QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Tiesha Marie Derbyshire**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2021/458
DELIVERED ON:	29 January 2026
DELIVERED AT:	Brisbane
HEARING DATE(s):	23 – 25 June 2025
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	Coroners: Inquest, Death in Care, Involuntary Mental Health Admission, Propranolol Overdose, Search Protocols and Procedures, Communication between Providers.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lane and Ms Sarah Ford.
Mr Andrew Derbyshire:	Ms Kara Thompson, instructed by Caxton Legal.
West Moreton Hospital and Health Service:	Mr Ben McMillan, instructed by West Moreton Hospital and Health Service (WMHHS).
Queensland Health[1]:	Ms Jesika Franco, instructed by Queensland Health.
Dr Tegan McMonagle:	Mr Sean Farrell, instructed by Minter Ellison.
Dr Barzan Pushdary:	Ms Kalina Pyra, Corrs Chambers Westgarth.
Ms Lourdes Wong:	Mr Patrick Wilson, instructed by QNMU Law.

[1] Incorporating the Office of the Chief Psychiatrist (OCP).

Contents

Introduction

1. Tiesha Marie Derbyshire[2] was an 18-year-old[3] single woman when she died at the Ipswich Hospital Adult Mental Health Unit (the AMHU), in Queensland, on 30 January 2021. She had been admitted to the AMHU under a Treatment Authority[4] (in-patient category)[5] pursuant to the *Mental Health Act 2016* (MHA).

2. As Tiesha died while she was being detained in an authorised mental health service as an involuntary patient under the MHA, Tiesha's death was a 'death in care'. Where the circumstances of Tiesha's death raised issues about her care, an inquest was mandatory[6].

3. An external examination was undertaken of Tiesha on 3 February 2021. The attending forensic pathologist, Dr Rebecca Williams, found the cause of death was:

   1(a) Mixed drug toxicity.

4. Relevantly, toxicological analysis undertaken upon femoral blood samples taken at examination found Propranolol to be present at a concentration within a potentially fatal range, namely 5.5 mg/L.

5. The coronial investigation was undertaken by another coroner up until March 2024, when I took over carriage of the matter.

6. The role of the coroner is limited to ascertaining what happened, not to ascribe guilt, attribute blame or apportion liability. A coroner must not include in findings any statement that a person is, or may be, guilty of an offence or civilly liable.

7. In addition to the findings required by Section 45 (2) of the *Coroners Act 2003* (CA), the issues I have to determine are:

   a. Whether Propranolol was an appropriate medication to be prescribed to Tiesha given her medical and mental health history; and
   b. Whether the information that Tiesha had been stockpiling medications and intended to overdose on medication was adequately considered upon and during her admission to the AMHU from 29 January 2021.

8. Additionally, a coroner may, whenever appropriate, comment on matters connected with a death investigated at an Inquest and make preventative recommendations concerning public health and safety, the administration of justice or ways to prevent deaths from happening again in similar circumstances in the future.

9. A coroner may also give information about a person's conduct in a profession or trade to a disciplinary body for the persons profession or trade, if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

[2] Referred to throughout as Tiesha, at the request of family.
[3] Having been born on 20 April 2002.
[4] Chapter 2, Part 4 of the MHA.
[5] Section 51 of the MHA.
[6] Section 27 (1)(a)(ii) CA.

10. For the reasons that appear in these findings, I make no recommendations or referrals of health care providers involved in Tiesha's health care at the AMHU[7] to their professional regulatory bodies. I have however, made some directions to highlight specific issues in this case to various entities.

11. I thank Counsel Assisting and the parties' representatives for their assistance during the investigation and inquest, and their comprehensive submissions following the hearing; the last of which was received on 23 September 2025. Further submissions informing on the status of Queensland Health's improvements to search protocols were received at my request on 22 December 2025[8].

Coronial issues

12. The coronial issues are best understood in the context of Tiesha's pre-existing conditions and circumstances, which underpin the below findings.

Pre-morbid status

13. Tiesha had a tragic history. Amongst other things, she had complex family dynamics, had been under the guardianship of Child Safety, had poor psycho-social supports, was sexually assaulted in 2012, overdosed in 2016, and experienced bullying at school.

14. According to Consultant Psychiatrist Dr Janet Bayley, whose expert opinion[9] was obtained during the coronial investigation, Tiesha's problems at the time of her death were:

    a. Adjustment Disorder with Depressed Mood;
    b. Post Traumatic Stress Disorder (PTSD) from childhood and adult traumatic experiences;
    c. Anorexia Nervosa;
    d. Unspecified Anxiety Disorder, including symptoms of generalised anxiety and panic episodes;
    e. Somatic Symptom Disorder (AKA Conversion Disorder/Functional Neurological Disorder/Non-Epileptic Seizures);
    f. Substance Use Disorder[10,] with reported Alprazolam[11] Use Disorder;
    g. Borderline Personality Disorder (AKA Emotionally Unstable Personality Disorder);
    h. Asthma;
    i. Gastro-Oesophageal Reflux Disease (GORD);
    j. Medical complications of her Eating Disorder including Amenorrhoea, Iron Deficiency Anaemia, Postural Tachycardia, Postural Hypotension and ECG changes;
    k. Medical complications of Misuse of Prescription Medications e.g. Chronic Urinary Retention Syndrome;
    l. Scoliosis;

[7] Noting that disciplinary proceedings have already taken place with respect to one of the health practitioners- see paragraph 19 below.
[8] The parties granted leave to appear in these proceedings were offered the opportunity to provide submissions on the further information provided by Queensland Health in this respect; none were received.
[9] Exhibits G1 and G1.1.
[10] Including at times, illicit substances.
[11] A fast acting and strong benzodiazepine; the brand name of which is Xanax.

m. Irritable Bowel Syndrome;
n. Right Ovarian Cyst;
o. Subclinical Hypothyroidism (December 2020); and
p. Neuropathic Pain consequent to self-inflicted lacerations (October 2020).

15. Tiesha's mental health history spanned from approximately 2017 until her death. She had had multiple episodes of care across two health services[12] on both a voluntary and involuntary basis under the MHA, as an inpatient and in the community, together with Emergency Department (ED) attendances following deliberate self-harm and suicide attempts[13].

16. In an increasing attempt to self soothe, Tiesha 'doctor shopped' for a range of prescription medications which she did not require (e.g. insulin) which she would then use to overdose.

17. In the lead up to her death, Tiesha experienced an increasing number of psycho-social stressors, including the death of a close friend, a move from Hannah's House to independent living, concerns about her father's alcohol misuse, her grandmother's cancer diagnosis, taking out a Domestic and Family Violence Order against an ex-boyfriend, and an inappropriate sexual relationship with a clinician from her treating team at WMHHS.

18. Against that background, I accept the opinion of Dr Bayley that:

a. Tiesha's diagnosis was extremely difficult to treat; there being a lack of robust curative treatment modalities in contemporary psychiatric practice for Tiesha's pathology;
b. her prognosis was poor and that it was inevitable she would not have a normal life expectancy;
c. the treatment and care of Tiesha at WMHHS was appropriate; and
d. treating health professionals and support workers appeared to have generally done their best within resource limitations to help Tiesha with her complex illnesses.

