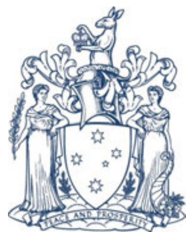

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 2716

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	Allison Leah RANDALL
Delivered on:	26 April 2024
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest dates: 25, 26 & 27 July 2023
Findings of:	Coroner Sarah Gebert
Coroner's Assistant:	Leading Senior Constable Dani Lord instructed by Coroners Court of Victoria
Counsel for NorthWest Mental Health:	N. Hodgson instructed by Lander and Rogers
Other Matters	*Death in Care, ensuite door design, prohibited items*

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INTRODUCTION

1. Allison Leah Randall[1], born 11 June 1982, was 37 years old at the time of her death. She was the daughter of Jan Duckford and William Randall. Ally's siblings are Danielle, David and Shannan. She was also the mother of [redacted], from her relationship with her partner Nicolas Brooker.

2. Tragically, Ally took her own life while an inpatient at the Northern Psychiatric Unit (**NPU**), at the Northern Hospital on the 22 May 2020. Ally was a compulsory patient at the time of her death and had been so since 15 May 2020.

THE CORONIAL INVESTIGATION

3. Ally's death was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) because her death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury. In addition, Ally was *in care* as defined by the Act at the time of her death.

The coronial role

4. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death. Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

5. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and making comments and or recommendations about any matter connected to the death they are investigating.

6. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

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[1] Referred to in my finding as 'Ally' unless more formality is required.

7. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles in *Briginshaw*.[2]

Mandatory inquest

8. As Ally died whilst *in care*, an inquest was mandatory under s52(2)(b) of the Act.[3]

Scope of Inquest

9. The inquest scope was determined as follows:

   1. The appropriateness of the care provided to Allison Randall whilst an inpatient at the Northern Hospital from 15 May 2020 until her passing, including the aspects of care related to:

      a. The documented diagnosis made during her admission

      b. The communication of any diagnosis with Ms Randall

      c. The frequency of risk assessments undertaken

      d. The documentation of any risk assessments undertaken

      e. Any formal systems in place to identify rapid changes in dynamic risks of patients

      f. The monitoring undertaken on the 21 and 22 May 2020

      g. The recognition and treatment of Ms Randall's substance withdrawal

   2. Any prevention issues arising from the circumstances of Allison Randall's death on 22 May 2020

Sources of evidence prior to inquest

10. As part of the coronial investigation, Coroner's Investigator Senior Constable Jeremy Fitzpatrick prepared a coronial brief. The brief comprises statements from witnesses including Ally's family, police involved with Ally prior to her admission to the NPU, her treating team at the Northern Hospital, other health professionals involved in her care, those present at the scene of the incident, the forensic pathologist who examined her, an

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[2] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially 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 …".*

[3] The Act provides an exception where the death is due to *natural causes*.

ambulance paramedic, investigating police officers, as well as other documentation such as photographs and CCTV. The WorkSafe brief also formed part of the evidence before the Court.

The Inquest

11. The inquest ran for 3 days and heard evidence from John Dermanakis, Area Manager, Northwest Mental Health (**NWMH**)[4], Dr Craig Johnstone, Psychiatric Registrar, and Dr Yang Yun, Consultant Psychiatrist. In addition, the Court sought an expert opinion from Consultant Psychiatrist, Dr Michael Lograsso[5], who gave evidence concurrently with consultant psychiatrist Professor Richard Newton[6] who was engaged by Melbourne Health to provide an expert opinion. Their evidence is sometimes referred to as the evidence of the **Expert Panel** in this finding.

12. After the conclusion of the Inquest, I received written submissions from Counsel Assisting and NWMH, and a reply submission from NWMH.

13. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, any documents tendered through counsel (including the Coroner's Assistant), written submissions and any reply following the conclusion of the Inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Ally's death. I do not purport to summarise all the material and evidence in this finding, but will refer to it only in such detail as is relevant to comply with my statutory obligations and necessary for narrative clarity.

BACKGROUND

14. Ally's parents separated when she was around 2 years old as a result of family violence and in the 4 years that followed, she and her brother David lived between their parent's homes in Rutherglen and Mornington until her father gained full custody. Ally's mother remarried

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[4] At the time of Ally's death, mental health services at the Northern Psychiatric Unit (**NPU**) were provided by NWMH, whereas they are now provided by Northern Health. CB, p. 379

[5] Report dated 31 May 2022. Dr Lograsso is employed by Mercy Mental Health with both a clinical inpatient role as well as the Deputy Clinical Services Director for Acute Inpatient Psychiatry.

[6] Reports dated 13 August 2020 and 13 August 2022. Professor Newton is the Consultant Psychiatrist at Peninsula Health.

and had a daughter but was unable to seek full custody of the children due to the history of violence she had experienced. Ally's mother stated that she felt guilty as she believed Ally took this as a further rejection and felt that she was not wanted. At around 10 years of age Ally was also exposed vicariously to details of a close family members experience of sexual abuse.

15. Ally's mental health started to deteriorate in high school. She also began to regularly smoke cannabis at about age 14 or 15 years. Ally reported that she experienced physical and emotional abuse by her new stepmother. Ally eventually moved out of her father's home and lived with a teacher (by arrangement with her mother who was living interstate at the time) and completed her VCE. She enrolled at Monash University where she completed a Degree in Health Promotion and Teaching in 2004 and later completed a teaching degree.

16. On 25 January 2004, Ally's father died in a motorcycle accident and Ally struggled as a result of his death. Her mother described it as a *mental breakdown*. She began to use amphetamines to help cope with her studies and she would also use ketamine to bring her down from the effects of the amphetamines.

17. Ally was attending pubs, music festivals and raves where she would use drugs, and it was in 2005 that she met her future partner Mr Brooker through mutual friends. At the time they met, Ally told him that she struggled with anxiety and depression. She continued to use speed, ecstasy and LSD on most weekends as well as smoking cannabis daily to 'self-medicate' her anxiety issues.

18. In June of 2018, the couple welcomed a baby girl. During her pregnancy Ally gave up using illicit drugs, save for cannabis which she did *cut back on*. While pregnant her depressive symptoms worsened and following the birth, she was feeling low and anxious and presented with symptoms consistent with post partem depression. These symptoms were managed by her general practitioner (**GP**) who prescribed the antidepressant Sertraline.

19. Mr Brooker described Ally as *an amazing mother to* ███, *she would always put* ███*'s needs first and invested in* ███*'s emotional needs.*[7]

20. On 29 October 2018, Ally was referred by her GP to a counsellor, Ester Reato, as Ally did not initially want to take any medications. During their sessions which commenced on

[7] Coronial Brief (**CB**), p.21

30 October 2018, Ally disclosed 'emotional and psychological abuse' perpetrated by her father and her stepmother, and she was also concerned that she may have been sexually abused in childhood. It was recorded that her traumatic childhood impacted her day-to-day functioning which led her to daily cannabis use to 'self-medicate' and dissociate.

21. Ally also disclosed having suicidal thoughts at times, *dark intrusive thoughts*, trust issues and reported that she often felt *not good enough*. Ms Reato also recorded that Ally *tends to minimise traumatic experiences as a coping mechanism.*

22. In March 2019, Mr Brooker made an inappropriate sexualised comment about the couples' daughter while he was changing her nappy. Mr Brooker agreed that he had done so but explained that it was *a joke* and, that he had *a very eccentric sense of humour.*[8]

23. Ally was distressed about the comment and was described as experiencing *turmoil* as a result (at a later family therapy session she said it, '*spun me out*'). She reported the incident to Child Protection [the Department of Health and Human Services (**DHHS**), as it then was] and presented to the Emergency Department (**ED**) at the Northern Hospital with thoughts of suicide and harming her daughter. She waited in the ED for a number of hours but left before being assessed. The hospital and Child Protection followed up with Ally given concerns for her daughter, and Ally returned to the Northern Hospital for an assessment on 11 March 2019.

24. Ally remained under the management of the Northern Area Mental Health Service (**NAMHS**) Acute Community Team until 1 April 2019. She was diagnosed with an Adjustment Disorder/Situational Crisis by a psychiatric registrar on 15 March 2019. Her risk level was said to have reduced quickly and she was referred back to her GP where her antidepressant was continued.

25. Child Protection commenced an investigation which later concluded that the comment made by Mr Brooker did not constitute a crime and the couple should see a counsellor. The couple subsequently participated in Single Session Family Therapy on 30 May 2019. Child Protection closed their file, having determined that there were no further concerns for their child's safety.

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[8] Northern Hospital (**NH**) Medical records, p.123 – 124

26. During further sessions with Ms Reato, Ally disclosed her presentation to the ED and that she had thoughts of overdosing herself and her daughter with poison. She said she would not do it, but a protective plan was put in place, and Ally did not report any further suicidal ideation or intent in the months that followed. She did continue to raise issues including her low sense of self-worth, her ability as a mother, and concerns about reports of molestation in her family history.

27. Ally's last face to face visit with Ms Reato was 17 December 2019. Her last communication to Ms Reato was on 19 May 2020 via text (detailed below).

28. Ally's mother noticed that around Christmas of 2019, Ally's mental health began to deteriorate, and she had started to smoke cannabis again.

May 2020

29. On 8 May 2020, Ally asked Mr Brooker to leave the house over her concerns about inappropriate behaviour towards their daughter the previous day. On the same day Senior Constable Lauren Shepherd from the Mernda Sexual Offences and Child Abuse Unit – (**SOCIT**), received a Child Protection Intake Report, containing information supplied by Ally about Mr Brooker's behaviour. Police determined on the information provided that there was no criminal element to the allegations and the report was returned to Child Protection to follow up with the family.

30. On 9 May 2020, Ally made a further report to Constable Emily James at Epping Police, relating to the same allegations of inappropriate behaviour by Mr Brooker towards their daughter. Constable James conveyed this information to the Mernda SOCIT, and was advised that they were aware of the allegations and an investigation by Child Protection was already underway.

31. On Tuesday 12 May 2020, Ms Duckford visited her daughter and stated that Ally was *not in a good mental state, she was worried about* ██████*, scared of Nic as he kept on saying she was delusional. She believed Nic was grooming* ██████ *for future harm.*[9]

32. On Wednesday 13 May 2020, Ms Duckford spoke to members of Northern Area Mental Health's Noogal Clinic (previously known as the CAT Team) and told them that she was

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[9] CB, p.18

concerned about Ally and her family. Mr Brooker also contacted them and raised concerns about Ally's behaviour and substance abuse. At this stage, Mr Brooker had moved out of the couple's home but had a friend attend the home to collect some of his belongings. According to Mr Brooker, this friend reported that Ally *was heavily affected by speed, anxious and erratic.*[10] A Mental Health Clinician from the Noogal Clinic contacted Ally at 4.20pm, and she was reported to be *bright and reactive* and agreeable to attend the clinic the following day at 12.30pm for an assessment.

