to-face review over the weekend.

Inquest

69. The inquest ran over 5 days and evidence was given by the following witnesses:

(a) Dr Philippa Costley (Consultant Obstetrician and Gynaecologist);

(b) Karen Lowry (MPH Registered Psychiatric Nurse);

(c) Dr Ruvanya Illesinghe (Consultant Psychiatrist);

(d) Danielle Dillon (MPH Registered Nurse);

(e) Karelle Kunst (MPH Registered Nurse/Midwife and Coordinator);

(f) Dorota Dudek (MPH Registered Nurse);

(g) Susanne Smith (MPH Registered Nurse and Coordinator);

(h) Joanna Clough (MPH Registered Nurse/Midwife);

(i) Kimberly Unthank (MPH Director of Clinical Services);

(j) Professor Anne Buist (Psychiatrist with perinatal expertise); and

(k) Dr Scott Hall (Consultant Psychiatrist).

70. Professor Buist and Dr Hall gave evidence concurrently at the inquest.

71. This finding is based on the evidence heard at the inquest, as well as the material in the Coronial Brief (including material tendered during the inquest) and the submissions made by counsel assisting and the interested parties following the conclusion of the evidence. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

SCOPE OF THE INQUEST

72. The following issues[64] were investigated at inquest in relation to the management of Sarah's care and treatment during her admission at MPH including:

    (a) The risk assessment conducted, and management plan developed by medical staff and the relevant processes and procedures in place at MPH;

    (b) The communication between MPH medical staff and Sarah's family;

    (c) The communication between MPH medical staff and Sarah's perinatal team;

    (d) The observation regime in place to ensure Sarah's wellbeing and the relevant processes and procedures at MPH;

    (e) The emergency response by MPH staff upon finding Sarah in her room; and

    (f) The suitability of the room in which Sarah was placed and the risk assessments that were conducted.

IDENTITY OF THE DECEASED

73. On 19 November 2023, Sarah was visually identified by her husband, Jarvis Johnson.

74. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

75. On 21 November 2023, Dr Brian Beer, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an examination and prepared a report of his findings dated 24 November 2023.

[64] These issues were drawn from the scope of the inquest which was identified at the directions hearing held on 5 December 2024.

76. Toxicological analysis of post-mortem blood samples identified the presence of diazepam (and its metabolite)[65], zopiclone[66] and quetiapine.[67]

77. Dr Beer expressed the opinion that the cause of death was "*1(a) Neck compression; and 1(b) Hanging*".

78. I accept Dr Beer's opinion.

79. In a supplementary report dated 11 March 2025, Dr Beer noted that Sarah's tympanic temperature was recorded by paramedics to be 31.9 degrees Celsius at 9.23am. Dr Beer stated that tympanic temperature measurements should only be used as a broad indicator when assessing time of death due to variability and error. He concluded that it is not possible based on the tympanic temperature obtained to exclude that Sarah may have been alive when Ms Dudek checked on her at 8.23am.

80. Further, he considered that witness perceptions in relation to rigor, hypostasis and temperature are unreliable in forming an opinion as to time of death.

THE RISK ASSESSMENT CONDUCTED, AND MANAGEMENT PLAN DEVELOPED BY MEDICAL STAFF AND THE RELEVANT PROCESSES AND PROCEDURES IN PLACE AT MPH

Diagnosis

81. I accept the evidence of Professor Buist that it is likely that Sarah was suffering from postpartum psychosis when she passed away. Dr Hall was not in a position to conclude a specific diagnosis in the circumstances but I am persuaded by Professor Buist's particular expertise in perinatal psychiatry and her extensive experience in treating and studying women with postpartum psychosis.

