QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Chloe Jane Campbell**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO:	2019/1852
DELIVERED ON:	17 September 2024
DELIVERED AT:	Brisbane
HEARING DATES:	31 October to 1 November 2023, Southport 28 February 2024, Brisbane
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	CORONERS – INQUEST – Death in Care – Involuntary Treatment – Mental Illness – Management of Environmental Hazards – Ligature Risk – Compliance with Statewide and Local Guidelines and Procedures.

REPRESENTATION:

Counsel Assisting:	Ms Sally Robb KC
Metro South Hospital and Health Service (MSHHS):	Ms Donna Callaghan, instructed by MetroSouth Hospital and Health Service (MSHHS).
Registered Nurse (RN) Rachel Noh:	Mr Nicholas Congram, instructed by Queensland Nurses and Midwives' Union (QNMU) Law.

Contents

Introduction

1. Chloe Jane Campbell was aged 32[1] when she died on 30 April 2019 at the Logan Hospital (LH), MetroSouth Hospital and Health Service (MSHHS).

2. Ms Campbell's death was reported to the Coroner as a violent or otherwise unnatural death, suspected suicide.[2]

3. Ms Campbell was subject to a Treatment Authority (TA) (inpatient category) under the *Mental Health Act* 2016 (MHA) at the time she died[3]. The TA authorised the treatment and care of her mental illness and her detention in an authorised mental health service without her consent[4]. As a result at the time she died, Ms Campbell was detained at an authorised mental health service as an involuntary patient under the MHA and her death was also a reportable death as a death in care.[5]

4. An inquest into a death in care must be held where the circumstances of the death raise issues about the deceased person's care.[6] That Ms Campbell died by suspected suicide while in care is a matter that prima facie raises issues about her care.

5. The coronial investigation was conducted by former Deputy State Coroner Jane Bentley up until May 2022, when I was appointed as Southeastern Coroner and took over carriage of the matter.

6. On 16 February 2022, former Deputy State Coroner Jane Bentley advised the parties that an Inquest would be held.

7. On 30 June 2023, a Pre-Inquest Conference (PIC) was held in Southport.

8. The Inquest was conducted in Southport and Brisbane over three days on 31 October 2023, 1 November 2023 and 28 February 2024 respectively.

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[1] Having been born on 29 December 1986.
[2] Exhibit A1; *Coroners Act* 2003 (CA), s 8(3)(b).
[3] MHA, Chapter 2 Part 4.
[4] The treatment criteria having been assessed as having been met, s 12 MHA.
[5] CA, ss 8(3)(f), 9(1)(b).
[6] Ibid, s 27(1)(a)(ii).

9. Following conclusion of the Inquest, the parties provided written submissions; the last of which was received on 8 August 2024.

The scope of the Coroner's Inquiry and Findings

10. A Coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the Coroner is required to find: -

    - who the deceased person is;
    - how the person died;
    - when the person died;
    - where the person died;
    - what caused the person to die.[7]

11. The scope of a Coroner's jurisdiction to inquire into the circumstances of a death and make statutory findings goes beyond merely establishing the medical cause of death.[8]

12. A Coroner may, whenever appropriate, comment on matters connected with a death investigated at an inquest and make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.[9] A Coroner must not include in the findings or comments made any statement that a person is, or may be, guilty of an offence or civilly liable for something.[10]

13. As a former State Coroner of Queensland has observed: '*an inquest is not a trial between opposing parties but an inquiry into the death…..The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths*'.[11]

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[7] CA, s 45(2).
[8] However, it has been held that the '*findings*' referred to in s 45 of the CA are '*to the matters required to be 'found' in s45(2) of the Act*'. It is said to be '*clear*' from the text of the CA that these '*findings*' are '*the ultimate findings which a coroner is required to make by s 45(2)*': *Hurley v Clements & Ors* [2009] QCA 167 at [20] per McMurdo P, Keane JA and Fraser JA.
[9] CA, s 46(1).
[10] Ibid, s 45(5), s 46(3).
[11] Findings of former State Coroner Michael Barnes in the Hamilton Island air crash *Inquest into the deaths of Joanne Bowles, Michael Bowles, Sophie Bowles, Kevin Bowles, Andrew Morris & Christopher Andre le Gallo*, Brisbane, p 2.

14. Fundamentally, an inquest is '*investigative, inquisitorial and does not result in findings which bind participants inter partes. The standard of proof which applies is not the criminal standard*.'[12]

The Admissibility of Evidence and the Standard of Proof

15. The Coroner's Court is not bound by rules of evidence but may inform itself in any way it considers appropriate. The inquiry undertaken by a Coroner '*must be sufficient for the purpose of investigating the death and making, if possible, the findings required by the Act*'. The Coroner *'cannot be limited to investigating the material placed before (the Coroner) by other persons*'.[13] That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a Coroner greater scope to receive information that may not be admissible in litigated proceedings and to have regard to its provenance when determining what weight should be given to the information.

16. This flexibility has been explained by reference to the nature of an inquest as a fact-finding exercise rather than a means of attributing blame: an inquiry rather than a trial.[14]

17. In *Doomadgee v Clements*[15], Justice Muir stated the test as follows:

> *'It is significant also that the rules of evidence do not bind a coroner's court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The evidence relied on by the coroner must be relevant to the matters within the scope of the coronial inquiry. The coroner may act "on any material which is logically probative"; that is, "the decision must be based upon material which tends logically to show the existence or non-existence of facts relevant to the issue to be determined, or to show the likelihood or unlikelihood of the occurrence of some future event the occurrence of which would be relevant.'*

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[12] See *Domaszewicz v The State Coroner* (2004) 11 VR 237 at par [81]; cf *Musumeci v Attorney-General (NSW)* (2003) 57 NSWLR 193 at 199 where the juristic nature of an inquest was described as a '*hybrid process*' containing both adversarial and inquisitorial elements.
[13] *Plover v McIndoe* (2000) 2 VR 385 at [19] per Balmford, J.
[14] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625.
[15] *Doomadgee v Clements* [2005] QSC 357 at [35].

18. It is generally accepted that the civil standard of proof applies in coronial investigations in relation to factual findings that are to be made. However, the '*clarity*' of the proof required (or the degree of satisfaction called for by application of the civil standard) may vary according to the '*gravity*' of the factual matter to be determined.[16] A Coroner must apply the civil standard in a way that is '*appropriate to the gravity of the allegations*' made against a person; if a finding may have an '*extremely deleterious effect*' upon a person's character, reputation or employment prospects, that circumstance will generally demand '*a weight of evidence that is commensurate with the gravity of the allegations*'.[17]

19. A Coroner is not required to exclude every possibility, but rather to establish, if possible, what is more likely to have occurred upon findings '*reasonably supported by the evidence*'.[18]

20. It is also clear that a Coroner is obliged to comply with common law rules of natural justice and act judicially.[19] Coroners must afford procedural fairness to parties that appear at an Inquest.[20]

The Issues

21. The following list of issues were proposed at the PIC undertaken on 30 June 2023:

    1. The findings required by s 45(2) of the *Coroners Act* 2003 – the identity of the deceased person, when, where and how she died and the cause of her death;

    2. The appropriateness of the treatment and care Ms Campbell received during her admission to the Mental Health Unit at Logan Hospital between 18 and 30 April 2019; and

[16] See *Briginshaw v. Briginshaw* (1938) 60 CLR 336 at p 362 per Dixon J, as qualified by *Rejfek v. McElroy* (1965) 112 CLR 517.
[17] *Anderson v Blashki* [1993] 2 V.R. 89 at 96-97 per Gobbo J.
[18] *Hurley v Clements & Ors* [2009] QCA 167 at [16].
[19] *Harmsworth v State Coroner* [1989] VR 989 at 994.
[20] *Annetts v McCann* (1990) 65 ALJR 167 at 168; *Danne v Coroner* [2012] VSC 454, [21]; *Victoria Police Special Operations Group Operators 16, 34, 41 and 64 v Coroners Court of Victoria* (2013) 42 VR 1, [36]; [2013] VSC 246.

3. The adequacy of steps that have been taken to assess and address ligature risks at the Logan Hospital's Mental Health Ward.

22. The parties were provided the opportunity to make submissions on the proposed issues, as follows:

    a. On behalf of MSHHS, submissions were received on 27 July 2023, which endorsed the proposed issues.

    b. No submissions were received on behalf of Ms Rachel Noh.

The Evidence

23. A large bundle of exhibits were tendered into evidence, comprising documents numbered A1-A4, B1-B22.8, C1-C4.1, D1-D5 and E1-E10.

