JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	15 - 18 MARCH 2022
DELIVERED	**:**	7 OCTOBER 2022
FILE NO/S	**:**	CORC 1079 of 2020
DECEASED	**:**	PAINTER, JUSTINE

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops assisted the Coroner.
Ms B Burke (ANF) appeared for Ms C M Meakes and Ms M Bryant.
Mr E Cade with Mr C D Tan (SSO) appeared for the East Metropolitan Health Service and Office of the Public Advocate.
Ms L Coci (Clyde & Co) appeared for Fresh Fields Aged Care Pty Ltd trading as Mosman Park Aged Care Home.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Justine PAINTER*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 15 March 2022 to 18 March 2022, find that the identity of the deceased person was* ***Justine PAINTER*** *and that death occurred on 4 June 2020 at the corner of Pier Street and Wellington Street, Perth, from multiple injuries in the following circumstances:*

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INTRODUCTION

1. Justine Painter was only 51 year old when she died in 2020 in tragic circumstances. Justine had developed very serious physical and mental health issues after many years of drug and alcohol abuse and was in poor general health for her age. Due to her health issues, Justine lived in secure care at the Mosman Park Aged Care and Home (the Mosman Park Home), as she was unable to safely live independently. Some of her personal affairs, such as where she would live and medical treatment decisions, were managed by the public guardian as she also did not have the capacity to make those decisions for herself.

2. Justine was generally settled and stable while living at the Mosman Park Home. She could move freely within the facility but she could not leave unsupervised as she was at risk of harming herself, or harming her reputation and putting herself at risk of harm by removing all her clothing. Justine was well known to staff and it is very clear from the evidence that she received a high level of care and support from them. The Mosman Park Home staff were aware that Justine would sometimes test the boundaries, looking for a way to abscond, so they kept a close eye on her and tried to keep her occupied with other activities.

3. Justine's significant health issues sometimes required her to attend hospital for treatment. Most of her care in the final years of her life was coordinated at Royal Perth Hospital (RPH). On 28 May 2020, Justine was received by RPH for a pre-planned admission to the gastroenterology department for a blood transfusion. The admission was arranged by the hospital's staff. It was originally only intended that Justine would be kept in hospital overnight, but the admission was then extended over a weekend. While in the hospital, Justine was no longer in a secure environment and the evidence indicates that the requirement for Justine to be closely supervised in those circumstances was not well understood by the RPH staff. Instead, after a short settling in period, Justine was allowed to regularly leave the hospital unsupervised.

4. On 4 June 2020, while Justine was still an inpatient at RPH, Justine left her bed and walked out of the hospital in her hospital gown. Justine walked approximately 500 metres from the hospital to a multi-storey public carpark. After making her way upstairs to the top of a multi-storey building, Justine sat on the retaining wall edge, pushed herself off the edge and fell to the footpath below. Justine died as a result of multiple injuries sustained in the fall.[1]

5. During the coronial investigation into Justine's death, a question arose as to why she had been allowed to go outside the hospital unsupervised given her known risk of absconding. Information was provided by the Director of Nursing from the Mosman Park Home that a clear handover had been given to RPH staff that Justine was a high absconding risk and that she had previously expressed suicidal thoughts and experienced episodes of acute psychosis with associated hallucinations. Staff from the Mosman Park Home and Justine's guardian had tried to express their concerns to the RPH nursing staff when they became aware she was going outside on her own. Nevertheless, Justine was allowed by RPH staff to go outside on her own on multiple occasions, including the day she absconded. When she was found missing from her bed

[1] Exhibit 1, Tab 6.

at about 3.00 pm, it was simply assumed that she had gone outside again to smoke, and no efforts were made by hospital staff to find her. The hospital staff only became aware Justine had absconded when they were informed by police of her death.

6. I determined that it was desirable to hold an inquest into Justine's death to explore further the issue of her lack of supervision at RPH leading up to her death, and whether more could or should have been done to ensure she was kept safe while an in-patient at the hospital. The decision to hold an inquest was supported by her family and the staff of the Mosman Park Home who had tried to raise their concerns with the hospital's staff.[2]

7. At the inquest, there was a significant amount of documentary evidence tendered in relation to Justine's extensive medical history, as well as her final hospital admission and the circumstances of her death. In addition, a number of witnesses were called from RPH and the Mosman Park Home, as well as Justine's general practitioner and her legal guardian from the Office of the Public Advocate. This evidence was led to expand upon what was known about Justine's risk to herself at the time she was admitted to RPH, and what relevant information was communicated to the hospital staff about that risk.

8. At the conclusion of the inquest, some concessions were made on behalf of the East Metropolitan Health Service (EMHS), and specifically RPH, in relation to a failure of communication within the RPH Ward 8A team that led to missed opportunities for staff to recognise Justine's level of risk and take appropriate steps in response. The hospital recognised that its internal processes required improvement, to try to prevent a similar event occurring, and provided information on the changes that have since been made to the relevant procedures to that end.

BACKGROUND

9. Justine's story is a sad one and demonstrates the very real dangers of illicit drug use. Justine was a gifted student who did well at high school and continued her educational achievements at university, where she pursued a double degree in Drama and Arts at Murdoch University. Unfortunately, during the course of her university studies, Justine succumbed to alcohol and illicit drug addiction. She developed an organic brain disorder and experienced psychosis for the first time in her twenties. Her life then slowly unravelled as her polysubstance use led to ongoing psychiatric illness. Justine did get married and had a daughter and step daughter, but she was divorced and had limited contact with the children at the time of her death. Justine's mother, however, remained a close support throughout her life.[3]

10. Justine was known to mental health services from 1999. She had multiple admissions to hospital for mental health assessment and treatment and received follow up from community mental health services, including the Inner City Clinic and the Lower West Older Adult community mental health service. Justine was diagnosed with chronic treatment-resistant schizoaffective disorder with comorbid polysubstance abuse, including alcohol and methamphetamine. It was suspected that Justine had acquired a

[2] Approval to inquest pursuant to s 24 of the *Coroners Act 1996* (WA) dated 24 September 2021.
[3] Exhibit 1, Tab 10, CMA Form.

brain injury secondary to hypotensive and anoxic cerebral trauma in 2018 and alcohol and methamphetamine abuse.[4] It was explained that scans showed she had more advanced shrinkage of the brain than would be expected for a woman of her age.[5]

11. Justine's alcohol and drug addictions meant that she tended to live a chaotic lifestyle, and she had periods of homelessness. When she abstained from alcohol and drugs, she would report feeling much better, but then she would relapse.

12. Justine developed medical complications of her drug and alcohol use, unhealthy lifestyle, and by middle age she had been diagnosed with:[6]

- hepatitis C and liver cirrhosis,
- chronic pancreatitis,
- oesophageal varices,
- type II diabetes that was insulin dependent and required thrice daily injections,
- hypertension,
- cholecystitis,
- gastro-oesophageal reflux disorder, and
- the blood conditions leukocytopenia, neutropenia and thrombocytopenia.

13. A particularly concerning issue was her oesophageal varices, for which she had undergone repeated banding procedures. Justine was at significant risk of sudden catastrophic bleeding from the varices, which if it occurred, was likely to be fatal.[7]

14. Justine was on a large number of regular medications to manage her conditions. In particular, she was prescribed multiple medications for her mental health conditions, including the monthly depot antipsychotic medication paliperidone, oral antipsychotic medications quetiapine and zuclopenthixol, and the antidepressant medication escitalopram. Her GP at the time of her death noted that the fact that Justine was on three antipsychotic medications was an indicator of how unwell she was.[8] The use of clozapine for her treatment-resistant schizophrenia had been excluded by her extensive medical history. Even with regular and consistent administration of her medications, it was documented that Justine would often become distressed by voices, anxiety or difficulty sleeping, and she regularly required extra medication in the form of lorazepam.[9]

15. On 21 August 2017, an application was made by the City East Community Mental Health Service for a guardian or administrator to be appointed for Justine under the *Guardianship and Administration Act 1990* (WA). The order was granted by the State Administrative Tribunal on 19 September 2017 on the basis that Justine was unable, by reason of a mental disability, to make reasonable judgments in respect of matters relating to her estate, was incapable of looking after her own health and safety, and was unable to make reasonable judgments in respect of matters relating to her person. The

[4] Exhibit 1, Tab 11.
[5] T 17.
[6] Exhibit 1, Tab 11.
[7] Exhibit 1, Tab 9.
[8] T 51.
[9] Exhibit 1, Tab 11; Exhibit 5, Tab 9, MHA 18.6.2018.

Public Advocate was appointed as a limited guardian to make specified decisions on behalf of Justine, including as to where she would live and treatment decisions on her behalf.[10]

16. In 2017 Justine had a prolonged stay of four months in Bentley Hospital under the *Mental Health Act 1994* (WA). She only lasted two days in the community after discharge before Justine was readmitted after she suffered a psychotic relapse and was found wandering naked along the Great Eastern Highway and taken back to Bentley Hospital. Justine reported she was responding to voices telling her to disrobe and "adjust to her environment".[11] She indicated she was happy to stay at Bentley Hospital, and was initially placed in the adult open ward as a voluntary patient but with a 1:1 nursing special, and then later moved to the secure adult ward of the Older Adult Ward with an impression of cognitive decline.[12]

17. A family meeting was held on 16 January 2018 with Justine's mother, the medical team and social workers. A few days later she attempted to set fire to her room in order to self-harm because of delusions that she had murdered people. She also continued to strip off her clothes regularly, so she was put in a dignity suit, which prevented her from taking her clothes off but still allowed her to self-toilet. She was noted to do very well with the suit and her stripping attempts ceased.[13]

18. After a total of seven months admission at Bentley Hospital, Justine was deemed unsafe to live in the community and efforts were made to find her safe and supported long-term accommodation.[14]

19. After trying at least one other accommodation option, from which she absconded,[15] on 23 March 2018 Justine was admitted to the Freshwater Bay Home. On the Bentley Hospital discharge summary, there was a note that Justine should not be left alone whilst smoking due to previous attempts to set fires. It was also indicated that she was at risk of absconding as she experienced command auditory hallucinations that told her to walk and not stop walking, as well as to strip naked.[16]

20. On entering the Freshwater Bay Home, Justine was noted to have poverty of speech and appeared to be responding to auditory hallucinations, mainly of a man's voice telling her to strip. She appeared to settle in, but then the staff became concerned as Justine seemed to be contemplating jumping over the second storey balcony in response to command hallucinations telling her to kill herself. She also admitted to trying to harm herself with an old razor and a general worsening of psychotic symptoms. She was admitted to Bentley Hospital in May 2018 as a voluntary patient and placed on 15 minute observations for suicide and self-harm risk. She had a variceal bleed during the admission that required emergency treatment at RPH before she returned to Bentley Hospital.[17]

[10] Exhibit 1, Tab 14.
[11] Exhibit 1, Tab 10; Exhibit 8, Discharge Summary (Amended) 28.3 2018.
[12] Exhibit 8, Discharge Summary (Amended) 28.3.2018.
[13] Exhibit 8, Discharge Summary (Amended) 28.3.2018.
[14] Exhibit 1, Tab 10.
[15] Exhibit 5, Tab 9, RPH CECMHS Out-Patient Case Noes, 15.1.2018.
[16] Exhibit 8, Discharge Summary (Amended) 28.3.2018.
[17] Exhibit 8, Discharge Summary 3.6.2018.

