IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2019 004648**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Deputy State Coroner Paresa Antoniadis Spanos |
| Deceased: | Karla Lee Jordan |
| Date of birth: | 8 October 1968 |
| Date of death: | 29 August 2019 |
| Cause of death: | 1(a) Hanging |
| Place of death: | 211 Swinglers Road, Invermay, Victoria, 3352 |
| Keywords: | Ballarat Health Services; Toxic Work Culture; Mental Health; Suicide |

## INTRODUCTION

1. On 29 August 2019, Karla Lee Jordan was 50 years old when she was found deceased at home in circumstances suggestive of suicide. At the time, Ms Jordan lived in Invermay with her family.

2. Ms Jordan was born and raised in the Ballarat area where she continued to live for her entire life. In the late 1990s, Ms Jordan met her future husband, Scott Jordan, who she later married in March 2002. The couple shared two daughters, Ella born in 2003, and Lily born in 2005.

3. Since 1998, Ms Jordan had been working as an accountant in the finance department of Ballarat Base Hospital operated by Ballarat Health Services[1] (**BHS**). At the time of her death, Ms Jordan worked four days a week and would ordinarily have Friday off, although some weeks would change her day off depending on her needs at the time.

4. According to Mr Jordan, his wife generally enjoyed working as an accountant with BHS until a restructure within the finance department in August 2017.

## THE CORONIAL INVESTIGATION

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

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Senior Constable Adam Hendrix to be the Coroner's Investigator for the investigation of Ms Jordan's death. The Coroner's Investigator conducted inquiries on my

[1] Ballarat Health Services is now 'Grampians Health.'

behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Karla Lee Jordan including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Identity of the deceased

10. On 29 August 2019, Karla Lee Jordan, born 8 October 1968, was identified by her husband, Scott Jordan, who signed a formal Statement of Identification to this effect.

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

### Medical cause of death

12. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Ms Jordan's body in the mortuary on 30 August 2019 and provided a written report of her findings dated 9 September 2019.

13. The post-mortem examination revealed ligature injuries consistent with stated circumstances. A post-mortem computerised tomography (**CT**) scan showed moderate faecal loading within the bowel.

14. There was no evidence of any other injuries which could have caused or contributed to death.

15. Routine toxicological analysis of post-mortem samples did not detect any ethanol (alcohol), prescription medication, or other common drugs or poisons.

16. Dr Archer provided an opinion that the medical cause of death was *1(a) hanging*.

17. I accept Dr Archer's opinion.

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

**Circumstances in which the death occurred**

18. On 28 August 2019, Ms Jordan returned home from work and appeared settled with nothing out of the ordinary. She was last seen alive by her husband at about 11.00 pm. In relation to his wife's mental health in the days leading up to her death, Mr Jordan stated:

> *"The time leading up to Karla's death, there were no indications that she was feeling down and no reasons to give me concern about her mental state."*[3]

19. The next day, being 29 September 2019, Mr Jordan left home at about 6.15 am for work. Ms Jordan rose a short time later and at around 7.45 am, briefly spoke with her daughters and wished them a good day as they left for school. She did not attend work and the evidence suggests this was the last time Ms Jordan was known to be alive.

20. At about 5.30 pm, Mr Jordan returned home after collecting one of his daughters from football. As he arrived, he noted his wife's car was parked in the shed which he considered unusual as she ordinarily parked her car in the garage.

21. Concerned, Mr Jordan entered the shed in search of his wife. He walked past her car and discovered Ms Jordan hanging in the rear right corner of the shed from a rope tied to a roof beam. A ladder and a notebook were on the floor nearby. Mr Jordan attended to his wife, touched her hand and noted she was cold to the touch. He exited the shed and contacted emergency services.

22. Ambulance Victoria paramedics attended a short time later and formally verified that Ms Jordan was deceased at the scene.

23. Victoria police members attended and did not identify anything to suggest that Ms Jordan had died in suspicious circumstances. The notebook discovered nearby to Ms Jordan contained a series of letters addressed to her family and expressed a clear intent to end her own life. In one of the letters, Ms Jordan referenced her fear of living with a colostomy.