Alan Smith

19. Following a mandatory notification made to the Office of the Health Ombudsman (OHO), the registered nurse who was Tiesha's Case Manager (CM) was subject to disciplinary proceedings in the Queensland Civil and Administrative Tribunal. In a judgment dated 1 February 2023, his conduct relating to boundary violations in respect of Tiesha was found to amount to professional misconduct, and he was reprimanded and subject to the imposition of extensive conditions on his registration as a nurse.[14]

[12] Initially the Child and Youth Mental Health Service at Metro South Hospital and Health Service (MSHHS), followed by WMHHS when she attained the age of majority.
[13] Tiesha had 14 recorded suicide attempts; 11 of which were by overdose.
[14] https://www.queenslandjudgments.com.au/caselaw/qcat/2024/376

Issue 1 – whether Propranolol was an appropriate medication to be prescribed to Tiesha given her medical and mental health history.

Circumstances surrounding the prescribing of Propranolol

20. According to available information, there were a number of General Practitioners (GP's) from different practices in the community who prescribed Propranolol to Tiesha proximate to her death, relevantly:

    a. Dr Chit Chit (3 July 2020);
    b. Dr Tegan McMonagle (7 August 2020); and
    c. Dr Robert Illingworth (29 December 2020).

21. Tiesha was not prescribed Propranolol by WMHHS.

22. Dr Tegan McMonagle was Tiesha's regular GP from March 2020 until Tiesha's death. Tiesha saw Dr McMonagle at two practices - Limestone Medical Centre and Hunter Street Medical. She presented to Dr McMonagle with diagnoses of Anorexia Nervosa with binging, PTSD, depression with severe self-harm, anxiety, dissociative convulsions, GORD, and subclinical hypothyroidism. Dr McMonagle recalls primarily treating Tiesha's eating disorder.

23. Despite becoming Tiesha's regular GP as of March 2020, Dr McMonagle did not prescribe Propranolol to Tiesha until 7 August 2020. Tiesha had, however, clearly been accessing Propranolol between March and August 2020 through other means[15].

24. On 3 July 2020, Tiesha attended upon Dr Chit Chit at the Riverlink Medical and Dental Centre in Ipswich. Dr Chit Chit prescribed Tiesha 100 tablets of Propranolol as well as 60 tablets of Quetiapine; each with five repeats.

25. Despite reviewing Tiesha on 28 July 2020 and referring her to the Ipswich Hospital[16] ED that day for review of complications of her eating disorder, Dr McMonagle's list of Tiesha's medications did not include Propranolol – the inference being that Dr McMonagle was unaware it had been prescribed to Tiesha.

26. The Medical Registrar who conducted a review of Tiesha at the Ipswich Hospital on 28 July 2020, noted that Tiesha's medications in the community included '*Propranolol 40mg daily*'. Tiesha's list of medications on admission also included Propranolol for anxiety, with the note '*UNCHANGED:- REVIEW WITH YOUR GP*'.

27. Tiesha was considered medically fit for discharge on 31 July 2020. During the pre-discharge medical review, the registrar noted '*Pt states has run [out of?] propranolol given recent presentation with overdose limited supply only 5 tabs this indication needs to be reviewed by GP*'.

28. Propranolol was again listed on Tiesha's medication list on 3 and 4 August 2020 while she was under the care of Logan Hospital[17] in respect of her psychiatric admission for suicidal ideation. Notably, on 5 August 2020, the AMHU registrar who reviewed Tiesha prior to her self-discharge that day recorded that Tiesha was to

[15] For example, on 19 June 2020, Tiesha was transported to Ipswich Hospital after hitting her head and fainting, where she self-reported that Propranolol was one of her usual medications.
[16] Part of the WMHHS.
[17] Part of MSHHS.

continue with Propranolol. There is, however, nothing in the corresponding progress note as to the reasons for this decision.

29. When Dr McMonagle first prescribed Propranolol on 7 August 2020, it was in circumstances where Tiesha had been discharged from Logan Hospital (as referred to above) with directions to take half a 40mg Propranolol tablet each morning. Dr McMonagle obtained this information by checking the medications tab in the Queensland Heath 'Viewer'[18].

30. Dr McMonagle understood that Tiesha had been prescribed Propranolol whilst in hospital to manage her anxiety and tremors. Dr McMonagle gave evidence that she could not remember the precise reasons for having prescribed Propranolol to Tiesha, but that she '*presumed*' her own prescription was '*purely based on the fact it was started already in the hospital*'.

31. When asked to explain the purpose of Propranolol, Dr McMonagle stated:

> *---So propranolol, essentially, it is a blood pressure medication, but the majority of the time it is used more to decrease heart rate or decrease the effects of – that you can get with anxieties, where your heart's racing. It helps to slow that down. Also helps with tremor, like it helps stop that shaking too…*

32. Dr McMonagle explained that where Tiesha had been discharged with only one Propranolol tablet on 5 August 2020, it was necessary to provide Tiesha with a prescription on 7 August 2020 so that she had a continued supply of her discharge medication regime, as requested by Tiesha.

The appropriateness of prescribing Propranolol

33. Dr Janet Bayley expressed concerns about the type of medications prescribed to Tiesha and the quantities of medications she had access to. Dr Bayley's concerns in this regard are set out below.

<u>Type of medications</u>

34. Dr Bayley opined that Tiesha's prescriptions for Propranolol, Prazosin, Metoprolol, and Levothyroxine were inappropriate and unnecessary, in circumstances where she had '*significant medical complications from an eating disorder and as well as for someone who as at high risk of stockpiling medications and overdosing*'.

35. In her experience, these medications can not only have adverse effects for patients with eating disorders, but further, they have a high lethality in overdose. For a patient like Tiesha who had significant postural tachycardia and postural hypotension from an eating disorder, the medications were potentially harmful:

> *…There's quite significant – um – cardiovascular effects of a long-term eating disorder, and where people will get postural hypotension, postural tachycardia – um – changes in – in ECG, in the – um – rhythm in the heart, and a lot of people with restrictive eating disorders, and even with the – um – ah – purging eating disorders can die from sudden cardiac arrest as a result of – um – the weakening of the heart, because when someone's a – undereating for a long time and in starvation syndrome, their – um – body is looking for glucose, so they start to actually do what we call [indistinct] genesis from the heart muscle to give the body*

[18] An application which allows practitioners to securely view limited statewide public hospital information.

glucose. So it starts to break down the heart muscle and they have a problem with that. Postural tachycardia is well-known in eating disorder psychiatry to be a – um – an issue with regards – um – signs of a – medical complications of an eating disorder. And Tiesha had a lot of these sort of symptoms on and off.

36. Dr McMonagle was asked to comment on Dr Bayley's opinions concerning the inappropriateness of Tiesha's Propranolol prescription. She gave evidence that:

    a. she was unaware that, for patients with an eating disorder, Propranolol was not appropriate;
    b. at the time of prescribing it to Tiesha, she did not investigate or verify the quantity of Propranolol that might be toxic or result in a patient's overdose; and
    c. she had not, since Tiesha's death, conducted any research about this. She '*presumed*' Dr Bayley was correct in her opinion.

37. Nevertheless, Dr McMonagle has accepted Dr Bayley's opinion and agreed that her future prescribing practices will now change.

38. Dr Robert Illingworth, who saw Tiesha once at Hunter Street Medical on 29 December 2020, and prescribed Propranolol to her on that occasion, also agreed with Dr Bayley's opinions about Propranolol, albeit with the following caveat:

    …the history of the postural hypotension being associated with her eating disorder was not divulged when taking Ms Derbyshire's medical history. I did question her about the need for the medication and she clearly stated that the propranolol was prescribed to treat Postural Orthostatic Tachycardia Syndrome (POTS) and also partly for symptoms of anxiety. These are both well-established indications for the prescription of propranolol and her reported dose was appropriate for these indications. Consequently, the request for a prescription did not seem unreasonable.