21. Justine was discharged back to the Freshwater Bay Home on 3 June 2018 and then moved to the Mosman Park Home in August 2018, as it was single storey and felt to be a safer option for her. Both facilities are run by the same company and have a crossover of staff.[18]

22. There was an incident at the Mosman Park Home in late 2018 when Justine managed to leave the facility in the middle of the night. She was found wandering naked at Cottesloe Beach. It appeared Justine had managed to work out the code combination for the main locked door. The codes on all the doors were upgraded and staff made sure there were no further opportunities for Justine to witness the codes being entered. No further incident occurred. Justine's tendency to strip continued to be managed within the Mosman Park Home with a dignity suit, as had been utilised at Bentley Hospital, and this also seemed to be effective without causing her additional distress.[19]

23. Justine was provided with holistic care at the Mosman Park Home and, as a result, she showed some marked improvements. She established good relationships with many of the staff members, who were similar in age to her, and they kept her occupied and engaged to give her a focus away from her auditory hallucinations.[20]

24. Justine was admitted to Selby Lodge, part of the Lower West Older Adult Mental Health Service, from 8 March 2019 to 19 June 2019 after an increase in command hallucinations to harm herself, disrobe and walk to Stirling Highway.[21] Her mental health deterioration occurred in the context of stress associated with renovations being undertaken at the Mosman Park Home.[22]

25. Following admission, Justine responded well to the ward environment with reduction of stress and reduced reports of auditory hallucinations. Her physical health issues hampered attempts to rationalise or adjust her psychotropic medications. A reduction in her dose of quetiapine and paliperidone was attempted but resulted in an escalation of distress and auditory hallucinations, so the dose was titrated back up to the level at the time of admission. She did, however, tolerate a reduction in her dose of escitalopram with no deterioration in mood.[23]

26. During the admission, Justine also had multiple medical appointments at various hospitals, which was identified as a factor hampering follow-up and coordination of her treatment. The Hepatology Clinic at RPH was contacted by staff from Selby Lodge to try to coordinate the treatment of her complications secondary to liver cirrhosis, such as pancytopenia, iron deficiency, oesophageal varices and bleeding risk. Her oesophageal varices were said to be hard to control and bled on many occasions. Referrals were initiated to consolidate her medical follow-up and treatment at RPH under the coordination of the hepatology team after discharge.[24] This was a very sensible and

[18] T 283 - 284.
[19] T 18; Exhibit 1, Tab 10.
[20] T 284; Exhibit 1, Tab 7.
[21] Exhibit 5, Tab 3, Discharge Summary 19.6.2019.
[22] Exhibit 1, Tab 11; Exhibit 5, Tab 3.
[23] Exhibit 1, Tab 11; Exhibit 5, Tab 3.
[24] Exhibit 1, Tab 10 and Tab 11; Exhibit 5, Tab 3.

positive step taken by the Selby Lodge psychiatric team and demonstrates the benefits of taking a holistic approach to medical care. It was noted that Justine also successfully ceased smoking during this admission to Selby Lodge.[25]

27. Consideration was given during her admission to alternative accommodation options where Justine could socialise with younger peers and have improved access to outdoor spaces. However, Justine reported that she had built strong relationships with staff members at the Mosman Park Home. It also seemed that she felt safe there.[26] Accordingly, the decision was made in consultation with her guardian to return Justine to the Mosman Park Home at that stage.[27]

28. Justine was discharged back to the Mosman Park Home and her mental health care was transferred to the Lower West Older Adult Mental Health Community team. She remained living at the Mosman Park Home and appeared settled, with minimal to no distress, on several occasions when reviewed by the community mental health team. However, interestingly given what occurred later, it was reported Justine had become distressed at a hepatology appointment in September 2019 and on arrival back at the Mosman Park Home she told a carer she wanted to die. She then settled and indicated she felt safe again when reviewed by the community mental health nurse.[28]

29. On 27 November 2019, Justine was considered well enough to be discharged from the community mental health service. It was planned she would continue on the same medications, without change, and her general practitioner was to continue to manage her mental health care. Justine was not re-referred to the community mental health service at any time prior to her death.[29]

RECENT MEDICAL CARE

30. Justine's general practitioner, Dr Jennifer Sudbury, provided a written report and gave evidence at the inquest. Dr Sudbury was a very compelling witness. It was apparent that she knew Justine well and managed her medical care closely in conjunction with the staff of the Mosman Park Home. Dr Sudbury explained that she has over thirty years working in a psychiatric unit locked ward and the Mosman Park Home is very good at handling people with quite severe mental health issues, so she believed Justine's placement at the Mosman Park Home was a very positive step. Working together, Dr Sudbury and the Mosman Park Home's staff achieved significant improvements to Justine's mental health. However, Dr Sudbury described Justine as "one of the most complex patients"[30] that they managed at the Mosman Park Home due to her multiple comorbidities, so managing her care was not easy. Dr Sudbury also acknowledged Justine had shown significant improvement in her physical health following a lot of treatment at RPH and Sir Charles Gairdner Hospital, and with the coordination of her care at RPH in later times.

[25] Exhibit 1, Tab 14A.3.
[26] T 30.
[27] Exhibit 1, Tab 11; Exhibit 5, Tab 3.
[28] Exhibit 1, Tab 11.
[29] Exhibit 1, Tab 11.
[30] T 13.

31. Dr Sudbury advised that Justine's mental state was stable over the last year of her life, which was why the community mental health team were able to withdraw from her active management.[31] Justine had initially been unhappy to be living in a nursing home and was irritable and distant,[32] but over time she appeared to settle. She engaged more and smiled, although she did not initiate conversation. Justine remained living in a locked environment but had as much freedom as possible within the containment of the Mosman Park Home and was able to engage in community activities with a carer, subject to the limitations of the COVID-19 restrictions. Dr Sudbury described Justine as being as "happy as she could have been in that last year".[33]

32. No changes were made to Justine's mental health medications and she always took her tablets, although even on her fairly robust medication regime her symptoms remained difficult to manage. Dr Sudbury was not aware of any reports of self-harm attempts or overt suicidal ideation. However, Dr Sudbury suspected Justine still had auditory hallucinations just below the surface, which were "always a male voice telling her what to do".[34] Dr Sudbury said that Justine responded well to the Mosman Park Home's staff and not long before her death she "looked the best she had ever looked"[35] in the time they had been caring for her.[36]

33. Justine spent many days in RPH over the months before her death. She was well known to the hospital, having been a patient there for many years, and there was a large RPH medical record relating to her care. There were many entries in the RPH medical record of Justine presenting as an absconding risk over the years.[37] In particular, I note the Bentley Hospital discharge form from 28 March 2018 identified a number of 'Special Points of Concern' specifying that Justine should not be left alone whilst smoking due to previous attempts to set fires, was at risk of absconding due to command auditory hallucinations to walk and not stop walking and was subject to command auditory hallucinations to strip naked, which meant she was at risk of frequent inappropriate undressing.[38]

34. There was evidence given at the inquest that the various discharge summaries, such as this one, would be available electronically to RPH doctors treating Justine.[39]

35. In addition, at each transfer, a Comprehensive Medical Assessment (CMA) form and medical charts were sent with her. The CMA was prepared by Dr Sudbury and updated annually.

36. I note the CMA records Justine's diagnosis of chronic psychosis resistant to medication, drug induced psychosis and schizoaffective disorder, amongst other things. She was noted to be a highly complex patient with multiple care needs. The form recorded that

[31] T 36.
[32] T 13.
[33] T 14.
[34] T 16; Exhibit 1, Tab 10, p. 2.
[35] T 30.
[36] T 45.
[37] Exhibit 4.
[38] Exhibit 8, Discharge Summary (Amended) Bentley Hospital for discharge 28 March 2018, finalised 16 April 2018.
[39] T 204 - 206.

Justine would often be "[p]leasant on approach but is often responding to unseen stimuli – particularly taker her clothes off. Disrobing is less of a problem, but is frequently exit seeking".[40] Dr Sudbury explained this meant she would wander past doors and gently try the locks, then move on.[41] Details were provided in the CMA that Justine experienced command hallucinations and believed she was a bad person who had murdered three people and did not deserve to live.[42] Dr Sudbury believed Justine's hallucinations caused her less distress at the Mosman Park Home than when she was in Bentley Hospital, but she still remained a risk to herself.[43]

37. In the 'Immediate Actions' portion at the end of the CMA form, it was indicated that Justine was very settled in the Mosman Park Home, where she responded very well to care staff whom she knew well, so self-harm within the Mosman Park Home was unlikely. However, it was also noted that she "continues to try and abscond, [and] then she is a risk to herself and her dignity"[44] as she would respond to command hallucinations to take off her clothes and harm herself. Dr Sudbury explained that Justine heard what she described as 'death commands' that prompted her to drown or burn herself or jump in order to alleviate some terrible event such as a war, death or murder.[45]

38. Justine's various medications, including her antipsychotic medications, were recorded on another form, as they changed more often.[46]

39. In addition, Dr Sudbury understood that the Mosman Park Home staff updated the hospital ward staff verbally and in written form on each transfer that Justine was not to be left unaccompanied whenever she was transferred to hospital.[47]

40. Dr Sudbury indicated that in the month before her death, while Justine was looking well and her mental health seemed stable, Dr Sudbury still considered her auditory hallucinations were "just below the surface",[48] and Dr Sudbury was conscious that Justine was vulnerable to a recurrence of her auditory hallucinations when exposed to stressful events. In that context, Dr Sudbury believes a further hospital admission into a new environment may have increased her vulnerability to regression to previous behaviours. Relevant to comments about Justine going outside to smoke once at RPH, Dr Sudbury also noted in her report that Justine had stopped smoking for many months prior to her death after her admission to Selby Lodge, as smoking was not permitted there.[49]

[40] Exhibit 1, Tab 10, CMA Form.
[41] T 18.
[42] Exhibit 1, Tab 10, CMA Form.
[43] T 19.
[44] Exhibit 1, Tab 10.
[45] T 22.
[46] T 20; Exhibit 1, Tab 10.
[47] Exhibit 1, Tab 10.
[48] Exhibit 1, Tab 10, p. 2.
[49] T 30; Exhibit 1, Tab 10.