33. Ally called the Noogal Clinic at 1.00pm, Thursday 14 May 2020, having gone to their old location and agreed to an outreach visit later that afternoon. Members of the Noogal Clinic and Child Protection workers attended Ally's home at about 4.30pm. The Noogal staff documented that Ally had *heightened stress, bordering on an acute stress response/psychosis*, but considered that there was no imminent risk to the welfare of either Ally, or her daughter and Ally could be managed in the community, with follow up from a treating psychiatrist the following day. This was discussed with Ally, and a plan was made to leave her daughter in her care, provided that another adult stayed with them overnight. Ally also undertook not to consume cannabis. Child Protection confirmed that they would continue their investigation into Ally's allegations.

34. The following day, being Friday 15 May 2020, Consultant Psychiatrist Dr Abhinav Nahar and Mental Health Clinician Justine Hunter from the Noogal Targeted Brief Intervention (**TBI**) Team, attended Ally's home for the purpose of an assessment in accordance with the plan made the previous day. Dr Nahar observed that Ally presented as emotionally labile, with pressured speech and a fluctuating mix of anxiety and tearfulness. Ally appeared to be fixated on her allegations concerning Mr Brooker and, that it was difficult to establish if her beliefs were delusional given her presentation. No direct risks to Ally or her daughter were noted but given Ally's state of agitation, anxiety and hypervigilance, there was an increased risk to Ally and her daughter, and a plan was put in place to manage and treat Ally in the community with assertive outreach. It was recognised that an inpatient admission would be traumatic for both Ally and her daughter by *disrupting attachment and displacing* the child. Ally was again accepting of this approach.

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[10] CB, p.22

35. As part of the management plan, Dr Nahar set a low threshold for assessment and treatment in hospital under the *Mental Health Act 2014*, should there be any further decline in Ally's mental state, or if there was any escalation in risk.

36. Later that afternoon, Ally's mental state did apparently deteriorate, and her mother contacted the Noogal Clinic to express her concerns[11]. Members from the Noogal Clinic discussed this development, and it was decided that an Inpatient Assessment Order would be appropriate given the escalating risk and Ally's reported paranoia.[12] They were also advised that Child Protection had made a decision to temporarily remove Ally's daughter from her care.

37. Members from the Noogal Clinic and Child Protection workers subsequently attended Ally's home address along with police and Ambulance Victoria (**AV**) personnel. The events that followed were captured by police on body worn camera (**BWC**) footage, which formed part of the evidence before the Court.

38. Ally was said to have been presenting in a highly agitated state, with significant mood disturbance, disorganised behaviour, possible delusional thinking and associated paranoia. The Inpatient Assessment Order was explained to Ally. She questioned the making of the order and said that her level of concern for her daughter was reasonable in the circumstances. Ally packed some of her belongings and she was conveyed by ambulance to the Northern Hospital ED. She made no threats of self-harm but was observed to display a high level of concern for the welfare of her daughter.

39. Arrangements to transfer the care of Ally's daughter to Ms Duckford were made on a temporary basis and she was conveyed by Child Protection to her grandmother's residence.

CIRCUMSTANCES OF DEATH

40. At approximately 5.50pm on Friday 15 May 2020, Ally arrived by ambulance to the Northern Hospital ED. On arrival, a check of Ally's property was made and recorded, with some items retained by staff.

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[11] *She reported that Ms Randall had expressed paranoid beliefs that her mother and sister were whispering about her and had proceeded to lock them out of the house.* CB, p.116

[12] The following was recorded on the Assessment Order: *Allison is presenting in a highly agitated state with significant mood disturbance, disorganised behaviour + possible delusional thinking + associated paranoia. Her judgement is considerably impaired posing risk to her 2 y.o. child who is currently in her sole care*

41. Ally was first medically assessed and then admitted to the NPU at approximately 2.15am on Saturday 16 May 2020.

42. At 11.30am, Ally was reviewed by the On Call Consultant Psychiatrist Dr Tharini Ketharanathan. The consultant queried whether Ally had overvalued ideation or delusion regarding her view about the behaviour of Mr Brooker towards their daughter, and given her presentation, determined that a diagnosis would need further clarification, and collateral information. Ally was placed on a Temporary Treatment Order and initial Critical Risk Assessment and Management (**CRAAM**) documentation was completed. Ally was allocated as 'Medium' risk in accordance with the CRAAM guidelines for new patients on initial assessment. A note was also made about withdrawal from daily cannabis use. Dr Ketharanathan recorded as the basis for the order made, *Labile, disorganised. Preoccupation very much suggestive of delusional misinterpretation – needs collateral however.*[13] The records also documented a query whether Ally was experiencing a *depressive episode.*

43. Ally indicated to the consultant that she was *not mentally healthy now* but not delusional and denied any suicidal ideation (*wants to be a healthy role model for her daughter*). She was willing to stay in hospital as long as it was required. She was admitted to the Low Dependency Unit (**LDU**) on Ward 7.

44. Ally's treating team during her admission comprised of Consultant Psychiatrist Dr Yang Yun, and Psychiatric Registrar Dr Craig Johnstone.

45. At 10.30am on Monday 18 May 2020 the treating team (including a nurse) conducted their first review of Ally. Dr Yun stated that Ally was cooperative but agitated at times. She reported concerns about her partner having made inappropriate contact with and comments about their daughter. She was also concerned that he may have put something in Ally's food/marijuana to affect her mental state but qualified this by saying that she had no proof and acknowledged that the suggestion sounded delusional. She reported no suicidal ideation at the time and stated *I want to live, I need to live, I need to see the truth.*[14] His differential diagnosis at the time was one of,

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[13] CB, p.232
[14] CB, p.91

situational crisis on a background of family dynamics, if it transpired that the allegations Ms Randall reported were real. Our management plan was to monitor her mental status, to provide her with reassurance and general support, and to collect collateral information from CPS and from family including her mother and her partner.[15]

46. Dr Johnstone notes on the assessment document that there was *significant diagnostic uncertainty* and, *Possibility of delusional disorder but not able to clearly identify psychosis based on present review. Requires ongoing monitoring of mental state and collateral.*

47. It is usual practice following a medical review to update the risk assessment, but none was recorded in the medical records. Dr Johnstone's clinical impression was however one of *low risk*.

48. Dr Johnston spoke to Child Protection who were advised that Ally was presenting as *stable and settled.*[16] He advised that there was a possibility of delusional disorder but there was insufficient information to make a diagnosis. They in turn said that no order had been made against Mr Brooker.

49. Dr Johnstone also spoke to Ally's mother who described that Ally had been *highly agitated and erratic the previous week,* and that she observed something that she regarded as *odd in light of the allegations Allison had made* against Mr Brooker. She further provided information regarding Ally's family history and drug use, including that Ally *is very much not herself when withdrawing from substances.*

50. Also on this date, Ally spoke by telephone with lawyer, Damien Anthony, from Victoria Legal Aid and provided him with instructions in relation to the Child Protection 'Accommodation Order' Application listed at the Broadmeadows Magistrates' Court regarding the temporary placement of her daughter. The Magistrate made an Interim Accommodation Order (**IAO**) for Ally's daughter to be placed with her mother which reflected the consent orders Ally agreed to. Child Protection recommended the IAO to allow further assessment in light of the allegations made by Ally.

51. On Tuesday 19 July, a Urine Drug Screen (taken the previous day) revealed a positive result for amphetamines, cannabinoids and benzodiazepines.

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[15] CB, p.87
[16] CB, p.124

52. Also on this date, Ally was reviewed in the morning by Dr Johnstone and Ally's allocated nurse. Ally said that she was *going well* but was anxious about all the things she needed to sort out, such as utility bills. During this review Ally reported ongoing concerns about her partner's inappropriate sexualised views towards their daughter, but was pleased, after being advised, that Child Protection had found no supporting evidence (*that's the last thing I want…I don't want him to be that way*). However, she expressed disquiet that *whenever she raises a concern, if she can't prove it people suggest she's delusional.* She also *reiterated her desire to live.*

53. The medical records further document around her concerns,

States she spoke to friends and they were not convinced, 'he's a nice guy', 'there's no way he is doing anything' – and she was inclined to agree with them at the time[17].

54. Dr Johnson documented the following as a result of his medical review,

diagnosis remains uncertain. Impression of borderline traits with evidence from reviews and collateral of childhood trauma, interpersonal difficulties, anger/impulsivity. Possibility of Delusional Disorder remains present with rigid belief partner has sexual views towards daughter despite seemingly fairly limited evidence for same - impression of overvalued ideas around perceived evidence however not able to present to label with certainty as psychotic in nature.[18]

55. Dr Johnstone also completed a Revised Risk Assessment CRAAM (at 11.35am) where Ally's risk rating was reduced from *medium* to *low* and *no leave* with the only elevated risk being that of substance use, at *medium*.

56. Also on this day Ally's counsellor, Ms Reato said she received a text from Ally which said, *Thank you, I just realised that you are the person who taught me I can and should trust myself. When I'm troubled it's your words, I find myself saying to myself. It's your eyes that saw me and helped me see myself. Not only is this gift for me, but (the) my daughter too. Forever grateful.* Ms Reato sent a response thanking her for her words and wishing her happy Mother's Day and Ally sent a further text which said, *Thankyou may you have a lovely day. It's my first as a single Mum. I got this!*

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[17] NH medical records, p.311
[18] NH medical records, p.312

57. On Wednesday 20 July, Dr Johnstone spoke to a Child Protection practitioner who advised that they did not have any concerns about Mr Brooker and that pending a hearing, [redacted] would reside with Ally's mother. They were however concerned about Ally's behaviour and her substance use. Dr Johnstone again advised that there was no firm diagnosis, but they *had an impression of borderline personality traits, with a query of possible delusional disorder*. In addition, that Ally would require ongoing input from the community health team.

58. At about 7.00pm, Dr Johnstone spoke to Mr Brooker who confirmed the inappropriate comments about their daughter in 2019 following which they went to counselling. He said that he had issues with empathy. Mr Brooker outlined his account of incidents where he was aware that Ally had raised concerns and provided his explanation. He also described Ally's dependence on cannabis, which he said she would smoke all day and, that recently her consumption of stimulants had increased. He was concerned about her potential withdrawal symptoms. He also said he was receiving abusive messages from Ally during her admission.

59. Ally continued to be monitored by ward staff in accordance with her CRAAM rating, which commenced at *medium* risk and was reduced to *low* on 20 May 2020.