<u>Quantities of medications</u>

39. Another issue identified by Dr Bayley were the quantities of medication Tiesha had access to '*with each dispensing episode and the number of repeat prescriptions given*'. As explained by Dr Bayley during her evidence:

    …You maybe get 100 tablets for – um – one month's supply, which is fine if you're a 70-year-old – um – woman who's very careful with her medications, and puts them in little, you know – um – in little boxes to take them. But if you're given 100 med – 100 tablets at a time for, like, propranolol for someone like Tiesha, and she stockpiles them, that means you can get an enormous amount very quickly. However – so I mean, like, what I do, and other psychiatrist and other doctors do would be – um – what we call a staged supply with a weekly pickup, or a – every couple of days. But even then – um – people can still stockpile medications. But giving people – um – with high suicidal risk – um – 100 tablets of propranolol is not a good idea.

40. Having regard to Tiesha's access to large quantities of Propranolol prescribed by GP's over a five-month period in 2020, one might consider at face value that Dr Bayley's concerns are justified, with the benefit of hindsight. The below timeline is relevant in this regard.

41. On the same day Tiesha was prescribed Propranolol by Dr Chit Chit (namely, on 3 July 2020), she was taken to the Ipswich Hospital ED after intentionally overdosing on 100 40mg Propranolol tablets and 100 200mg Quetiapine tablets.

42. Dr McMonagle was asked whether, at the time of prescribing Propranolol to Tiesha next on 7 August 2020, she had knowledge of Tiesha's overdose on 3 July 2020. She gave evidence to the effect that she '*believed*' she first became aware on 16 July 2020 when she received (and reviewed) the Ipswich Hospital discharge summary about her psychiatric admission.

43. When asked whether, having that knowledge, she took any steps on 7 August 2020 to mitigate the risk of future overdose, Dr McMonagle told the court that she:

> *…sent the prescription directly to the pharmacy, so that she had to go to that particular pharmacy for it, and I asked them to put it in her Webster pack so that she was getting a very small dose at a time, instead of having a whole box of 100 at her disposal.*

44. Dr McMonagle's intention was to ensure the prescription was held by the pharmacy in circumstances where the Propranolol would be dispensed weekly, meaning that Tiesha would only receive 3.5 tablets each week.

45. Dr McMonagle also gave evidence that she believed she spoke to Tiesha about how the Propranolol was to be dispensed (in that it was to be Webster-packed) and she faxed the prescription, along with the Webster-pack instructions, to the Ipswich Day and Night Pharmacy. I have no reason to doubt that account.

46. Unfortunately, the Ipswich Day and Night Pharmacy was unable to confirm whether the Propranolol prescribed by Dr McMonagle was Webster-packed as directed – their only remaining records after a flood event are undated and may relate to a different prescription of Propranolol.

47. On 29 December 2020, despite Dr McMonagle having ceased Tiesha's Propranolol prescription on 6 November 2020, Dr Illingworth, a GP at Hunter Street Medical, prescribed Tiesha a further 100 tablets with five repeats. That prescription was not accompanied by instructions to dispense the medication by way of Webster packs.

48. In a statement provided to the court, Dr Illingworth explained that, where he had no reason to doubt Tiesha's self-reported medical history and medication regime, and as Tiesha would be continuing her long-term care with Dr McMonagle, he saw no reason to interfere with her medication regime and so he provided her with prescriptions in accordance with her medical record.

49. Dr McMonagle was not aware Tiesha had seen Dr Illingworth on 29 December 2020. At that time, she was still practicing at the Limestone Medical Centre.

50. Relevantly, on the same day Tiesha saw Dr Illingworth, she wrote a suicide note. Then, on 30 December 2020, Tiesha disclosed to her acting CM that she had been '*stockpiling Quetiapine and other medications she had been acquiring from random GP clinics*'.

51. Tragically, it was only one month later that Tiesha intentionally overdosed on Propranolol and died.

52. Dr Bayley's ultimate opinion was that, where Tiesha had been identified as a risk for overdosing on accumulated tablets, '*requiring her to be more accountable for safe medication use and prescribing of her medications for weekly dispensing (i.e. weekly pick-ups) may have helped to mitigate the risk of her acquiring lethal quantities of prescribed medications*.'

53. In WMHHS's response to Dr Bayley's opinion, it stated that where Tiesha had capacity and lived independently in the community, there was no way of monitoring her compliance with or stockpiling of medication. I accept that submission.

54. The responsibility for trying to manage Tiesha's medication, and to restrict her access to large quantities of medication she had previously overdosed on lay, for practical purposes, with her regular GP. Dr McMonagle's evidence is that, on the single occasion on which she did prescribe Propranolol to Tiesha, she did take steps to have the medication Wester-packed and dispensed weekly. Unfortunately, Tiesha appeared to be well acquainted with ways to get around these restrictions by seeing new GP's who were unfamiliar with her history and risk factors.

55. Although Propranolol was a high-risk medication in Tiesha's case, it is not considered high-risk in all cases in which it is prescribed, and so is not subject to the same strict legislative controls as Schedule 8 medications[19] which have a high potential for misuse, abuse and dependence.

56. Accordingly, I consider it was not unreasonable that GP's in the context of isolated and one off involvement such as Dr Chit Chit and Dr Illingworth, with limited information, to have prescribed large quantities to Tiesha without attempting to restrict the amount she had available to her at any one time.

Determination

57. Having regard to the expert evidence of Dr Bayley, together with the concessions made by Dr McMonagle and Dr Illingworth, I find with the benefit of hindsight and subject to paragraph 59 below, that Propranolol was not an appropriate medication to prescribe to Tiesha.

58. Whilst I accept Dr Bayley's evidence that a staged supply of Propranolol would have been preferable for Tiesha, there is no evidence that there was any failure by any of the prescribers which was responsible for her ability to stockpile the medication. Tragically, it was Tiesha's own resourcefulness and determination that achieved this.

59. Against that background, I do not consider it is appropriate to criticise the GP's in the specific context in which they prescribed Propranolol to Tiesha, especially given that:

    a. the criticism by Dr Bayley about Propranolol being inappropriate is from the perspective of a specialist psychiatrist, not a GP. Equally, the criticism was made on clinical grounds associated with Tiesha's eating disorder based on cardiovascular concerns, not overdose *per se*;
    b. Tiesha deliberately sought out different GP's from different practices (two of whom did not know her) in the space of a five month period, in order to obtain the medication she used to overdose;
    c. the GPs had limited engagement with Tiesha;
    d. Tiesha had been admitted to two specialist facilities in July and August 2020 (Logan and Ipswich Hospital's), which amongst other things, noted that she had been prescribed Propranolol as a regular medication in the community, likely from Tiesha's self-report;

[19] *Medicines and Poisons Act 2019* and *Medicines and Poisons Regulation 2021*.

e. regarding the prescription of 7 August 2020, Dr McMonagle accessed information about an engagement with Logan Hospital 24 hours before, via the Viewer and the corresponding discharge summary;
f. primed with this knowledge, Dr McMonagle did take precautions by arranging a staged supply of Propranolol on 7 August 2020, which was an appropriate mitigation strategy;
g. there is no evidence that Dr McMonagle's prescription was not dispensed in accordance with the prescribers' instructions. Accepting that it was dispensed as instructed, Tiesha should only have been dispensed with 3.5 tablets per week, which would explain why it was necessary for her to seek out more from another GP at a different practice (Dr Illingworth), who saw Tiesha for the first time, with no available information other than Tiesha's self-report. It can be inferred by provision of an un-staged script that Tiesha omitted to mention the restrictions placed on her previously;
h. the Propranolol used by Tiesha to end her life was dispensed at a pharmacy other than the regular pharmacy utilised for the prescriptions made by the preceding two GP's. It is unexplained from the evidence why Tiesha went to a pharmacy other than her regular pharmacy. An inference can be drawn that she purposely did so with stockpiling and overdose in mind; and
i. the prescription was presented and dispensed on two occasions, on 29 December 2020 (the same day of the GP's prescription and the writing of a suicide note) and again on 25 January 2021, which accounted for the terminal amount of Propranolol she ultimately ingested. This is consistent with her reporting to her CM on 30 December 2020 that she was stockpiling.