TRANSFER TO RPH – 28 MAY 2020

41. Justine was administered her last antipsychotic depot medication on 7 May 2020. She received an injection every 28 days, so her next one was due the day after her death. Evidence was given that the medication has a long half-life, so the fact she was due another dose was unlikely to have had any bearing on her mental state at the time she died.[50]

42. On 22 May 2020, a call was made from RPH to the Director of Nursing at the Mosman Park Home to discuss Justine's abnormal blood result (low haemoglobin). It was planned to repeat the bloods the following week.[51] There were also plans around this time to commence her treatment for hepatitis C as an outpatient, which were discussed with Justine's guardian.[52]

43. On 27 May 2020, RPH staff contacted the Mosman Park Home to advise that Justine's haemoglobin was still low and she required a blood transfusion. That evening, at 10.00 pm, Justine was recorded as having requested PRN (as needed) medication for her anxiety as she was hearing voices and was unable to sleep. She was given the medication, as charted, and reassured. She fell asleep not long after.[53] This evidence confirms Dr Sudbury's belief that Justine was still being troubled by her auditory hallucinations immediately prior to her transfer to hospital.

44. On 28 May 2020, RPH staff contacted the Mosman Park Home to advise that they had an available bed in Ward 8A for Justine for her blood transfusion. Clinical Nurse Manager Charisse Santiago (formerly Charisse Joshi) advised that Justine was under the public guardian. Ms Anne Warner generally acted in the role of her SAT guardian at that time, so Nurse Santiago provided the RPH staff member with Ms Warner's contact details so they could obtain her consent. Ms Warner provided her consent, so Nurse Santiago was informed in another phone call from RPH staff that Justine could be sent to RPH.[54]

45. Ms Warner gave evidence that Justine's mental state had been stable for quite some time leading up to this date, so there was nothing to indicate that she would require a mental health assessment upon her arrival at the hospital.[55] Ms Warner also gave evidence she assumed the hospital staff were aware of Justine's complex mental health issues, as she had received treatment at RPH in the past.[56]

46. Nurse Santiago had been working at the Mosman Park Home since 2013 and in the role of Clinical Nurse Manager since 2018. As the Clinical Nurse Manager, Nurse Santiago had a supervisory role over more junior staff and was involved in updating the clinical files and care plans of the patients. Nurse Santiago was aware that Justine was a high absconding risk as she had been informed of the incident when Justine escaped from the Mosman Park Home in late 2018. Nurse Santiago was also aware that Justine was at

[50] T 17.
[51] Exhibit 5, Tab 7.
[52] Exhibit 5, Tab 2.
[53] Exhibit 1, Tab 21 and Attachment CS1.
[54] Exhibit 1, Tab 21 and Attachment CS1.
[55] T 191.
[56] T 194.

risk of self-harm due to hearing voices in her head telling her to do things, and Nurse Santiago had read in Justine's file that she was a suicide risk.[57]

47. Nurse Santiago explained at the inquest that, due to her mental health issues, Justine required full assistance in all aspects of her care. This included constant monitoring and emotional support to help Justine manage her hallucinations/delusions.[58]

48. Nurse Santiago stated that in one of her two telephone conversations with RPH staff on 28 May 2020, she told the RPH representative that Justine would need a carer with her at all times. The RPH representative asked why, and Nurse Santiago replied with words to the effect that Justine was "a high absconding risk resident".[59] Nurse Santiago could not recall whether she had that conversation in the first or second phone call that day, but was certain the discussion occurred.[60]

49. There was a handover policy in place for the Mosman Park Home at the time Justine was transferred to RPH on that date. The policy referred to the transfer occurring by ambulance, but it was indicated at the inquest that the same approach was taken to transfer by another means, as occurred in this instance. The policy specifies what documentation is to accompany the resident, and it included a Transfer Form and the CMA. With the assistance of Enrolled Nurse Caroline Lawson, Nurse Santiago prepared the relevant paperwork for Justine's transfer to RPH.

50. I have been provided with the documentation that accompanied Justine to the hospital on 28 May 2020. There are two different versions of the Transfer Form, both dated 28 May 2020, with one prepared by Nurse Santiago and one prepared by Nurse Lawson, as they were each unaware the other had commenced the task. The first copy is relatively brief, but I note that in relation to specific nursing care issues, her absconding risk is highlighted with asterisks. The form also directs the reader to the CMA. The second version also refers the reader to the CMA and notes Justine's high absconding risk with a single asterisk, as well as her diagnosis of Hepatitis C.[61] It appeared from the evidence that it was the first Transfer Form[62] that accompanied Justine on this occasion, but in my view it is of little moment as they were both very similar.

51. As noted above, Justine's CMA that accompanied the Transfer Form quite clearly identifies Justine's complex mental health history, risk of absconding and, if successful, the potential risk to herself and her dignity. However, the evidence at the inquest also indicated that either all or most of the staff at RPH who were directly involved in caring for and supervising Justine did not read the CMA, so that information was not communicated to the nursing staff caring for her. The evidence suggested that the form was simply put on the blue medical file, usually used by the doctors, at the back of other paperwork.

[57] T 61 - 62; Exhibit 1, Tab 21.
[58] T 61.
[59] Exhibit 1, Tab 21 [17].
[60] Exhibit 1, Tab 21.
[61] Exhibit 1, Tab 25, Attachment CL1 – CL3.
[62] Exhibit 5, Tab 1.

52. Rather than going to hospital by ambulance, Justine was escorted to RPH on this occasion by a staff member from the Mosman Park Home, Assistant in Nursing Cindy Lee, in a taxi. Ms Lee had been working at the Mosman Park Home since 2019 and had worked with Justine often during that time. Ms Lee indicated in her statement that she had learned about Justine's "personal care needs, risk of running away and risk of committing suicide"[63] from her regular interactions with Justine, as well as discussions with other staff members and Justine's file. The evidence indicated Ms Lee had developed a good rapport with Justine, which was why she was chosen to accompany her to the hospital as a focus of the transfer policy was to ensure that the distress to the resident was minimised.[64]

53. Ms Lee recalled that she was asked to escort Justine to RPH for a blood transfusion by Nurse Santiago. Nurse Santiago gave Ms Lee an envelope containing Justine's documentation, but Ms Lee did not open the envelope and view the documents herself. Ms Lee stated that she was told by Nurse Santiago that she did not need to wait with Justine after making the handover.[65] I note the evidence of Nurse Santiago that she instructed Ms Lee to stay with Justine until the completion of the handover, because Justine was an absconding risk and a suicide risk, but it does not seem there was any specific discussion about what that handover looked like, in terms of it being 'completed'.[66] Ms Lee had never done such a transfer of a resident to hospital before, and had done a group training session some time before, but she could not remember the details of the training. Ms Lee gave evidence that at the time she accompanied Justine to the hospital, she understood in her mind that the handover would be complete after she had passed the envelope of information to RPH staff and admitted Justine into a room.[67] The evidence from Ms Lee is that this is what she then did.

54. Ms Lee and Justine took at taxi to RPH at 2.35 pm, arriving at about 3.00 pm. Ms Lee escorted Justine to the ground floor reception of RPH. She told the person at reception that Justine was there for a blood transfusion and handed over the envelope of documentation. The RPH staff member at the reception desk opened the envelope, took out the documents and inspected them. They then checked the computer and made a telephone call, before the RPH staff member put the documents back in the envelope and returned them to Ms Lee. Ms Lee was directed to take Justine to the second floor reception.[68]

55. Ms Lee escorted Justine to the second floor reception and Ms Lee again handed over the envelope. This time, Ms Lee's evidence was that she also told the person at reception that Justine "was an absconding risk".[69] She recalled that the person at reception responded that someone would be with Justine and that she should take Justine to her room. Ms Lee stated that she understood from the conversation with the staff member at reception that someone from RPH would go to Justine's room and attend to her. Ms Lee was given directions to Justine's assigned room and she then escorted Justine to the

[63] Exhibit 1, Tab 24.
[64] T 68, 303; Exhibit 1, Tab 23.
[65] Exhibit 1, Tab 24.
[66] Exhibit 1, Tab 21 [22].
[67] T 54 - 55.
[68] Exhibit 1, Tab 24.
[69] Exhibit 1, Tab 24 [16].

room, as requested. Justine's room was about 20 metres from the second reception area, and Ms Lee noted that for Justine to leave the hospital, she would have needed to walk past the second reception area to reach the lifts.[70]

56. After finding Justine's room, Ms Lee helped Justine to get comfortable by adjusting her bed and turning on her television. She then asked Justine to have a rest on the bed while she waited for a nurse or doctor to attend to her. Ms Lee stayed with Justine in the room for about 10 minutes, but nobody came during that time. Eventually, after the 10 minutes had elapsed, Ms Lee stated she left Justine on her own in the room and returned to the Mosman Park Home by taxi.[71]

57. In her evidence, Ms Lee said that if a staff member had arrived before she left, she simply intended to tell them that she would not be staying with Justine, and remind them that Justine was an absconding risk. However, they did not come and she had been told by her superior at the Mosman Park Home that she did not need to stay, so she left.[72] The evidence of a nurse from RPH, Enrolled Nurse Sally Pain, was put to Ms Lee to give her an opportunity to respond.

58. Nurse Pain's evidence was that she had an independent recollection of admitting Justine on 28 May 2020 and that at the time of the admission a carer (which, if correct, must have been Ms Lee) was with her. Nurse Pain recalled that she told the carer that she was going to get her notes and then would return to admit Justine. When Nurse Pain returned to Justine's hospital room, she requested a handover and risk assessment update from the carer, who indicated that any questions could be directed to Justine. Nurse Pain could not recall the name or description of the carer she spoke to on that day. She noted that the carer sat in a corner looking at her phone and then left "early in the beginning",[73] of the admission process. Nurse Pain completed the Patient Care Plan for Justine at 3.30 pm, according to the records. Nurse Pain said the information in the plan would have come from answers given by Justine. There is no mention of a carer in the records, although it did note that Justine lived in a nursing home, which information apparently came from Justine.[74] Nurse Pain could not recall anything being mentioned by the carer at any stage about Justine being an absconding risk nor seeing or receiving any handover or transfer form from the Mosman Park Home.