24. The following persons were called as witnesses to give oral evidence at the Inquest. All, save for independent expert Dr Reddan, were employees of MSHHS:

    a. Dr Nirosha Jayawardena, Consultant Psychiatrist.

    b. Dr Samuel Dal Pra, Psychiatry Registrar.

    c. Ms Lorna Ann Graham, Registered Nurse.

    d. Ms Rachel Noh, Registered Nurse.

    e. Dr Jill Reddan, Consultant Psychiatrist.

    f. Dr Balaji Motamarri, Director, Medical Services.

    g. Ms Teresa Burgess, Nursing Director.

    h. Mr Kieran Kinsella, Executive Director.

25. The parties were provided the opportunity to make submissions on the proposed witnesses, as follows:

    a. On behalf of MSHHS, submissions were received on 27 July 2023, which endorsed the proposed witnesses with the addition of two further witnesses, who held executive positions at the MetroSouth Health and Addiction and Mental Health Service (MSAMHS) and who could give evidence on issues 2 and 3. Dr Motamarri and Ms Hipper were

subsequently added; the latter of whom was subsequently replaced by Mr Kinsella. Ms Burgess who provided a statement on 22 February 2024 addressing issue 3, was also added.[21]

b. No submissions were received on behalf of Ms Rachel Noh.

26. The following is a summary of the relevant facts, circumstances and opinions in evidence at the Inquest. I am indebted to Counsel Assisting for her comprehensive submissions in this respect which have largely been adopted.

Ms Campbell's background.

27. Ms Campbell had "*a known and well-documented prejudicial upbringing. Including significant psychological trauma and disordered attachment*"[22] and a history of substance abuse (alcohol and THC[23]) and depression. Ms Campbell was a transgender woman. She was assigned male at birth and given a male name.[24]

28. Ms Campbell had long standing mental health diagnoses including complex post-traumatic stress disorder, major depressive disorder, borderline personality disorder and an eating disorder (unspecified).[25] Ms Campbell also had a long history of suicidal ideation and attempts and self-harm.[26] Her baseline mental state included chronic suicidal ideation.[27]

29. Ms Campbell was historically well engaged with mental health services. This was also the case at the time of her death and in the preceding months.

30. Ms Campbell's initial contact with mental health services was in 2003 when she was admitted to Toowoomba Hospital (TH) after a suicide attempt at age 17. Ms Campbell had at least 28 inpatient psychiatric admissions to either TH (at least 21 admissions between 2003 and January 2018) or LH (seven admissions between May 2018 and April 2019).[28]

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[21] Exhibit B22.
[22] Exhibit B5 Dr Jayawardena [6].
[23] Delta-9- tetrahydrocannabinol.
[24] Exhibit B13 Dr Taylor [6].
[25] Statement of Dr Jayawardena dated 12 August 2020 Exhibit B5 at [7]; Dr Jayawardena oral evidence, transcript day 1, 31 October 2023 (**T1**), p9 line 39 – p10 line 4; Exhibit B14 Dr Dal Pra [7]; Exhibit B13 Dr Taylor [6].
[26] Exhibit B5 Dr Jayawardena [8].
[27] Dr Jayawardena oral evidence, T1, pp14, 17.
[28] Exhibit B5 Dr Jayawardena [8]; Exhibit B13 Dr Taylor [7].

31. Ms Campbell was at times a voluntary patient and at times an involuntary patient under the MHA.[29]

32. On 28 June 2018, Ms Campbell was made subject to a TA (inpatient category). Although the category of the TA was either inpatient or community depending on where Ms Campbell was at any point in time, the TA remained in place until and at the time of Ms Campbell's death.[30]

33. Between May 2018 and April 2019, when not an inpatient, Ms Campbell was referred to and under the care of the Logan Mood Continuing Care Team, Beenleigh Adult Mental Health Service (the Logan Mood Team).[31]

34. Ms Campbell appears to have been well-engaged with the Logan Mood Team as an outpatient.[32]

35. In June 2018, the Logan Mood Team developed an acute management plan (AMP) to guide decision making around when admission to a mental health inpatient unit was appropriate for Ms Campbell.[33] The AMP was updated on 12 December 2018.[34]

36. As described by Dr Jayawardena in oral evidence, an AMP:

> … *is something that we usually do for someone who has frequent presentations and having a diagnosis like complex PTSD, borderline personality disorder. There can be frequent presentations to ED* [emergency department] *but what's a consequence is we need to admit and then provide reassurance and have a plan with a community team and discharge. That's mainly documented in that plan*.[35]

37. With respect to the utility of AMP's in managing patients with diagnoses such as borderline personality disorder who present to the ED frequently, Dr Jayawardena noted:

> *Here, the patients with – especially with borderline personality disorder and complex PTSD; because of their symptomatology with poor emotional*

[29] Exhibit B5 Dr Jayawardena [8].
[30] TA 29 June 2019 Exhibit C2.5; TA amendment 19 April 2019 Exhibit C2.12, p 19.
[31] Exhibit C2.4, p142; Exhibit B13 Dr Taylor [5].
[32] Exhibit B13 Dr Taylor [6], [9]; Exhibit B10 Readett [5]-[109]
[33] AMP 15 June 2018: Exhibit C2.4, p74.
[34] AMP 12 December 2018: Exhibit C2.4, p309.
[35] T1, p11, lines 33-38.

regulation and poor distress tolerance, they frequently present to ED for – in crisis for admission. So when we're managing borderline personality disorder and complex – complex post-traumatic stress disorder, it is not always therapeutic to them to get admission to inpatient units, because in one way, the – it is difficult for them to learn coping strategies in the community if they are admitted all the time when they presented to the ED – emergency department. Sometimes, what happens is, they were assessed, and by the time the assessment happens, they – they were – they were able to self-regulate themself, and then they may not anymore appear to suicidal, and they can send – they can go back to the community for the community treatment. But – so it's some – in – in the ED, and when they assess not from their usual treatment teams – community or inpatient – it will be difficult someone to make an assessment for the first time if they seeing this patient if they don't know the patient, and it's sort of like a guideline– guidelines, and it's prepared by the community team, which occasions that they should consider admissions, and which occasions they should commit – consider send them back home for community management.[36]

38. On the morning of 18 April 2019, Ms Campbell called the Logan Mood Team intake service and reported ceasing her medication five days earlier and experiencing increased auditory hallucinations and thoughts to harm herself. The duty intake officer asked Ms Campbell to attend the ED.[37] In a progress note made at 10.38 am, Ms Campbell's interim case manager documented a follow up call to Ms Campbell in which she said she planned to organise transport to the hospital.[38]

Admission to Logan Hospital 18 to 29 April 2019

39. Ms Campbell attended the ED at the LH on 18 April 2019. She was reviewed by an ED Registrar, Dr Bradley Brennan, who made an entry in the progress notes at 12.01 pm documenting a comprehensive review.[39] Dr Brennan noted that Ms Campbell had presented following referral from her case manager with suicidal ideation and auditory hallucinations. She had self-harmed by dropping furniture

[36] T1, p16 lines 6-23.
[37] Exhibit C2.12, p1; Exhibit C2.4 p501.
[38] Exhibit C2.12, p4.
[39] Exhibit C2.2, pp141-143.

on her foot. The plan was to make a Recommendation for Assessment given Ms Campbell's active plans for and risk of suicide.[40]

40. At 12.25 pm, Dr Brennan made a Recommendation for Assessment under the MHA[41] authorising Ms Campbell's detention for assessment, because she was "*at risk of harm to self; needs formal mental health review*".[42] At 12.37 pm, the ED Registrar documented that Ms Campbell was "*under recommendation*", had been referred to mental health and was awaiting review.[43]

41. Ms Campbell was triaged by a registered nurse with Mental Health Services that afternoon.[44] She stated that she had not taken medications for weeks.[45] The action plan resulting from the comprehensive assessment was that Ms Campbell was to be reviewed by a registrar and was for possible admission to the Mental Health Unit.[46]

42. On 18 April 2019, Ms Campbell was medically reviewed by a psychiatric registrar in the ED, Dr Sweta Lal, who made an entry in the progress notes at 11.13 pm.[47] Ms Campbell was noted to meet the criteria for crisis admission in the AMP. Dr Lal documented that Ms Campbell's admission should be continued under the Recommendation for Assessment and that her PRN[48] medication should remain as charted.[49]

43. Dr Lal made a comprehensive note in the Mental Health Service progress notes (as distinct to the ED progress notes) at 6.02 am on 19 April 2019.[50] Dr Lal documented that Ms Campbell was presenting as an acute increased risk to self and was at "*increased vulnerability risk due to restricting behaviours*". She was assessed as "*meeting criteria for admission: 1. non-compliant with medications, not accepting medications in the ED 2. voices suicidal ideation with intent and plan, and is unable to guarantee her safety, is socially withdrawn – ongoing intent and plan*". The plan was reiterated as:

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[40] Exhibit C2.2, p144.
[41] MHA, s39.
[42] Exhibit C2.12, p14.
[43] Exhibit C2.2, p141.
[44] Exhibit C2.12, pp6-13.
[45] Exhibit C2.12, pp7, 13.
[46] Exhibit C2.12, p13.
[47] Exhibit C2.2, pp136-137.
[48] Administer medications as required.
[49] Exhibit C2.2, p137.
[50] Exhibit C2.4, pp500-501.