**BACKGROUND**

24. Apart from an isolated incident of stress and insomnia related to workload in 2015, Ms Jordan appeared to have enjoyed her job at BHS until a change of leadership in August 2017. The

[3] Statement of Scott Jordan dated 21 November 2019.

restructure involved the appointment of Mr Adam Lane as the new Director of Finance at BHS.

25. According to Mr Jordan, his wife complained of a toxic work environment after Mr Lane's commencement. Ms Jordan informed her husband of a range of issues at work - she expressed concern she would lose her job; discomfort with the behaviour of management, complained of additional workload due to other employees leaving, felt singled out by management, and felt intimidated and unable to approach management with issues.

26. In May 2018, Mr Levi Walker started employment as a Financial Controller at BHS and became Ms Jordan's supervisor. Her husband reported that from this point onwards Ms Jordan appeared continually stressed and was no longer happy at work.

27. On 11 September 2018, Ms Jordan was asked to attend a meeting at work with Mr Walker and Mr Lane. The meeting lasted 30 minutes and discussion centred around Ms Jordan's reportedly negative attitude to the workplace and management. Ms Jordan later reported to Mr Kevin Stewart, Director of Employee Relations, that the meeting caused her to feel intimidated, unsupported, and unreasonably singled out.

28. During this period, Ms Jordan first consulted General Practitioner (**GP**) Dr Adam Rouse of the UFS Medical clinic in Ballarat. She had previously engaged with other GPs at the clinic. Their initial consultation was on 8 October 2018 and Ms Jordan presented with anxiety in relation to her workplace. Dr Rouse stated it was clear from Ms Jordan's medical records and her own account that workplace stress had been an issue for her in the past.[4]

29. Workload pressures on Ms Jordan continued to increase. In March 2019, Mr Jordan stated his wife began working extended hours as she was unable to complete her work during the day.

> "*Karla had been working back late to 3am most nights. Karla felt like she needed to spend that long at work to catch up and get what she needed to do done. She'd start at 9am and leave at 3am the next morning*."[5]

30. On 7 March 2019, Ms Jordan was involved in a heated workplace altercation with her supervisor, Mr Walker. After the incident, Ms Jordan left the building in a distressed state and

[4] Statement of Dr Adam Rouse dated December 2019, coronial brief.
[5] Statement of Scott Jordan dated 21 November 2019, page 4.

sought the support of Mr Stewart who contacted her husband due to concerns for her wellbeing.

31. The incident with Mr Walker coincided with a long weekend and afterwards Ms Jordan and her family travelled to Warrnambool. Throughout the trip, Ms Jordan was elevated, agitated, emotional, hypersensitive to noise, and unable to sleep.

32. The family returned on 11 March 2019 and the following day Ms Jordan attended her GP Dr Rouse. Ms Jordan was prescribed sleeping tablets and provided with a medical certificate to have the week off work. According to Mr Jordan, during this consultation, his wife reported to Dr Rouse that she had experienced suicidal thoughts in the past.

33. Ms Jordan consumed the sleeping tablets after her appointment with Dr Rouse as prescribed. She experienced negative side-effects including ongoing lethargy, expressed concerns that the medication may cause her to hallucinate, and subsequently ceased the medication.

**Presentation to Ballarat Hospital**

34. Over the coming days Ms Jordan's mental health further declined. On 16 March 2019, she was taken to hospital by ambulance under section 351 of the *Mental Health Act 2014* (Vic) ('**the MHA**').[6] On review she presented with elevated and labile mood, disorganised thoughts, restlessness, and significant workplace stress since October 2018.[7] That day she was admitted as an involuntary patient to the Adult Acute Unit under a Temporary Treatment Order.

35. When Ms Jordan was reviewed by psychiatrist Dr Anoop Lalitha, she presented with thought disorder and was paranoid about her safety. A diagnosis of Acute Polymorphic Psychosis without symptoms of schizophrenia was made with a differential diagnosis of Manic Episode with Psychosis.

36. Ms Jordan was treated with the anti-psychotic, olanzapine 15 mg daily, and diazepam 2 mg twice daily. She complained her medication regime caused drowsiness. The anti-psychotic brexpiprazole 1mg was commenced and diazepam was ceased all together.