60. At about 7.00am on Thursday 21 May 2020 Registered Nurse (**RN**) Sarah McFayden said she had a conversation with Ally, in which she related that the overnight room checks wake her up sometimes with the *noise from the keys and unlocking the doors.*

61. Sometime before 1.48pm, a final consultant review was conducted by Drs Yun and Johnstone. At this review Ally was advised that her diagnosis was Delusional Disorder. Ally disputed the diagnosis, expressing that her level of thought on her concerns for her daughter was appropriate and, was *prompted by the treating team asking her about it*. She *disputed she had ever suggested Nick had sex with* [their daughter] – *only that he had an 'inappropriate attitude' towards her.* Ally had previously spoken of her concerns that when she raised these issues she was labelled as delusional. She was assessed as not meeting the criteria for compulsory treatment but suitable to be returned to community-based care.

62. Ally requested time to consider information about the proposed prescribing of antipsychotic medication paliperidone. She also said she would disregard thoughts about Mr Brooker, because she trusted the team's professional judgement, and was willing to remain in hospital for further observations. When advised about the positive Urine Drug Screen, Ally was surprised. The plan at the close of the review was to begin the prescribed medication, continue to monitor Ally and prepare for her discharge.

63. Dr Johnstone completed a Revised Risk Assessment CRAAM where Ally's risk rating was recorded as unchanged from '*low*' with the only elevated risk being that of substance use, at *medium*.

64. During her admission, Ally had been in contact with her mother, with most of the text messages about Ally daughter's welfare. Ms Duckford said that she gave no *hint of self harm.*

65. At approximately 12.08pm, Ms Duckford received a text message from Ally saying,

I just had an interview with treating doctor, who said you and child protection have no concerns with Nic and ████. Is this true? I'm not allowed to talk about it, cos that's viewed as heightened fixation, on possible delusions. He said just move on, when you and Nic are living under the same roof again…What the fuck?

The doctor sees me going back home to my concerned partner

I don't know what to do anymore.[19]

66. Sometime before 2.00pm, Dr Johnstone spoke to Ally, and she consented to the medication paliperidone. He documented the following comments about what Ally said at that time,

"*I feel like I don't have any choice*"

"*I'm paranoid*"

"*I'm not right*".[20]

67. She was upset that Dr Yang referred to Ally and Mr Brooker '*living under the same roof again*' and Dr Johnstone said he assured her that she had the right to decide who she would live with. He reinforced that the medication was not compulsory and the records document that Ally confirmed that she was happy to take it. Following that discussion, he prescribed 3mg oral paliperidone to commence that evening.

68. Sometime before 4.35pm, Dr Johnstone had a conversation with Ally's mother who said that she had received a text from Ally saying that the doctors had *stated her mum and CPS had*

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[19] CB, p.330-331
[20] CB, p.97

no concerns about Nick. She related that Ally *will feel betrayed by her.* She *expressed she did have concerns based on what* Ally had told her about a particular incident and something she had observed.

69. At 5.01pm, Ms Duckford received a further text message from Ally stating,

"Mum I'm sorry, I'm not well. I've surrendered to the doctors. I will do as I'm told, please tell (daughter) I love her. Talk tomorrow morning xx", "I've told Nic I'm sick and I'm sorry", "And thank you."

70. Around 9.00pm, Ally exchanged several text messages with her long-time friend Robyn Cooper, advising that she was in hospital and had concerns about Mr Brooker. During the exchange she messaged that, *I regret having a child to him. Almost regret having a child. Feeling pretty low.*, *I can't talk out loud too much in case my conversations are taken as fixation…*, and *How do I show stable mood? Future focussed goals to prove my fitness as a mum? Done!...*

71. Ms Cooper offered to call the next afternoon, and Ally thanked her in her last message at 9.01pm.

72. Ally is also said to have messaged Mr Brooker that evening and requested a picture of her cat.

73. At 9.07pm, CCTV from outside Ally's room shows RN McFayden checking on Ally by listening for noise coming from her room. No verbal or sight check was conducted at that time.

74. At 9.15pm, Ally can be seen via CCTV walking out of her room and returning 5 minutes later. At 9.40pm Ally again exits her room, looks around and walks down the hall, returning to her room at 9.41pm. This is the last time that Ally is seen alive.

75. At 9.27pm, the PM nursing note documented that Ally denied self-harm,

Alison was nursed in LDU on low CRAAM. Dx of BPD v Del disorder hx PND. Legal status TTO. Alison was in communal areas at the COS. Casually dressed. Kempt in appearance. Polite and pleasant on approach, some underlying irritability noted. Good engagement with nursing staff. Speech normal rate, tone and volume. Good level of eye contact on interaction. Reported mood as "low" reactive during engagement. Denied any SI/HI/TOSH/VH/AH. Continue to have believe about partner' behaviours towards their 2yo

child. One on one time spent, prn medication given as charted. AWS 6. Reported tolerating diet and fluids. Physical OBS unremarkable. Nil other concerns voiced this shift.[21]

76. At 10.18pm, Ally sent a text saying *Love you* to her long-time friend, Jacqueline (Jaxx) Busuttil, who she had been exchanging texts with over the previous day.[22]

77. In accordance with the CRAAM guidelines at the time for patients in the LDU who are assessed as being at low risk, Ally was to be checked overnight at midnight, 3.00am and 6.00am, although the practice adopted was that checks were performed each hour until midnight. RN McFayden conducted checks at 9.07pm, 10.00pm and 11.10pm that evening, and the following morning being Friday 22 May 2020 at 12.04am and 2.10am. She did not visually sight Ally at any of the checks but stated that she could hear snoring coming from Ally's room on all these occasions from outside the door. These checks are marked off on a clip board.[23] The observations that evening conformed with the expectations set within the CRAAM guideline policy in place at the time, that is, they did not require a physical check of the patient.

78. At 3.00am Registered Psychiatric Nurse (**RPN**) Peter Lam[24] conducted a welfare check on Ally. As the verbal check and door knock did not illicit a response, RPN Lam entered the room, and it was at this time that Ally was located hanging from the strap of her handbag which had been hooked over her ensuite door with the bag portion at the rear. The door had towels padded across the top of it to help secure the strap. The bag was made from a strong synthetic material. The ensuite door had been cut down in size and had special anti-ligature hinges.

79. RPN Lam immediately summoned help and a Code Blue was called. The strap was cut down and Cardiopulmonary Resuscitation (**CPR**) was commenced but Ally was already cold and unresponsive. Staff continued to assist Ally for 10 minutes, but she was unable to be revived. Ally was pronounced deceased at 3.10am and at 3.30am, Triple Zero was called to advise of the incident.

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[21] NH medical records, p.332
[22] CB, p.282
[23] A document headed *NPU1 Bed List Night* shows a patient's room number, name, risk night, time and a box to fill recording the results of a check. WorkSafe Brief, Exhibit 10. There were four ticks for Ally against Arrival night shift, 2200, 2300 and 0000.
[24] He was working in the Intensive Care Area but offered to assist with the check so RPN McFayden could go on her break.

80. Police investigators subsequently attended the scene from Mernda, Epping and the Hume Criminal Investigation Unit, and an investigation was commenced. Ally's room was searched and photographed, and a number of items were retained. A suicide note was also discovered.

81. Police examined the bag from which the strap had been removed. A search of its contents revealed a small plastic zip lock bag containing white powder. This substance was 'spot tested' by the Coroner's Investigator and returned a strong indication of 'MDMA'.[25] The bag was not recorded by hospital staff with Ally's property on her arrival, and at the time of admission, the hospital search policy did not specifically prohibit 'long bag straps'.

82. Following the police investigation, they found no suspicious circumstances surrounding Ally's death.

IDENTITY OF THE DECEASED

83. On 22 May 2020, Nicolas Brooker identified Allison Leah Randall born on 11 June 1982, who he had known for 18 years.

84. Identity is not in issue and required no further investigation.

CAUSE OF DEATH

85. On 25 May 2020, Dr Linda Iles, forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and prepared a written report dated 26 May 2020.

86. Toxicological analysis of post-mortem samples identified the presence of diazepam (~0.1mg/L)[26] and its metabolite nordiazepam (~0.05mg/L), sertraline (~0.4mg/L)[27] and cannabis (~67ng/mL).[28]

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[25] CB, p.66

[26] A sedative (hypnotic) drug of the benzodiazepines class. Nordiazepam, a metabolite of diazepam, was also detected. Blood concentrations of diazepam and its active metabolite nordiazepam following oral dosing of 30mg daily generally range from 0.7 to 1.5 mg/L and 0.3 to 0.5 mg/L, respectively.

[27] Sertraline is an anti-depressant drug for use in cases of major depression.

[28] Delta-9-tetrahydrocannabinol is the active form of cannabis (marijuana). The extent of cannabis effects during the intoxication phase of 1-3 hrs post-dose may diminish with time due to tolerance. It is still likely that consumption of street doses of cannabis will lead to significant adverse effects on the brain even in regular users, but again usually in the few hours after a dose. Chronic and/or long-term use is likely to lead to impairment over a longer period of time and

87. Dr Iles formulated the cause of death as *1(a) Hanging.*

88. I accept Dr Iles' opinion as to the medical cause of death.

OTHER INVESTIGATIONS

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

WorkSafe Investigation

90. WorkSafe Victoria (**WorkSafe**) is Victoria's workplace health and safety regulator as well as the workplace injury insurer.

91. WorkSafe were advised of Ally's passing and attended the scene on 22 May 2020.

92. WorkSafe subsequently issued an Improvement Notice to Melbourne Health – NWMH on 29 June 2020 in relation to the ensuite door fitted in Ally's room.

93. The Improvement Notice was later noted to have been complied with in an Entry Report dated 2 August 2020, following consideration by WorkSafe of modifications made to the ensuite door, which are discussed below.[29]

Root Cause Analysis

94. As a result of Ally's passing, a Root Cause Analysis (**RCA**) was conducted by Melbourne Health, which was submitted to Safer Care Victoria on 4 December 2020. The root causes of the *event* were identified as:

    a. the ensuite door provided a ligature point despite having been modified to reduce this risk; and

    b. the strap on Ally's bag provided a ligature and it appeared that the potential risk was not appreciated due to the bag serving as her handbag.

95. The recommendations from the RCA were to:

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of a higher intensity. Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance, and impaired reaction times and coordination.

[29] Exhibit 32, WorkSafe Brief

a. further modify the ensuite doors to provide a sloping top edge;

b. update the procedure on prohibited items to specifically identify long bag straps as potential ligatures, and remove them from patients in the inpatient units; and

c. make nursing observations occur at more random intervals rather than set times and focus on engagement with patients.