59. When Nurse Pain was shown the transfer form and CMA provided by Ms Lee to a ward clerk at RPH, Nurse Pain indicated she had not seen that documentation before and, in particular, had not seen the information about Justine being an absconding risk. Nurse Pain gave evidence that she saw this phrase frequently as a nurse and it would mean to her that a patient would try to leave the ward and "they're not to leave the ward".[75] Nurse Pain gave evidence that if she had seen that notation about the absconding risk on the transfer form, she would have alerted the team leader or nurse coordinator and she would have assumed that they might get the psychiatric liaison nurse to assess the patient. Nurse Pain gave evidence she would also have asked the carer for more

[70] Exhibit 1, Tab 24.
[71] T 55; Exhibit 1, Tab 24.
[72] T 56.
[73] T 107.
[74] Exhibit 1, Tab 13, SP1.
[75] T 109.

information.[76] Nurse Pain was asked whether she would have also read the detailed information in the CMA, but she answered that she would not have had the time to do so, even if the form had been provided to her.

60. Nurse Pain acknowledged that, given Justine's age, the information that she was living in a nursing home did indicate to her that Justine had some kind of brain injury or mental health condition, but she did not know any particulars and considered that Justine presented very well and did not seem agitated or difficult to engage with while completing the admission. For that reason, Nurse Pain circled that Justine had no 'Known cognitive impairment' on the form.[77] Nurse Pain acknowledged that Justine's general appearance and demeanour wasn't normal, and it was clear she had some kind of brain impairment or mental health disorder, but she was calm and cooperative, so there was nothing about her behaviour that made Nurse Pain concerned.[78]

61. Ms Lee was asked if she recalled having any conversation with Nurse Pain. Ms Lee was clear in her evidence that she did not speak to anyone before she left Justine in her hospital room.[79]

62. Submissions were made on behalf of the Mosman Park Home that the factual inconsistency between Ms Lee and Nurse Pain's evidence should be resolved in favour of Ms Lee's evidence that she did not speak to any clinical staff before leaving. Nurse Pain had not made any entry in the Inpatient Case Notes that Justine had been 'brought in by carer' as was the usual practice, and had not recorded the presence of a carer in any of the documentation. It was submitted that, given Nurse Pain was recollecting events from some time before without the benefit of any contemporaneous notes about contact with a carer and without being able to recall the name or appearance of the carer, her evidence on this point was unreliable. It was possible she was confusing another patient's handover with this event. In that context, Nurse Pain would have seen many such patients and had no particular reason to remember this one clearly, whereas Ms Lee knew Justine well and had never escorted another patient to hospital before this event. I accept this submission, and agree that to the extent there is a discrepancy in the evidence, it is more likely that Nurse Pain is mistaken about her contact with Ms Lee.[80]

63. It is further submitted that ultimately, nothing significant turns on this inconsistent evidence, and I also agree with this submission. The salient information had been provided in the documentation handed over by Ms Lee to the ward clerk and her absconding risk was noted in the medical notes by another nurse after Nurse Pain's first interaction with Justine and also raised orally with other RPH staff by clinical staff from the Mosman Park Home. Therefore, the relevant information about Justine's absconding risk had definitely been communicated before Justine's death even if there was a missed opportunity for Ms Lee to be able to verbally pass on that information at the initial admission.[81]

[76] T 104 – 108.
[77] T 107 – 108, 112; Exhibit 1, Tab 13, SP1.
[78] T 129.
[79] T 58.
[80] Closing Submissions of Fresh Fields Aged Care Pty Ltd t/a Mosman Park Aged Care Home filed 22 April 2022, [63] – [76].
[81] Closing Submissions of Fresh Fields Aged Care Pty Ltd t/a Mosman Park Aged Care Home filed 22 April 2022, [63] – [76].

LAST ADMISSION TO RPH

64. Before Justine was admitted to RPH by Nurse Pain that day, Clinical Nurse Celene-Marie Meakes, who was performing the role of the nursing shift coordinator, looked at the Electronic Bed Management System in conjunction with the ward manager in order to allocate Justine a bed on Ward 8A under Gastroenterology. Nurse Meakes recalled that when she was looking at Justine's entry as part of that virtual bed allocation, she noted there was information for Justine that referred to her previous intravenous drug and alcohol use and also reference to a nursing home. As a result of this information, which Nurse Meakes said she saw as "sort of suspicious things", Nurse Meakes and the Nurse Unit Manager, Registered Nurse Vathsala Nanthakumar, decided to note her as a 'patient of concern' or 'patient-staff safety risk' on the ward patient journey board. Nurse Meakes indicated this would not occur automatically for nursing home patients. It was done in this case due to the combined information that was available. Nurse Meakes clarified at the inquest that she had not seen the patient transfer form at this stage, and she did not see it until after Justine's death, when she was compiling the medical information for the coronial investigation into Justine's death. Therefore, the notation on the journey board did not relate to Justine's absconding risk, as Nurse Meakes was unaware of this issue at the time she made the entry.[82]

65. Nurse Meakes also clarified after the inquest, once a copy of the electronic bed management system information had been provided, that her recollection may have been flawed in relation to the information about Justine's alcohol and drug use, and that she may have inferred this history from the information about Justine's diagnosis of cirrhosis and Hepatitis C, which are often connected with alcohol abuse and intravenous drug use. In any event, certainly Nurse Meakes recalled Justine's case being flagged as a risk for some reason from the information they had available at the hospital, prior to any documentation being provided by the Mosman Park Home.[83]

66. Evidence was given that nurses would 'huddle' at the journey board at the handover between shifts so any important information could be relayed to the nurses starting the next shift, then they would move to a bedside handover for each patient.[84]

67. Nurse Meakes indicated that they will often make patients a 'patient/staff safety risk' on the ward journey board to alert others of presumed issues until they have physically reviewed the patient on the ward.[85] Nurse Meakes described the process as placing a yellow and black magnet with the words 'Patient/Staff Safety Risk' next to the patient's name on the whiteboard, which is the journey board, and it would also be put on the electronic record iSoFT and on the handover sheets. Nurse Meakes indicated that at that stage a Behavioural Observation Form (BOF) should also be commenced. Nurse Meakes gave evidence this form was not commenced for Justine. She did not know why, but assumed it was probably because she was too busy. Nurse Meakes was frank in her acknowledgment that she should probably have delegated that task to someone

[82] T 131 – 135, 151 - 153; Exhibit 1, Tab 19.
[83] Exhibit 12.
[84] T 159.
[85] Exhibit 1, Tab 19.

else if she did not have the time, but she noted that being so busy made errors more likely to occur. Nurse Meakes gave evidence if Nurse Pain had raised any concerns about Justine following the admission, this would have increased her level of concern and probably have led to a BOF being commenced, but this did not occur. It could also have been commenced at any stage by a staff member throughout Justine's admission, but there is no evidence to suggest that it was ever commenced.[86]

68. Information was provided at the inquest that the usual Nurse Unit Manager of Ward 8A, Ms Nanthakumar, was on leave for most of Justine's admission but Ms Nanthakumar was present on the day of Justine's admission, and recalled the patient/safety risk alert being put beside Justine's name. Ms Nanthakumar acknowledged that a BOF should have been started, but for some reason in this case was not.[87]

69. Nurse Meakes and Ms Nanthakumar were not involved in Justine's physical admission, which was completed solely by Nurse Pain. It does not appear that Nurse Pain was aware of the journey board note of a patient/staff safety risk next to Justine's name, and she saw nothing to raise her own concern when admitting Justine that might have led to the commencement of a BOF.

70. If the process of commencing a BOF had begun, it would not have automatically resulted in Justine being allocated a 'one-to-one nursing special' or a psychiatric referral. Rather, it would have acted as an alert to indicate that there might be an issue with the patient that requires attention or management so she would have received some extra attention/observations in the early stages, for a day or two. As Justine was not aggressive or agitated or actively attempting to abscond, Nurse Meakes and Ms Nanthakumar suggested it was unlikely to have led to any further action in Justine's case.[88]

71. Nurse Meakes did suggest that there was some additional level of scrutiny of Justine initially, due to the notation on the journey board, but there was no concerning behaviour demonstrated by Justine at any stage. Nurse Meakes did not provide any direct nursing care to Justine, but she did exchange pleasantries with her. She recalled that Justine was "a little bit off"[89] but there was nothing particularly unusual or alarming about her presentation.

72. Nurse Meakes gave evidence that the first time she saw the transfer form, it was at the back of the blue file containing the medical notes that are used by the doctors, rather than in the red file with the nursing notes that are used by the nurses.[90] Nurse Meakes said they would usually try to put it in the red file, but sometimes this did not occur. The files are created by the ward clerks, and Nurse Meakes said she would not have expected a ward clerk to read the transfer form, understand its importance, and consider where it should be placed.[91] Nurse Meakes gave evidence she was quite surprised when she finally saw the transfer form, after Justine's death. She was standing with one of the

[86] T 134 – 135, 138 - 139.
[87] T 220; Exhibit 1, Tab 16,
[88] T 139 – 140, 221, 225.
[89] T 142.
[90] T 135 – 136.
[91] T 136.

hospital executives at the time and they were "both shocked"[92] to read that Justine was an absconding risk. Nurse Meakes gave evidence that it would have made a difference to what she did if she had known that Justine was living in a locked facility and was an absconding risk. Nurse Meakes said that if she had read the form and seen that notation, it would have prompted her to find out more by calling the Mosman Park Home.[93]

73. Ms Nanthakumar provided information that the role of the Nurse Unit Manager "is to provide the single point of accountability for clinical and management leadership to Nursing and other team members within the unit".[94] It is a supervisory role, so they provide advice and guidance to nurses, doctors and allied disciplinary team members to deliver patient care in the area of speciality, which for Ward 8A is neurology and gastroenterology.[95] Although she was there on the day of Justine's admission, after that time Ms Nanthakumar was on leave and another person was covering her role. The person covering Ms Nanthakumar's role was, however, still covering their own ward as well, with approximately 34 patients in addition to the 28 patients on Ward 8A. Therefore, their ability to provide oversight and supervision was necessarily limited.

74. It was acknowledged that Ward 8A is a really busy ward, with many very ill patients and patient turnover every day and another person trying to manage it, along with their own ward, would have meant that there was not the same close oversight that would usually occur.[96] Ms Nanthakumar suggested things might have been slightly different if she had been working that week, as she would have been present on the ward and easily able to be approached by staff. This is particularly so in relation to contact between nurses on the ward, Justine's guardian and the Mosman Park home staff, which I discuss below.[97]

75. The first doctor to review Justine after her admission was a junior doctor who was a gastroenterology intern at the time, Dr Tan. Dr Tan documented a thorough account of Justine's background and medications. In the information Dr Tan recorded in his entry in the medical notes at 4.00 pm on 28 May 2020 that Justine had a diagnosis of schizoaffective disorder and suicidal ideation and she lived at a residential care facility. Her long history of intravenous drug use was also noted. I assume most of this information came from the previous medical records and/or the transfer documentation provided by the Mosman Park Home.