[6] Section 351 of the MHA permits a police officer to apprehend a person if they appear to have a mental illness, and because of their apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to themselves or another person. As of 1 September 2023, the MHA was replaced by the *Mental Health and Wellbeing Act 2022* (Vic) and section 351 was replaced by section 232 which is similar in operation.

[7] Statement of Dr Ravindra Mutha, Consultant Psychiatrist dated 17 January 2020.

37. Throughout her presentation Ms Jordan showed signs of improvement and denied thoughts of self-harm or suicide. It appeared she had no ongoing issues with her new medication regime. The Temporary Treatment Order was revoked and on 28 March 2019 she was discharged home with community mental health engagement and management by Dr Rouse. A discharge summary was sent by BHS to Dr Rouse.[8]

38. In the community, Ms Jordan was managed by Consultant Psychiatrist Dr Ravindra Mutha, and registered nurse Ms Tania Bannister of the BHS community mental health team. Following her discharge, Ms Jordan was initially reviewed weekly by Ms Bannister.

39. The first assessment post-discharge was conducted by Dr Mutha on 18 April 2019. Ms Jordan was noted to appear well, reported she was sleeping about 5 hours per night which was her baseline, and denied paranoia, perceptual abnormalities, or mood fluctuations. She also denied any thoughts of self-harm or suicide.

40. In June 2019, Ms Jordan presented to Dr Rouse with anxiety about her bowels and a belief she was experiencing ongoing constipation and a bowel obstruction. Multiple investigations were arranged by Dr Rouse, including CT imaging, which did not reveal any organic cause.

41. Despite a lack of conclusive evidence of any underlying pathology, Ms Jordan remained highly concerned about her perceived bowel issues. Dr Rouse suspected that her bowel symptoms were likely a manifestation of her ongoing anxiety and noted that bowel symptoms are common in people with anxiety. Dr Rouse also raised concerns that delusions may have been the cause for Ms Jordan's concerns about her bowels.

42. The next review by Dr Mutha was performed on 13 June 2019. Ms Jordan disclosed that she self-ceased her antipsychotics due to side effects. As she was stable at the time and was thought to have recovered from her stress induced psychotic episode, Dr Mutha was supportive and encouraged her to monitor for early warning signs of relapse (mood fluctuations, reduced sleep, racing thoughts and irritability) and to recommence olanzapine if these emerged.

43. On 1 August 2019, Ms Jordan discussed the concerns regarding her bowels with Ms Bannister who subsequently discussed the issue with Dr Mutha. Given that Ms Jordan ceased psychotropic medications in June, Dr Mutha considered Ms Jordan's concerns about

[8] Statement of Tania Bannister dated 4 February 2021.

constipation and her bowel were unlikely to be caused her medications. Dr Mutha recommended a physical review with Ms Jordan's GP.

44. Ms Jordan's final consultation with Ms Bannister was on 23 August 2019. The consultation was conducted over the phone and Ms Jordan was recorded as calm, logical and goal directed. she again complained of ongoing bowel issues but otherwise denied any suicidal thoughts, plan or intent.

**WorkCover Claim**

45. Following the incident that occurred on 7 March 2019, Ms Jordan lodged a WorkCover claim due to bullying and harassment experienced in the workplace. She cited her date of injury as 7 March 2019. The claim included reference to the incident on 7 March 2019, the meeting on 11 September 2018, and other behaviours displayed by management.

46. Ms Jordan's WorkCover claim was accepted on 15 May 2019, and she transitioned back to work on restricted duties on 2 July 2019. WorkCover engaged an occupational rehabilitation service (Nabenet) to oversee her Return-to-Work (**RTW**) plan. The senior consultant allocated to Ms Jordan's RTW plan was Matthew Farrell.

47. Part of the RTW plan involved a change in Ms Jordan's direct report from Mr Walker to Mr Chris Aylen. Her location of work was also changed to the main BHS campus.