- crisis admission as per AMP.
- continue R+A as enacted by ED.
- PRN's as charted.
- as per d/w on call Consultant Psychiatrist Dr Beckmann.

44. Details of the medications Ms Campbell was prescribed in the community are listed in the notes made by the ED Registrar[51] and in the notes made by Dr Lal.[52]

45. Dr Lal documented that Ms Campbell was experiencing ongoing pseudo-hallucinations at admission.[53] In evidence at the Inquest hearing, Dr Jayawardena explained that Ms Campbell was not experiencing symptoms of psychosis, but rather, that her pseudo-hallucinations were consistent with her having borderline personality disorder and post-traumatic stress disorder.[54] Dr Jayawardena explained the distinction between a pseudo-hallucination and a delusion arising from a psychosis:

> … *people … with psychosis experience things that usually other people won't experience so that means they can hear voices when there is nobody there and can appear paranoid without any obvious reason. That … may be due to a chemical imbalance in your brain. Pseudo hallucinations, those have two psychotic symptoms but people who have like a complex trauma history like Chloe and also having a borderline personality disorder, in their symptomatology, they can hear voices but those things are not truly coming from outside as in a psychotic patient. It is mainly that they are hearing their internal monologues*.[55]

46. On 19 April 2019 at around 12.25 am, during 15-minute observations, Ms Campbell was found on the floor of the ED with oxygen tubing wrapped around her neck. The progress notes indicate that Ms Campbell was awake and pink in colour when found, that the tubing cord was cut, medical assistance obtained, and observations conducted.[56] The notes indicate that a Riskman entry was made and that Ms Campbell had continual observations conducted by way of a

[51] Exhibit C2.2, p143.
[52] Exhibit C2.12 p2; T1 p3-6.
[53] Exhibit C2.12, p3.
[54] T1, p13 lines 6-9; Exhibit B14 Dr Dal Pra [20], [21].
[55] T1, p12 lines 38-46.
[56] Exhibit C2.2, p135-136, 139.

nursing special.[57] Following medical review the decision was made to transfer her to the Mental Health Unit.[58]

47. On 19 April 2019 at 9.03 am, Ms Campbell's TA was changed to inpatient category.[59]

48. On 19 April 2019 at 11.30 am, Ms Campbell was admitted to Ward 2C in the Mental Health Unit.[60]

49. Dr Jayawardena reviewed Ms Campbell on 24 April 2019 while she was admitted to Ward 2C.

50. Dr Jayawardena was the Consultant Psychiatrist working in Ward 2J, a women's only ward suitable for vulnerable female patients.[61] She had worked in that role since February 2018.[62] At the time of the review, Dr Jayawardena expected that Ms Campbell would become her patient when a bed became available in Ward 2J.[63] Ms Campbell had been admitted to Ward 2J on previous admissions to the Mental Health Unit.[64] Dr Jayawardena knew Ms Campbell from previous admissions to Ward 2J.[65]

51. In her statement, Dr Jayawardena noted that on review, Ms Campbell's "*mental state was not dissimilar to her previous presentations to the hospital and the pattern was similar – Ms Campbell having self-ceased her medication and restricted her eating. No clear trigger was identified; she had suicidal intention with no plan and intent*".[66]

52. In oral evidence, Dr Jayawardena clarified that this represented a change in presentation from admission. On admission Ms Campbell expressed clear suicidal intent and on 19 April 2019, Ms Campbell had attempted to choke herself with oxygen tubing in the ED. However, by the time Dr Jayawardena reviewed Ms Campbell on 24 April 2019, her intention to act on the suicidal ideation had reduced and Ms Campbell was "*closer to her baseline chronic suicidal*

[57] Exhibit C2.2, p 138.
[58] Exhibit B5, Dr Jayawardena [11].
[59] Exhibit C2.12, p19-21.
[60] Exhibit C2.2 p308-310; Exhibit B14, Dr Dal Pra [12].
[61] T1, p9 lines 9 to 19.
[62] T1, p10 lines 26-33.
[63] T1, p13 lines15-16.
[64] T1, p10 lines 26-43.
[65] T1, p10 lines 26-33.
[66] Exhibit B5, Dr Jayawardena [13].

ideation";[67] "*she had chronic suicidal ideation but she did not mention any plan or intent. Our main concern was her poor oral intake at that time*".[68]

53. Given the remaining concerns regarding Ms Campbell's oral intake, in circumstances where Ms Campbell "*has a history of significant physical deterioration when she restricts her intake*" a plan was made for Ms Campbell to be reviewed by a dietician for a nasogastric tube (NGT) to be inserted.[69] In oral evidence, Dr Jayawardena clarified that the decision to have a NGT inserted was consented to by Ms Campbell.[70]

54. Ms Campbell was subject to a TA. No limited community treatment (LCT) was authorised "*due to risk of physical deterioration due to eating disorder*", meaning that she was not authorised to leave the unit. Ms Campbell agreed to comply with her medication regime. She was placed on 15-minute visual observations and a decision was made to transfer her to ward 2J.[71]

55. In the first week of her admission, Ms Campbell was "*intermittently compliant with her prescribed meal plan*" and required occasional feeds via a NGT.[72]

56. Ms Campbell was transferred to Ward 2J on 26 April 2019 when a bed became available.[73] A note in a risk screening tool dated 26 April 2019 records that Ms Campbell "*is currently quite settled on the ward and compliant with meal plan*".[74] Between 26 April 2019 and her death, Ms Campbell was fully compliant with her meal plan and had no NGT feeds.[75]

57. Between 20 April 2019 and 29 April 2019, Ms Campbell remained on 15-minute observations with no LCT.[76] During that time, she did not demonstrate any self-harming behaviours or make any suicide attempts.[77]

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[67] T1, p17, lines 39-44.
[68] T1, p13 lines 18-23.
[69] Exhibit B5, Dr Jayawardena [13].
[70] T1, p14 line 9.
[71] Exhibit B5 Dr Jayawardena [13].
[72] Exhibit B5 Dr Jayawardena [16]; Risk Screening Tool 26 April 2019 C2.4 pp519-522 and Care Plan 26 April 2019 Exhibit C2.4, pp523-525.
[73] T1, p8 lines 45-46.
[74] Exhibit C2.4, p521.
[75] Exhibit B5 Dr Jayawardena [16]; Risk Screening Tool 26 April 2019 Exhibit C2.4, pp519-522 and Care Plan 26 April 2019 Exhibit C2.4, pp523-525.
[76] Exhibit B5 Dr Jayawardena [14].
[77] Exhibit B5 Dr Jayawardena [15].

Events of 29 April 2019

58. On 29 April 2019, Dr Jayawardena attended the morning handover meeting. Ms Campbell was settled, complying with her meal plan, and no significant concerns were raised by the nursing staff.[78][79]

59. Between 11.00 am and 12.00 pm, psychiatric registrar Dr Dal Pra was approached by nursing staff and advised that Ms Campbell wished to access temporary leave from the ward. He reviewed Ms Campbell at around midday. Ms Campbell sought to access up to an hour's leave from the inpatient unit so that she could smoke cigarettes. It was the first time Dr Dal Pra had seen Ms Campbell during this admission, however Ms Campbell was known to him from previous admissions.[80]

60. Having assessed Ms Campbell and her mental state, and her progress notes on iEMR[81] and CIMHA[82], Dr Dal Pra authorised Ms Campbell to access 30 minutes of LCT twice a day, and commensurately decreased her level of visual observations from 15 minutely to hourly.[83]

61. After making the decision regarding Ms Campbell's leave and observations, and after Ms Campbell accessed the leave, Dr Dal Pra discussed this plan with Dr Jayawardena.[84]

62. It is unclear at what time Ms Campbell accessed the leave on 29 April 2019, because the relevant paperwork is now unable to be located. Notwithstanding this, it is uncontroversial that Ms Campbell accessed unescorted leave and returned to the ward without issue.[85] Thereafter she remained on hourly visual observations.