76. It was documented by Dr Tan that collateral information was received from the Mosman Park Home. We now know that this collateral information was obtained by Dr Tan via a telephone conversation with Ms Subramaniam, the Director of Nursing at the Mosman Park Home. Ms Subramaniam gave evidence Dr Tan rang and asked her, in effect, why Justine had been admitted. She explained it was for a blood transfusion and they discussed information related to that procedure.[98] According to his note, Dr Tan

[92] T 134.
[93] T 140 – 141.
[94] Exhibit 1, Tab 16 [4].
[95] T 219 – 220; Exhibit 1, Tab 16.
[96] T 266.
[97] T 231.
[98] T 290.

also obtained information directly from Justine in relation to her symptoms and how she was feeling.[99]

77. Dr Tan then formulated a treatment plan, which he discussed with a Gastroenterology Registrar, Dr Wallefeld. A plan was made to give Justine a blood transfusion and a scope, so Dr Tan rang the on-call after-hours guardian from the Public Advocate to obtain their consent.

78. Justine was reviewed personally by Dr Wallefeld later that evening at 5.50 pm after he received a verbal handover from Dr Tan. Justine reported fatigue and felt her abdomen was distended, which was confirmed to be mildly tender on examination. Dr Wallefeld reviewed the treatment plan and then confirmed the plan with his Consultant.[100]

79. An entry at 5.00 am the next morning, being 29 May 2020, noted that Justine was found wandering outside her room after transfusion and she was easily directed back to bed. Importantly, the nurse also recorded that Justine was an absconding risk, which suggests the nurse had seen that information on the Mosman Park Home transfer form. The alternative theory is that the nurse formed their own opinion that Justine was an absconding risk after finding her outside her room, but I think the former is the more likely reason for the notation, given there was nothing of particular note about this interaction.[101] This nursing note is significant as it shows that at least one nurse who cared for Justine very early in her admission was aware that she was an absconding risk and should be sent back to her room. The notes made after this entry do not appear to refer back to this information at any stage.

80. Mid-morning, there appears to have been a conversation between Nurse Meakes and the Mosman Park Home staff advising that Justine would be staying in hospital until 2 June 2020. Nurse Meakes agreed that she could have taken the opportunity during this phone call to ask for more information about Justine, given her initial entry on the journey board, but at the time it did not occur to her to do so. Sometime after this, the risk notation was removed from the journey board.[102]

81. During the evening of 29 May 2020, Justine had a hypoglycaemic episode (low glucose). A Medical Emergency Team call was made and she was given a dextrose infusion, which was administered overnight with good effect.[103] She was reviewed on 30 May 2020 and found to be drowsy but rousable and oriented to time and place. She was waiting for a haematology review and plans were also being made for Justine to scopes after the weekend.[104]

82. Until this time, Justine appears to have been staying on the ward and generally remained in her room. However, that changed on 31 May 2020. A nursing entry at 2.10 pm on 31 May 2020 reported that Justine had gone "downstairs for smoke." A later nursing entry at 8.30 pm that evening reported she had been off the ward a couple of times and

[99] Exhibit 5, Tab 13.
[100] T 207; Exhibit 1, Tab 15; Exhibit 5, Tab 13.
[101] Exhibit 5, Tab 14.
[102] T 144.
[103] Exhibit 1, Tab 12.
[104] Exhibit 5, Tab 14.

returned by herself.[105] Nursing entries the following day, being 1 June 2020, again noted that she had left the ward at 2.40 pm and 8.45 pm to smoke.[106]

83. Nurse Meakes gave evidence that she was aware the patient/staff safety risk notation was taken away from Justine's name on the journey board a few days into her admission, although she did not think it was not removed by her. Nurse Meakes indicated this would have been done as the staff had built up rapport with Justine and had started to know her, so they would have formed their own assessment of the risk. This also explained why she was initially not permitted to leave the ward, but was then later allowed to go downstairs unaccompanied.[107]

84. The Mosman Park Home staff became aware that Justine was being allowed to go outside on her own to smoke on 2 June 2020. Nurse Santiago recalled that she overheard a telephone conversation between Nurse Lawson and an RPH staff member on 2 June 2020. Nurse Lawson had rung RPH to try to find out what was happening, as Justine had been at the hospital longer than expected.[108] Nurse Lawson recalled that she spoke to an RPH staff member and asked when Justine was likely to be discharged. The staff member responded that they did not know where Justine was or when she would be discharged.[109] Nurse Lawson said she was "taken back a little bit"[110] by the response and a bit concerned. The person also told Nurse Lawson that Justine had been smoking. Nurse Lawson responded that Justine had no cigarettes. She asked if they knew where Justine was getting them from and why she was going outside. The person responded that they did not know.[111]

85. Nurse Santiago gave evidence that she could see Nurse Lawson's face during the conversation and saw her look surprised. She then exclaimed out loud at information provided that Justine was smoking. Nurse Santiago said she and Nurse Lawson were surprised at the information, both because Justine no longer smoked and because it raised the question as to who was with her when she went outside to smoke. Nurse Santiago said they both felt shocked and, in response, Nurse Santiago immediately emailed Justine's guardian, Ms Warner.

86. Email correspondence between Nurse Santiago at the Mosman Park Home and Ms Warner on 2 June 2020 at 2.13 pm mentioned that the Mosman Park Home staff had contacted RPH Ward 8A to follow up on Justine's condition and had been told by a nurse that she smokes in the hospital, although they were unsure who gave her the cigarettes, and that she was allowed to smoke multiple times a day, unsupervised. According to the email, the Mosman Park Home staff advised the RPH staff member that she does not smoke when at the Mosman Park Home, they had not provided Justine

[105] Exhibit 5, Tab 15.
[106] Exhibit 5, Tab 16.d
[107] T 148.
[108] T 70.
[109] T 91; Exhibit 1, Tab 25.
[110] T 91.
[111] Exhibit 1, Tab 25.

with any cigarettes, and she was "an absconding risk".[112] Nurse Santiago also queried what was happening with Justine's care as they didn't have much detail.

87. Nurse Santiago gave evidence she had raised the issue with Justine's guardian as she hoped Ms Warner might be able to call the hospital and find out a bit more information about where Justine might be getting the cigarettes and what else was happening, as the hospital staff would not generally tell the Mosman Park Home staff any detailed information as they were not Justine's next of kin.[113]

88. Ms Subramaniam, the Director of Nursing of the Mosman Park Home, also emailed Ms Warner with her concerns about Justine going outside the hospital unsupervised to smoke. She had sent her email at 2.19 pm on 2 June 2020, six minutes after Nurse Santiago had sent the first email. Ms Subramaniam had emphasised that this was a "major concern"[114] and asked Ms Warner to call and speak to the RPH staff about it. Ms Subramaniam was clearly concerned both about Justine smoking and being allowed to be outside unsupervised, but it seems that Ms Warner's focus was more on the issue of the smoking.

89. Ms Warner stated that she had called Justine's ward nurse at RPH and informed the nurse (who did not provide her name) that Justine was at risk of absconding. The nurse did not appear receptive to Ms Warner's concerns about Justine's risk of absconding and advised Ms Warner that Justine could go downstairs when she wanted and always returned. The nurse said she thought that Justine saying she was going for a cigarette may have been her way of saying that she wanted fresh air, rather than Justine actually going outside to smoke.[115] Ms Warner's note of the call records that spoke about the question of Justine smoking, but does not mention the lack of supervision.[116]

90. In a similar vein, Ms Warner responded to Nurse Santiago's email in relation to the issue of smoking but did not refer to the other issue of her lack of supervision.[117] Ms Warner did also provide some more information about the medical procedures Justine was about to undergo and why, which had been Nurse Santiago's other concern.

91. In her statement, Ms Warner indicated that she understood at that time that she did not have the authority in her role as guardian to instruct RPH staff to stop Justine from going outside for these so-called 'smoke breaks', even if it was understood that Justine did not smoke. She also could not order Justine to stay in bed. Ms Warner stated that while she could pass on the relevant information about Justine's absconding risk, "it was ultimately a matter for the hospital whether to restrict [Justine's] movements".[118]

92. Ms Warner maintained that she did still reiterate Justine's absconding risk during the call to RPH. Although it is not reflected in her events report note, Ms Warner's recollection is supported by her email response to Ms Subramaniam on 2 June 2020.

[112] Exhibit 1, Tab 14A.2
[113] T 71.
[114] Exhibit 1, Tab 14A.4.
[115] Exhibit 1, Tab 14A.5 and Tab 14B.
[116] Exhibit 1, Tab 14A.5.
[117] Exhibit 1, Tab 14A.2.
[118][118] Exhibit 1, Tab 14A [16].

The email reports that she raised Justine's risk of absconding with the RPH staff "but they said that they have been letting her go downstairs when she wants to and she has always come back".[119] Ms Warner then commented, "[i]t's not an ideal answer but the best I could get".[120] Ms Warner explained at the inquest that this information related to a second telephone conversation she had with RPH staff, which was prompted by Ms Subramaniam's email. Ms Warner gave evidence that she did not make a record of that second telephone conversation with RPH. Ms Warner said that the nurse hung up on her, which is why she remembered the call so clearly without a contemporaneous note.[121]

93. Ms Subramaniam's response is significant when read in the context of what we know now occurred. Ms Subramaniam wrote to Ms Warner,[122]:

> *"It is at times shocking to see how the hospital operates. Bless them. Can't wait for Justine to return back home safe and sound".*

94. Nurse Santiago made a note in the Mosman Park Home's Integrated Progress Notes on 3 June 2020 that Ms Warner had called RPH and the RPH staff had informed her that Justine did not literally go outside to smoke, but rather went outside for fresh air. In her note of the discussion with Ms Warner, Nurse Santiago recorded that the RPH staff had been "reminded that Justine is an absconding risk".[123] This appears to have been taken from the email received from Ms Warner.