AREAS OF INVESTIGATION

Ensuite door design

96. It was apparent that the design of ensuite doors in the mental health sector had been recognised as a long standing and ongoing issue around patient safety. For several years, annual Environmental Audits of Ligature Risks[30] carried out by Melbourne Health highlighted ensuite doors as a major concern and they had undertaken to try to mitigate risk, through a number of strategies.

97. In evidence at the Inquest, Mr Dermanakis explained that solutions had been discussed in the sector for many years and there was inconsistency, and no standard for doors across the sector, citing continual improvements in technology and thinking. There was evidence of previous trials at NPU of door design in 2019, and Mr Dermanakis stated that the design of the ensuite door in Ally's unit at the time of her passing was best practice. He also commented that there was a need for a balance between safety and dignity and privacy of the individual.

98. Following Ally passing, Melbourne Health specifically undertook enquiries of other mental health facilities to determine best practice in relation to ensuite doors to determine whether there was any consistency between the psychiatric services across Victoria. Peter Kelly, Director Operations at NWMH, noted that a number of mental health service directors in Victoria were canvassed and it became apparent that there was no consistency or standardisation of door design (six examples were described), potentially highlighting an opportunity for improvement in risk prevention across the sector.[31]

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[30] Exhibit 20, WorkSafe Brief. *Bedrooms remain the 'high' risk areas on both Units, in-particular ensuite doors. Given various reduction strategies over years, continue to be major concern.*
[31] CB, p.211

99. Melbourne Health subsequently determined to modify the doors at the NPU by cutting them at an angle, with a curved profile to minimise the risk of the door to be used as a ligature anchor point ('sloping edge'). The doors were ultimately modified throughout the facility with completion achieved on 31 August 2020.

100. When asked about the utility of the Chief Psychiatrist setting a consistent design standard for ensuite doors, both Mr Dermanakis and Mr Kelly agreed guidance would potentially improve safety across the whole sector.[32]

101. Mr Kelly provided further advice that significant research and consultation has occurred within the sector in recent years, and the Orygen IPU has trialled a new bedroom door design manufactured in the UK, the 'Sentry Model Kingsway' door set. The door can be locked by the patient but overridden via a master key held by staff, and can close a viewing panel, but staff can open the panel for routine observations or safety. Two thousand of these doors have been installed in National Health Service (**NHS**) mental health facilities within the UK, and there have been no reported fatal events involving these facilities. Mr Kelly reported that capital planning and procurement processes had begun within units with a view to installing these doors.

102. I note that Dr Lograsso referred to the design of the ensuite door at the time of Ally's death when reflecting on prevention opportunities arising in this case,

That would be one way I could think it was preventable.[33]

Long bag strap and prohibited items

103. On arrival at the NPU on 16 May 2020 Ally's property was checked and recorded, with some items retained by staff.[34] Ally kept her handbag which had a long strap handle, and there is no note made on the 'Patients Clothing and Valuables' form of the bag itself.[35]

104. Mr Dermanakis noted that while the risks associated with personal items where clearly identified in policy (CRAAM guideline and Search Procedure), and Clinical Risk Bulletins (9,13, and 16), they did not specifically refer to long handbag straps as prohibited items. Mr Dermanakis highlighted several examples within policy and previous risk bulletins

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[32] T53 L25-29
[33] T415 L19-23
[34] CB, p.99; NH medical records, p.382
[35] NH medical records, p.382

where items analogous to a long handbag strap (such as neck scarfs, long pieces of fabric including dressing gown cords) were prohibited in the IPU.

105. Dr Lograsso made comment that the challenge in relation to determinations about prohibited items *is a balance between overly restrictive limits on items for patients versus risk, essentially patient recovery principles, civil liberties versus risk mitigation including duty of care*. There are ligature items that are commonly allowed in an LDU that are considered prohibited in a High Dependency Unit, for example, shoelaces. He further stated that,

.... it is near impossible to list every possible object of self-harm. I do not see a day when pencils and pens are prohibited items in a LDU, for example, and yet they are objects that can be used to cause considerable self-harm if one is determined.[36]

106. The hospital subsequently updated their policy on prohibited items in IPUs to specifically identify 'long bag straps' as potential ligatures which are to be removed from a patient. A Clinical Risk Management Bulletin was also released to staff highlighting the risk of bags with long straps.

Observation conduct and frequency

107. The RCA recommended that the timing of nursing observations occur at more random intervals rather than set times and there be a focus on engagement with patients to reduce predictability (while noting that this issue was not causative in the death).

108. Mr Dermanakis commented that there was sector wide consideration of room entry methods that might be less disruptive to patients overnight. His view was that swipe access and viewing panels in bedroom doors had pros and cons and noted that there is a recognition of the importance of sleep hygiene in terms of someone's mental health but that *there probably isn't a sector-wide view on the best way to move forward with regards to that.*[37]

109. He further indicated that a more varied approach to overnight observation times has been considered for use by staff on a case-by-case basis. He cited consideration of patient risk, workflow and environmental considerations as factors staff used to assess suitable times. He said this would be developed as part of a conversation amongst nursing staff at the relevant times and overseen by the nurse unit manager or the associate nurse unit manager. It would

[36] CB, p. 365
[37] T70 L11-13

also be expected that the outcome for each patient would be documented in their records should it deviate from the standard.

Frequency of checks overnight in an LDU

110. Dr Lograsso gave evidence at inquest that how often checks should be conducted in a low dependency overnight depended on many things. In Ally's case, he considered that 3 hourly checks were reasonable, but it would depend on the risk and clinically what a patient is experiencing. He stated that whether the checks should be visual or not depends on what you are trying to achieve. For example, if you are worried about a patient absconding or at risk of self harm, then you would need to see them.

111. Dr Lograsso said that in retrospect, no visual observation other than a one to one nurse special could have prevented Ally's death. He noted that getting a good night sleep is important and you cannot wake people, shine a light and ask how they are on a frequent basis. Sleep is essential to good mental health and helping with sleep hygiene has a direct therapeutic effect that can change the course of a patient's illness.

112. Professor Newton agreed that visual observations need to be seen as a clinical function that should include seeing the person and confirming their wellbeing. He noted in Ally's case that the CRAAM included with respect to overnight observations that in *some situations less intrusive forms of observation may enable better sleeping patterns in people who are hyper vigilant and who may awaken or be startled*. And, for a low-risk patient who had identified that they found the overnight observations interfered with their sleep, listening at the door rather than entering would seem a patient centred approach to completing the overnight routine check.

113. When asked about best practice for overnight checks for someone who was persistently at low risk, it was Professor Newton's view that midnight and 6.00am would be appropriate, and that would include a visual observation, including proof of wellbeing.

Ligature audit tool

114. A Ligature Audit tool was developed by NWMH following an extensive review in 2012 with the purpose of the tool being,

to minimise the risk of injury/death from hanging in the Psychiatry Inpatient, Residential and Secure units of NWMH. It is a requirement of the Victorian Chief Psychiatrist and the

National Safety and Quality Health Service Standards for all inpatient units to annually review their surroundings to minimize such events. Hanging is the most common method of suicide for mental health service users, whether they are in inpatient units or in the community. A significant proportion of suicides are believed to occur through impulsive acts, using what may be seen as reasonably obvious ligature points. In terms of good practice, two or more clinical staff, from an area (or service) other than the one in which they work will be included in the audit team. This is to reduce the effects of over-familiarity with the environment.[38]

115. Mr Dermanakis explained at inquest that the process within units and the 'tool' used by NWMH, was used by other services, but varied within the sector.

116. Professor Newton added that each health service has different policies, procedures and standards, and that this was one of the *flaws* in the statewide system. He said,

And I think there is a huge need for more universal expectations to be set … - particularly when there's a strong and clear evidence-based.[39]

117. The expert panel agreed that despite the value of the current audit tools utilised by the mental health sector, a prime undertaking should be to share the information sector wide to enable a consistent informed approach, *if it's a trend and this is something people are doing, then it should be shared across the state for state wide learning.*[40]

118. The expert panel further agreed that consideration should be given to the Chief Psychiatrist identifying or developing a standard ligature audit tool for consistent use across all Victorian public mental health services, and further, that state-wide implementation of such a tool should be accompanied by appropriate guidelines and training for staff in the effective use of the audit tool.

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[38] Exhibit 21, WorkSafe Brief. Reference was made to the Chief Psychiatrist investigation of in-patient deaths 2008-2010. The investigation considered unexpected, unnatural and violent deaths of inpatients from 1 January 2008-31 December 2010 to assess the adequacy and appropriateness of the service response which followed. Recommendations included implementation of a schedule of audits of ligature points on a unit.
Documents produced during the WorkSafe investigation include the Chief Psychiatrists Audit of in-patient deaths 2011 – 2014 which noted the following in relation to the environmental safety of in-patient wards,
As a result of the previous inpatient death audit, all Victorian mental health services conduct regular safety audits of inpatient units using a structured checklist, looking for ligature points and other opportunities for self-harm.
Hanging accounts for between half and three-quarters of suicides in UK and US inpatient units.
The most common ligature anchor points were bedroom and bathroom doors, followed by hooks, handles and rails. Ligatures included bedding, towels, clothing, belts and cables. Exhibit 28 at p.14, WorkSafe Brief

[39] T409 L28-31; T410 L1-7

[40] T412 L26-28

119. The development of a consistent statewide tool, schedule and audit process informed by shared information prior to conduct of audits, would therefore appear to be a prevention opportunity within the sector.

General searches

120. Following Ally's death, a small bag of white powder was located in her handbag. While it is unclear how and when Ally obtained it (noting that it is not causative in the death), Mr Dermanakis agreed that it would be appropriate to search Ally's bag, and that all bags are searched upon admission. He also detailed a new trial of random drug dog searches (2-3 times a year), to address the risk of illicit substances within inpatient units.

Ally's final diagnosis of Delusional Disorder

What is delusional disorder?

121. According to Dr Lograsso, a diagnosis of delusional disorder is made based on the primary presence of a psychotic syndrome followed by a process of elimination of each known psychotic disorder to find the most likely specific psychiatric diagnosis. He said that in Australia this diagnosis is based on criteria from the Diagnostic and Statistical Manual of Mental Disorders currently 5th edition and published by the American Psychiatric Association, referred to as the DSM-V.[41]

122. Dr Lograsso stated that the DSM-V requires five criteria to be met to confirm the diagnosis of delusional disorder as follows,

A. The presence of one (or more) delusions with a duration of 1 month or longer.

B. Criterion A for schizophrenia has never been met, i.e.. not two or more or delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour and negative symptoms. If hallucinations are present, they are not prominent.

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behaviour is not obviously bizarre or odd.