63. RN Noh was rostered as the Nurse in Charge on the 2.30 pm to 11.00 pm afternoon shift on Ward 2J.[86] RN Noh knew Ms Campbell from previous

[78] Exhibit B5 Dr Jayawardena [17]-[19].
[79] The NGT nevertheless remined in-situ in the event Ms Campbell's oral intake deteriorated and again required dietary supplementation: T1, p18, lines 18-23.
[80] Exhibit B14 Dr Dal Pra [10], [16], [17], [19].
[81] Integrated Electronic Medical Record.
[82] Consumer Integrated Mental Health and Addiction record.
[83] Exhibit B14 Dr Dal Pra [18]-[20], [23]-[27].
[84] Exhibit B14 Dr Dal Pra [18]-[19], [23]-[27].
[85] Exhibit B14 Dr Dal Pra [25].
[86] Exhibit B8 RN Noh [10].

admissions to the Mental Health Unit.[87] RN Noh allocated Ms Campbell's care to Enrolled Nurse (EN) Arianne Krenske and the visual observations to RN Graham.[88]

64. At around 5.30 pm, Ms Campbell ate a meal. At approximately 6.15 pm, RN Graham says that Ms Campbell voiced suicidal ideations to EN Krenske. RN Noh was notified (as the team leader) and Ms Campbell was given 2 mg Lorazepam at 6.51 pm.[89]

65. After been given the PRN Lorazepam, RN Noh invited Ms Campbell to sit with RN Graham in the common area "*if she was concerned about the suicidal ideations*", which invitation Ms Campbell accepted.[90]

66. RN Graham reports that Ms Campbell coloured in an activity book while other patients were playing a board game at the same table. After some time, Ms Campbell appeared sleepy. She did not express any intent to self-harm or suicidal ideation. RN Graham walked Ms Campbell back to her room and asked her if she would like her to stay until she fell asleep, which offer Ms Campbell declined.[91]

67. At approximately 8.40 pm on 29 April 2019, Ms Campbell requested Panadol for a headache from RN Graham, which request was declined as she had received same at 5.58 pm.[92]

68. Because RN Graham was sitting with patients at 9.00 pm, RN Noh decided to attend to the visual observations so as not to interrupt RN Graham.[93]

69. At 9.00 pm on 29 April 2019, RN Noh commenced visual observations in the 10-bed ward, starting with beds 6 to 10, then 1 to 5 – Ms Campbell was in bed 5. The light was off in Ms Campbell's room. RN Noh reports that it looked to her as though Ms Campbell was standing against the bathroom door. RN Noh turned

[87] Exhibit B8 RN Noh [7].
[88] Exhibit B8 RN Noh [12].
[89] Exhibit C2.2, p888; Exhibit B8 RN Noh [18].
[90] Exhibit B2 Dr Estensen [18], [19].
[91] Exhibit B4 RN Graham [5].
[92] Exhibit C2.2, p254.
[93] Exhibit B8 RN Noh [21].

on the light and saw that Ms Campbell was hanging at standing height with the bedsheet wrapped around her neck and swung over the bathroom door.[94]

70. On discovering Ms Campbell, RN Noh called for help, initiated a Code Blue/MET call at 9.08 pm and activated the duress alarm.[95]

71. RN Orlando Ferrer and RN Lorna Graham attended immediately and untied the bed sheet and the NGT, which was under the bed sheet. RN Ferrer and RN Graham moved Ms Campbell to the bed, cleared her airway and commenced cardiopulmonary resuscitation (CPR). Ms Campbell was unresponsive and pulseless. EN Krenske brought the emergency trolley and placed a bag valve mask on Ms Campbell while CPR continued.[96]

72. The Code Blue team arrived at 9.12 pm (including the Intensive Care Unit (ICU) registrar and ED registrar, as was standard[97]), with CPR in progress. Defibrillation pads were applied and intravenous access was gained. Resuscitation was continued, adrenaline was given, and Ms Campbell was intubated. Return of spontaneous circulation (ROSC) was noted at approximately 9.18 pm, with a palpable femoral pulse, heart rate of 140, and very low blood pressure of 67/32. Ms Campbell was urgently transferred to the ICU.[98]

73. Ms Campbell was admitted to the ICU on 29 April 2019 at 9.53 pm, under the care of ICU Staff Specialist Dr Estensen.[99] Dr Estensen reports that:

> *From the timeline of events and history obtained we determined that Chloe may have had up to 10 minutes of "downtime" prior to her being discovered and then approximately 10 minutes of CPR/ resuscitation before ROSC could be achieved. So, a total of 20 minutes where the circulation had ceased or was insufficient. This is very important in assessing and treating this type of injury as by "downtime" we mean the period of time elapsed where the circulation has ceased and there is a lack of oxygen/nutrients delivered to the brain and organs*.[100]

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[94] Exhibit B8 RN Noh [22].
[95] Exhibit B8 RN Noh [23]; Exhibit C2.2, pp 254, 257.
[96] Exhibit B8 RN Noh [23], [24], Exhibit C2.2, p254; Exhibit B4 RN Graham [6], Exhibit C2.2, p257; Exhibit B3 Ferrer [12]; Exhibit C2.2, p257.
[97] Exhibit B2 Dr Estensen [5], [7].
[98] Exhibit B2 Dr Estensen B2 [9]; Exhibit C2.2 ICU notes, pp244-260.
[99] Exhibit C2.2, pp 254, 257; Exhibit B2 Dr Estensen [5], [7].
[100] Exhibit B2 Dr Estensen [9].

74. Once in the ICU, Ms Campbell was placed on a ventilator and an arterial line, central venous line, indwelling catheter and other access devices were placed. Investigations proceeded including a radiology investigations and pathology tests.[101]

75. Four unsuccessful attempts were made to contact Ms Campbell's next of kin between the psychiatric, ICU and medical registrars.[102]

Events of 30 April 2019

76. Dr Estensen examined Ms Campbell the morning of 30 April 2019, at 8.30 am and 11.00 am. At the 11 am assessment, when Ms Campbell was neurologically assessed absent the effect of sedating medications, Ms Campbell was afebrile and was given a Glasgow Coma Scale score of 3/15.[103]

77. The Nurse Unit Manager (NUM) of ward 2J documented that efforts were made to contact Ms Campbell's next of kin by phone, text message and email. At 10.30 am on 30 April 2019, Ms Campbell's cousin Shane called the NUM and was advised that Ms Campbell was in the ICU.[104]

78. At 12.44 pm on 30 April 2019, a scan of Ms Campbell's brain was conducted which was interpreted to mean that Ms Campbell had sustained a hypoxic brain injury post hanging and subsequent cardiac arrest requiring resuscitation.[105]

79. Dr Estensen reports that as a result of her clinical examination and the CT scan, she "*felt strongly that Chloe would not survive even with all available ICU treatments*".[106] Dr Estensen reports that "*Chloe's prognosis was particularly poor given her clinical neurological examination and investigations in the context of her hanging injury / suicide attempt*".[107]

80. Between approximately 6.30 pm to 6.45 pm on 30 April 2019, Ms Campbell became haemodynamically unstable, and her family were advised that she was progressing towards death despite all supportive treatments.[108] Ms Campbell

[101] Exhibit B2 Dr Estensen [10].
[102] Exhibit B2 Dr Estensen [10].
[103] Exhibit B2 Dr Estensen [11].
[104] Exhibit C2.2, pp250-251.
[105] Exhibit B2 Dr Estensen [12], [13]; Exhibit C2.2, p886.
[106] Exhibit B2 Dr Estensen [15].
[107] Exhibit B2 Dr Estensen [16].
[108] Exhibit B2 Dr Estensen [18].

became unsupportable in the ICU and Fentanyl was administered to prevent any distress as she died.[109]

81. Ms Campbell died at 9.28 pm on 30 April 2019, in bed 6 at the LH ICU.[110]

Following Ms Campbell's death

82. Ms Campbell's death was reported to the Queensland Police Service by ICU physician, Dr Alanna Platz at about 10.00 pm on 30 April 2019, as a suspected suicide.[111]

83. The door that Ms Campbell used to create a ligature point was removed the day of her death.[112]

84. Dr Nathan Milne, the Forensic Pathologist who conducted the autopsy and produced the autopsy report, opined that the cause of Ms Campbell's death was:

    1(a) Hypoxic-ischaemic encephalopathy, *due to or as a consequence of;*

    1(b) Hanging.[113]

85. The conclusion regarding cause of death drawn by Dr Milne is consistent with that drawn by Dr Estensen, that the cause of Ms Campbell's death was a hypoxic brain injury secondary to hypoxic cardiac arrest in the setting of a hanging injury (suicide attempt).[114]

86. Ms Campbell's death was categorised as a suspected suicide and a reportable death by MSHHS under the *Hospital and Health Boards Act* 2011, and a Root Cause Analysis was commissioned (RCA). The RCA report is in evidence.[115] The RCA Report identified that the AMP for Ms Campbell was competent and comprehensive. The RCA report identifies high level opportunities for improvements in areas relating to:

    a. The desirability for all nursing staff working in mental health units to have specific mental health backgrounds;

[109] Exhibit B2 Dr Estensen [19]; Exhibit C2.2, pp244-260.
[110] Exhibit B2 Dr Estensen [19]; Exhibit C2.2, pp244-260.
[111] Exhibit A1, p6.
[112] Exhibit B22 Teresa Burgess [23].
[113] Exhibit A2 Autopsy report 6 August 2019.
[114] Exhibit B2 Dr Estensen [20].
[115] Exhibit C1.

b. Shortages of the availability of diversionary therapies available in the inpatient setting; and

c. That better awareness and education regarding Borderline Personality Disorder and gender dysphoria for clinical staff in inpatient units was required.[116]

87. A note was found in circumstances that are unclear.[117] The note has been interpreted in the course of the investigation to be a suicide note left by Ms Campbell.[118]

Expert evidence

88. Consultant Psychiatrist Dr Jill Reddan was engaged by the Coroners Court of Queensland to provide expert opinion evidence. Dr Reddan has provided five reports dated 2 April 2021, 25 September 2022, 3 April 2023, 20 October 2023 and 23 February 2024, exhibits D1 through D5 respectively.