82. I am satisfied that Dr Illesinghe's provisional diagnosis of postnatal anxiety was reasonable at the time of Sarah's admission. She had excluded postpartum psychosis at that stage but

[65] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[66] Zopiclone is a cyclopyrrolone derivative used in the short-term treatment of insomnia.
[67] Quetiapine is an atypical antipsychotic drug.

was aware there was a risk of it emerging during Sarah's admission where there was an opportunity for longitudinal assessment. The panel agreed that postpartum psychosis is difficult to diagnose *"in the moment"* and could present in a similar way to anxiety. It's an *"iterative process"* that *"emerges over time"*.[68]

Risk assessment

83. I am satisfied that the risk assessment conducted by Dr Illesinghe was reasonable in the circumstances given Sarah's presentation and provisional diagnosis. This is consistent with the evidence of the expert panel although it is clear from their views that reasonable minds may differ in relation to the nuances of the conduct of a mental state examination and associated risk assessment. For example, Professor Buist stated that Sarah's case was *"lineball"* as to whether she would have justified an overall assessment of a *"moderate"* as opposed to *"low"* risk. However, she acknowledged that her opinion was reached with the benefit of hindsight and that Dr Illesinghe's assessment was *"still within acceptable peer group practice"*.[69]

84. It is clear from the expert evidence that reasonable minds may differ as to whether patients should be directly confronted with the question as to whether they have thoughts of self-harm.[70] It reflects the delicate balance between the need for direct and potentially confrontational questioning at an early stage of the admission process, and the promotion of an environment and therapeutic dynamic that will encourage the acceptance of treatment by the patient. Dr Illesinghe could not recall asking the question directly of Sarah but I am satisfied that it was not unreasonable for the question to not be directly asked in the circumstances. Dr Illesinghe was reassured by Sarah's future focus and was seeking to build a rapport with her. Further, given Sarah's reticence and consistently with other occasions when the issue had been raised by nursing staff, I am not satisfied she would have disclosed any suicidal ideation in the event she had been directly asked by Dr Illesinghe.

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[68] T462.
[69] T426;T437.
[70] T425-T427.

85. In the circumstances, given her risk assessment, I am satisfied that it was reasonable for staff not to remove Sarah's handbag during her admission. There is a need to create a balance between keeping patients safe and providing a therapeutic environment for mothers and babies, bearing in mind that the majority of patients on the Unit at MPH are experiencing anxiety and present a low risk of self-harm. Although staff should negotiate with patients to remove clearly unsafe items, there comes a tipping point where an overly conservative approach may be counter-therapeutic.[71]

86. A reasonable mental health assessment performed by a competent clinician that identified that a person presents a low risk of self-harm can seem obviously inadequate where that person takes their life soon afterwards. However, that tragic outcome does not automatically lead to the conclusion that the risk assessment performed by the clinician was inadequate. In many cases, it is a function of the limitations of the process itself, the complex nature of suicide and the difficulty in predicting its likelihood in any particular case.

Forms

87. The *Nursing Admission Form* completed by Ms Lowry, as opposed to the *Psychiatric Examination* form completed by Dr Illesinghe, did not contain a specific heading relating to family history. The expert panel agreed that a patient's family history is *"relevant"* and *"an important piece of the jigsaw"* during the admission stage. In particular, Professor Buist noted that a family history of bipolar disorder and suicide is relevant to the risk of the development of postpartum psychosis. She stated in evidence that she would have expected that such a heading would be part of the *Nursing Admission Form*.[72]

88. Further, a number of the documents completed by clinicians as part of Sarah's admission and risk assessment process were only partially completed. Ideally, these documents would be fully completed at an appropriate stage during an admission as they provide useful information to staff who examine and care for the patient which may inform their dynamic assessment as to whether particular changes in presentation require escalation. However,

[71] T457.
[72] T470.

I accept the evidence given by Dr Hall that the focus of a psychiatric assessment should be *"risk formulation"* as opposed to over-emphasis on *"stratified risk assessment tools or proformas"*. The former involves "*fully understanding, connecting, having a full history, developing a formulation of reasons why this person is presenting in distress, why this person may be experiencing suicidal thoughts, and sharing that in a succinct form so that the rest of the team can understand"* and leads to a *"more wholistic connection with the patient and understanding of their predicament"*.[73]

Management plan

89. I am satisfied that it was appropriate for Sarah to be accepted for admission to the Unit at MPH. The expert panel agreed that she did not meet the criteria for compulsory treatment under the MHWB Act.