60. I find accordingly.

Issue 2 – whether the information that Tiesha had been stockpiling medications and intended to overdose on medication was adequately considered upon and during her admission to the Ipswich Hospital Adult Mental Health Unit from 29 January 2021.

The information available to the AMHU on 29 January 2021

Tiesha's medical records

61. At the outset, it should be noted that Tiesha's medical records include more than 7000 pages from WMHHS and approximately 6000 pages from MSHHS. I accept submissions made on behalf of WMHHS that caution should be exercised when viewing what information from the medical records was available to the AMHU staff on 29 January 2021, having regard to the volume of material across two record keeping systems (CIMHA[20] and ieMR[21]) and across two health services.

62. And further, in that context, I accept that it is not reasonable to conclude that any staff member would consider the entirety of those records, which I consider would be challenging when making time critical clinical decisions in an acute mental health presentation.

63. Against that background, prior to her admission to the Ipswich Hospital ED on 28 January 2021, it appears that Tiesha's medical records at least contained a history of overdoses; the most proximate of which was 3 known overdoses in 2020.

[20] Consumer Integrated Mental Health Application.
[21] Integrated electronic medical record.

64. Insofar as Tiesha's *known* history of stockpiling medications in 2020, at the very least, Tiesha's medical records contained notes from an incident on 30 December 2020, during which Tiesha reported to her acting CM that she had been '*stockpiling Quetiapine and other medications she had been acquiring from random GP clinics*'.

65. This information at least was available to the AMHU on 29 January 2021 as it was contained in the CIMHA, which AMHU staff had access to.

Information obtained on 28 January 2021

66. The AMHU also had access to information recorded by the Psychiatry Registrar, Dr Matilda Kolandaisamy, on 28 January 2021 prior to Tiesha's admission to the Ipswich Hospital ED later that day.

67. Dr Kolandaisamy recorded concerns about Tiesha stockpiling medication at her residence and researching how to overdose. She also recorded that Tiesha had been assessed as a moderate to high risk to self and had both a plan and intent. This information was recorded in Tiesha's progress notes of that date.

68. Furthermore, Tiesha's community psychiatrist, Dr David Mendels, subsequently phoned WMHHS Consultant Psychiatrist, Dr Barzan Pushdary (the in-patient AMHU psychiatrist) to let him know Tiesha was to be admitted to the AMHU. It was decided that Tiesha would '*go through the emergency department and to be assessed, ah, and to be deemed to be medically fit to be admitted to mental health unit'*.

69. Dr Pushdary could not recall whether, during his conversation with Dr Mendels, Dr Mendels mentioned anything about Tiesha stockpiling medications. In any case, both the ED and AMHU staff had access to Dr Kolandaisamy's notes in CIMHA.

Whether the information was adequately considered

70. The adequacy of the AMHU's consideration of the relevant information needs to be assessed with reference to:

    a. the searches conducted of Tiesha upon her admission to the AMHU on 29 January 2021; and
    b. Tiesha's levels of observations between 29 and 30 January 2021.

The searches

71. Upon Tiesha's arrival to the AMHU at around 1:00am on 29 January 2021, RN Lourdes Wong (the nursing Team Leader for that shift) prepared Tiesha for admission. RN Wong was assisted by EN Talita Rieck and RN Jocelyn Anderson.

72. RN Wong conducted an interview with Tiesha using the risk screening tool form. Tiesha was said to be irritable and reluctant to be in the AMHU.

73. Having reviewed Tiesha's CIMHA records, RN Wong listed seven 'static factors' (risk factor variables that do not change) in the screening form. The list included '*History of consuming more than the prescribed dose of drugs*'.

74. As for Tiesha's 'dynamic factors', RN Wong recorded, amongst other things, that Tiesha had chronic suicidal ideation and a suicide plan. RN Wong assessed these factors based on her observations of Tiesha as well as her CIMHA records – including the notes entered by Dr Kolandaisamy on 28 January 2021. Tiesha, however, denied suicidal ideation at the time of the risk screening.

75. RN Wong initially gave evidence that she could not recall whether, when reviewing Dr Kolandaisamy's notes for the risk screen, she saw the concerns about Tiesha stockpiling medications. However, she said later during her evidence that Dr Kolandaisamy's notes about Tiesha's stockpiling were in fact considered by her during her risk assessment.

76. In any case, RN Wong concluded that Tiesha's level of risk was '*elevated and highly changeable*', and under the heading 'Future factors' she recorded:

> *'Given history, personality structure, patient remains a chronic elevated risk of intentional harm to self and potential for death through misadventure.'*

77. It seems, based on RN Wong's evidence, that while she was interviewing Tiesha for the risk screen, Tiesha was also being searched (presumably by the other nurses).

78. The WMHHS 'Searches of Patients and Possessions' procedure applied to the AMHU at the time of Tiesha's admission on 29 January 2021.

79. The procedure was based on compliance requirements and on obligations under the statewide Office of the Chief Psychiatrist (OCP) Searches and Security Policy.

80. The procedure essentially allowed for three types of searches of a patient - a general search, scanning search, or personal search. Searches could be undertaken at any time provided '*a doctor or health practitioner believes the patient may have something harmful in their possession*'.

81. Relevantly to this inquest, a <u>general search</u> was defined as a search of a patient:

    a. *To reveal the content of their outer clothing or hand luggage without touching the person or the luggage, or*
    b. *In which the person may be required to open their hands or mouth for a visual inspection, and/or to shake his or her hair vigorously (Chief Psychiatrist Practice Guidelines, 2017).*

82. Whereas a <u>personal search</u> was defined as follows:

    A search in which light pressure is momentarily applied to the patient over their general clothes without direct contact being made with their genital or anal areas (including breast for female persons).

    It may include any or all of the following:

    a. *Remove and inspect an outer garment or footwear of the patient;*
    b. *Remove and inspect all things from the pockets of the patient's clothing;*
    c. *Touch the clothing worn by the patient to the extent necessary to detect things in their possession; and*
    d. *Remove and inspect any item found (Chief Psychiatrist Practice Guidelines, 2017).*

83. The removal of a patient's clothing for the purposes of a search required approval by '*the Administrator (or delegate)*' and only where it is believed that the removal of clothing is necessary in the circumstances.

84. Approval was not required for a search involving the touching of clothing.

85. All searches could be performed without the patient's consent, with the assistance of security officers, and using necessary and reasonable force. In considering the need for to search, the doctor or health practitioner must consider the individual circumstances of the patient's case. This includes the patient's history and any collateral information.

86. In Tiesha's case, a general search was conducted first. This involved searching Tiesha's backpack – within which, the nurses found a Webster pack of medications, contraceptive medications, cigarettes, and keys. The medication and cigarettes were confiscated.

87. When giving evidence about that search, RN Wong explained:

> *Her – her bag was taken away, and we taken all the medication that she had in her bag, and it was kept double-locked in a treatment room, yeah, with her – labelled with her name on it, and, um, her belonging – her bag has been searched for any sharp objects or, um, anything that could cause, um, them to self-harm or anything like that…*

88. Tiesha had also, reluctantly, handed over her phone and charger to security.

89. RN Wong gave evidence that a 'personal search' was also conducted. However, this involved only the removal and inspection of Tiesha's shoes and any items in her pockets (which she was asked to remove herself). No contact was made with Tiesha's clothing or body, nor was she asked to remove her clothes.