89. In her report of 2 April 2021, Dr Reddan opines that of the diagnoses Ms Campbell had been given over the years, "*the most relevant appear to have been Borderline Personality Disorder (sometimes referred to as "complex PTSD"), Gender Dysphoria, an Eating Disorder (which appears to have mostly presented as Anorexia Nervosa) and a Substance Use Disorder with abuse at times of alcohol and cannabis*".[119]

90. Dr Reddan set out the features of borderline personality disorder in oral evidence:

> … *the core features of a borderline personality disorder, and that's instability of mood, an inner sense of emptiness, usually unstable interpersonal relationships, sensitivity to real or perceived abandonment … identity diffusion or confusion, which is a difficult thing to explain, but when you see people and talk with them, you – you get a sense of it. … And various forms of anxiety, but also the use of primitive if – and very immature psychological defence mechanisms. One could see the gender dysphoria*

[116] Exhibit C1, pp4-6.
[117] Exhibit A1, p10 "… *the initial location of the note was unable to be confirmed, and it was not yet ascertained how the deceased obtained the paper or pen*". Exhibit A1 p13 "*Note located with deceased* …".
[118] Exhibit A4.
[119] Exhibit D1, p5.

in this case as perhaps being part of the identity diffusion. … It's also – the eating problems are also part of that as well, and part of forms of anxiety as well. So there's a lot of symptoms here. And often, patients with borderline personality are either chronically self-harming or chronically suicidal, and the two are not the same, but that's often part of trying to resolve their identity diffusion and often uncomfortable feelings, their mood instability, and their difficulties interpersonally. The aim of treatment is always to try and get these patients to stand outside their immediate feelings – – – … and their immediate desires to act them out, and that's one of the difficulties of treating them.[120]

91. With respect to issue 2, the appropriateness of the treatment and care Ms Campbell received during her admission to the Mental Health Unit at LH between 18 and 30 April 2019, Dr Reddan was asked to provide opinions as to:

    a. The appropriateness of the suicide and risk assessments conducted of Ms Campbell;

    b. Whether the level of observations of Ms Campbell during her admission were appropriate in light of her presentation and history;

    c. Any comment regarding the appropriateness of the medications given to Ms Campbell; and

    d. Any comment regarding the care and treatment of Ms Campbell during her admission and more generally.

92. Dr Reddan opined that the suicide assessments and risk assessment conducted on Ms Campbell during her admissions 19 to 30 April 2024 were reasonably appropriate.[121] In oral evidence Dr Reddan stressed her view as expressed in her report of 2 April 2019 that risk assessments are not risk predictions.[122] Risk assessments are not a standalone exercise, and their utility lies in guiding management.[123]

93. Dr Reddan opined that the level of observations conducted on Ms Campbell during her admission were appropriate in the light of her presentation and

[120] T day 3, 28 February 2024, p9 lines 5-25.
[121] Exhibit D1, p3 [2].
[122] Exhibit D1, p3; T3, p5 lines 28-31.
[123] T3, p6 lines 1-3.

history.[124] Dr Reddan opined that the change in the frequency of observations by the psychiatric registrar Dr Dal Pra following Ms Campbell's request for leave on 29 April 2019 was appropriate given her longitudinal history.[125] Dr Reddan went on to note that "*I think what Dr Dal Pra did was quite reasonable. He consulted with others. He looked at the notes*."[126]

94. In addition, Dr Reddan commented that it was clear that the staff were talking with Ms Campbell regularly;[127] *"… that in fact the staff were having more interactions with her than merely one hourly, particularly that evening*".[128] That while observations are useful "*it's more important that staff actually talk with patients … a therapeutic alliance is a major part of risk management*".[129]

95. Dr Reddan raised some concerns with respect to the medications given to Ms Campbell during her April 2019 admission and more generally in relation to those with borderline personality disorder. Dr Reddan reports that the evidence base for the use of psychotropic medication to treat borderline personality disorder is mixed – notwithstanding that it is a common practice. Dr Reddan notes that the prescription of an antidepressant such as a selective serotonin reuptake inhibitor with an antipsychotic such as Quetiapine "*can be justified in many cases*".[130]

96. Dr Reddan raised concerns with the use of Lorazepam in the treatment of borderline personality disorder:

> *In my opinion, the use of PRN medication in this group of patients should generally be avoided. The difficulty is that the use of PRN medication is very much a part of the culture in psychiatric inpatient units. There is really no evidence of efficacy for PRN medication in Borderline Personality Disorder and it can undermine efforts to assist the patient to learn to manage uncomfortable emotions and anxiety and there is always a risk, depending on the medication used, of creating tolerance and dependency to the medication. There is also the risk of increasing drug-seeking behaviour and in increasing the externalisation of responsibility by the patient for his or her behaviour. It can send a message to a patient, that*

[124] Exhibit D1, p3-7 [3].
[125] T3, p6 lines 10 – p7 line 1.
[126] T3, p7 lines 25-26.
[127] T3, p8 lines 28 -31.
[128] Exhibit D1, p5; T3, p 6 lines 19-23.
[129] T3, p8 lines 6-13.
[130] Exhibit D1, pp7-8.

uncomfortable and dysphoric emotions cannot be tolerated and must be responded to chemically. It can send a message to a patient that he or she does not need to or cannot learn to manage uncomfortable emotional states thus undermining the more important treatment, namely psychotherapy and further undermining the patient's self-esteem. There is also the risk (although not observed in this particular case during that particular night), that staff will administer PRN medications rather than speaking with the patient and imply to the patient that his or her communications cannot be tolerated by the staff.[131]

97. Dr Reddan was clear that she did not draw any causal relationship between the management of Ms Campbell's medication and her death.[132]

98. In oral evidence Dr Reddan said that:

> *I have myself prescribed sometimes certain medications in people who are borderline personalities but I think that – I'm not saying what they did was unreasonable. There would be many of my colleagues who would do what they did. … So I think it's important for me to say that to a court … but I think it was – it's a mistake. … And I think we need a massive relook at use of PRN medications in psychiatric units generally*.[133]

99. And in the following exchange with Counsel Assisting:

> *So if I could just be clear, Dr Reddan, then, whilst you're not necessarily overly critical, even specifically critical of individual staff administering PRN? Not at all, no*.
>
> …
>
> *So I think, again, I can't say this is something that none of my colleagues would have done. That would not be fair or reasonable to say that. But I think we need to have a much bigger conversation about the use of PRNs generally*.[134]

[131] Exhibit D1, p8.
[132] T3, p 21 lines 28-33.
[133] T3, p15 line 49 – p16 line 9.
[134] T3, p 16 lines 23-45.

100. Dr Reddan also raised concerns about the use of inpatient mental health admissions for individuals with borderline personality disorder. In oral evidence Dr Reddan said that:

> *The evidence that inpatient care is particularly useful is actually poor. In fact, it can actually make them worse. … when I look at the management of this particular individual, and I think that what … would have been the word useful … would have been to try to break that nexus between I'm suicidal therefore I get admitted.*
>
> *…*
>
> *… this kind of management is very well meaning. I'm not saying it's wrong or that it wouldn't be what many of my colleagues would do. But I would regard this management and the support unsophisticated, really*.[135]

101. Dr Reddan clarified that her opinion was not that Ms Campbell should not have been admitted on this occasion,[136] but that where patients are chronically unstable and suicidal, as was Ms Campbell, a longitudinal approach that guides the patient towards "*actually doing some real psychotherapy*" can be very successful.[137]

102. With respect to the issue of ligature risks, in oral evidence Dr Reddan agreed that in around 2018, the risk mitigation approach at the health service was focused on the individual consumer and what observations and interventions were required, rather than on the built environment and undertaking capital works to remove identifiable ligature risks. Dr Reddan said:

> *That was acceptable and fairly standard then … from my recollection of those times. The other difficulty is staff have – that you've always got to balance up is it's pretty unpleasant to be in a place where you can't close a door. …And so you – you've got to balance up what's … competing considerations that – you – you don't also want to do things that actually might have the opposite effect of what you intend. In other words, unintended consequences. You don't want to make your services so unpleasant … that they actually worsen people, you know*.

[135] T3, p10 lines 20-43.
[136] T3, p12 lines 27-28
[137] T3, pp12-13.

…

And so … you've got to be careful you don't go so far another way that you turn … your service into, like, you're living in a glass box.