90. I accept the evidence of the expert panel that the medication prescribed by Dr Illesinghe was reasonable in the circumstances, together with the recommendation to see a psychologist and for engagement in group sessions.

91. Dr Illesinghe assessed Sarah on 16 November 2023 with a plan to next review her again on 20 November 2023. There was no psychiatrist on the Unit over the weekend. I am satisfied that the planned period between face-to-face reviews was reasonable on the assumption that Sarah would be adequately observed and engaged with by nursing staff who could identify changes in her mental state that may have required escalation to Dr Illesinghe.[74]

92. Further, I consider that Category 1 observations were appropriate for Sarah given her presentation and her assessed level of risk.

[73] CB20A-20; T422-T423; See also, *White paper: On principles of mental health risk assessment*, Office of the Chief Psychiatrist, October 2024.
[74] T433; T460.

THE COMMUNICATION BETWEEN MPH MEDICAL STAFF AND SARAH'S FAMILY

93. It is acknowledged that Karen and Jarvis's experience of the environment at MPH and the level of communication with staff led to feelings of alienation and anxiety.

94. I accept the evidence of the expert panel that it was reasonable for Dr Illesinghe to defer the gathering of further collateral information about Sarah's history (perhaps from Karen) to later in her admission if necessary. It is clear that Sarah was reticent and ambivalent in relation to the provision of information but Jarvis was present during the assessment to provide input and as stated by Professor Buist, an admitting psychiatrist is often *"walking on egg-shells"* to avoid a level of confrontation that may lead to the patient not proceeding with the admission.[75]

95. Karen and Ms Lowry had differing recollections of the conversations between them in the afternoon on 17 November 2023. It is unsurprising that people's memories of the same events may differ particularly where the intervening period is coloured with grief and distress. I am satisfied that both witnesses gave evidence that was faithful to their recollections. Further, I am satisfied that nothing was disclosed to Ms Lowry which would have warranted escalation to Dr Illesinghe.

THE COMMUNICATION BETWEEN MPH MEDICAL STAFF AND SARAH'S PERINATAL TEAM

96. Dr Costley was appropriately concerned about Sarah's escalating anxiety during her stay at Frances Perry House and the potential development of postpartum psychosis. Her treatment and management of Sarah was reasonable and appropriate and reflected her concern.

97. Dr Costley discussed with Sarah the possibility of an inpatient stay at MPH, but it was Dr Vuong, and not Dr Costley, who actually made the referral. It was reasonable for her to leave Sarah's treatment to the clinicians at MPH. Further, an experienced midwife from

[75] T429.

her rooms had contacted MPH to confirm the referral and see if they needed anything further to ensure they had sufficient context for the admission.

98. Dr Illesinghe stated in evidence that, although not routine, she would contact a patient's obstetrician directly in some circumstances if she needed more information. However, in Sarah's case, she considered that she had sufficient information about her history and did not consider contact with Dr Costley was necessary.[76]

99. The expert panel did not consider that it was necessary for Dr Illesinghe to contact Dr Costley on Sarah's admission to MPH although Dr Illesinghe conceded it would have been helpful to have Dr Costley's insights on Sarah's anxiety.[77] Although I do not consider that Dr Illesinghe acted unreasonably in not contacting Ms Costley, such contact would have provided useful information relevant to Sarah's assessment. Particularly in circumstances where it appears common that discharge summaries from maternity hospitals may not record concerns about a patient's mental health.[78] In any event, I am not satisfied that a discussion between Dr Costley and Dr Illesinghe would have led to a different provisional diagnosis or care plan at MPH.