90. As noted by Dr Bayley, Tiesha had evidently concealed the Propranolol she overdosed on in her underwear. For AMHU staff to have found it, a more invasive personal search, such as the removal of Tiesha's clothing, would have been required.

91. When asked about the option of removing Tiesha's clothing for the search, RN Wong said approval had to be obtained from '*higher up'*. Further, she had never been involved in a search of that nature.

92. RN Wong's understanding of the procedure was that '*weapons and things like that*' would be the type of circumstances required for a removal of clothing search. She also explained that in Tiesha's case, "*knowing her background of a sexual assault, we…wouldn't do a body search on her*".

93. Under cross-examination about this, RN Wong explained that for each patient, an assessment is conducted in respect of whether a 'body search' might cause further trauma. RN Wong's ultimate assessment was that an invasive search would have been detrimental to Tiesha (having regard to her sexual assault history).

94. Dr Pushdary was also asked about his understanding of the procedure in respect of when an 'invasive search' might be justified. The following exchange occurred:

> *All right. What would such a reason be, in your view, doctor?*
>
> *---Ah, so in my view, given that I see search as an intrusive, coercive, non-therapeutic, which potentially can cause significant harm, I need to have justification to balance the benefits outweigh the risk.* ***In Tiesha's case, unfortunately she had a horrendous background history of abuse and trauma and – sexual in nature – and rape, and, more recently, there was allegation of abuse by the health practitioner, unfortunately. Ah, it would***

have been very difficult decision to conduct in-depth or intrusive coercive search *without considering the actual benefit of it, and to justify that, I need to have an indicators why I should conduct this search. Ah, one of the suspicion that if there was a concern while the patient was transported from the community to the emergency department, or while the patient was waiting in emergency department to be transported to mental health unit, or at the point while the patient* ***– at the point of entry to mental health unit, if there was any increased suspicion that the patient may be in possession of contraband, or she may have expressed that she had a plan to commit suicide in the mental health unit by using medication or other harmful things, I think there would have been enough justification, ah, to make a decision to do a search.*** [emphasis added].

Now, from what you've just said, it seems to me that the justification would have required some indication from Tiesha herself that she had such a plan; is that correct?

---Not necessarily just herself, ah, but it could be evidence from other observers that she might be in a possession of the probands[22]. So we not entirely just rely on Tiesha because it's not fair for the patient – the patient. Usually she – in particular, Tiesha was very secretive, so very unlikely she would tell anybody about her plan, if she had a plan. Um, but if there's evidence from other staff or during the initial search that there was a concern that she might have – she may have had some probands[23] in her possession, which warrant a search.

95. Counsel Assisting then asked Dr Pushdary about whether, the information provided by Dr Kolandaisamy on 28 January 2021, might have triggered a more invasive search of Tiesha. Dr Pushdary's answer, in essence, was that based on a patient's history of stockpiling alone, it would be difficult to justify the search. In Tiesha's case, where she was already in the AMHU and the information about her stockpiling was provided at a time when Tiesha had access to medications in the community, her risk of accessing and stockpiling medications was '*minimal*'.

96. Under cross-examination by the legal representative for WMHHS, Dr Pushdary explained:

…we know, based on the acute management plan that, ah, formulated by, ah, a longstanding team that looked after Tiesha, that any approach that's coercive in nature, ah, that means is done – expose her, for example, private parts, that would be a coercion. Tiesha would responded in, ah, in aggressive manner and would become very combative.

…Um, so I – in my opinion, that if the decision of a search was made, quite likely, she would have gone through the state that she required to be restrained, as comes in that policy that reasonable force to be used. And I don't know how justifiable to use reasonable force to undress a patient, um, I think in those situation, probably the – the harm would be eminent, um, unless the patient – I mean, Tiesha was really not a sort of person would have accepted voluntary search.

97. The Chief Psychiatrist, Dr John Reilly, was asked whether he agreed with Dr Pushdary's assessment. Ultimately, Dr Reilly's evidence was that an invasive search may well have been counter-therapeutic for Tiesha, however, '*if the risks are*

[22] Presumably this is a transcription error, having regard to his use of the term 'contraband' earlier in paragraph 94.
[23] Ibid.

considered to be particularly high then it might still be appropriate to do a more, you know, intensive search'.

98. In Dr Bayley's opinion, the '*potential point of staff intervention with regards preventing Tiesha's death would have been for mental health staff at Ipswich Hospital to have conducted a person search of Tiesha on admission and to have found the hidden Propranolol she later used to overdose*'.

Determination

99. Ultimately, Counsel Assisting submits that there can be no doubt that had a more invasive search been conducted upon Tiesha's admission to the AMHU, the Propranolol might have been discovered and confiscated from Tiesha, and that accordingly, it is open for me to find as follows:

    a. Had an invasive search involving the removal of clothing been performed, the Propranolol would likely have been found on Tiesha; and
    b. Had the Propranolol been found, Tiesha's death on 29 January 2021 may have been prevented.

100. Whilst that might have been true with the benefit of hindsight, having considered the evidence, I accept the further submissions given by Counsel Assisting that the evidence is not sufficient to support a finding that the information about Tiesha's stockpiling and intention to overdose was not adequately considered for the purposes of the search, as follows:

    a. the evidence provided by RN Wong and Dr Pushdary makes it clear that the primary barrier to a more invasive search, at least in RN Wong's mind, was the risk of further trauma to Tiesha, having regard to her sexual assault history and the likely use of restraint if it was initiated. Where the procedure requires an assessment of each individual case, RN Wong's decision-making cannot be criticised;
    b. Dr Bayley conceded that conducting such a search is '*very intrusive'*, particularly for a patient with a history of sexual trauma. Also, that person searches are not easily initiated and have many negative impacts upon therapeutic relationships;
    c. In Dr Bayley's opinion, AMHU staff correctly followed the procedure; and
    d. Dr Pushdary's evidence about the difficulties in justifying a more invasive search (as discussed in paragraph 96 above) suggests that even he may not have proceeded with a more invasive search

101. Consistent with this, I also accept the following submissions made on behalf of WMHHS:

    a. the information about stockpiling was that Tiesha was stockpiling medication at her residence and that such risk in accessing and stockpiling in the AMHU was minimal;
    b. the evidence establishes the clinical reasoning for not undertaking a more invasive search; and
    c. no criticism is made of that decision in the circumstances.

102. On that basis, I find as follows:

a. Due to Tiesha's sexual assault history, combined with the difficulties in justifying an invasive search, AMHU staff were justified in not conducting a search of Tiesha that involved the removal of her clothing; and
b. The decision not to conduct a search did not involve a breach of any policy or procedure.

103. In reaching that conclusion, I have considered the submission made on behalf of the family, that at no time did it appear from the documentation that Tiesha was ever asked if she had on her person or possession any non-disclosed or concealed medication. Whilst it does not appear that this was specifically documented in the medical record, RN Wong gave oral evidence that they did ask Tiesha[24]. I have no reason to doubt that account. Accepting this, it follows that Tiesha denied having medication on her person or possessions. With the benefit of hindsight, I note this was consistent with Tiesha's behaviour on previous engagements, where she was known to be secretive, resourceful and determined.

Observation levels

104. On admission to the AMHU on 29 January 2021, Tiesha was on Level 2 observations. Thus, constant visual observation of Tiesha was required at all times, within the confines of 'within eyesight'.