… And people are going to leave your facility eventually and go somewhere else where there's going to be ligature points.

So … removing them everywhere is going to be extremely difficult, but you've also got to weigh that up with actually treating people with some dignity … and some consideration to normal kind of feelings about privacy and – and for some people who've perhaps been abused in the past, that's a particularly anxiety-provoking thing is not having a door … in bathrooms, all that. So – but then you've got to look at how your doors are. Like, they – have they got the sloping tops and things? So there are other things you can do in terms of built environment, but you – you've got to keep watching for it, because sometimes people are amazingly inventive about where they find a ligature point.[138]

103. In relation to the use of the ensuite door as a ligature point in this matter, Dr Reddan said in oral evidence that the presence of the ensuite door in Ms Campbell's room was not causative; "*I don't think that in itself – it's not like it's an invitation*".[139]

104. Dr Reddan also addressed several matters of concern to the family in her reports and oral evidence, including with respect to what it means to provide the least restrictive involuntary care in circumstances where someone presents with chronic suicide ideation.

MSHHS response to issues

105. Dr Motamarri is a Consultant Psychiatrist employed by MSHHS as the Director of Medical Services, Mental Health Executive.[140] Dr Motamarri was not involved in Ms Campbell's care directly.[141]

[138] T3, p 25 line 35 – p26 line 34.
[139] T3, p26 lines 45-46.
[140] Exhibit B20 Dr Motamarri 25 October 2023 [1], [5].
[141] Exhibit B21 Dr Motamarri 27 September 2023 [8].

106. Dr Motamarri addressed the use of PRN medication and specifically PRN Lorazepam in statements and oral evidence.[142] Dr Motamarri noted that Lorazepam and similar medications are used in the inpatient mental health setting for behaviour management. Their use is "*directed towards alleviating or resolving the patient's anxiety and acute distress so that they can return to the community to continue or commence the appropriate therapies*". Dr Motamarri's view is that acutely distressed patients with PTSD and/or borderline personality disorder who require inpatient care are not receptive to therapy until their distress is stabilised.[143]

107. Dr Motamarri does not have a direct role in the ligature risk auditing of the mental health wards.[144] Dr Motamarri gave evidence that the risk represented ligature points in mental health inpatient settings is a universal issue in mental health care, and that "*it is recognised that the availability of 'obvious' ligature points increase the risk of a patient to act on an impulse of suicidal idea*tion". He further noted that:

> *While the aim is to remove all ligature points, the practicalities of maintaining an inpatient environment that respects the privacy and dignity of the patients, and the provision of activities of daily living, including nutrition, ventilation and hygiene, mean that it is not possible to remove all ligature risks*.[145]

108. In oral evidence, Dr Motamarri acknowledged he had listened to the oral evidence of Dr Reddan[146] and agreed regarding ligature risk management that no method is foolproof "*But there have been significant proactive measures, and that's where we stand at this stage*".[147]

109. In oral evidence, Dr Jayawardena provided an opinion as to the purpose or utility of each medication Ms Campbell was prescribed on admission (not by Dr Jayawardena, but not modified by Dr Jayawardena).[148]

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[142] Exhibit B21 Dr Motamarri 27 September 2023 [9] to [21]; Exhibit B20 Dr Motamarri 25 October 2023 [13]-[14].
[143] Exhibit B20 Dr Motamarri 25 October 2023 [13]-[14].
[144] Exhibit B20 Dr Motamarri 25 October 2023 [9].
[145] Exhibit B20 Dr Motamarri 25 October 2023 [10].
[146] With leave, there being no objection.
[147] T3, p39 lines 15-16.
[148] T1, p11 lines 33-38.

110. MSHHS provided an undated response to matters Dr Reddan raised in her report of 2 April 2021 under the hand of Kieran Kinsella, Executive Director, MSAMHS[149] Relevantly, that response annexed:

    a. MSAMHS - Ligature Risk Assessment Summary Report May 2019;[150]

    b. MSAMHS - Ligature Audit High Risk Action Plan as at 8 July 2019;[151]

    c. MSAMHS - Ligature Risk Audit 2021;[152] and

    d. Information regarding staff training about and awareness of borderline personality disorder.[153]

111. Mr Kinsella responded to Dr Reddan's concern that the RCA team did not comment on the usefulness of PRN lorazepam:

> … *the RCA team would like to confirm that they deeply considered the prescribing of Lorazepam for Ms Campbell. This was supported by the expert opinion of a senior Mental Health Pharmacist on the analysis team. Documentation within the report may have appeared limited as the team determined that the use of Lorazepam during her management was consistent with protocols such as the Mental Health Alcohol and Other Drugs Branch, Acute Behavioural Disturbance Management (including acute sedation) in Queensland Health Authorised Mental Health Services (adults) Guideline. It was also the clinical opinion of the analysis team that Lorazepam is very commonly used to treat anxiety, agitation and distress in patients with Bipolar Personality Disorder (BPD), and it was prescribed to Ms Campbell with appropriate monitoring of risk. The information in the RCA Report was appropriate for the intended audience and the RCA team recognise that a wider audience would require additional context and information. We will take this into consideration in future reports*.[154]

112. Further information was disclosed by MSHHS at the commencement of day 2 of Inquest in relation to issue 3, which ultimately resulted in an adjournment of the

[149] Exhibit E1.
[150] Exhibit E1.2.
[151] Exhibit E1.3.
[152] Exhibit E3.1.
[153] Exhibit E2, E2.1 - E2.7.
[154] Exhibit E1.

hearing to allow further enquiries to be made. The disclosed information included:

a. A ligature risk audit of Ward 2J dated 16 November 2015;[155] and

b. A ligature risk audit of Ward 2J dated 30 May 2018.[156]

113. The 2015 and 2018 audits conducted prior to Ms Campbell's death are difficult to interpret but appear to score the ensuite doors as presenting a higher risk than most other identifiable ligature points (only exceeded by beds and soap dispensers in 2015, and not exceeded by any other scored ligature points in 2018). On both audits, the identified recommended remedial action option was to "*locally manage*" the risk.

114. On 21 November 2023, MSHHS provided further documents in response to a Form 25 issued on 7 November 2023 seeking information on '*Any ligature risk summary report or mitigation or management plan produced in response to, separately, the 2015 ligature audit and the 2018 ligature audit*'. The effect of the response is that no specific local action plans were located that were responsive to the audits of ligature risks conducted in Ward 2J of LH on 16 November 2015 and 30 May 2018.

115. A number of forms and minutes of committee meetings were disclosed that map the progression of matters arising from the ligature audits.[157] Relevantly, it is noted in a "Risk identification and escalation form" dated 9 May 2018 that:

> *A statewide discussion is occurring regarding doors in inpatient units following a Coroner's report. Townsville have implemented doors that have a slope on the top. This is on the agenda for the next Adult Acute Operational Meeting*.[158]

116. Teresa Burgess, Nursing Director of MSAMHS at LH since 2018, provided a statement dated 21 February 2024 ahead of the resumed inquest hearing.[159] Ms Burgess also gave oral evidence at the inquest hearing on 28 February 2024.[160]

[155] Exhibit E9.2.
[156] Exhibit E9.3.
[157] Exhibit E9.4 – E9.18.
[158] Exhibit E9.4.
[159] Exhibit B22 [1], [5].
[160] T3, pp31-34.

117. Ms Burgess gave evidence that in her experience the nursing approach to managing ligature risks at the service had always been proactive. In addition to prioritising patient needs in matters such as bedroom placement the nursing approach included engaging with patients and building therapeutic alliances to mitigate risk.[161]

118. Ms Burgess agreed that there had been a change in approach to managing identified ligature points since she had been in the Nursing Director role that extended to making physical changes to the built environment with the assistance of the building and engineering department.[162]

119. Ms Burgess spoke to the need to balance patients' right to privacy against the desirability of removing ligature points such as bathroom doors. Ms Burgess said after Ms Campbell's death, she made the decision to have the ensuite doors in the single rooms in Wards 2J and 2K removed immediately.[163]

120. Mr Kinsella gave oral evidence to the effect that in 2019 and 2020 there was a "*a very robust process to follow through the outcome of the ligature audits*", and that "*the Office of the Chief Psychiatrist also reviewed the process of ligature risk assessment across the state*" which resulted in feedback and recommendations being returned to the health services in 2020.[164]

Guidelines and procedures

121. There are several documents in evidence – in addition to the clinical record - including several Queensland Health Guidelines and MSHHS specific procedures.

122. The most relevant of these documents to issues 2 and 3 are:

    a. MSAMHS Procedure "*Acute behavioural disturbance management within the Acute Adult Inpatient Units,* effective 17 August 2016";[165] and

[161] T3, p33 line 45 – p34 line 11.
[162] T3, p32 lines 23-43.
[163] T3, p33 lines 19-36.
[164] T3, p40 line 46 – p41 line 17.
[165] Exhibit E6.

b. Queensland Health Guideline "*Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (adults)*" 2017.[166]

123. This Procedure and Guideline provide that the use of PRN Benzodiazepine/Lorazepam is the second recommended step following the use of non-medication measures to deescalate a behaviourally disturbed adult, the aim being to "*calm with light sedation*".