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[41] American Psychiatric Association: Diagnostic and Statistical Manual or Mental Disorders. 5th Ed. Washington, DC: American Psychiatric Association; 2013.

D. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional period.

E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

123. Dr Lograsso stated that many psychiatrists still practice in keeping with the previous DSM-IV (4th edition) which defined criterion A as the presence of nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or loved, or having a disease).

124. The DSM-V defines a delusion as a fixed belief that is not amenable to change in the light of conflicting evidence and that these delusions can be subtyped into themes. Delusions are deemed to be bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences. He said that the distinction between a delusion and a *strongly held idea* is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

125. He further stated that two other phenomena worth considering when trying to confirm the presence of delusions are *overvalued ideas* and *obsessions*. Overvalued ideas are defined as a false or unreasonable belief or idea that is sustained beyond the bounds of reason. It is held with less intensity or duration than a delusion, but is usually associated with mental illness. An obsession is defined as a persistent and recurrent idea, thought, or impulse that cannot be eliminated from consciousness by logic or reasoning; obsessions are involuntary and ego-dystonic.

126. In circumstances where there is a possible reality base to a concern being held, Dr Lograsso said that it is not uncommon for delusions to be both plausible and based in reality. Therefore, the strict definition of a delusion in DSM-V, no longer considers if they are false/true, but if they are *a fixed belief not amenable to change in light of conflicting evidence*, i.e., can be challenged. Those not experiencing delusions will commonly entertain the possibility that there is a margin of error in their beliefs and that they are not 100% true.

127. An individual may, when challenged with conflicting evidence or logic acknowledge this as possible, but may still default on their belief as strongly held. In this circumstance the individual may be considered to be experiencing an *overvalued idea* or *obsession*. In the

case of an overvalued idea the individual may be unable to focus on any other ideas, but the primary concern. With obsession, the individual will experience ego-dystonia, perhaps stating the belief is illogical, but being unable to be eliminated from their thoughts. The process of determining if an individual is experiencing a delusion is through challenging these beliefs and examining how amenable to change the belief is as well as careful consideration of the logical steps the individual is using to reach these conclusions.

128. Delusions are sometimes considered a process of faulty logic and so examining how someone reaches a conclusion and how much weight they put on evidence can be helpful.

129. Dr Lograsso said that it is worth noting that in the circumstance of plausible delusions there are many occasions when it is not possible to be certain as to the presence of a delusion and it may be left as a differential diagnosis. Ultimately, the mental health concern may be more to do with how these beliefs impact on the individual and those around them regardless of whether they are delusional or not.

Accepted best practice treatment for delusional disorder

130. Dr Lograsso stated that the evidence base is very limited around the best practice for the treatment of delusional disorder, but in his opinion the first step in any psychiatric treatment is being as clear as possible around the exact diagnosis, which he said was usually the challenging part. If a differential diagnosis of delusional disorder is considered, the current peer accepted practice is to treat with antipsychotic medications and ensure assertive follow-up. There is no specific evidence around which antipsychotic is a best choice and it would come down to clinical judgement around factors including side effect profiles, compliance and individual patient factors. As with all psychotic disorders, treatment would include the use of all available tools including family therapy, psychotherapy with a preference for Cognitive Behaviour Therapy (**CBT**), management of comorbidities and elements of psychosocial rehabilitation to list a few.

131. It was Dr Lograsso's opinion that the treatment provided to Ally was reasonable for the consideration of delusional disorder as a differential diagnosis. He said that it was good practice to hold off on initiating an antipsychotic treatment too early until sufficient evidence had been collected and then it was also a fair choice to start paliperidone 3mg nocte. It also appeared that sufficient physical examination and investigations had been completed to address The Royal Australian and New Zealand College of Psychiatrists

(**RANZCP**) advice around the treatment of first episode psychosis. The progress notes also indicate community mental health treatment was suggested as part of her discharge plan.

132. Professor Newton also noted that Ally had appropriately been recommenced on her anti-depressant and agreed that having received a working diagnosis of delusional disorder, 3mg paliperidone is an appropriate initial low dose antipsychotic for this diagnosis. He said that antipsychotics have a long history of being used as an augmenter for an antidepressant, so it was justifiable from that point of view, and it would not have been relevant to Ally's decision to end her life.

Ally's diagnosis of delusional disorder on 21 May 2020

Dr Yun's diagnosis

133. In Dr Yun's role he took full clinical responsibility for Ally's treatment including her diagnosis, the assessment management and anything else related to her clinical management.

134. Dr Yun gave evidence at inquest that the basis for his diagnosis of delusional disorder, as delivered to Ally on 21 May 2020 was,

.... she has a belief as a kind of delusion for – ... a time. And that delusion has significant impact,..., her functioning level. And that delusion cannot be explained by other illness, for example, schizophrenia, depression, or schizoaffective disorder.[42]

135. He further stated that the main difference between *overvalued ideas* and *delusion*, is how fixed the belief is,

If it's very fixed, it is a delusion, if it is not that fixed, which can be changed by the change of the stress, or the triggers, or whatever things, it is more like a kind of overvalued ideas.[43]

If it's changeable, it's more likely overvalued ideas.[44]

136. Dr Yun stated that in terms of confirming a diagnosis of delusion, it is not about whether or not the *thing* complained of happened, but why the patient reached that conclusion.[45]

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[42] T257, L12-17
[43] T196, L25-30
[44] T197, L11
[45] T199, L29-31, T200, L1-2

137. He said that in general, he is not the type of doctor who is focused or fixed,

on diagnosis too much, like, battle with patient, 'you are this, you are that', no. I'm more focused on what shall we do next?[46]

138. Dr Yun agreed that Ally was settled and stable when the issues in relation to Mr Brooker were not raised and, that she became more heightened and agitated when they were raised. It was also apparent from her records that Ally was worried her mental state and her mood might change if she had interactions with Mr Brooker and that she presented as *quite calm, if we're not addressing these issues.*[47]

139. Dr Yun agreed that Ally was in a difficult position in relation to justifying her thinking (in the context of her comment, *that whenever she raises a concern, if she can't prove it to people, suggest she's delusional*) and considered that to be recognised as not delusional, she would have to have proof of the allegation, stop fixating or believing in the things claimed or find evidence to support her claims.[48]

140. Dr Yun further stated that one of the reasons he confirmed his belief about delusions rather than over valued ideas was,

because on one hand, Child Protection have zero concern, report have zero concern about the allegation and now the Child Protection has already involved, which means Child Protection is not really close the case. They will monitor that the current Ally's with is a – ... – the daughter is with the, ... grandmother. Also, the patient reported no matter it – this allegation is real or not real, she already decided to terminate the,... , relationship with the partner which means are going to in the process of divorce. And currently their baby is under the care of her mother rather than other people, so it's very likely, in the future once the patient breakup with the partner, the custody of the baby will be with her or with her mother, which means there alleged, ... , partner will have no free contact with the baby. To normal people, if overvalued idea, that is a good protection means that man is out of the picture in a large cases. No more people will probably – can still have concerns, but with

[46] T206, L9-12
[47] T208, L19-20
[48] T233, L7-18

this kind of process prevent that man to access the daughter freely. Most of people will have less fixed thoughts about that. But which, in her case, it's opposite.[49]

141. Dr Yun said he was reasonably confident that the delusion was evident for more than a month for the following reasons,

behaviour patterns, .., between the client and the partner. So they have these issues and, ..., also the other things that remind me is the one year ago, have similar presentations and, ..., with or not after that one-year period of time, ..., whether or not she still experienced that or she just, during the family session, mention that everything sorted out. So that is the uncertainty. But for clinical decisions, you put everything together. The other thing that she mention about is she have these kind of relational problems with the partner for the past nearly two years, and I guess that is partly related to the – this sexual related issue. And also, considering the clear – the reported to the, ..., Child Protection and also before that, they had contacted the police. So I will – you reasonably confident that the duration of the illness is ... - earlier on than that.[50]

142. When the duration of one to two weeks was put to Dr Yun as the length Dr Lograsso estimated in his report of any potential delusion, he said it was a *bit difficult* to provide clear evidence of a month, so for *that part* he said *I will probably a little bit agree* but what was more important was the whole clinical impression.

143. Dr Yun disagreed that Ally demonstrated a *fluctuating course* as described in Dr Lograsso's report to the Court and stated,

So from observation you can see a kind of fluctuation course as Dr Lograsso mentioned but my explanation for that is the patient also have some borderline personality traits on the background and the borderline personality traits or disorder will influence her presentation of her psychological symptoms but actually even Dr Lograsso - because we are focussed on the symptom whether or not it's an overvalued idea or it's a kind of delusion. If it's overvalued idea, you can't see it's a psychosis. If it's a delusion, then it is a delusional disorder which is a psychosis. .... Dr Lograsso mention about he or she is more confident about a diagnosis of amphetamine and cannabis induced psychosis. That's from

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[49] T234, 1-22
[50] T267, L7-23

Dr Lograsso's impression which means at least Dr Lograsso agree with it's a psychosis. It's not an overvalued idea.[51]

144. Dr Yun also disagreed that Ally's views were changeable and able to be challenged as Dr Lograsso concluded in his report to the Court. He said,

I do not agree with that. I think it's a fluctuation or she want to just engage with us and to try to get discharged and I think that's partially relate to the fluctuation cause which I explained earlier, my view is it's still a delusional disorder but ... coloured by the personality traits.[52]

145. Dr Yun said of Ally's 2019 admission that it was a presentation of delusions and was a prodrome of the illness, even though there was an acknowledgement by Mr Brooker that the basis of Ally's concerns in 2019 were founded in reality,

I concerned the feature is very likely a delusion but is so short so I can't diagnose it as a delusion. So if I were there, even if I have concerns about that part, I feel it's delusional in nature but because of short duration I still cannot diagnose it as delusional disorder at that moment. 2019. So if at that moment she present to me I probably can only diagnose the others as a mixed anxiety depression, but I would have concerns about that. But she does not meet the criteria for delusion so I cannot diagnose as delusional disorder. However longitudinally the second episode in 2020, leading up to the admission this time is much longer. If we can think back, to me the challenge of that episode is a kind of hiccup of the early development psychosis is much bigger than other possibilities.[53]

The Expert Panel's view

146. At the outset it should be noted that despite the opinions given in their reports and at inquest, the expert panel agreed that reasonable minds may differ regarding Ally's diagnosis. In addition, that a patient cannot be diagnosed in practice without seeing the patient, and it is also better to see a patient in person and have discussions with other clinicians and members of the care team on the ward.