95. Also on 3 June 2020, Ms Subramaniam, recorded in the Integrated Progress notes her understanding that Ms Warner had been contacted and asked to contact RPH and remind them of the need for Justine to be supervised. The following entry in the Mosman Park Home documented: "Guardian was contacted to call and advise the staff of resident's mental health condition & resident being a high risk of absconding".[124]

96. After seeking Ms Warner's consent, on 2 June 2020, Justine had undergone a gastroscopy and endoscopy and iron infusion. The procedures were without incident, but during the gastroscopy the surgeons found some varices that were bleeding. They obtained Ms Warner's permission to do another procedure on 3 June 2020 to band them. It was noted she might have some uncomfortable symptoms after waking up.[125]

97. At 8.30 am on 4 June 2020, Justine was reviewed by the gastroenterology team and appeared stable.[126]

98. At 3.20 pm, Nurse Melissa Bryant, who had cared for Justine during the day shift, made an entry indicating that Justine was waiting for her injection of paliperidone, which had been ordered from the pharmacy. The rest of the entry suggests nothing alarming or concerning happened during the day. Nurse Bryant had no independent recollection of

[119] Exhibit 1, Tab 14A.6.
[120] Exhibit 1, Tab 14A.6.
[121] T 183 – 189.
[122] Exhibit 1, Tab14.A.6.d
[123] Exhibit 1, Tab 21, CS1.
[124] Exhibit 1, Tab 25, CL7.
[125] Exhibit 1, Tab 14A.10 -11.
[126] Exhibit 1, Tab 19.

Justine, given the lapse of time, so no more information is available as to how Justine was behaving in the morning.[127]

99. Ms Subramaniam recorded in the Mosman Park Home's Integrated Progress Notes at 3.00 pm on the afternoon of 4 June 2020 that she received a phone call from Justine's mother who had been trying to contact Justine but every time she got put through to Justine's hospital room, the phone was never answered and would ring out. Accordingly, she had rung the Mosman Park Home to try to get some information about Justine's progress at the hospital. At that time, being unaware of the events taking place at the hospital, Ms Subramaniam reassured Justine's mother and advised her that she would call her the next day with further updates. Sadly, later that night Justine's mother called Ms Subramaniam again to advise that she had been notified by Justine's death, which had occurred around the time Ms Subramaniam was making that last entry in the records.[128]

EVENTS LEADING TO DEATH

100. A retrospective nursing entry at 4.00 pm (made after Justine's death had been reported to Nurse Meakes by police at 3.30 pm) documented that Registered Nurse Shiby Paul had taken over Justine's care at 1.30 pm from Nurse Bryant. Nurse Paul had a chat with Justine during the handover at 1.15 pm. Justine was in her bed at the time. Nurse Paul checked Justine again at about 2.15 pm and noted that Justine's blood sugar was high, so she gave Justine her diabetic medication metformin (which had not been administered that morning) and informed Justine's doctor, who ordered insulin. Nurse Paul spent about ten minutes with Justine at this time, giving Justine her medication and some afternoon tea and jelly. Nurse Paul indicated in her note that Justine showed no signs of agitation at this time. She seemed pleasant and was behaving like her usual self.[129]

101. Justine's doctor had also ordered an intravenous dose of the medication frusemide (which is used to treat oedema/swelling) be given to Justine straight away, so Nurse Paul left Justine to obtain the medication. When Nurse Paul returned to administer the frusemide to Justine at about 3.00 pm, she was not in her room.[130]

102. Nurse Paul had cared for Justine over the previous days and gave evidence she had not been advised of any absconding risk in relation to Justine or any need for Justine to be escorted when off the ward. Nurse Paul had noted on the evening of 31 May 2020 that Justine had been off the ward a couple of times that shift and returned back each time, and again on 2 June 2020, with the additional note that she was leaving the ward to smoke.[131] Therefore, Nurse Paul had become accustomed to Justine leaving the ward during her shift to go outside and smoke and was not concerned on this day when Justine was not in her bed. Nurse Paul simply assumed that Justine had gone downstairs

[127] T 161; Exhibit 1, Tab 20.
[128] Exhibit 1, Tab 25, CL7.
[129] T 164 – 167; Exhibit 1, Tab 18; Exhibit 5, Tab 21.
[130] Exhibit 5, Tab 21.
[131] T 170 – 171; Exhibit 5, Tab 15 and Tab 17.

to smoke again and would return as usual. Therefore, Nurse Paul did not take any action in relation to Justine's absence.[132]

103. The window of time for Justine to leave her hospital room was between about 2.30 pm and 3.00 pm, based upon Nurse Paul's evidence, and the evidence obtained from the Perth City Council CCTV cameras confirms that Justine had left the hospital building just before 3.00 pm.

104. Justine's passage through the Perth CBD is captured on the CCTV footage and showed that Justine, still dressed in her hospital gown, walked away from the hospital at about 2.58 pm and then walked slowly down Murray Street, heading west. She was seen by some witnesses, who looked somewhat surprised but they did not take any action or try to approach her. Justine then turned onto Pier Street and entered a multi-storey public carpark on the corner of Pier Street and Wellington Street at 3.06 pm. It would appear that Justine went there with a plan in mind to end her life, although whether she was responding to auditory command hallucinations to take that action, or if she had a genuine desire take her own life, is unclear. The footage shows her walking purposefully, albeit slowly, and she does not deviate in her path. When Justine reached the carpark, she entered the stairwell and is not seen again on the footage until just before her death. The police investigation established that she made her way up to the top floor of the carpark, as police later found one of her shoes on the top floor and the other was found on her body.[133] Justine sat on the low wall and appeared to wait until pedestrians had moved out of the way before she deliberately fell to her death at 3.12 pm.[134]

105. Justine landed on the footpath in front of a Department of Health administration building staffed by doctors and nurses. They immediately came outside to try to provide emergency first aid to Justine and commenced CPR. Police officers who were patrolling the area came to assist and they noted that Justine was wearing a hospital gown and hospital identification tag, which identified her as a hospital patient and recorded her name. St John Ambulance officers arrived on the scene quickly and took over resuscitation efforts, but despite best efforts, Justine died from her injuries at the scene. Her death was certified at 3.28 pm.[135]

106. The police officers at the scene made enquiries based on the information on Justine's identification tag and contacted RPH, given its proximity. Their enquiries confirmed that Justine was missing from her hospital bed, so her identity was able to be established very quickly.[136]

CAUSE OF DEATH

107. An external post mortem examination and CT scan was performed on Justine's body, which showed changes of recent medical care and widespread severe injury, including

[132] Exhibit 1, Tab 18; Exhibit 5, Tab 21.
[133] Exhibit 1, Tab 6.
[134] Exhibit 1, Tab 6.
[135] Exhibit 1, Tab 6.
[136] Exhibit 1, Tab 6A.

multiple fractures and internal injuries. Given the nature of her injuries, it was possible for a forensic pathologist to determine a cause of death on the basis of those limited investigations. The forensic pathologist, Dr Cooke, formed the opinion the cause of death was multiple injuries.[137]

108. Toxicology analysis was performed, and it showed the presence of a number of medications at normal levels, together with a high level of caffeine, consistent with a recent, high intake, presumably from something she consumed not long before her death and considered in the context of her liver dysfunction causing poor metabolism of caffeine.[138]

109. I accept and adopt the opinion of Dr Cooke and find that Justine died as a result of multiple injuries.

MANNER OF DEATH

110. The CCTV footage shows Justine walked slowly but surely to the carpark. She appeared to walk with a sense of purpose and without any real deviation in her chosen path. She did not appear distressed or to be suffering from indecision about what she was doing. Her actions appeared deliberate although her demeanour is clearly of someone who is not responding to her surroundings. Dr Sudbury explained that Justine's appearance, as I have described it, would be consistent with Justine engaging with the voices she was hearing, as that was her world most of the time.[139]

111. Dr Sudbury was asked whether she could assist with any opinion as to why Justine went to the carpark and jumped. Dr Sudbury expressed the opinion it would have been an intentional act on Justine's part, but Justine would have done so as she believed she was being told what to do as part of the 'death command' hallucinations she regularly experienced.[140] I understand from the evidence that Justine would understand that taking such an action would cause her death, but she believed due to her hallucinations that her death was necessary to prevent some kind of catastrophic event. Dr Sudbury commented that "whether she thinks of that as killing herself, I don't know".[141] Dr Sudbury said she was never able to get Justine to explain what she believed would be the results of following the instructions of the man's voice that she heard, as Justine was unable to express what she understood the consequences of following the commands would be.[142]

112. It is an unusual set of circumstances. The evidence suggests that Justine did have a capacity to form an intention to act in a way that would end her life, in the sense of voluntarily doing an act that would almost certainly result in her life ending. However, in doing that act it is very likely she was following auditory commands from a person she heard in her head (as part of her psychosis), rather than exercising her own free choice. It makes it harder in those circumstances to reach a determination as to whether

[137] Exhibit 1, Tab 5.
[138] Exhibit 1, Tab 4 and Tab 5.
[139] T 16 – 17.
[140] T 23.
[141] T 40.
[142] T 40.

Justine intentionally committed suicide, in the sense of feeling actively suicidal, hoping to end her life and understanding the nature and consequences of the act she was committing.

113. Accordingly, although her death appears to all intents and purposes to have been a suicide, I leave the manner of her death open as there is insufficient evidence before me to determine that at the time Justine jumped from the carpark she was capable of forming the reasoned intention to take her life and understanding the consequences of her actions.

HOSPITAL INTERNAL INVESTIGATION

114. Justine's death was classified as a Severity Assessment Code 1 (SAC1) Clinical Incident, which required an investigation known as a root cause analysis to be undertaken within 28 working days. The SAC1 investigation was initiated by EMHS as RPH falls within that service and Justine was an inpatient at the time of her death. The purpose of the investigation is to identify any systemic issues that might require amendment to policy or procedures or require further education, rather than any focus or blame being placed on the conduct of individuals. As noted above, it has a short timeframe for commencement and completion, and in this case the report was completed on 19 August 2020, just over six weeks after Justine's death.[143] Often, these time limitations and the concern to avoid targeting individual staff members can lead to errors and gaps in the materials obtained by the investigators, and a number of such factual errors were identified in submissions made on behalf of the Mosman Park Home.[144] I also note the panel kept the investigation internal, and did not interview the nursing home staff, which meant there was a significant gap in the relevant information available to them. Therefore, my focus is primarily on the recommendations that arose from the investigation, in the sense of whether they have adequately addressed the concerns that have arisen in this inquest, rather than the detail provided in the investigation of the actual factual events.

115. It was submitted on behalf of the Mosman Park Home that I should also treat the two recommendations of the panel with caution, given they were based on a number of factual inaccuracies. In addition, one of the two recommendations was incorrectly said to be complete, when it was conceded at the inquest that it was not.[145] Submissions were made on behalf of the Mosman Park Home that a number of different recommendations might, instead, be usefully made by me arising out of this inquest, that could assist in preventing another such death. I address them below in my comments on public health.