124. It is noted in the Procedure:

> *Behavioural disturbance occurring in a non-psychosis context warrants the use of Benzodiazepines alone.*
>
> *Shorter acting Benzodiazepines (e.g., Lorazepam) are relatively safe options because they do not accumulate with repeated doses. Lorazepam is also the preferred option for the management of acute behavioural disturbance in older adults and patients with impaired liver function.*
>
> *Behavioural disturbance arising in the context of personality disorder should not be managed with medication unless there is an imminent risk of severe harm to self and others as there is a risk of encouraging reliance on substances to manage distress*.[167]

125. In relation to the ligature risks issues, the Queensland Health Guideline "*Managing Ligature Risks in Queensland public mental health alcohol and other drug inpatient units 2016*" is of particular relevance.[168] The ligature risk Guideline and included audit tool "*is a resource for Services to assist in undertaking regular assessments of ligature risks and inform the service response for the removal (where possible) or management of ligature risks*".

Coronial inquests and the management of ligature risks

126. On 5 February 2018, former Northern Coroner Kevin Priestly handed down the findings in the *Inquest into the deaths of Steven John Hitchins and Shawn Bradley Joseph Gudge* (the *Hitchins* and *Gudge* Inquest).[169] The *Hitchins* and

[166] Exhibit E8.
[167] Exhibit E6, p3.
[168] Exhibit E4.
[169] https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0017/553310/cif-hitchins-sj-gudge-sbj-20180205.pdf.

Gudge Inquest was concerned with the management of ligature risks and environmental hazards in inpatient mental health units.

127. The *Hitchins* and *Gudge* Inquest findings are likely the coronial findings that are referred to in the MSHHS material in May 2018 as the impetus for "*A statewide discussion … regarding doors in inpatient units"*.

128. The *Hitchins* and *Gudge* Inquest was concerned with two deaths of inpatients at the Townsville Hospital, inpatient mental health unit. Mr Hitchins died in the low dependency unit and Mr Gudge in the high dependency unit.

129. Mr Gudge died in circumstances similar to those in which Ms Campbell died. Mr Gudge used the sheet from his hospital bed secured in the ensuite door and wrapped around his neck to create a ligature to hang himself.

130. Dr Reddan provided expert opinion evidence at the *Hitchins* and *Gudge* Inquest. Relevant aspects of Dr Reddan's evidence are summarised in the findings at 19 and include that in her opinion, mental health services should be built with anti-ligature measures in the built environment, including walls, doors and doorways.[170]

131. In the analysis section of the findings, his Honour noted a concern that Mr Gudge was able to access a ligature point "*particularly given there are mechanisms and door designs that can decrease the risk of* [the bathroom door's] *use for this purpose*".[171]

132. His Honour sets out the landscape with respect to the management of environmental hazards in inpatient mental health settings in Queensland at the times of Mr Gudge's and Mr Hitchins' deaths (2015 and 2014, respectively).[172]

133. His Honour identifies that a report was published in 2005, *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events*. The report concerned the review of 23 inpatient suicides between 2002 and 2003 and identified a number of systemic issues. The report identified that '*in the prevention of suicide, important environmental issues include … access to the means of suicide such as hanging points and ligatures … in inpatient wards*'. The

[170] At 19.
[171] At 22.
[172] At 25-31.

report recommendations included that potential means of suicide be removed wherever possible, including by correcting potential structural factors in all inpatient mental health units and their immediate environment to.[173]

134. His Honour reports that in 2008, Queensland Health reported that in response to the *Achieving Balance* recommendations that it had commenced assessing the suitability of a utilising a standardised ligature risk audit tool throughout Queensland Health, and that statewide guidelines were being developed.

135. His Honour identifies that he was the Coroner in the Inquest into the death of Justin, in which findings were delivered on 2 July 2013.[174] Justin died in 2009 by choking on a bar of soap while an inpatient at Townsville Hospital Mental Health Unit.

136. In the *Hitchins* and *Gudge* Inquest findings, Coroner Priestly addressed the issue of environmental hazard management in mental health units at a systemic level, noting:

> *On reflection, the death of Justin should have put the broader issue of environmental hazard management back on the radar for Queensland Health. Did any other mental health units in Queensland learn from the experience at Townsville Mental Health Unit? If not, was there a system for statewide dissemination of lessons learnt and how effective was it?*[175]

137. His Honour identified that two Queensland Health guidelines have been introduced to address environmental hazards in inpatient units, the Ligature Risk Guideline 2016 (in evidence in this inquest at E4) and the Environmental Hazard Guidelines 2016 (E10).[176]

138. Coroner Priestly made the following recommendations:

> ***Recommendation 1***
>
> *I recommend Queensland Mental Health centralise within the State a body, with oversight from the Office of Chief Psychiatrist, tasked with the function of reviewing Findings in the inquest into the deaths of Steven John Hitchins and Shawn Bradley Joseph Gudge and reporting to Hospital and Health*

[173] At 26.
[174] https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/203030/cif-justin-20130702.pdf.
[175] At 28.
[176] At 31-32.

Services on lessons learnt and other opportunities for improvement through internal and external investigations (including RCA reports, Health Service Investigation Reports, Health Ombudsman Reports, Coronial findings and recommendations) as well as like reports from other States.

Recommendation 2

I recommend that the Office of the Chief Psychiatrist commission an independent, external audit and review of the extent to which each relevant Hospital and Health Service has implemented the Ligature and Environmental Guidelines as well as the effectiveness of that implementation. The results of that audit and review be shared with each Hospital and Health Service as well as any opportunities for improvement.[177]

139. A summary of Queensland Government responses to the *Hitchens* and *Gudge* inquest recommendations is published on the Coroner's Court website.[178]

140. In response to Recommendation 1, the following response is noted:

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded*:*

On 5 September 2018, the director-general approved the establishment of the Mental Health Alcohol and Other Drugs Quality Assurance Committee (MHAOD QAC), with oversight from the Office of the Chief Psychiatrist. The function of the MHAOD QAC relevant to this recommendation is to monitor and review qualitative and quantitative clinical and other information, including investigation documents (for example coronial reviews), as required, from relevant departments and entities to identify trends and system level improvements.

…

[177] At 34-35.
[178] https://www.justice.qld.gov.au/__data/assets/pdf_file/0008/587051/qgr-hitchens-sj-gudge-sb-20210713.pdf.

141. In response to Recommendation 2, the following response is noted:

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health is working with Hospital and Health Service (HHS) clinical governance units to review the effectiveness of the implementation of the guidelines Managing ligature risks in public Mental Health Alcohol and Other Drug inpatient services and Recognising and managing potential environmental hazards in Queensland public Mental Health Alcohol and Other Drug services.

…

Results of all HHS reviews will be aggregated by the Office of the Chief Psychiatrist and presented to the Mental Health Alcohol and Other Drugs Quality Assurance Committee (MHAOD QAC) to inform dissemination of lessons across Queensland Health mental health services.

The project reviewing the implementation of environmental safety guidelines within authorised mental health service inpatient units is undergoing final planning and will be tabled for approval by the MHAOD QAC. Subject to approval, the review process as described above will commence in late 2018.

On 2 June 2019 the Minister for Health and Minister for Ambulance Services responded:

Based on feedback gained from trial stakeholders, a revised methodology was developed for the statewide review into the effectiveness of the implementation of ligature and environmental safety guidelines.

Implementation of the review will commence once materials are refined. On completion, the findings will be collated by the Office of the Chief Psychiatrist and presented to the MHAOD QAC to inform dissemination of lessons across Queensland Health mental health services.

On 11 December 2019 the Minister for Health and Minister for Ambulance Services responded:

Following a trial of the review methodology, all support materials were approved by project sponsors. Three briefing sessions for stakeholders were held 4 – 8 March 2019, with the review commencing 11 March 2019.

A local review and report will be completed by each participating hospital and health service. Findings from all participating sites will be collated into one report for presentation to the Mental Health Alcohol and Other Drugs Quality Assurance Committee to inform dissemination of lessons and opportunities for improvement across Queensland Health's mental health alcohol and other drug services.

Determination

142. I accept the comprehensive submissions provided by Counsel Assisting following the Inquest and note that neither of the representatives for MSHHS and RN Noh disputed or made alternate submissions.

143. After careful analysis of the available evidence, I make the following findings in respect of the identified coronial issues.

Coronial Issue 1:

The findings required by s 45(2) of the Coroners Act 2003 – the identity of the deceased person, when, where and how she died and the cause of her death.