48. Just prior to Ms Jordan returning to work, Mr Jordan recalled she "*was a bit anxious but was keen to get back to work at the same time*."[9]

49. After her first week back at work, Ms Jordan told her husband she was frustrated as that she was being given basic and insufficient work to keep her occupied. Ms Jordan also had concerns about her job security as well as Mr Aylen's management style she described as aggressive in discussions with her husband and a colleague.[10]

50. In his statement to the Court, Mr Aylen reported that Ms Jordan appeared "*very fragile*" when she returned to work and joined the team. He further reported initially erring on the side of simplicity when assigning tasks to Ms Jordan to help her regain her confidence.[11]

[9] Statement of Scott Jordan dated 21 November 2019, page 12.
[10] Statement of Scott Jordan dated 21 November 2019, page 13; Statement of Charlotte Haddon Havard, undated.
[11] Statement of Chris Aylen dated 16 December 2022.

**Return to full capacity**

51. On 27 August 2019, Ms Jordan attended her GP Dr Adam Rouse in relation to her return-to-work plan. Dr Rouse stated Ms Jordan expressed a desire to return to full time hours at work, although noted it was clear she was experiencing some distress around her return to work plan. In Mr Jordan's statement in the coronial brief, he reported that his wife had discussed with him that she was ready to return to work on a fulltime basis and at full capacity.

52. Accordingly, Dr Rouse provided a certificate of capacity which medically cleared Ms Jordan to return to her pre-injury responsibilities and work location. According to Dr Rouse, Ms Jordan did not present with any thoughts of suicidal or self-harm on 27 August 2019.

53. That same day, Ms Jordan's colleague, Ms Charlotte Haddon-Havard, attended a meeting with Mr Kevin Stewart and Gillian Kennedy (Health Workers Union). During the meeting, Ms Haddon- Havard reported that Karla was having "*dark thoughts (suicide)*."[12]

54. In a statement provided to the Court, Ms Haddon-Havard stated that Ms Jordan informed her during a conversation on 12 August 2019 she wanted to commit suicide and that she regretted going on WorkCover as she now feared for her job security. It appears, although is not entirely clear, that Ms Jordan's disclosure on this date formed the basis of Ms Haddon's report to Mr Stewart and Mr Kennedy on 27 August 2019.

55. Ms Jordan attended work the following day and was assigned a task by her direct line manager, Mr Aylen. The task involved performing a budget reconciliation from the previous financial year to identify why the budget was overspent. Mr Aylen stated that Ms Jordan had performed several other reconciliation tasks since joining his team on her return to work.

56. Ms Jordan found the budget task highly difficult, and she approached Ms Haddon-Havard for assistance with the task. Ms Haddon-Havard stated she was "*taken back by the complexity of the task assigned*" and reported that this particular budget was, in her view, one of the most complex at BHS.

57. According to Ms Haddon-Havard, Ms Jordan cried throughout the time she was assisted with the task and confided that she was too afraid to approach Mr Aylen for assistance with the task for fear he would belittle her.[13]

[12] Statement of Charlotte Haddon-Havard, undated.
[13] As above.

## CPU REVIEW

58. Having reviewed the available materials, I obtained advice from the Coroners Prevention Unit (**CPU**) about the clinical management and care provided to Ms Jordan by the Ballarat Health Service, both in its capacity as her employer and health care provider.

59. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

60. To assist the CPU in their review, the Court obtained statements from:

    i. Adam Lane, Director of Finance, Ballarat Health Service

    ii. Levi Walker, Financial Controller, Ballarat Health Service

    iii. Kevin Stewart, former Director of Employee Relations, Ballarat Health Service

    iv. Further statement from Dr Adam Rouse, General Practitioner

    v. Ms Tania Bannister, Registered Nurse, Ballarat Mental Health Service

    vi. Dr Anoop Lalitha, Director of Clinical Services, Ballarat Mental Health Service

61. The Court also requested and obtained copies of the BHS Workplace Bullying Policy, Safety and Wellbeing Policy, Working Together Guideline, and the information available to BHS employees regarding their Employee Assistance Program.

62. As part of their review, the CPU were assisted by the above statements and policies, the medical records from BHS, the WorkCover and Nabenet records, the coronial brief and the court file.