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[51] T271, L21-31 – T272, L1-6
[52] T274, L14-22
[53] T244, L7-22

147. It is worthwhile noting however that the BWC footage was available to the experts from the day Ally was taken into hospital being Friday 15 May 2020, and while this was not viewed prior to the experts preparing their reports, Dr Lograsso made the following comments at inquest as a result of seeing the footage,

What I can say is, having viewed the, ... , body camera footage, that's a very good example of - we saw, potentially, an hour or two of her not being preoccupied with these concerns at all. , she was far more preoccupied with ... - her daughter at the time.[54]

But in this case, it would feel to be, at the minimum, an overvalued idea. The body camera footage would suggest it wasn't even that, ... - at that point.[55]

148. In Dr Lograsso report, he provided advice that it would be *reasonable* to consider a diagnosis of delusional disorder as a *provisional* diagnosis, but he would not make a definitive diagnosis of delusional disorder based on the information in Ally's medical records. He stated that it appeared Ally's symptomology would best fit overvalued ideation rather than that of full delusional intent much of the time. He noted many entries in the medical records provide examples of where Ally was demonstrably insightful and able to see her over preoccupation with these beliefs. But also noted other times, where she was very convinced of these beliefs, and they may have been at a delusional intensity at these times. He stated that this suggested a *fluctuating course*.

149. He stated that in a strict sense a formal delusional disorder diagnosis would require confirmation of the duration of these delusions and their intensity in accordance with criterion A. He commented that it appeared from Ally's medical file that their intensity was for about 1 – 2 weeks, certainly less than the one month required for a formal diagnosis of delusional disorder. He said that the preoccupation with the sexualised comments from her partner are well documented during family therapy throughout the 2019 family therapy notes and that through these notes it is clear that Ally's partner admitted to several of these incidents including lurid comments around his daughter. In addition, that through family therapy it became clear this was not delusional in 2019, but a sensitivity to such comments by Ally and an appreciation that, although thought to be in jest, her partner appreciated these were inappropriate.

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[54] T353 L22-27
[55] T355 L28-30

150. Dr Lograsso further noted that significant collateral information around the comments was obtained by Dr Johnstone on 21 May 2021 which clearly demonstrated a reality basis to her concerns but prior to admission and early in the admission Ally may have interpreted these to an overvalued extent. Thus, he said that over the admission she was able to demonstrate an ability at times to challenge her beliefs in view of conflicting evidence and did not hold them as strongly as expected.

151. Dr Lograsso further stated that a second reason not to support a diagnosis of delusional disorder would be with reference to criterion E. He said that it was clear from admission that Ally had a confirmed diagnosis of cannabis dependence, or at least abuse, given her clear admission to regular cannabis use. He said that this was likely underestimated by herself, given there were concerns from her mother and partner around the extent of her cannabis use and potential amphetamine use as well. He noted that a Urine Drug Screen was obtained on 18 May 2020 which was found to be positive for amphetamines, benzodiazepines and cannabinoids the following day. This was consistent with reports from Ally's mother and a friend of Ally's partner in the previous week.

152. Dr Lograsso said that given this evidence and the acute onset of these overvalued ideas/delusions, it is far more likely that a diagnosis of amphetamine and cannabis induced psychosis would better explain her experiences rather than delusional disorder. He noted that typically, a substance induced psychosis fluctuates and is short lived which also correlates with this presentation.

153. Dr Lograsso said it was also worth noting that Ally had experienced a mild version of her symptoms the previous year and at this time a diagnosis of post-natal depression was recorded, and her experience at that time was understood in the context of relationship disharmony and her sensitisation to paedophilic concerns based on her memories of her own mother's reported sexual abuse as a child. He commented that this may be considered an adjustment disorder and it is likely that in the face of amphetamine intoxication these previous concerns were exacerbated severely.

154. At inquest, Dr Lograsso confirmed in his evidence that he would not have made a final diagnosis of delusional order based on the medical records, including those prior to her admission, but conceded that *another colleague's conclusion may differ*. He said he was not seeing evidence of bizarre delusions or highly implausible delusions or major faults in logic.

155. In Professor Newton's report, he stated that delusional disorder is an uncommon disorder that requires the presence of delusions for at least one month, in the absence of any impairment of functioning or strange behaviour outside of the direct effect of the delusion, only brief mood symptoms, and should only be made in the absence of the effects of another mental, physical or substance induced disorder.

156. Professor Newton considered that the records reflect that Ally's concerns that her partner may be a risk to her daughter may be better understood as *overvalued ideas* rather than delusions. He stated that overvalued ideas are exaggerated beliefs that a person sustains beyond reason and that they may spend a large amount of energy or time upon, they are held with less than delusional intensity and may be understood given the persons background or experiences. He noted that within the short time period of her admission Ally began to consider that she may have something wrong with her and that she was 'paranoid' and this fairly rapid change in intensity of her paranoid concern is also more suggestive of overvalued ideas rather than a delusion. Overall, Professor Newton stated that it is most likely that the diagnosis of possible delusional disorder would not have been sustained over a long-term period of treatment.

157. Professor Newton further noted that on admission, when reviewed by the consultant she described very low mood, poor sleep, guilt feelings, poor appetite, weight loss, irritability, anxiety, and some decreased self-care and, that these symptoms are supportive of an ongoing diagnosis of *depressive illness*. And further, that the fears about her partner's risk of sexualised abuse to her daughter can be construed as congruent with her lowered mood.

158. At inquest, Professor Newton gave evidence that throughout the notes there is evidence of Ally becoming more reflective, and also clarifying and challenging what she had told them, and that it was not of *delusional intensity.* For example,

You said that he was having sex with his daughter.' 'No, I didn't say that. Actually what I said was that because of these other behaviours that he's admitted to, and there's evidence for, I'm worried about the impacts that he might have on my child.[56]

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[56] T373, L25-29

159. Professor Newton confirmed in his evidence at inquest that delusional disorder was reasonable to consider but he believed the diagnosis *would not have been sustained over time* and he was not seeing delusional intensity reflected in the notes.

160. In the alternative, Professor Newton observed that Ally was clearly saying to people, *'actually, I feel depressed'* and she had all of the symptoms suggestive of a depressive illness, and she'd been diagnosed with depression, perinatal depression, earlier on in 2019. He commented that you can see her preoccupations and worries about Mr Brooker and his behaviour and the potential risks that he might pose to their daughter as being understandable *from the point of view of someone who was feeling pessimistic, guilty, anxious, worried about the future, worried about safety, those kinds of things, which are all part of a depressive syndrome*.[57]

161. There were several areas in the medical records, the expert panel were asked to consider, with particular reference to whether they demonstrated that Ally's views were not fixed or were amenable to change, they included,

    a. Medical records document Ally's concern about the manner in which Mr Brooker changed his daughter's nappy: '*If it's not necessary, why does he do it?' Reports she raised this with him many times, and eventually he agreed to stop. Suggested to him taking a video and posting to a parenting forum to see what their opinion was and he then said 'ok I'll stop doing it then*'.[58]

       Professor Newton commented that this appeared to be somebody with profoundly low self-esteem and self-doubt, and she is looking elsewhere for validation. Dr Lograsso commented that she is really asking people, *'Well, what do you make of this?' That is, to me, not delusional. This is someone who is inquisitive*.

    b. Medical records document the views of Child Protection and Ally's response:

       States CPS have advised they have found no evidence of sexual abuse of daughter - which she states she is very pleased about. 'that's the last thing I want' 'I don't want

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[57] T378, L1-25
[58] NH medical records, p.307

him to be that way' Asked if that changes her mind on any of her thoughts about Nick however she is clear she still believes he has sexual views towards [59]

Dr Lograsso commented,

She's been told - Child Protection are saying they've got no evidence of this. I mean, I think, this is a normal dialogue. This is not delusional nor psychotic at all. This is someone saying, 'Well, that's reassuring. That's the last thing I want' that this is a normal dialogue, this is not delusional nor psychotic at all but someone saying, 'Well, that's reassuring, that's the last thing I want'. [60]

But then she's not convinced, because most people don't have a very trusting relationship with Child Protection Services. Probably challenging relationship most mothers have with Child Protection Services. I think she's like, 'Well that sounds good, but you haven't got me over the line yet'. [61]

That's not a delusionary process to me at all, or even an (indistinct) idea. I think she's still worried, as a mother would be. [62]

162. Both Dr Lograsso and Professor Newton agreed that in terms of assessing the duration of a month required by the diagnostic tool, that it was somewhat moveable. Dr Lograsso said that *you interpret that in the larger clinical picture.* [63]

Delusional disorder diagnosis – delivery of diagnosis

Ally's treating team

163. Dr Yun agreed that telling Ally she had a delusional disorder could increase her stress level and as a result, he said they closely monitored her during the session and had follow up observations at the end of the session to assess her risk. He did not however believe the risk level had increased, noting that this diagnosis was discussed throughout the admission.

164. Dr Yun said that for the purpose of delivering a diagnosis to Ally, he would try to emphasise that the diagnosis is not important but what is more important is the management plan and

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[59] NH medical records, p. 311
[60] T439 L11-15
[61] T439 L17-22
[62] T439 L24-26
[63] T363, L25-31 – T364, L1-5

what is to be done next. And in her case, to start antipsychotic medication and then discharge her into the community with continuous treatment.

165. Dr Johnstone stated that,

-so in general terms, ..., it would be very important that we be, ..., conscious, ..., of how a patient, ..., responds to diagnosis, ..., understanding that that can often be a quite confronting conversation, ..., and can be something that can - lead to a degree of distress, ..., and we would have been careful to conduct a risk assessment, as always, ..., as part of that comprehensive review, ..., which would include, ..., a consideration of how she had taken the news .... and her behaviour and apparent mental state during the review thereafter.[64]

166. He stated however that there was no evidence of any escalated risk profile that emerged from that review to warrant a revision of the CRAMM nor following his further engagement with Ally.

167. Dr Yun agreed that it was a rare diagnosis and on reflection of Ally's case,

I probably would carry on the same management plan, but probably will try to further minimise the importance of diagnosis with her.[65]

The Expert Panel

168. Professor Newton said in relation to the delivery of a diagnosis,

The first bit is how you communicate. And so there is a risk that if you communicate in a didactic authoritarian way, ... that's going to have a very deep impact on people. When you're communicating diagnosis or differentiate diagnoses, the starting point is how you do it. And so if you read through the notes, it does seems that the diagnoses were communicated in a kind of open, that these are potential – that it wasn't done in that kind of authoritarian kind of way, which is really important because the risks are that you lose – break therapeutic rapport. People feel really invalidated.[66]

[64] T134, L9-19
[65] T292, L22-24
[66] T374, L26-31 – T375, L 1-10

169. He said the risks might include withdrawal of therapeutic contact, suicidal risks, self-harm risk, risk of going back to more substance use. He said in managing those risks it's about how you establish a therapeutic relationship with somebody. He said it was important to have a diagnostic discussion as it is important to work out what they think and how they experience, and what the meaning of each diagnosis is to that person. He described the *world of psychiatry* as a world of relationships and conversations as much as anything else, and connection.