105. Later that day, when Tiesha commenced nasogastric tube (NGT) feeding, Dr Pushdary upgraded her observation level to Level 1. He said it was standard practice to place any patient undergoing NGT feeding on '*special 1:1 observations*' to ensure they do not interfere with the NGT.

106. After pulling out her NGT late that evening and after Dr Pushdary had completed his shift, Tiesha's observation level was changed back to Level 2. Having reviewed the nursing notes, Dr Pushdary could not comprehend why the change in observation levels occurred. He says that ideally, such a change would not be made without the psychiatric registrar personally reviewing the patient.

107. In any case, in the afternoon of 30 January 2021, Tiesha was reviewed by a psychiatrist who assessed that her Level 2 observations continue.

108. No criticism has been made regarding the level of observations Tiesha was subject to on 30 January 2021. Indeed, Dr Bayley gave evidence that Tiesha's Level 2 observations were '*adequate*'.

109. Having regard to Dr Bayley's opinion, it follows that the information about Tiesha's risk of suicide must have invariably been adequately considered when the AMHU staff decided to resume her Level 2 observations.

110. Dr Bayley opined that there was most likely a period of '*broken*' Level 2 observations that allowed Tiesha to take the Propranolol from her hiding place and put it into her drink. This was, in Dr Bayley's opinion, an outcome-changing opportunity. However, Dr Bayley does recognise the '*human factors'* associated with close observation – including fatigue and busy workloads. Dr Bayley also acknowledged that WMHHS has since undertaken a multidisciplinary review of their visual observation processes.

111. It is relevant that the two nurses involved in Tiesha's observations gave evidence that Tiesha *was* within eyesight of one or both of them throughout the key period

[24] Transcript 1, pages 43, 44.

when she consumed the secreted Propranolol. I am of the view that being within eyesight includes walking directly behind a patient in circumstances when they suddenly leave a room, as Tiesha did in a heightened state when departing the dining room to go to her bedroom whilst carrying her cordial drink. Being behind Tiesha, the nurse was unable to see Tiesha reach into her bra to retrieve the medication and place it into her drink. In those circumstances, I am unable to find that there was a 'break' in the Level 2 observations. The effect of this is that the staff complied with the relevant policy and procedure, and find accordingly.

Recommendations

112. In accordance with s46 of the Act, the court may also if appropriate, comment or make recommendations in respect of anything connected with a death investigated at an inquest that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

113. Two primary considerations arise in this regard - firstly, the communication between GP's and public mental health services within Queensland, and secondly, patient search policies and procedures.

Communication between GP's and public mental health services

114. Dr Bayley, whilst sympathetic towards GP's who manage cases as complex as Tiesha's, was critical of the clinical communication between Tiesha's prescribing GP's and psychiatrists. In her opinion, opportunities were missed for psychiatrists who might have been aware of the negative impact of Propranolol on Tiesha to communicate to her GP the inadvisability of prescribing it. This was particularly so where Tiesha had a tendency to '*doctor shop*'.

115. When asked about her opinion, Dr Bayley explained:

> *…when I tried to piece together her – ah – medication list, they were constantly changing. Ah – and that's not because of any – um – ah – I think any particular – um – major – ah – negligence on any of the doctor's parts. It was just really confusing. So there'd be one list on admission, one list on discharge. The GP would have another list. Um – and I presume that she was complicit in that herself, that she was – there were certain medications that she wanted – um – and she would tell the – the doctors what she wanted to be on by the sound of it. So it – it was all very confusing, and I think it would have been – um – and I – this is not directly also solely related to this case, but in general the GP's are doing a lot of heavy lifting for the – ah – patients with complex issues like Tiesha, and are not included in the treating team, so to speak, with the tertiary services. There's a big disconnect between private, public, and general practice, and tertiary-level services.*

116. On this topic, Dr McMonagle gave evidence that she felt there was a lack of communication '*between the parties*' and particularly, from Tiesha's mental health providers. This meant that Dr McMonagle was reliant on Tiesha to communicate about her medication regime, and to do so honestly and candidly. Unfortunately, as we now know, this proved to be unreliable.

117. When asked how communication in this regard could be improved, Dr McMonagle suggested more regular and written communication from mental health service providers:

…perhaps letters from the mental health team or from the psychiatry team if things were changed or updated, um, or even in the form of discharge summaries, which weren't always available after she'd been admitted.

118. She also agreed that interdisciplinary meetings or reviews may have assisted with Tiesha's care.

119. The opinions expressed by Dr Bayley and Dr McMonagle were put to Dr Pushdary, for his comment. When asked whether he thought there could be more engagement with GP's, he said:

…the standard clinical practice that we communicate with the general practitioner through, ah, thorough discharge summary. Ah, and if there is any, um, imminent concern that we will address that concern, um, and we hand over the care to the community to – for ongoing, ah, input and communication between the community team and general practitioner.

120. However, Dr Pushdary went on to say that '*ongoing communication between the community team and the GP was essential' to keep Tiesha 'safe*'.

121. In its statement to the court, WMHHS outlined 13 occasions of recorded contact between WMHHS and Tiesha's GP's and say that its ability to communicate with Tiesha's GP's was complicated by virtue of her attendance at GP clinics she was not previously known to attend. Given the above timeline of Tiesha's attendances on GP's leading up to her death, I accept this submission.

122. Dr Bayley considered WMHHS's response in this regard. In her opinion, while there was communication between Tiesha's regular GP and the WMHHS clinical mental health team clinicians, it was '*somewhat superficial'*. She considered that a more collaborative team arrangement that integrated Tiesha's GP as a '*key member'* of Tiesha's interdisciplinary team, would have been helpful for Tiesha's care.

123. Dr Bayley did, however, acknowledge that:

a. superficial communication is often the case when it comes to clinical communication between primary care and tertiary mental health services;
b. there is not a robust model for this type of GP collaboration within Queensland public mental health services and the federally funded primary care sector, and Tiesha took advantage of this structure;
c. Tiesha's case is not unique in that there often is a disconnect between primary care and tertiary care mental health services; and
d. the fact that the close involvement of Tiesha's GP did not appear to be fully appreciated is not uncommon in public mental health services.

124. Under cross-examination by the legal representative for Queensland Health, Dr Bayley was asked whether she was aware of a Federal Government Medicare-based initiative which allows for case conferencing. Dr Bayley stated that she was aware of the initiative and had indeed arranged such conferences herself.

125. Although Dr Bayley conceded that the platform is accessible by GP's and others '*involved in care of similar patients to Tiesha'*, in her opinion '*most of the case management teams…would not think to do that*.' In any case, Dr Bayley told the court that the initiative was a '*really good start'*.

126. Dr Reilly was also asked about this initiative. When asked whether, in his opinion, the initiative would improve access to collaborative and coordinated mental health

care, he said it '*does*', however he queried the level of '*uptake*' by Queensland Health services.

127. Given that this collaborative based initiative already exists, namely that the Medicare Benefits Scheme funds eligible providers to organise and participate in case conferences, it is unlikely that any meaningful recommendation can be made in this respect. However, in my view there is room for improvement to this capability which can be best addressed by enhancement of the 'uptake' issue.

Directions

128. Accordingly, I direct that a copy of these findings be provided to the Deputy Secretary of the Primary and Community Care Group of the Australian Government Department of Health and Aged Care in order for this issue to be highlighted to the Primary Health Networks, who are best placed to consider system integration improvement opportunities.