### Review of mental health treatment

63. At no point during her engagement with the BHS community mental health team did Ms Jordan present with any suicidal thoughts, plan or intent. Her suicide/ self-harm risk was assessed as low by the team.

64. The CPU noted that Ms Bannister became aware of Ms Jordan's concerns regarding her constipation on 31 July 2019. These concerns were discussed with Dr Mutha the following day who recommended a physical examination by Ms Jordan's GP. Although Ms Jordan's potential delusions regarding her bowel issue fell outside of her previously identified early warning signs for psychosis (mood fluctuations, reduced sleep, racing thoughts and irritability), the CPU considered that if her mental health team had been aware of the intensity of Ms Jordan's concerns, it may have prompted review of her mental state and potentially re-commencing antipsychotic medication.

65. In his subsequent statement to the court, Dr Rouse advised he did not speak with Ms Jordan's community mental health team from BHS about her bowel symptoms as he wished to fully investigate and exclude any underlying physical cause. Further, Dr Rouse reported that he generally only contacted the mental health team if patients were experiencing significant acute mental distress or crisis.[14]

66. Ms Bannister reported that clinicians from BHS community team would contact a patient's GP a case-by-case basis depending on the patient's ability to manage their own physical and mental health needs with their GP. Moreover, she reported communication with a patient's GP can be difficult at times as they are often very busy with a high workload. Ms Bannister stated it would be helpful to have a more specific guideline regarding when and how to liaise with a patient's treating GP.

67. As a result of Ms Jordan's death, Dr Rouse stated he is now aware that the mental health team welcome input from GPs about any ongoing issues that arise in terms of a patient's mental health and reported his intention to engage more with the mental health team in future regarding patients under shared care.

68. The CPU advised that ideally there would have been more communication between Dr Rouse, Ms Bannister, and consultant psychiatrist Dr Mutha, particularly in relation to the extent of concern about her bowel issues. That said, the CPU did not consider it likely that enhanced communication between Dr Rouse and the community mental health team would have identified Ms Jordan as high risk of suicide or as so impaired as to require more assertive treatment.

[14] Statement of Dr Adam Rouse dated 9 February 2021.

69. The CPU considered the mental health treatment provided to Karla was generally appropriate although more transparent communication between her community mental health team and GP would have been optimal.

70. The CPU endorsed Ms Bannister's comments that it would be helpful to have a more specific BHS guideline about when and how to liaise with a patient's treating GP.

71. I accept the CPU's advice.

**Workplace Culture at BHS**

72. The CPU considered Ms Jordan experienced work-related stress since at least May 2018, which coincided with the change in her reporting line management to Mr Walker. The decline in her mental health appeared to peak in March 2019 which culminated in the workplace incident with Mr Walker on 7 March 2019.

73. As regards the devolution of Ms Jordan's mental health in March 2019, Mr Walker confirmed that Ms Jordan worked extended hours at the beginning of March. Building swipe pass access records recorded Ms Jordan's swipe out times:[15]

    i. Monday 4 March 2019: swipe out 10.14 pm.

    ii. Tuesday 5 March 2019: swipe out 12.40 am.

    iii. Wednesday 6 March 2019: swipe out 3.33 am.

74. On 7 March 2019, Ms Jordan arrived at work at 9.47 am, only six hours after finishing the night before. Mr Walker advised Ms Jordan had completed tasks relating to the end of the month, including the payroll, at 5.43 pm on 4 March 2019. As Ms Jordan had completed payroll reporting, Mr Walker stated he was unaware why she worked such extended hours throughout the remainder of the week.[16]

75. Mr Jordan stated that his wife expressed to him that management spoke about a restructure and that she was concerned she would lose her job in any restructure.

[15] Statement of Levi Walker dated 4 February 2021.
[16] As above.