144. The following findings are uncontroversial:

a. The deceased is Chloe Jane Campbell;

b. Ms Campbell died in the ICU at LH after sustaining a hypoxic brain injury after a suicide attempt by hanging and subsequent cardiac arrest requiring resuscitation the previous evening. At the time she sustained the hanging injury, Ms Campbell was an inpatient at the MHU at the LH and was subject to a TA under the MHA. Ms Campbell received prompt attention from nursing staff, the Code Blue team and admission to the ICU and supportive treatment and care following the hanging injury. Notwithstanding the treatment and care provided, Ms Campbell

become haemodynamically unstable and unsupportable in the ICU, and Fentanyl was administered to prevent any distress as she died;

c. Ms Campbell died on 30 April 2019;

d. Ms Campbell died at the LH, Meadowbrook, in the State of Queensland;

e. Ms Campbell's death was caused by hypoxic-ischaemic encephalopathy, due to or as a consequence of hanging.

Coronial Issue 2:

The appropriateness of the treatment and care Ms Campbell received during her admission to the Mental Health Unit at Logan Hospital between 18 and 30 April 2019.

145. To clarify the facts assumed by issue 2, Ms Campbell presented to the LH ED on 18 April 2019 and was admitted to the MHU on 19 April 2019.

146. While issue 2 is focused on the treatment and care provided in the MHU, for completeness there is no suggestion on the evidence that the care provided to Ms Campbell in the ED on 18 and 19 April 2019 or in the ICU on 29 and 30 April 2019 was other than appropriate.

147. The effect of the evidence, including the expert evidence and responses to it, is that:

    a. The suicide and risk assessments conducted on Ms Campbell were reasonably appropriate;

    b. While inpatient admissions are of variable utility for a person with borderline personality disorder and chronic suicidal ideation, in Ms Campbell's case, there was an AMP in place that set out circumstances in which Ms Campbell's presentation would warrant a crisis admission – the circumstances in which Ms Campbell was admitted in April 2019 fit those criteria, which Dr Reddan accepted; and

    c. While psychopharmacological treatment for patients with borderline personality disorder is complicated, and Ms Campbell's case is no exception, it appears that there was a clinical basis for each of the medications Ms Campbell was prescribed in the community. The

prescribing and administering of PRN Lorazepam to Ms Campbell while she was an inpatient at the LH MHU was consistent with the MSAMHS Procedure: *Acute Behavioural Disturbance Management within the Acute Adult Inpatient Units*, effective 17 August 2016.[179]

148. I find that the treatment and care Ms Campbell received at LH between 18 and 30 April 2019, including during her admission to the MHU, was appropriate.

Coronial Issue 3:

The adequacy of steps that have been taken to assess and address ligature risks at the Logan Hospital's Mental Health Ward.

149. Issue 3 is concerned with (a) whether there were any opportunities to address ligature risks prior to Ms Campbell's death on 30 April 2019 and whether those opportunities were taken; and (b) whether there were any opportunities to address ligature risks after Ms Campbell's death on 30 April 2019 and whether those opportunities were taken.

Steps taken to address ligature risks prior to April 2019

150. In order to assess the reasonableness of the measures taken by MSHHS to assess and address ligature risks at the LH's MHU prior to Ms Campbell's death, it is necessary to have regard to the statewide approach to managing ligature risks at the relevant times. This is a space in which it appears that coronial findings have had some significant impact.

151. The Queensland Health Guideline, *Managing Ligature Risks in Queensland Public Mental Health Alcohol and Other Drug Inpatient Units 2016* was effective from 6 October 2016.

152. As at Ms Campbell's death in April 2019, the risk represented by the ensuite doors in Ward 2J had been identified in audits conducted on 16 November 2015 and 30 May 2018. Those risks were marked for local management. MSHHS has not located any local action plans that align with the 2015 or 2018 audits, and it does not appear that any remedial action was taken contemporaneously in

[179] E6.

response to the 2015 or 2018 audits. In short, the risk represented by the ensuite doors in Ward 2J had not been addressed at a "*capital works*" level.

153. Having regard to the findings in the *Hitchins* and *Gudge* Inquest, the Queensland Government response, and the further information disclosed by MSHHS in response to the Form 25 issued 25 November 2023, it is apparent that in 2018 and 2019 there was a statewide governance shift regarding the way in which ligature risks would be managed in the physical environment in MHU's.

154. The changes that ensued were being rolled out at around the time of Ms Campbell's death – the State Government had accepted both recommendations made in the *Hitchins* and *Gudge* Inquest, but not implemented the second – conducting a planned project reviewing the implementation of environmental safety guidelines within authorised mental health service inpatient units.

155. In these circumstances, while the 2015 and 2018 audits appear to each represent a missed opportunity to mitigate the identified risk of the ensuite doors in the MHU at LH being used as ligature points, the approach taken by the MSHHS at those points in time to manage the risk at the patient rather than the built environment level is consistent with the systemic approach to the management of ligature risks at those times.

156. Ms Campbell's death undoubtedly expedited the removal of the ensuite doors in Ward 2J at the LH. But for Ms Campbell's tragic death, it is reasonable to assume that the risk posed by the ensuite doors would have been addressed given the systemic shift in the management of ligature risks in the built environment in MHU's in Queensland in 2018 and 2019. Having regard to that shift, the steps taken by MSHHS to assess and address ligature risks at the LH prior to April 2019 were (a) focused on the individual patient rather than modifications to the built environment; (b) consistent with the status quo in public MHU's in Queensland at the relevant times; and (c) in all the circumstances reasonable.

Steps taken to address ligature risks post April 2019

157. As noted above, Ms Burgess gave evidence that the ensuite doors in single bedrooms in the LH's MHU were removed the day of Ms Campbell's death, removing the risk of the doors being used to create ligature points.

158. As noted in correspondence from Ms Linda Hipper, then Acting Executive Director MSAMHS, dated 17 August 2022, the audits conducted since Ms Campbell's death indicate that MSHHS is monitoring and managing ligature risks in inpatient units.[180]

159. Regarding the ligature risk auditing conducted after Ms Campbell's death, Dr Reddan notes:

> *It is clear from the accompanying material that ligature risk auditing is occurring in the Metro South Addiction and Mental Health Services and the material indicates that this is an ongoing process with changes in the built environment to reduce the risk of hanging.*
>
> *In summary, the ligature risk audit clarifies that attention to the issue of access to means to self-harm or to suicide is an ongoing process in the service*.[181]

160. Against that background, I find that MSHHS appears to have taken reasonable measures to assess and address ligature risks at the LH's MHU since the time of Ms Campbell's death in 2019, which conclusion is supported by the subsequent ligature risk assessment reports and Dr Reddan's evidence.[182]

Recommendations in accordance with Section 46

161. While the scope and facts of this inquest are limited to those that arise in relation to Ms Campbell's death, the information disclosed tends to suggest that the systemic issues identified in the *Hitchens* and *Gudge* Inquest findings with respect to the management of ligature risks in the physical environment of MHU's have been addressed at a statewide level.

162. In that context, there are no matters arising that could be addressed meaningfully by recommendations relating to: (a) public health and safety; (b) the administration of justice; or (c) ways to prevent deaths from happening in similar circumstances in the future, under section 46 of the CA.

[180] Exhibit E3.
[181] Exhibit D2, p1.
[182] Exhibit D2, p1.

Conclusion

163. At the conclusion of the evidence at the Inquest, I invited Ms Campbell's loved ones to read out family statements, which was done by Counsel Assisting and myself. Suffice to say that the statement was heartfelt and sincere. It is clear that the loss of Ms Campbell has had an impact on those that loved and cared for her.

164. I offer my sincere condolences for the loss suffered by Ms Campbell's family and loved ones. I trust that these proceedings have addressed any concerns and assists in bringing a measure of healing.

Findings required by Section 45

Identity of the deceased: Chloe Jane Campbell

How she died: Ms Campbell died in the Intensive Care Unit at Logan Hospital after sustaining a hypoxic brain injury after a suicide attempt by hanging and subsequent cardiac arrest requiring resuscitation the previous evening. At the time she sustained the hanging injury, Ms Campbell was an inpatient at the Mental Health Unit at the Logan Hospital and was subject to a Treatment Authority under the *Mental Health Act* 2016. Ms Campbell received prompt attention from nursing staff, the Code Blue team and admission to the Intensive Care Unit and supportive treatment and care following the hanging injury. Notwithstanding the treatment and care provided, Ms Campbell became haemodynamically unstable and unsupportable in the Intensive Care Unit, and Fentanyl was administered to prevent any distress as she died.

Place of death: Intensive Care Unit
Logan Hospital
MEADOWBROOK QLD 4131
AUSTRALIA

Date of death:	30 April 2019
Cause of death:	1(a) Hypoxic-ischaemic encephalopathy, *due to, or as a consequence of,* 1(b) Hanging

I close the inquest.

Carol Lee
Coroner
BRISBANE