THE OBSERVATION REGIME IN PLACE TO ENSURE SARAH'S WELLBEING AND THE RELEVANT PROCESSES AND PROCEDURES AT MPH

100. After her review by Dr Illesinghe on 16 November 2023, Sarah was placed on Category 1 observations which required her to be observed every 2 hours. Consistent with general practice on the Unit at MPH she was also required to be observed hourly overnight. As already referred to above, the instructions on the *Category Sighting Chart* require staff to *"Sight patient…, if asleep, check for signs of life (eg rise and fall chest, respiration rate)"*. Staff are required to complete the chart by recording the time and location of their observation, the activity the patient is engaged in at the time, note any changes in mental status and report it to the nurse in charge if necessary and initial the entry. Further, Ramsay

[76] T150; T181.
[77] T153.
[78] T29; Sarah's discharge summary from Frances Perry House did not contain any information about her anxiety and was forwarded to her previous General Practitioner at South Yarra Medical.

Health Care *Risk Assessment & Category Observation* policy provided that the *"actual time the patient was sighted must be recorded on the Category Sighting Chart"*.[79]

101. Although she kept a low profile on the ward, the progress notes record that Sarah had a number of one-to-one engagements with nurses during her stay. Further, she did participate in a number of groups. Ms Lowry, Ms Dillon and Ms Dudek also gave evidence about their interactions with Sarah.

102. There was no evidence observed by nursing staff or communicated to them of any significant change in Sarah's mental state after Dr Illesinghe's assessment which would have warranted an escalation of her treatment. Dr Illesinghe had two subsequent communications with nursing staff about Sarah (by phone call and text message) but the expert panel stated in evidence that it was reasonable for Dr Illesinghe to conclude that these communications did not require a change to her treatment plan.[80]

103. Contrary to policy, Sarah was not observed overnight on 18/19 November 2023 which gave her the opportunity to carry out her plan to take her life uninterrupted. She was last observed and confirmed to be alive by Ms Dillon and Ms Dudek on 18 November 2023 just before 10:00pm. She was last seen alive by Jarvis at around 10.27pm.

104. There is inconsistent evidence as to whether Ms Dudek observed Sarah through the window to her room before 7.23am on 19 November 2023. Ms Dillon gave evidence that she did not make any observations of Sarah and there is no relevant CCTV recording between 7.01am to 7.16am. However, even assuming that the observation occurred, it was not performed in accordance with policy as there is no evidence that staff entered the room and confirmed that Sarah was alive. The observation at 8.23am was also not conducted pursuant to policy as signs of life were not positively confirmed. Further, Ms Dudek stated in evidence that it is possible that what she had perceived to be Sarah sleeping in bed during both observations may have been the silhouette of rumpled bedding.

[79] CB13-32.
[80] T453-T454.

105. The note written by Sarah (likely before she was admitted to MPH) which was found subsequent to her death, illustrated her feelings of desperation and her intent and plan to take her life. She had this opportunity throughout the night on 18/19 November 2023 as she was not observed by staff. Sarah's clear intention, together with the fact that she was not confirmed to be alive in the morning on 19 November 2023, does not enable me to be comfortably satisfied that Sarah was alive when Ms Dudek recalled checking on her before 7.23am or at 8.23am. She may already have been deceased at this point.

Staffing

106. Professor Buist stated in evidence that it would be best practice to have two staff working on the Unit at all times, with at least one of them having a mental health qualification.[81] However, the evidence of Ms Dillon does not support a finding that the failure to perform observations of Sarah overnight on 18/19 November 2023 was due to staffing pressures. Rather, Ms Dillon stated that she was prioritising the mothers' sleep while caring for the babies that had been roomed out. Further, she had been confident that she would have been able to hear Sarah if she got out of bed.