> *When she got home she would tell me she was worried about what he (Adam) would say about her and others in the team. This would make her stress more, because of the threat of possibly losing her job through the restructure that Adam talked about*.[17]

76. A review of the WorkCover records confirmed BHS management was considering a restructure proximate to Ms Jordan's death. In an email included in the Nabenet records, Mr Chris Aylen wrote "*there is also the issue that her past role no longer exists to be dealt with*."[18]

77. While the restructure did not eventuate, it is unclear to what extent Ms Jordan was aware of a potential restructure at the time. The fact that Mr Jordan mentions a restructure in his statement indicates Ms Jordan believed it to be a possibility.

78. The WorkCover records referred to multiple employees, not only Ms Jordan, reporting difficulty in approaching managers. Unnamed employees within the finance team at BHS reported aggression from management and an impression that if work was not completed, their job may be in jeopardy.[19]

79. Mr Jordan noted that his wife reported that Mr Lane would bang his fists loudly on the desk and use profanity about other staff members after being on the phone with them. The WorkCover record materials showed employees made multiple complaints about management. On 12 August 2019 Ms Jordan advised Ms Haddon-Havard that she found Mr Aylen "*aggressive*", that he made her "*feel like an idiot and unable to do her job.*"[20]

80. Also in his statement, Mr Jordan noted that his wife's duties increased as other employees in the finance team left. These duties included the end of month payroll system duties which Ms Jordan told him she was the only one who knew how to perform.

81. On the other hand, Mr Lane stated that between September 2018 and March 2019, there were no staff departures in Ms Jordan's team which required her to assume additional duties. Mr Lane also advised that there were three other staff members who could perform the payroll system duties ordinarily assigned to Ms Jordan.

82. Having reviewed the available evidence, the CPU considered Ms Jordan's workplace environment was the primary stressor in the lead up to her acute mental health decline and

[17] Statement of Scott Jordan dated 21 November 2019.
[18] Nabanet records, page 33.
[19] WorkCover records, page 538.
[20] Statement of Charlotte Haddon-Havard, undated.

suicide. Ms Jordan developed a fixation on her physical health and in relation to her perceived issue with her bowels.

83. No underlying or organic cause for Ms Jordan's bowel issues was identified and Dr Rouse considered it to be a manifestation of her ongoing anxiety. The CPU concurred and considered Ms Jordan's bowel issues appeared to be a feature of her mental ill health.

84. In a submission to the Court, Grampians Health accepted that the workplace culture within the BHS Finance Department at the time material to Ms Jordan's mental health was suboptimal, if not toxic.[21]

**Response to potential suicide risk - 27 August 2019**

85. In her statement, Ms Haddon-Harvard stated that Ms Jordan confided in her on 12 August 2019, inter alia, that she wanted to commit suicide and that her family were better off without her. This information was not passed on to BHS/management until a discussion on 27 August 2019 apparently initiated by Ms Haddon-Harvard with Kevin Stewart and Gillian Kennedy.

86. The report of Ms Jordan suffering mental ill health became known to Ms Chrissie Stone, Director of Health Safety and Wellbeing. According to Ms Stone, following the initial disclosure from Ms Haddon-Havard, Mr Stewart contacted Ms Tabetha Pearce, the Injury Management Advisor at BHS overseeing Ms Jordan's WorkCover claim, to relay concerns about Ms Jordan's mental health.

87. Ms Pearce and Mr Stewart discussed that BHS received a certificate of capacity which cleared Ms Jordan to return to full duties effective 28 August 2019. In her statement, Ms Stone advised that a plan was made for Ms Pearce to relay the reports of mental ill health to Ms Jordan's rehabilitation case manager, Matthew Farrell.

88. Nabenet records indicate that after Ms Pearce spoke to Mr Farrell, he spoke to Dr Rouse who confirmed he was happy for Ms Jordan to return to unrestricted pre-injury role. The records do not indicate if there was a discussion of suicidality. The conversation is further evidenced in Dr Rouse's records however similarly does not refer to the details of the conversation, including whether suicidal thoughts were discussed.

89. In short, it is unclear whether Ms Jordan's suicidal thoughts were passed on to anyone beyond Mr Stewart and Ms Kennedy. It is not clear whether the suicidal thoughts were known by Mr

[21] Grampians Health submission dated 31 march 2025.