170. Both experts agreed that Ally's risks were appropriately assessed after the delivery of the diagnosis on 21 May 2020.

Stigma associated with a diagnosis of delusional disorder

171. There was agreement amongst the clinicians and experts at inquest that the focus in psychiatry is on treatment and management of a patient rather than diagnosis. Whilst acknowledging this view, I was concerned about the impact of having a final diagnosis of delusional disorder and the *stigma* associated with such a diagnosis on a clinical file as well as the impact of the diagnosis itself, and raised this with the clinicians at inquest.

172. Dr Lograsso agreed that the diagnosis would *be absolutely significant*. He stated at inquest,

.... diagnosing someone with a delusional disorder, ... , most intelligent people are well aware of, as you've used the word, stigma.[67]

One, you're now on medication for this, and the much-wider risks of, ... , now anything she says - will be considered delusional.[68]

To give it certainty has that meaning and has quite an impact. And I feel it can be a delayed impact. ...

So this ... diagnosis ..., I think, has a massive impact on the delivery of it. And to be fair to the team, they spent time discussing it, and the team did come back and talk about it. But it's not to forget it has a massive impact on someone who's spent, pre-occupied or not, ... - since 2019, since the birth of her daughter, has been very worried that this is her worst-case scenario. This is her worst fear, that her daughter could be interfered with. And they're very

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[67] T440 L25- 26
[68] T440 L28-31

common thoughts for mothers, the worst-case things that can happen. It's pretty standard perinatal stuff, that mothers worry. And also, the second thing they worry about, which is a depressive thought, young mothers with depression frequently - it's not just the standard guilt of depression, but will end up with the mindset of, 'I'm a bad mum. I can't protect and I'm a bad mum'. That is a really common thought that comes in and, you know, here she's not just trying to understand it.[69]

173. Professor Newton also agreed that there would be some impact about a final diagnosis of delusional disorder in a medical file and that being told that that's the diagnosis when you're feeling depressed and hopeless, would be impactful as well. He said that becoming fixed about all sorts of troubles or potential troubles in life, can be a feature of depressive illness, referring to it as *depressive cognitions.*

174. Professor Newton reflected in Ally's case about *a different conversation with her* and stated at inquest,

…. she's very concerned about her child's safety, its wellbeing, she's had the baby taken away and taken on by CPS. When you see all of this through a lens, the depression, you feel guilty, negative about the future, hopeless, and you hear somebody say, 'well, actually, all of those concerns, even though they're - there's plenty of evidence to (Indistinct) reality base for some of it, that actually, we think it's a psychosis, it has implications for whether or not you're going to [be] *seen'. You can just imagine the thoughts about whether or not this is going to affect my ability to get my child back.*[70]

175. He did however consider that the medical notes demonstrated *connectedness and plenty of compassion*.

The management of Ally's substance use and risk of withdrawal

176. Professor Newton commented that there is insufficient evidence to support the hypothesis that Ally's symptoms can be mainly understood as part of an ongoing substance use disorder but that her substance use would undoubtedly have contributed to some of her presenting symptomatology. He noted however that the progress notes do not describe someone in

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[69] T441 L13-31- T442 L1-6
[70] T379, L23-31 – T380, L1-4

significant withdrawal that would warrant hard treatment and that Ally does not appear to have developed any withdrawal symptoms or cravings after her admission to hospital.

177. He further noted that her positive drug screening suggested that Ally would have been affected by amphetamines up to three days earlier which could have explained her disorganised behaviour, incongruous and labile affect, pressured speech and irritability and may have also contributed to her paranoid beliefs and the guarded suspiciousness noted by the clinicians on 14 and 15 May.

178. He commented that her cannabis use was noted on admission and specific questions about withdrawal symptoms were asked two days later on the Monday, the day when withdrawal symptoms may begin to peak. Ally did not appear to demonstrate a pattern of symptoms suggestive of cannabis withdrawal and cannabis withdrawal per se does not carry a high risk of serious adverse outcomes. She was prescribed benzodiazepines which she did use on a PRN (as needed) basis if she felt anxious or agitated and there are as yet no specific treatments approved for cannabis withdrawal.

179. At inquest, the expert panel concluded after discussion that the management of Ally's substance use reached an acceptable standard. Noting that substance use issues were identified on admission, withdrawal signs and symptoms were interrogated, and were considered in the context of her diagnosis and benzodiazepines were prescribed to cover any withdrawal signs. There was urine drug screening conducted and drug and alcohol counselling put in place following her discharge from the unit.

Assessment of Risks

180. The purpose of assessing a patient's risk throughout their admission is to stratify people into low, medium and high risk and usually each of those risks are linked to a particular level of observation and risk assessment as well as possibly a particular part of the unit where they are allocated to stay.

181. Dr Lograsso considered that on the basis of Ally's presentation her placement at the LDU was appropriate throughout her admission and therefore it was appropriate she be subject to the low-risk monitoring as specified in the CRAAM. He noted that Ally had no prior mental health unit exposure.

182. Professor Newton also considered that nursing Ally in the LDU was consistent with the principals of least restrictive care environment and appropriate for her level of engagement

and her assessed risks to self and others. He further stated that the change in CRAAM risk rating to low after a number of days in which she was essentially settled, consistently stating and behaving as someone at low risk and beginning to engage in discharge planning was also appropriate.

183. Professor Newton said that in his reading of the notes, on every day there was an overt, explicit progress note that referred to risk issues and Ally appeared to consistently deny a range of risks. He considered from a review of the medical records that Ally *received engaged and connected care* during her admission. He noted her statements that she did not have any current suicidal or homicidal ideas and these risks appear to have been explored on a number of occasions through the admission by her consultant, treating junior doctors and nursing staff in a manner consistent with good care.

184. He further stated that it was clear from the CRAAM record of observations and from the nursing progress notes that nursing staff did not merely observe Ally but regularly engaged with her and assessed her mental state as well as her physical presence.

185. It was noted that there was no CRAAM completed by Dr Johnston following Ally's assessment on 18 May 2020, in accordance with the policy and his practice, however the result of that is that Ally was reviewed hourly (medium risk) and therefore monitored more closely for another 24 hours between 18 after 3pm on 19 May 2020.

186. The expert panel ultimately agreed that risk assessments were regularly done and appropriately documented consistent with contemporary practice.

187. In addition it was agreed that at the time of Ally's passing the NWMH CRAAM Guideline had an appropriate formal system in place to identifying rapid changes in the dynamic risk of patients.[71]

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[71] This included trigger points for conducting a revised risk assessment at: the 24-hour consultant review; daily in for consumers in the Intensive Care Area or consumers managed on High risk in the LDU environment (with one-on-one nursing care); at clinical reviews; at any time risk factors are perceived to have changed, including feedback or information from families and carers; within 24 hours of the last assessment where the clinician believes there is a low level of assessment confidence – low levels of assessment confidence need to be documented in the clinical file; whenever an absconded consumer returns to the unit; when a consumer is transferred between LDU and ICA or ICA to LDU or transferred from a medical ward; any change to leave conditions; pre discharge.

Risk Assessment as a predictive tool

188. Professor Newton highlighted the importance of recognising that the predictive value of psychiatric risk assessments is <u>extremely low</u>. Only 5% or less of those people identified as at *high* risk of suicide will go on to die by suicide within the subsequent two years. The majority of people who suicide are rated by comprehensive psychological postmortem risk assessments as being of *low* risk of suicide.

189. He further stated,

The NICE (National Institute for Health and Care Excellence) guideline 2022 'Self-harm: assessment, management and preventing recurrence' (www.nice.org.uk/guidance/ng225) states that risk assessment tools and scales cannot accurately predict risk of self-harm or suicide. These guidelines make the following recommendations:

a. Do not use risk assessment tools and scales to predict future suicide.

b. Do not use global risk stratification into low, medium or high risk to predict future suicide.

c. Focus the assessment (see the section on principles for assessment and care by healthcare professionals and social care practitioners) on the person's needs and how to support their immediate and long-term psychological and physical safety.

d. Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

190. Professor Newton said that there is an expectation set in the NWMH CRAAM that in every shift every interaction with that person is meaningful and will incorporate thinking about risk and how it needs to be responded to. He said that this is a formal system to identify and appropriately respond to rapid change and dynamic risk, and more importantly,

It's close to best practice as far as I can see. As you say, it doesn't get all the way there but that's because nothing does, and you were talking about formal tools that might help. The conclusion is that none of those tools are fit for purpose, and, at the end of the day, we're left with just kind of seeing somebody interacting with them meaningfully, thinking about what the means for them and responding appropriately. And this is contemporary - At least

contemporaneous good practice in place, and it makes you feel a little anxious because it's not got tick boxes and it's not got frequencies and all of that, but it's actually best practice.[72]

191. The expert panel agreed that generally the risk assessment process is *deeply flawed* and although it might be the intent to identify people at increased risk the ability to do that, particularly for completed suicide and to a lesser extent aggression to other people, on the basis of a risk assessment is very low, that is, it is not possible to identify, the majority of people who take their own lives.

192. Dr Lograsso said that the idea of risk assessment was more an 'actuarial' process, used to quantify risk, like an insurance company, but with limited evidence of working in psychiatry and, it *would be a lovely ideal but it's not something that evidence has ever shown to work in psychiatry at all.*[73]

National Safety and Quality Health Service Standards

193. Professor Newton referred to the National Safety and Quality Health Service Standards[74] which are the nationally adopted standards for accreditation of hospitals and the work which has been done around how to identify people who might be at increased risk of harm to themselves or other people or vulnerable to other poor outcomes.

194. In particular, the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* which is regarded as contemporary practice. The Australian Commission on Safety and Quality in Health Care (**the Commission**) identified the need to develop consensus on a set of signs that can be used for monitoring deterioration in a person's mental state.

195. The Commission engaged Gaskin Research to undertake the project and provide a report on *Recognising Signs of Deterioration in a Person's Mental State*. [75] The authors conducted a literature review and interviews with key stakeholders to generate a list of signs and then undertook a sequential survey process to develop consensus on the signs, resulting in a proposed set of 28 clusters of signs, arranged into five indicators:

[72] T396, L17-28
[73] T384, L23-25
[74] safetyandquality.gov.au
[75] The Commission will undertake further work with stakeholders on the alignment of the proposed signs with existing systems to ensure safe and effective response to deterioration in a person's mental state.