107. It appears that a culture had developed, particularly in relation to some night staff on the Unit, where observations were not performed appropriately and in accordance with policy. Exact times for observations were not recorded and at times bulk entries would be made in the chart.[82] As stated in evidence by Professor Buist, staff who consistently work night shift are less exposed to peer review and practice.[83] Ms Unthank advised the Court in evidence that staff have been trained and she has now observed that they are recording more exact rather than approximate times of their observations.[84] Further, the SAPSE panel recommended that a new practice should be implemented where the Afterhours Nursing Coordinator conducts one set of observation on the unit together with night staff to provide an opportunity for peer experience.

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[81] Ramsay Health Care submitted that a 2 nurse model would not be operationally feasible and implementing it may impact on maintaining the viability of the Unit at MPH; Mitcham Private Hospital dated 20 May 2025, [45].

[82] T357-360; T373.

[83] T448.

[84] T360-T361.

108. So, although the evidence in this case does not indicate that two nursing staff are necessarily required overnight to safely complete the required duties, it does suggest that it would nevertheless be appropriate as it would provide valuable peer support which promotes good practice.

109. In terms of staffing during the day, I consider that there should be two staff on the ward with one of them having a mental health expertise. Ms Dudek stated that she may have performed a more thorough observation of Sarah at 8.23am had she been less under pressure from being the only staff member on the Unit at that busy time. It had been planned for another staff member to be on the Unit from 8.00am, but she had been allocated to the maternity ward. As stated by Ms Unthank, sometimes unexpected staffing emergencies occur. The ecalation process is for staff to call upon the Nursing Coordinator if they need assistance. In circumstances where there is only one nurse on duty during the day in the Unit due to unexpected staff absences, it would be appropriate for the Coordinator to base themselves in that unit until an additional relieving staff member is available.

Training

110. It is clear from the evidence that the majority of the nursing staff on the Unit during Sarah's admission did not have formal mental health qualifications.[85] The benefit of a nurse who is trained and experienced in mental health is that they are more likely to be able to observe the subtle trajectory of a *"brewing"* postpartum psychosis.[86] This may lead to the signs of a deterioration being identified and communicated to a psychiatrist, resulting in escalation and intervention.

111. The expert panel stated in evidence that it can be challenging to identify the emergence of postpartum psychosis in the moment, and that it can be difficult to distinguish from postnatal anxiety. There is no evidence that nursing staff on the Unit receive specific and

[85] Ms Lowry, Ms Dudek and Ms Kunst had undertaken mental health training. Ramsay Health Care has noted that an undergraduate psychiatric nursing qualification is no longer offered in Australia but that registered nurses who have worked solely in the mental health setting for a period of time could be considered expert in mental health; Mitcham Private Hospital dated 20 May 2025, [38]-[39].

[86] CB20-2; T440.

tailored training in relation to recognising the signs and symptoms of postpartum psychosis which may require escalation.

THE EMERGENCY RESPONSE

112. Staff were not sufficiently prepared and trained for confronting the traumatic circumstance of finding a patient hanging. Ms Dudek was understandably shocked and traumatised by the circumstances of finding Sarah which affected her ability to decisively respond to the emergency situation. Ms Smith stated that she had not received any specific training in how to respond to finding a patient hanging.[87] In any event, I am satisfied that any delay in providing an emergency response after Ms Dudek located Sarah did not contribute to her death. I am satisfied that she had likely passed away by the time she was located at 8.57am. Further, I am satisfied that the emergency response was swift and reasonable once Sarah had been removed from the bathroom door and lowered to the ground.

THE SUITABILITY OF THE ROOM IN WHICH SARAH WAS PLACED AND THE RISK ASSESSMENTS THAT WERE CONDUCTED

113. Sarah would not have been able to take her life in the way that she did if the bathroom door had been altered to prevent it from being used as an anchor point. There is no evidence that MPH had conducted an appropriate ligature audit prior to Sarah's death. Ms Unthank advised that such an audit has since taken place with a schedule for ongoing and regular audits. Further, the rooms in the Unit have been modified to remove ligature points including the alteration of the bathroom doors. [88]