Aylen as Ms Jordan's direct line manager or by senior management at BHS beyond Ms Stone. Moreover, it is unclear whether the suicidal thoughts were conveyed externally to Mr Farrell or Dr Rouse.

**Justitia and Peacemaker ADR reviews**

90. As part of their investigation into the workplace culture at BHS, the CPU identified media reports from 2016 regarding toxic workplace culture and allegations of bullying at BHS.

91. The now historic allegations resulted in two external consultants, Justitia and Peacemaker ADR, being engaged to examine cultural issues identified within the organisation. Justitia were tasked to conduct a review of the culture that exists within BHS whereas the Peacemaker ADR was confined to issues within a particular unit[22] at BHS

92. Reports from both consultant firms were completed in August 2016. In response to the reports, then BHS Board Chair Rowena Coutts advised:

> *The reports have uncovered a number of issues affecting the morale and culture of the BHS workforce, including incidences of bullying, favouritism, excessive workloads and weaknesses in recruitment processes…On both a professional and personal level, I'm deeply concerned about the cultural issues identified within these reports.*[23]

93. Both the Justitia and Peacemaker ADR reports included several recommendations aimed at improving processes at BHS and thereby providing a safe and healthy workplace for all employees. The CPU advised these included but were not limited to the establishment of a new Complaints Manager position, establishment of a People and Culture subcommittee, and a commitment to enhancing training of all staff to include workplace behaviour and values.

94. Review of the WorkCover records indicated that Mr Walker completed values-based training in August 2018 and Mr Lane completed values-based training in 2017. The available evidence suggested that Mr Aylen had not completed values or workplace behaviour-based training since the publication of the Justitia review and prior to Ms Jordan's death.

[22] The Adult Mental Health Service.
[23] Statement from BHS Board Chair, Rowena Coutts, 4 August 2016, https://www2.bhs.org.au/node/607

**CPU Conclusion**

95. The CPU considered there was evidence of long-term workplace stress resulting from issues within the management and culture of BHS, and Ms Jordan's department, which impacted her mental state. Outside of concerns regarding her physical health, which appeared to be a manifestation of anxiety, Ms Jordan did not have any other identifiable life stressors proximate to her death.

96. The CPU advised the escalation and management of concerns regarding Ms Jordan's potential suicidality following the meeting on 27 August 2019 was concerning. It is unclear whether Ms Jordan's suicidal thoughts were passed all the way along to Ms Jordan's GP or to senior management at BHS. The CPU advised that if the information had been appropriately relayed to all relevant parties, Ms Jordan's RTW arrangements should have been reviewed in the context of her disclosed suicidal thoughts.

**WORKCOVER REVIEW**

97. Included in the WorkCover records was an Improvement Notice issued by WorkCover to BHS in connection to Ms Jordan's death dated 9 January 2020, to be addressed by 23 April 2020.[24]

98. The notice required BHS to employ a suitably qualified person in OHS issues to advise about the health and safety of the Finance & Accounting team regarding organisational factors contributing to work related stress – factors that include but are not limited to work demands, low level of control over work, poor level of support by supervisors, poorly managed relationships, poorly managed change, and incivility.

99. I requested a statement from WorkSafe Victoria to inform the coronial investigation by advising if BHS had complied with the improvement of 9 January 2020.

100. Ms Anita Forde, Manager of Industry and Representation Support, WorkSafe Victoria provided a statement to the Court on 20 December 2023.[25] It was Ms Forde who issued the improvement notice after attending a workplace inspection at BHS on 9 January 2020.

[24] WorkCover records, page 448.
[25] Ms Forde's statement itself is undated.

101. On 23 April 2021, the Improvement Notice was withdrawn on the basis of a technical service irregularity. However, prior to its withdrawal, Ms Forde noted that BHS had implemented the following measures in response to the notice:

    i. Engaged Worklogic to conduct a Workplace Review of the Finance Department.

    ii. Conducted best practice surveys which were completed throughout 2020.

    iii. Facilitated discussions with management and employees in the Finance Department across three sessions in August 2020. The attendance list showed 45 people participated in these discussions.

    iv. Finance Department workgroups were established and had regular scheduled formal meetings.

    v. From 23 April 2021, accountants in the Financial Accounting Team met daily to discuss workload and other issues.

    vi. Leadership development and organisational training was arranged for late 2021.

    vii. Relevant employees in the People & Culture area were provided additional training.