129. To the extent that there may be gaps in 'uptake' beyond this:

    a. I direct that the Chair of the Royal Australian College of GP's (Queensland faculty be provided with a copy of these findings, with a view to highlighting the availability of this capability to their Fellows;
    b. given that collaboration is a two-way street between providers in the community and public mental health services and noting Dr Reilly's query about uptake in these settings, I encourage the OCP/Queensland Health to take an active role in highlighting the availability of this initiative in its statewide communications to services. Given its proactive attitude to addressing the policy issues arising from this case, I have every confidence the OCP/Queensland Health will do so; and
    c. otherwise, that publication of these findings in the public domain will assist in further educating providers about utilisation of this quality improvement initiative.

Patient search policies and procedures

130. In responding to Dr Bayley's opinion (in her first report) that '*the Statewide Search Guidelines and WMHHS Search Procedure are not clear as to when a 'person search' [i.e. searching the person's body] should be conducted particularly when there is suspicion of contraband items being hidden on a person's body'*, WMHHS stated (inter alia):

    Any decision requiring a patient to remove clothing for the purposes of a search is to be tempered by considerations of previous trauma. Ms Derbyshire had a history of sexual assault and chronic PTSD symptoms related to that assault. An invasive body search would have been highly triggering for Ms Derbyshire and may have further destabilised her mental state.

131. Dr Bayley conceded that conducting an invasive search is '*very intrusive*' – particularly for a patient with a history of sexual trauma. Also, that person searches are not easily initiated and have many negative impacts upon staff and patient therapeutic relationships.

132. However, she says that a patient's privacy and rights need to be balanced with the health service's duty of care to ensure harmful items are not brought in. In her opinion, there needs to be more of an understanding about what might trigger a more in-depth person search.

133. When asked to expand on her concerns, Dr Bayley gave evidence that, in her experience, '*people are not searched enough, because there's an awful lot of illegal drugs that get into mental health units because people are hiding them in – on their body, in their body, whatever, and also of harmful things*'. Ultimately, she considers that patients should be searched more invasively to prevent patients bringing in '*contraband*' that could cause harm to themselves.

134. Under cross-examination, Dr Bayley said that '*helpful guidelines'* would assist front line workers in making good judgments about risk and when to increase the level of searching.

135. Dr Bayley was asked whether she saw any concerns with having a prescriptive list in this regard. She responded that there would be benefits from a prescriptive list '*because it gives people on the front line some very practical, hard guidelines to follow*'. She acknowledged though, that the use of such a list may result in staff not asking questions beyond the list.

136. Dr Pushdary gave evidence in a similar vein to Dr Bayley. In his opinion, the 'guidelines' need to be much clearer and increasing awareness amongst practitioners about the guidelines would be helpful.

137. When Dr Pushdary was asked whether he would agree that 'prescriptive guidelines' could be problematic, he replied:

> *Not necessarily in situations when the clinician doesn't know what to do, including a consulting psychiatrist. If I would be confronted with a situation, ah, when I have two option, one is worse than the other, ah, I think there will need be a guideline so the staff could be protected, if things go wrong either way. Um, and if there is a clear guidelines, ah, especially in patient with a significant history of trauma, um, to which extent you will go and implement the search? Where do you stop?*

138. Dr Reilly confirmed that there is no framework or checklist practitioners can use when considering a removal of clothing search. He said that a challenge with 'checkboxes' is:

> *…people saying do this, do that, and so it's a constant tension again going back to the discussion earlier also with regard to it – it's always sounds good that we've now got an extra checkbox to address something. The problem is that when you're – um – a commission then – um – you're – there's multiple different areas that we could look at, and it's sometimes actually not really helpful to be thinking about what the focus is here when we simply are saying as long as you've ticked that checkbox now you'll be – that's okay. So I appreciate the kind of intent of getting more guidance, but it does come at a cost potentially as well.*

139. Dr Reilly told the court that the OCP policy is currently under review.

140. Dr Bayley, aware of the OCP policy review, opined that the subject matter expert group (SMEG)[25] undertaking the review needs to include '*representatives from the floor*' (specifically, doctors and nurses from ED's).

141. When asked for her views on what that group might consider in relation to Dr Bayley's suggestion of more '*helpful guidelines'*, Dr Bayley said this:

[25] Responsible for reviewing the OCP Searches and Security policy, from a Statewide perspective.

Um – helping the person who is admitting the patient to a mental health unit understand – um – when it is appropriate to go a bit further with the – the searching. So understanding very clearly what the risks – what the triggers are, the red flags. I think – um – in a lot of – um – guide – medical guidelines that I read, like for example GP guidelines and how to – ah – refer people for mental health issues, they talk about the red flags. So having a – a very clear red flag – ah – panel on the protocols about – so it's not so prescriptive, but, red flags might make you consider doing this.

142. Dr Steadman gave evidence about amendments made to the WMHHS 'Admission to Acute Mental Health Unit and Older Person Mental Health Unit' since Tiesha's death. These amendments were in response to recommendation 2 as contained in the WMHHS' Root Cause Analysis Report, namely:

    Recommendation 2

    Develop a local work instruction and minimum question set to ask inpatients on admission to the AMHU to assist in the identification of harmful items. This question set will be included in the clinical handover process from the Ipswich Hospital Emergency Department to the AMHU.

143. As a result of the amendments, the admission procedure now includes a 'ACT Harmful Items Check'. Dr Steadman explained that this checklist applies to the admission of any patient to the AMHU and a record of the checklist to be kept (and noted on CIMHA as having been completed).

144. Notably though, whilst the checklist requires a discussion with the patient regarding harmful items in their possession – it does not alleviate the concerns expressed by Dr Bayley and Dr Pushdary about:

    a. the low likelihood of patients like Tiesha admitting to the possession of harmful items or a suicide plan; or
    b. the lack of clarity around when an invasive search should be undertaken.

145. As noted by Dr Bayley, if '*services want to be proactive in preventing harmful items such as stockpiled medications from being brought on to mental health units, this issue requires more rigorous consideration*'.

146. With this in mind, and having regard to Dr Bayley's suggestions in relation to the OCP policy review, Counsel Assisting submits that a recommendation along the following lines may be appropriate:

    The Office of the Chief Psychiatrist consider:

    a. broadening the review of the Searches and Security policy to take into account the issues raised in this inquest about invasive search procedures; and
    b. including, in the SMEG undertaking the review, nurses from mental health units.

147. Tiesha's family supports this approach, adding that questions be incorporated in the admission process about an immediate risk of stockpiling medication and potential harm/suicide, together with some additional intervention such as a personal (non-clothed) search such that it should be escalated in accordance with the policy.

148. Queensland Health's submissions relevantly included the following:

a. the MHA provides detailed statutory provisions regarding personal searches of individuals in AMHU's in Queensland[26]. The Chief Psychiatrist has a statutory role and is responsible for overseeing the administration of the MHA and ensuring compliance with its provisions. As part of this, it issues policies and guidelines to ensure consistency and adherence to legislative requirements across Queensland's mental health services, which support the effective implementation of same in operations across services. Relevantly, this includes the Searches and Security Policy, which is then implemented locally within a clinical setting, with decisions informed by clinical decision making, and the associated training, guidance and professional development which supports those decisions within each facility;
b. there remains a balance between the protection of human rights and the administration of the MHA in Queensland. Section 3(2) of the MHA explicitly states that its main objects are to be achieved in a way that safeguards the rights of persons in the least restrictive way of their rights and liberties and promotes recovery and community reintegration without the need for involuntary treatment and care. The relevant policy specifies that it must be implemented in a way that is consistent with the objects and principles of the MHA;
c. that the Searches and Security Policy was already under review by the SMEG in accordance with the OCP's usual review processes, and there are opportunities for the issues arising out of this inquest to be considered by the SMEG; and
d. confirmation that the SMEG already includes mental health nurses, in addition to lived experience representatives, carers and independent patient rights advisors. Additionally, the Searches and Security Policy had also been distributed to Administrators at services for review and comment as part of broad consultation with all AMHS's, providing further opportunity for nurses to participate.