114. Private mental health facilities, such as MPH, are required to comply with the design requirements in the *Health Services (Health Services Establishments) Regulations 2024* and the Australasian Health Facility Design Guidelines (**AusHFG**).[89] The Department of Health considers a facility's compliance with the AusHFG in determining applications for

[87] T336.
[88] T366; T394; CB13-6.
[89] The AusHFG is national set of design guidelines for health facilities, which were first released in 2007 by the Australasian Health Infrastructure Alliance (AHIA). The AHIA is an Australian and New Zealand public sector collaboration established in 2004 and is comprised of senior asset managers from the public health authority of each Australian state and territory and New Zealand.

renewal of registration under the *Health Services Act 1988*. The last regulatory inspection conducted by the Department of Health was on 4 February 2025.

Safer Care Victoria Guide – Improving safety for consumers at risk of harm of ligature

115. In December 2024, after commissioning an expert advisory working group, Safer Care Victoria published a clinical guidance document entitled *Improving safety for consumers at risk of harm of ligature*. It is recommended for mental health and wellbeing services in the public system and has been designed to *"reflect contemporary practices that are essential for advancing organisational and clinical practice standards in the delivery of mental health care"*. The guide also states that it "*may also be considered and recommended for a whole-of-health response for improving safety of consumers at risk of harm of ligature"*.[90]

116. Relevantly, the SCV guide provides the following:

    (a) Health services should strive to support an environment that promotes open discussion, accountability, and learning from mistakes rather than assigning blame;

    (b) Ligature incidents require an emergency response as early intervention and aggressive resuscitation can reduce the risk of serious injury or death;

    (c) Staff in mental health bed-based services need to be aware of the specific risk of ligatures and be supported by employers through mandatory education and training to effectively provide emergency responses to ligature incidents;

    (d) Health services are responsible for maintaining up-to-date policies or procedures that clearly outline their organisational approach to managing ligature safety, including protocols for identifying ligature risks through

[90] SCV guide – *Improving safety for consumers at risk of harm of ligature*, December 2024, pp3-4.

audits and workforce training which includes guidelines on the use of "ligature cutters";

(e) Ligature identification audits should occur annually in inpatient settings;

(f) Therapeutic engagement is understood to be a powerful tool for reducing the risk of someone who is experiencing overwhelming emotional distress from creating or using a ligature; and

(g) Policies and procedures should identify pathways for consumers and families to escalate distress and seek support.

FINDINGS AND CONCLUSION

117. I am satisfied Sarah intended to take her own life but in circumstances where she was suffering from postpartum psychosis. The evidence does not enable me to determine precisely when Sarah left her bed to carry out her plan. I am able to positively conclude that Sarah was last seen alive was by Jarvis at around 10.27pm on 18 November 2023. I am unable to be comfortably satisfied that Sarah was seen alive again prior to her being located hanging and deceased by Ms Dudek at around 8.57am the following morning.

118. I am satisfied that the clinicians who looked after Sarah during her admission at MPH were motivated to care for her and Lily and support Sarah to get some rest to reduce her anxiety. They did not foresee that she would harm herself in the way that she did. It was the first time a patient had taken their life at MPH. However, critical aspects of her care were significantly undermined by the availability of ligature points in her room and a failure to properly observe her overnight and in the morning on 19 September 2023.

119. I am unable to conclude that Sarah's death could have been prevented had she been appropriately observed overnight and in the morning on 19 November 2023.[91] Even if hourly observations had been performed, Sarah would still have had an opportunity to take her life in the intervening periods when she would have been alone in her room. However,

[91] See also the evidence of Professor Buist and Dr Hall who stated that Sarah's death may not have been able to be prevented in the circumstances; T466-T467.

I find that it is unlikely that she would have had the opportunity to take her life in the way that she did without the availability of the ligature points in her room which have since been removed.

120. Having held an inquest into Sarah's death, I make the following findings, pursuant to section 67(1) of the Act:

(a) the identity of the deceased was Sarah Louise Skillington, born on 26 January 1990;

(b) her death occurred on 19 November 2023 at Mitcham Private Hospital, 27 Doncaster East Road, Mitcham, Victoria, from neck compression and hanging; and

(c) the death occurred in the circumstances set out above.