102. Despite the improvement notice being withdrawn on a technicality, Ms Forde considered that BHS complied with the requirements set out in the improvement notice. In a workplace inspection on 23 March 2021, WorkSafe inspectors documented:

> *Based on information and discussions held at the time of my visit, in addition to documents that were provided to me to view previously, I formed the belief that Ballarat Health Services have taken adequate actions to address the issues that were raised in the Improvement Notice.*[26]

**FINDINGS AND CONCLUSION**

103. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[27]

[26] Statement of Ms Anita Forde, undated.

[27] Briginshaw v Briginshaw (1938) 60 C.L.R. 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*

104. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused or contributed to the death.

105. It is axiomatic that the material departure from applicable standards be assessed without the benefit of hindsight, on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may be appreciated at a later time or may even obvious once the tragic outcome has come to pass are to be eschewed in favour of a fair assessment made.

106. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

i. the identity of the deceased was Karla Lee Jordan, born 8 October 1968;

ii. the death occurred on 29 August 2019 at 211 Swinglers Road, Invermay, Victoria, 3352;

iii. the cause of Ms Jordan's death was hanging and

iv. the death occurred in the circumstances described above.

107. The available evidence, including the lethality of means chosen, the presence of a suicide note, and Ms Jordan's history of mental ill health, supports a finding that Ms Jordan intentionally took her own life.

108. The available evidence does not support a finding that there was any want of clinical management or care on the part of Dr Rouse or her treating community team at BHS that caused or contributed to Ms Jordan's death.

109. The evidence suggests that workplace stress stemming from a toxic workplace culture within the finance department at Ballarat Health Services was Ms Jordan's primary identifiable suicide stressor. Although Ms Jordan repeatedly reported bowel complaints to healthcare professionals around the time of her death, no organic cause was identified for her symptoms, and I find it likely that they were a manifestation of anxiety and stress she was experiencing.

110. Ms Jordan did not appear at risk of suicide to her husband or to her GP Dr Rouse in the days leading up to her death. Experience in the coronial jurisdiction is that suicide is notoriously

*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…".*

difficult to foresee and it is always possible that there are issues only known to the deceased which are not revealed by a coronial investigation. The *possibility* that Ms Jordan experienced suicide stressors beyond her workplace stress and associated bowel issues cannot sensibly be excluded. That said, the investigation of her death did not reveal other *probable* suicide stressors, nor did they come to light during her significant engagement in mental health treatment.

111. Ms Jordan's return to full duties on 27 August 2019 was managed sub-optimally with the allocation of an excessively complex task which overwhelmed Ms Jordan who was an experienced accountant but was somewhat fragile at the time. The fact that this coincided with a report of mental-ill health by a colleague, albeit based on Ms Jordan's disclosure of 'dark thoughts' two weeks prior, represented a missed opportunity to re-evaluate the return-to-work plan and re-integrate Ms Jordan safely into the workplace.

112. It is a matter of concern that workplace culture at BHS was examined by Justitia and Peacemaker ADR in 2016 but that some three years later significant deficiencies persisted in the workplace culture at BHS a evidenced by the investigation of Ms Jordan's death.

113. I recognise the remediation made by BHS as an employer following Ms Jordan's death and the resultant WorkCover improvement notice. I encourage, without making a formal recommendation, that Grampians Health (formerly Ballarat Health Services) remain vigilant to its workplace culture and the safety of its employees.

I convey my sincere condolences to Ms Jordan's husband, daughters, and family for their loss.

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

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

Scott Jordan, senior next of kin

Grampians Health (formerly Ballarat Health Services) c/o Barry Nilsson Lawyers

WorkSafe Victoria

Dr Adam Rouse

Office of the Chief Psychiatrist

Senior Constable Adam Hendrix, Victoria Police, Coroner's Investigator

Signature:


Deputy State Coroner Paresa Antoniadis Spanos

Date : 11 April 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an 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.