116. Moving to the details of the SAC1 investigation, I heard evidence from Ms Linda Brearley, who is the Co-Director of the Medical Division of Royal Perth Bentley Group and was part of the panel that investigated Justine's death and prepared the SAC1 report. Ms Brearley gave evidence at the inquest in relation to changes that have been

[143] Exhibit 1, Tab 12.
[144] Closing Submissions of Fresh Fields Aged Care Pty Ltd t/a Mosman Park Aged Care Home filed 22 April 2022, [109].
[145] Closing Submissions of Fresh Fields Aged Care Pty Ltd t/a Mosman Park Aged Care Home filed 22 April 2022, [110] – [112]

made at RPH subsequent to Justine's death following on from that clinical incident investigation and the recommendations that were made. Ms Brearley, who is a registered nurse and also has a Bachelor of Economics and Master of Public Health, indicated that she was not involved in Justine's care at any stage, but became involved in the matter after receiving a report of her death shortly after it occurred as Ward 8A falls within her area of managerial responsibility.[146]

117. Ms Brearley became aware of Justine's death from her Coordinator of Nursing, Rebecca Credlin. Ms Credlin told Ms Brearley about Justine's death sometime between 3.45 to 4.00 pm on 4 June 2020. They immediately went to Ward 8A and spoke to Nurse Meakes, and were advised that a ward clerk had received a phone call from the RPH Anita Clayton Tuberculosis Clinic, which is located on Pier Street next to the location where Justine died. RPH Respiratory physicians from the clinic had attempted to resuscitate Justine without success. Police attended the hospital soon after and efforts were made to notify Justine's mother and guardian of her death. The Mosman Park Home staff were not contacted on this day.[147]

118. The Nursing Coordinator, Ms Credlin, spoke to Ms Subramaniam at the Mosman Park Home on 5 June 2020 and formally advised her of Justine's death. Ms Subramaniam had already been informed by Justine's mother the previous day, and it was her recollection that she made the call to RPH and was put through to Ms Credlin, who confirmed the information.[148] Ms Subramaniam was, understandably "very distressed and angry"[149] and so the matter was escalated to Ms Brearley. Ms Brearley and Ms Credlin offered to visit Ms Subramaniam and run through the known events, as a mark of respect to the nursing home staff rather than as part of the formal investigation.[150] They eventually met on 29 June 2020.[151]

119. Ms Brearley noted that after the meeting Ms Subramaniam was still quite upset and Ms Brearley reassured her that the hospital would conduct an internal investigation and then communicate the outcome of that investigation to her. It was also one of the recommendations of the SAC1 investigation that Ms Brearley contact Ms Subramaniam to share learnings from the investigation. Unfortunately, there was a miscommunication and Ms Brearley assumed the Nurse Coordinator, Ms Credlin, would undertake this task and it seems Ms Credlin was unaware that she was supposed to do so. Ms Brearley assumed the information had been provided, and only became aware around the time of the inquest that this task was not completed. She acknowledged that she was ultimately responsible for ensuring this was done and apologised for her mistake.[152]

120. Ms Brearley commented that the hospital has not changed its handover policy as part of the review, as it was always clear that they required a good handover. The RPH *Clinical Handover Policy* "defines the clinical handover as an explicit transfer of information supporting the transfer of clinical accountability and responsibility between health care

[146] T 245.
[147] Exhibit 1, Tab 17.
[148] Exhibit 1, Tab 22.
[149] T 246.
[150] T 245 – 246.
[151] Exhibit 1, Tab 17.
[152] T 246 - 247.

professionals to enable the continuity of patient focussed safe and high quality care".[153] In relation to inter facility transfer, the policy specifies handover should be between treating clinicians and, ideally, should be face to face, although this is not always possible.

121. Noting the failures in the handover in this case, RPH staff are still applying the same handover policy, but are now focussed on ensuring the handover is done more synergistically with input from all of the relevant staff, rather than simply relying on the nursing staff alone to identify risk. In the new admission process, Ms Brearley indicated that there is an increased opportunity to identify patient risks and flag them for other staff. There is also a focus on encouraging staff to look at relevant documentation, even when busy, so that they can provide holistic care.[154]

122. Looking then to the actual SAC1 investigation, I note a focus of the recommendations was ensuring in future cases that a sufficient handover occurs for transfers of patients from outside agencies. This includes hospital staff being conscious of the need to actively seek information when patients risks are flagged. In Justine's case, Ms Brearley acknowledged there were enough red flags to have prompted RPH staff to pursue further information from the nursing home about Justine, but this did not occur. The panel investigating the matter agreed that, if the real risks presented by Justine being left unsupervised had been understood by RPH staff then she would have been allocated a 'one-to-one' companion, at least in the early stages of her admission. It was suggested that due to her calm demeanour, this allocation of a nursing special might have been reviewed by hospital staff in the following days, but any change to that position would have been undertaken in consultation with the psychiatric liaison team and with a good understanding of her psychiatric history. This obviously did not occur in Justine's case, so the importance of good communication with external agencies and between disciplines was emphasised by the internal review.[155]

123. RPH is now working to ensure that a more holistic assessment of a patient, including considering their background history and their current treatment needs, is done in every part of the hospital. Ms Brearley noted in some other areas, such as geriatrics, there has always been a tight multidisciplinary team and the risk assessment happens very naturally in that setting. The hospital is now trying to ensure the holistic manner of patient care happens irrespective of which ward the patient is admitted. Ms Brearley explained that this change is necessary as historically it would be rare for a psychiatric patient to be treated in a general health ward, but that has very much changed and it is a much more common occurrence, which puts enormous pressure on the system, and the nurses in particular. Therefore, there needs to be a greater focus on all of the patient's health issues, rather than just the particular treatment focus of a specific admission.[156]

124. Ms Brearley gave evidence that they have now removed the nursing admission form and made it a multidisciplinary form so that the whole interdisciplinary team can contribute to that admission. That means allied health, medical staff and nursing staff are all involved. It has been an ongoing process over the last 18 months to two years and

[153] Exhibit 1, Tab 17, Annexure 1.
[154] T 255, 261, 272.
[155] T 250.
[156] T 254 – 262.

Ms Brearley described it effectively as a work in progress, as it has involved a "really big culture change for the medical staff"[157] and a change in the critical thinking of nurses to help them to look at, and assess, risks. Ms Brearley said she accepts there is still a way to go, but thinks the hospital is "heading in the right direction".[158]

125. Ms Brearley also advised that the hospital is now training auditors so that the process can be audited in order to ensure they are meeting those standards and to demonstrate that RPH does actually provide "comprehensive care to patients from a holistic point of view".[159] Ms Brearley commented that in Justine's case it is clear that the physical and mental side of her patient care were not joined up, which led to things being missed.[160]

126. Ms Brearley emphasised in her evidence the seriousness with which the hospital has viewed Justine's death and the great regret felt by staff about the failures in her care as "it's certainly not the level of care we strive to provide".[161]

127. When I read the SAC1 investigation prior to the inquest, my impression was that there was some suggestion that the Mosman Park Home staff had provided an 'inadequate handover' to RPH staff. While the investigation acknowledged that where a patient is flagged 'at risk' there is an obligation on RPH staff to follow up and ascertain what the risk entails, there remained a suggestion that the nursing home did not provide appropriate information. This seemed to come from the fact the transfer form simply refers to 'absconding risk' without more detail, but ignores the referral of the reader to the much more detailed attached patient care summary prepared by Dr Sudbury.

128. The SAC1 panel also concluded that Justine's death was spontaneous and difficult to predict. I note Ms Brearley's evidence that the panel did not have a lot of background information on Justine when reaching their conclusions, which perhaps explains why the panel reached that conclusion. In my view there was a lot of information in Justine's history that suggested her death was predictable, if she was not supervised closely. Certainly, the Mosman Park Home staff were able to identify in advance that Justine was at risk at the hospital while she was being allowed to go outside unsupervised and they were rightly concerned.

129. I raise these issues simply to note that, at the conclusion of the inquest, it was acknowledged by counsel appearing on behalf of the hospital that the SAC1 report did not cover some important issues and was missing some relevant information in relation to other issues. It was acknowledged that the real issue was in relation to communication or miscommunication within the hospital, rather than any inadequacy in the communication from the Mosman Park Home, and there were missed opportunities to follow up on red flags and find out important information that might have led to different decisions being made in relation to Justine's supervision.[162] This is particularly within the context that Justine was a regular patient at RPH and her psychiatric history was well documented.

[157] T 254.
[158] T 254.
[159] T 255.
[160] T 255.
[161] T 274.
[162] T 318 – 320.

130. Dr Sudbury referred to the requirement that Justine be held at RPH in the haematology ward for her blood transfusion was inherently problematic, noting that, "for somebody as complex as Justine, that particular place wouldn't have been ideal".[163] I queried whether it might have been more appropriate to have Justine managed on a psychiatric ward while receiving her blood transfusion, but Dr Sudbury and other witnesses suggested that given the limited number of such beds available in the public health system, and her relatively stable mental state, this was unlikely to have been possible, and also unlikely to have been a calm and supportive environment for Justine. Instead, the best approach if Justine was to be managed on a general ward, was for her particular psychiatric risks to be understood and appropriately managed by the staff working on that ward. Regrettably, this did not occur.

EVIDENCE FROM THE MOSMAN PARK HOME

131. As part of the coronial investigation, the Corporate Services Manager of Hall & Prior Health and Aged Care Group, Mr Daniel Hitchcock, provided information about Justine's care while a resident at the Freshwater Bay and Mosman Park Homes. Mr Hitchcock advised that Justine had been receiving care and support for her complex health needs, which was believed to have been having a "real and tangible effect"[164] on Justine's quality of life. Justine was described as an "engaged and well liked member of the Mosman Park Home community"[165] and it is clear that her death came as a great shock and has had a profound impact on her fellow residents, the management and clinical team who provided Justine with care and support.

132. Ms Subramaniam provided her own comments in the letter sent by Mr Hitchcock, and it was very clear from reading Ms Subramaniam's account that she felt let down by the system. In relation to being notified of Justine's death, Ms Subramaniam wrote,

> *I was personally devastated by that news. Ms Painter is not another statistic of people committing suicide. This has occurred due to failure of understanding of her condition and lack of care. Nothing we do now is going to bring back Ms Painter to her family, however, I humbly request that this matter is investigated thoroughly and a better plan is developed to prevent another loss due to lack of care. Ms Painter's family and we at Mosman Park Nursing Home need closure and justice in relation to Ms Justine Painter's death.* [166]

133. Ms Subramaniam made it clear that she believed the Mosman Park Home staff had done their best to highlight Justine's absconding risk to the hospital staff, but their concerns had been ignored. If they had listened, her death might have been prevented.[167]

134. Ms Subramaniam was an impressive witness. She has the heavy responsibility of managing the care of 81 residents at two residential homes and she is involved in every

[163] T 41.
[164] Exhibit 1, Tab 7.
[165] Exhibit 1, Tab 7.
[166] Exhibit 1, Tab 7.
[167] Exhibit 1, Tab 7.

aspect of the running of the homes, yet it is clear she makes time to get to know every single resident. Ms Subramaniam stated, the "main big responsibility I carry is caring for my residents"[168] and it is very clear that she takes her responsibility very seriously. She emphasised the importance of providing personalised care to every individual resident, which involves knowing their background as well as their current needs.