COMMENTS

121. Pursuant to section 67(3) of the Act, I make the following comments connected with Sarah's death:

(a) Sarah's death was a tragedy which has devastated her family and friends. It has also had a significant impact on the clinicians who sought to care for her. The inquest was a necessary but challenging and distressing process for both family and the witnesses and it is clear that the circumstances of Sarah's death have led to significant clinical reflection.

(b) Although the risk of self-harm cannot be completely eliminated for voluntary patients in mental health facilities, patients and families should be able to be confident that they will be appropriately supervised and cared for in a safe environment. The observations of nursing staff are critical to ensuring wellbeing and perceiving changes in a patient's mental state which may require escalation and intervention.

(c) The experience of giving birth and the following weeks is a vulnerable time for women. The pressures, expectations, physical and mental demands can give rise to high levels of anxiety which require support, understanding and sometimes

treatment. In rare cases, postpartum psychosis may develop. It is a serious mental illness but it is capable of being effectively treated once recognised.

(d) The insidious nature of postpartum psychosis presents challenges to clinicians in reaching a definitive diagnosis. Its signs and symptoms can overlap with those of postnatal anxiety and a longitudinal assessment may be required. In the critical weeks after a woman has given birth, given its potentially devastating outcomes, postpartum psychosis should never be definitively ruled out as a differential diagnosis to postnatal anxiety.

RECOMMENDATIONS

122. I have noted the relevant recommendations made in the SAPSE Report and the evidence of MPH in relation to their implementation. I do not propose to repeat them but I have formulated a number of recommendations which I consider are appropriate and clearly arise from the evidence given at the inquest.

123. Pursuant to section 72(2) of the Act, I make the following recommendations:

1. Ramsay Health Care implement a system to ensure that regular ligature audits are conducted at mental health facilities managed by it in Victoria.

2. Ramsay Health Care review the mental health facilities managed by it to ensure consistency where possible with the clinical guide *Improving safety for consumers at risk of harm of ligature* published by Safer Care Victoria.

3. Ramsay Health Care provide specific training to nursing staff in the Perinatal Mental Health Unit at Mitcham Private Hospital in relation to postpartum psychosis.

4. Ramsay Health Care provide specific training to nursing staff working in mental health units in how to appropriately respond to finding a patient hanging.

5. Ramsay Health Care review the staffing arrangements on the Perinatal Mental Health Unit at Mitcham Private Hospital to:

(a) provide for two nursing staff to be rostered on the unit at all times, one of whom has mental health training and experience; and

(b) provide for the Nursing Coordinator to be based in the unit in the event of only one staff member being available due to unplanned leave.

6. Ramsay Health Care update the *Nursing Admission Form* to include a heading for family history.

7. Engagement in clinical supervision by nursing staff on the Perinatal Mental Health Unit at Mitcham Private Hospital be actively encouraged and supported by Ramsay Health Care and all obstacles to attendance minimised.

I am grateful for the valuable assistance provided to me in this investigation by Counsel Assisting Megan Fitzgerald and Solicitor Bemani Abeysinghe.

I convey my sincerest sympathy to Sarah's family.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Jarvis Johnson and Peter Skillington c/- Maurice Blackburn

Karen and Robert Skillington c/- Brave Legal

Ramsay Health Care and Mitcham Private Hospital c/- MinterEllison

Dr Philippa Costley c/- Avant Law

Dr Ruvanya Illesinghe c/- Wotton Kearney

Danielle Dillon c/- Gordon Legal

Dorota Dudek c/- Laila Hamzi of Counsel

Australian Health Practitioner Regulation Agency

WorkSafe Victoria

Rachel Skillington

Senior Constable Billy Elliot, Coronial Investigator

Signature:

Coroner David Ryan

Date: 18 June 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.