1. Reported change[76],

2. Distress[77],

3. Loss of touch with reality or consequences of behaviours[78],

4. Loss of function[79] and

5. Elevated risk to self, others or property[80].

196. Professor Newton highlighted that the focus should be about connection and engagement and listening to a patient and having the kind of relationship with the patient that maximises the likelihood of that person telling you what is in their mind and how they are feeling.

197. In addition, that rather than concentrating on the various levels of risk what may be helpful is to identify static risk. That is, if a person has a history of trying to kill themselves; if they've got a history of aggression to other people; if they've got a history of not taking their medication or absconding or using substances or not being open about what's happening inside their head; that is a good indicator that this behaviour is likely to be an issue into the future. Although not considered a strong one, *it is the best thing* the sector has. Therefore, there is a good reason, to get a history of what people have done in the past because that's a good indicator of the things that might happen in the future.

198. The expert panel agreed there was consensus that the mental health sector needs to move away from thinking about risk in terms of – low, medium, and high – which clearly still influences aspects of treatment, but in the end gives the sector more of a sense that they're doing the right thing in delivering a safer outcome for a person – and to start thinking about the *person in the room and how we might connect with them*.[81]

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[76] Professor Newton commented: the person or people that knew them, including healthcare staff but particularly families, or the person themselves actually saying, '*Actually, I feel different. I'm not the same as I was*.' So reported change or asking for help, or the people asking for help for them is one of the strongest signs that something is amiss.
[77] Professor Newton commented: Evidence of manifested stress and, that would be observed.
[78] Professor Newton commented: Some psychotic phenomena.
[79] Professor Newton commented: Change in function, the inability to do things that they used to be able to do.
[80] Professor Newton commented: An increased risk to self, others, or property, that is essentially identified through change in behaviour, not through changes in what people say. Actions that indicate an increased risk rather than statements, because those statements are not associated with really good evidence that they lead to an increased risk, whereas actions are.
[81] I note: Department of Health 2010: Suicide risk assessment and management *A systemic evidence review for the Clinical practice guidelines for emergency departments and mental health services report*

199. This approach is consistent with the Department of Health guideline: *Nursing observation through engagement in psychiatric inpatient care* which highlights,

the integral role that person-centred therapeutic engagement plays in enabling nurses to reach a comprehensive understanding of the most pressing issues of people receiving care. Nurses' active engagement with people receiving care and their carers means that people's experience of inpatient settings is supportive of recovery, more positive and therapeutic, and will contribute to better outcomes for people and their families.

CONCLUSION

200. Ally was admitted on a compulsory basis to NH on 15 May 2020 following a period of instability in the community and likely increased use of amphetamines in addition to her long-standing daily cannabis use. There were no outward expressions of self-harm made by Ally prior to her admission or throughout her stay in the LDU. Ally was worried about her partner's behaviour with their daughter and had raised this concern with Child Protection and police in the weeks before her admission. Ally previously suffered with anxiety and depression which increased during her pregnancy such that she later experienced symptoms consistent with postnatal depression.

201. Ally was admitted to NH in 2019 following lurid comments being made by her partner regarding their daughter, which although expressed to be in jest, her partner appreciated were inappropriate. Ally's concerns were not considered delusional at that time and she was diagnosed with an Adjustment Disorder/Situational Crisis. It was apparent that Ally had a sensitivity to these type of comments given the history of childhood sexual abuse suffered by a close family member and, perhaps concerns about whether she was a victim of abuse herself.

202. Ally was found deceased on 22 May 2020 whilst staying in the LDU. It is clearly distressing that in circumstances where Ally was near the end of her admission and soon to be released into the community that she took her own life – in the safety of a care environment and while receiving involuntary care.

203. The RCA conducted following Ally's death identified the root causes as the ensuite door in Ally's room having provided a ligature point despite previous modifications to reduce this risk; and the strap on Ally's bag having provided a ligature and this potential risk not being appreciated.

204. The ensuite door at the time was regarded as best practice design and, following it being established that there is no consistency or standardisation of door design across the mental health sector in Victoria, the doors at the NPU were modified by cutting them at an angle, with a curved profile to minimise the risk of the door to be used as a ligature anchor point ('sloping edge').

205. In addition, bags with long straps are now included in the list of prohibited items in the LDU.

206. Expert advice was obtained by the Court from a clinical psychiatrist, Dr Lograsso, in relation to the appropriateness of the care provided to Ally whilst an inpatient from 15 May 2020 until her passing. In addition, NWMH also provided expert advice from a clinical psychiatrist, Professor Newton. The experts gave evidence concurrently and mostly provided consistent advice regarding the care Ally received, in addition to potential prevention opportunities arising from Ally's tragic passing. I am grateful to them both.

207. Having considered the advice of the expert panel, I accept the conclusions they reached in relation to Ally's care, which I have detailed in this finding. In summary the expert panel concluded the care was appropriate including: the manner in which Ally's final diagnosis was delivered; the treatment for her diagnosed condition; the frequency and manner in which the risks assessments were undertaken and their documentation in the medical records; the adequacy of the system in place at NWMH to identify rapid changes in dynamic risks of patient; the monitoring undertaken on the 21 and 22 May 2020 as being in accordance with the policy guidelines at the time; and the treatment of Ally's substance withdrawal as meeting appropriate standards at the time.

208. Testament to the care the nurses provided to Ally were the following words from her mother,

I wish to also acknowledge and send my heartfelt thoughts to the nursing staff at Northern Hospital who cared for Ally and thus the anguish they experienced upon discovering that Ally was deceased and in the early hours of the 22nd May. Thankyou for your kindness and passion to care. Ally had shared with me that the Nursing staff were very loving and gentle towards her during this time.

209. As part of my investigation, I also sought expert advice about the reasonableness of Ally's final diagnosis of delusional disorder, which is a rare condition, as a matter I considered to be properly part of this inquiry, noting that Ally was a compulsory patient under mental

health legislation at the time of her passing. It was a potential diagnosis which Ally disputed when it was first raised as a possibility on 15 May 2020 until its delivery as a final diagnosis on 21 May 2020.

210. Whether Ally was diagnosed with a mental illness was important to her as she reflected in a text to her mother on 18 May 2020: *PS. No diagnosis of mental illness! Have not been prescribed anti-psychotics! Yah!! That is so good!*[82]

211. During her admission, Ally challenged her treating team when she said that the reason she continued to talk about the concerns she held for her daughter was that they kept asking her about it. In addition, she considered her level of thought and concern about the issue, which focussed on the welfare of her daughter, as appropriate in the circumstances.

212. Ultimately the expert panel provided support for Ally's view on the final diagnosis. Whilst each differed in their view on her likely diagnosis, they considered that the diagnosis of delusional disorder was a reasonable provisional diagnosis, but it would likely not have been sustained over time. Dr Lograsso said he was not seeing evidence of bizarre delusions or highly implausible delusions or major faults in logic. Dr Newton said he was not seeing delusional intensity reflected in the notes. The expert panel did however note that reasonable minds could differ regarding Ally's diagnosis, that a patient can't be diagnosed in practice without seeing the patient, and it is better to see a patient in person and have discussions with other clinicians and members of the care team on the ward.

213. What will never be known is the impact of the delivery of the final diagnosis on the fatal outcome, which can only be a matter of speculation, including its potential impact on Ally's view of herself and reality as well as her thoughts on her ability to keep her daughter safe.

214. Dr Lograsso provided the following comment on this matter,

The one question we will not be able to answer is what was going through her mind on the night that she decided to take her own life. One could only hypothesise that she may have been distressed around the new diagnosis of delusional disorder and the consequent invalidation of her fears, the fear of returning home with her partner given her interpretation from medical staff that she voiced to her mother, or even a fear that CPS would remove her daughter.

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[82] CB, p.320-321

.... Ms. Randall did voice these concerns and in my experience this can be a strong cause of worthlessness in mothers leading to increased suicidal thoughts.[83]

215. Areas of speculation concerning prevention include whether the outcome would have altered if there had been different ensuite doors in the LDU at the time and/or the bag strap had not been available to be used as a ligature. In this context, Ally's actions may have been impulsive and therefore she used the means available to her, but it is possible she may also have found other means of self-harm, if she was so determined.

216. In terms of broader opportunities, it is apparent that the expert panel were most concerned about the lack of consistency in the mental health sector with respect to at least ligature audit tools and prohibited items (noting doors in addition). The expert panel also emphasised the lack of an effective risk assessment tool to predict suicide, which was unfortunately demonstrated in this case, and a need for health practitioners to focus on appropriate and meaningful engagement with a patient.

FINDINGS

217. Pursuant to section 67(1) of the Act I find as follows:

    (a) the identity of the deceased was Allison Leah Randall born on 11 June 1982;

    (b) Allison Leah Randall died on 22 May 2020 at Northern Hospital, 185 Cooper Street, Epping, Victoria, from *1(a) Hanging*; and

    (c) the death occurred in the circumstances described above.

218. I convey my sincere condolences to Ally's family and friends for their loss and acknowledge the heartbreaking circumstances in which her passing occurred.

219. In addition to the coronial impact statement from Ally's mother, I noted at the conclusion of the inquest that statements had been received from many dear and long standing friends of Ally including Christie Oats, Robyn Cooper and Catherine Griffiths who described Ally as an extraordinary person; a gifted and unique human being; as well as a beautiful friend, who was still painfully missed in the many years after her passing.

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[83] CB, p.366

RECOMMENDATIONS

220. Accordingly, pursuant to section 72(2) of the Act, I make the following recommendations connected with the death:

The Chief Psychiatrist consider the following with a view to promote consistency and sharing across Victorian mental health services,

a. The development of research ligature audit tools appropriate for Victorian public mental health services and identify or develop a standard ligature audit tool for consistent use across all Victorian public mental health services;

b. Further, that state-wide implementation of such a tool should be accompanied by appropriate guidelines and training for staff in the effective use of the audit tool;

c. Assess whether the Chief Psychiatrist's guideline - *Criteria for searches to maintain safety in an inpatient unit* should be revised to include reference to a long-handled bag as an example of a dangerous item, or its implications should otherwise be the subject of a communication with the sector; and

d. The development of best practice information around what is considered appropriate ensuite door design in patient's rooms, noting in this case that a WorkSafe Improvement notice was issued, despite the facility's best endeavours to minimise a known risk.

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

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

Nicolas Brooker, Senior Next of Kin

Jan Duckford, Ally's mother

Lander & Rogers

NorthWest Mental Health

Melbourne Health

WorkSafe Victoria

Safer Care Victoria

Constable Jeremy Fitzpatrick, Coroner's Investigator, Victoria Police

Signature:

SARAH GEBERT

Date: 26 April 2024

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 investigation. 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.