149. Subsequently at my request, Queensland Health provided an update as to the status of the SMEG review; the substance of which is set out as follows:

a. the Administrative and Tribunal SMEG met on 6 November 2025 and, in principle, endorsed a draft Searches and Security Policy;
b. the Steering Committee (SC) subsequently met on 4 December 2025 and provided their endorsement for a human rights compatibility assessment to be undertaken for the draft version of the policy and associated fact sheet[27];
c. dependent upon the level of changes required following this assessment and whether further consideration is required, the Policy is anticipated to be approved in principle by the SC and the Chief Psychiatrist by the end of the first quarter of 2026;
d. once approved in principle, there will be an implementation period of eight weeks before the policies are formally approved by the CP and published on the Queensland Health website;
e. in the event any further policy recommendations arise from this inquest, it would be beneficial if they could be provided as soon as practicable in order to be considered in the current review process. Irrespective, it should be noted that there are continuous reviews of the OCP policies and any recommendations arising out of this inquest will be considered by the OCP when they are delivered, if the timelines do not align;
f. additionally, the OCP confirms that the issues raised in this inquest were shared with the SMEG and in particular, strengthening the guidelines related

[26] Chapter 11, Part 7.
[27] Anticipated to be completed in early 2026.

to searches to address the complexities of clinical decision making and to ensure that the risk of harm is appropriately balanced against patient rights when decisions pertaining to searches are being made;

g. several changes have been made to the draft Searches and Security Policy which are reflected in the draft approved by the SMEG. These include but are not limited to a restructure of information to improve clarity, readability and better reflect process flow. The SMEG also considered approaches for search guidelines in other jurisdictions, in particular guidelines issued by the Victorian OCP. These guidelines helped inform the revised overview of search types and general principles. In the draft Searches and Security Policy, the following sentences in italics, were added specifically as a result of the SMEG's consideration of the general issues raised in this inquest:

    i. Section 3: General Principles:
    Minimally Restrictive Approach: Searches should be conducted in the least restrictive way possible, proportionate to the identified risk, and only when necessary for the safety and security of individuals within the AMHS or Public Health Sector Health Service Facilities (PSHSF). *Risk assessments and management must be tailored to the individual, taking into account their personal history, current circumstances, and dynamic factors that may influence their level of risk at any given time.*
    ii. Section 6.1: Searches of Patients in AMHS or PSHSF
    The patient's history, *current circumstances and dynamic factors that may influence a patient's risk.*

h. similar wording was also added to the draft Searches factsheet to highlight the need for tailored risk assessments. The fact sheet will be aligned to the policy and subject to final endorsement by the SC and the Chief Psychiatrist:

    i. Searches should be conducted in the least restrictive way possible, proportionate to the identified risk, and only when necessary for the safety and security of individuals within the AMHS or PSHSF. *Risk assessments and management must be tailored to the individual, taking into account their personal history, current circumstances, and dynamic factors that may influence their level of risk at any given time.*

150. Having regard to the nature and extent of work that has been undertaken at a statewide and local (WMHHS) level and noting that WMHHS (like all services) will undoubtably implement the relevant statewide policy locally, once disseminated, I am satisfied that the initiatives have/will address the issues raised in this inquest about searches. Accordingly, I respectfully decline to make the recommendations proposed by Counsel Assisting and the family.

151. In reaching this decision, I have had regard to and accept the submissions made on behalf of Queensland Health, relevantly:

    a. the importance of clinical judgement in determining whether the evidence relating to possible harms justifies the removal of clothing. It highlights the complexity of such cases, emphasizing the need for clinical decision making that carefully considers any identified risks of each individual weighed against the evidence that a clothing removal search is necessary. In that context,

discretion is crucial, and guidelines should be a framework for such process to support decision making;

b. a search is just one tool available to mitigate the risk of self-harm or suicide;
c. whilst Queensland Health accepts Dr Bayley's opinion regarding the difficulty clinicians may face when considering when a more intrusive search is necessary as demonstrated by the evidence in this matter, the generalised opinion of Dr Bayley cannot be accepted by the court because:
    i. There is no evidence before the Court that there is a systemic problem within Queensland regarding medications that patients are going to overdose on coming onto the ward, or illicit substances such as methamphetamine coming onto the ward;
    ii. In fairness, neither Dr Pushdary, Dr Steadman nor Dr Reilly were asked about this; and
    iii. Although the Coroners Court is not bound by the rules of evidence, it must base its findings and comments on relevant and logically probative evidence. The opinion provided by Dr Bayley must be given little weight accordingly, constrained to specific services which Dr Bayley has worked at historically and is not indicative of a statewide issue; and
d. the balance between the protection of human rights and the administration of the MHA, which safeguards the rights of persons in the least restrictive way and promotes recovery and community reintegration without the need for involuntary treatment and care.

Findings required by s. 45

Identity of the deceased – Tiesha Marie Derbyshire, aged 18 years.

How she died – Tiesha had a complex history of eating disorders, sexual assault, and significant mental health issues, with frequent admissions to ED's and AMHU's for suicidal behaviour - including prescription overdoses. On 28 January 2021, due to concerns about increasing suicidality, Tiesha was taken to the Ipswich Hospital ED. In the early hours of 29 January 2021, she was admitted to the AMHU under a TA (inpatient category). On admission, Tiesha managed to conceal a quantity of her Propranolol medication. During dinner on 30 January 2021, Tiesha appeared unwell, and her cordial looked frothy. She told a nurse that she had consumed 200 crushed up Propranolol tablets. Despite receiving immediate medical attention, Tiesha could not be revived. The cordial which Tiesha had been drinking was not tested for drugs. However, at autopsy, toxicology analysis showed that Propranolol was present in Tiesha's blood at a concentration which was within a potentially fatal range. Other substances were also detected, including Fluvoxamine at a concentration greater than the usual therapeutic range but less than the potentially fatal range, Diazepam, Lorazepam and Olanzapine, all at concentrations within the usual therapeutic range, and low levels of Quetiapine. The forensic pathologist who conducted the autopsy found that it was this combination of drugs which was responsible for Tiesha's death.

Place of death – Ipswich Hospital Adult Mental Health Unit IPSWICH QLD 4305 AUSTRALIA

Date of death– 30/01/2021

Cause of death – Mixed drug toxicity.

Concluding comments

152. This tragic case highlights the challenges involved in managing a complex patient like Tiesha within the available health framework in the public and private sectors. Whilst acknowledging the inevitability of Tiesha's ultimate outcome, it is hoped that the quality improvement initiatives made with search protocols and case conferencing will have the effect of preventing similar deaths in the future.

153. In Tiesha's memory, a family statement was read out at the conclusion of the evidence. It is perhaps best expressed by the words of her brother, as follows:

> *Every day we feel the anguish, the guilt, anger, the heartbreak, the sadness, and the longing. In all that we think of and know of Tiesha, her endless potential, her spark, and her spirit, it wasn't that she lost it or that it was wasted. It was taken from her. It wasn't one single moment, but a lifetime of dysfunction, inadequacy and harm, predatory men, a fragmented system, all compounding over time. Adults who were supposed to protect her but didn't.*

154. Suffice to say that the sentiments expressed were heartfelt and sincere. It is clear that the loss of Tiesha has had a profound impact on those that loved and cherished her.

155. I offer my sincere condolences to Tiesha's loved ones. To the extent that it is able, it is hoped these proceedings have addressed any questions or concerns and assists in bringing a measure of healing.

I close the inquest.

Carol Lee
Coroner
BRISBANE