135. Ms Subramaniam knew Justine and her needs very well. She described Justine as a "beautiful, intelligent girl"[169] who, unfortunately, had her pathway diverted at the end of her university years and was never able to reach her full potential. The staff did their best to care for and love Justine and help her to live the best life that she could. It was apparent that Justine did not have long to live due to her co-morbidities, particularly her oesophageal varices. Accordingly, the staff went out of their way to hold a party for Justine's 50th birthday in December 2018. It was described as a joyful day for Justine, her family and the residents and staff at the Mosman Park Home.[170]

136. It was very clear during the inquest that all of the Mosman Park Home staff were devastated by the news of Justine's death. Nurse Santiago mentioned they had got Justine's room ready for her return and they were clearly keen to try to get her back to their care as soon as possible. Nurse Santiago described Justine as "very sweet, and vulnerable"[171] and the thought of her being outside had worried them. Their efforts to convey their concerns to RPH staff seemed to fall on deaf ears, so their primary aim was to try to get her back to them as soon as possible, so they could keep her safe.[172] Sadly, she died before this could occur.

137. As I indicated to Ms Subramaniam at the inquest, her comments about the failures in Justine's care at RPH played a pivotal role in my determination to hold an inquest in this matter. Further, the materials before me, and the evidence of the witnesses at the inquest, supported her contention that the lack of understanding of Justine's absconding risk and the failures in her care that led to her death could not be attributed to an inadequate handover from the Mosman Park Home, despite the conclusions of the hospital's internal investigation.

138. In relation to the issue of the lack of detail about the absconding risk noted on the transfer form, Nurse Santiago was asked whether she felt she should have provided more information about the absconding risk to the hospital. She responded that the risk was referenced on the transfer form and in the CMA, she had told an RPH staff member over the telephone that Justine could not be left alone and Justine had been brought to the hospital by a carer. In Nurse Santiago's clinical judgment, all of this information should have been sufficient to convey the risk.[173] Nurse Santiago's expectation was that, with this knowledge, the clinical staff at RPH would receive Justine from Ms Lee but they would not require an extensive verbal handover from Ms Lee. Ms Lee's role was simply to escort Justine to the hospital safely. If the hospital staff required more information than had been provided in the documentation, Nurse Santiago assumed they

[168] T 285.
[169] T 284.
[170] T 284, 304; Exhibit 1, Tab 7.
[171] T 85.
[172] T 84 – 85.
[173] T 64 – 66.

would contact the Mosman Park Home by telephone.[174] This is a reasonable assumption.

139. Similarly, Ms Subramaniam gave evidence that she believed the Mosman Park Home staff had provided more than sufficient information to the hospital to identify Justine's level of risk. Ms Subramaniam noted it was a direct admission to the ward by pre-arrangement with RPH staff and Nurse Santiago had given some handover on the phone before Justine went to the hospital. Further detailed written information was given to RPH staff as part of the patient handover by Ms Lee, and if any further information was required, it could have been followed up by a telephone call. Indeed, Dr Tan did ring Ms Subramaniam on the day of Justine's admission seeking further information about why she was admitted.[175] Ms Subramaniam gave evidence she was surprised he didn't know this already, but understood he was probably busy and was happy to provide what information he required.

140. Ms Subramaniam recalled that the rest of her conversation with Dr Tan focussed on whether she had shown any indication of bleeding, such as vomiting blood. He did not query the reasons for Justine being noted as an absconding risk or seek further information about her psychiatric issues. Ms Subramaniam quite reasonably assumed he had sufficient information on this point as he did not ask her about it.[176] Dr Tan certainly was aware Justine had a psychiatric condition, as he made a note of it in her background in the medical notes, but he was not called at the inquest so he did not get an opportunity to elaborate further.

141. Putting to one side the information contained in the transfer form and CMA about Justine's absconding risk, the Mosman Park Home staff clearly raised verbally the issue of Justine's absconding risk directly with RPH staff in the days prior to her death. Ms Subramaniam recalled that one of the nursing staff called the hospital as Justine was originally only supposed to be in hospital overnight, so they were trying to find out what was happening. They had also tried to call Justine, as had her mother, but no one could get hold of her. After their conversation with a nurse about Justine going outside on her own to smoke, the matter was escalated to Ms Subramaniam, who as noted above, raised the matter with Justine's guardian, Ms Warner. Ms Subramaniam explained she did this as she was aware the RPH nursing staff had not been responsive to the concerns raised by her staff, and she hoped that going through Ms Warner might be more effective.[177]

142. Ms Warner then raised the issue with hospital staff, who indicated their experience of Justine leaving the ward and returning again without incident, so they believed this was a reasonable course to continue. Ms Warner was not in a position to insist on the hospital staff taking a different approach, and she was guided by the clinical staff's advice as to the appropriateness of the practice.

[174] T 68.
[175] T 290.
[176] T 286 - 291.
[177] T 293 – 294.

COMMENTS ON PUBLIC HEALTH

143. As this inquest was not a mandatory inquest, I am not required to comment on the treatment, supervision and care provided to Justine prior to her death. However, I am empowered under s 25(2) the *Coroners Act 1996* (WA) to comment on matters of public health that, in my view, are connected with Justine's death.

144. As I have noted above, Justine had a complex history of drug abuse, chronic medical conditions and psychiatric issues. She had been in deteriorating health for many years and had experienced homelessness, before a guardian was appointed and accommodation was found for her in a secure facility due to her risk of absconding and self-harm. In the last years of her life, Justine lived in the facility other than some brief periods. The evidence shows she was able to be kept safe and relatively comfortable in that environment. The Mosman Park Home staff (in which group I include Dr Sudbury) also did their best to ensure Justine lived as full a life as was possible for her at that time. The efforts made by the Mosman Park Home staff to achieve this were exceptional.

145. At the conclusion of the inquest, Justine's parents provided a short statement. I have included some of the most relevant portions below,[178]:

> *Because of the tireless efforts of a wonderful social worker at Bentley Health, Justine found a home at Freshwater Bay and Mosman Park Nursing Home, where she was cared for and enjoyed the social activities, especially the swimming, the occasional movie and cooking. She became friends with the staff and was content, residing in particular in Mosman Park. We thank them and are truly grateful. You hear many nursing home horror stories. Well, this is a good one, run by people who care.*

146. The evidence I heard from the staff who worked at the Mosman Park Home, particularly Ms Subramaniam, confirmed what Justine's parents told the Court. They cared for Justine like a family member.

147. However, many of Justine's health issues required more intensive medical input than could be provided at the Mosman Park Home, which seems to be where the main risk to her wellbeing and safety arose. When attending RPH for treatment for her general health issues, Justine was not admitted to a psychiatric unit, but instead was placed in a general ward with a focus on her physical health issues. I understand that this was appropriate, but it did increase the risk that Justine's psychiatric issues might be overlooked, and that is what did occur.

148. The Mosman Park Home staff made sure Justine was delivered safely to the hospital, at a time and place arranged by the RPH staff. Accompanying her was a carer to ensure she was delivered safely and some written documentation to explain some of Justine's background and risks, including her absconding risk. The Mosman Park Home clinical staff assumed the RPH staff would read that documentation and then call them if they needed more information.

[178] T 312.

149. Unfortunately, the evidence suggests the documentation was put on a file and very few, if any, of the RPH staff read it. As a result, there was a lack of appreciation by the hospital staff caring for Justine of the risk Justine presented to herself and her consequent need for a high level of supervision in such a ward. Before she arrived, her name was flagged on the nurses' journey board to alert any nurses to the fact that Justine might present a risk to patient or staff safety. However, no risk assessment or mental health assessment was done at the time of her admission, and no consideration appears to have been given to allocating a nursing special to monitor Justine on the ward or to arranging for a psychiatric liaison nurse review. Instead, she received only general nursing supervision and after a day or two of getting to know her, the staff were reassured she seemed calms and compliant, so she was allowed to come and go from the ward as she pleased.

150. Justine was allowed to leave the ward unsupervised and go outside the hospital to smoke on at least five occasions, despite the fact she was noted as not being a smoker on her admission form and her transfer form indicated she was an absconding risk.

151. As Justine's mental state was not formally assessed during her admission, it is impossible to know whether she decompensated due to the stress of her admission or whether she was simply suffering from her usual level of hallucinations, which Dr Sudbury gave evidence were always just below the surface. Justine's symptoms were described by Dr Sudbury as "subtle",[179] and she was generally a compliant patient, so it was not entirely surprising that the nursing staff did not appreciate how serious her hallucinations were at the time. I accept she would have seemed calm and generally compliant to the RPH staff on a superficial level. However, given her well documented psychiatric history in the medical records and the information provided by the Mosman Park Home staff, there were red flags that should have prompted them to find out more about Justine's psychiatric background and risk.[180]

152. This was particularly so on 2 June 2020, when staff from the Mosman Park Home and Justine's guardian raised some concerns directly with the staff about Justine going outside to smoke unsupervised. Rather than escalating these concerns or seeking further information, the concerns were dismissed by one or more nurses who received these calls. It was only a couple of days later that it became apparent to the RPH staff why the Mosman Park Home staff were so concerned. Sadly, by then it was too late.

153. I am satisfied that Justine's death was preventable if her risk of absconding had been properly understood and addressed during her admission to RPH. A simple option, that is done routinely in hospitals where there is a high level of risk, would have been to allocate Justine a one-to-one nursing special to mitigate her risk of absconding. This is the option that Dr Sudbury suggested would have been the most suitable to keep Justine safe in that environment. She did not require a stay in a psychiatric unit at that time, as her symptoms were generally stable and she was compliant, and the instability of a psychiatric unit might have been detrimental to Justine.[181] If the need for a nursing special to continue had been questioned, given her ongoing compliance on the ward, she could have been reviewed by a psychiatric liaison nurse who would have performed a

[179] T 25.
[180] T 24.
[181] T 25 – 26.

proper comprehensive risk assessment. Perhaps they may have then made the decision not to continue with close supervision, but I personally think it is unlikely if they had properly reviewed her history and spoken to Dr Sudbury and Ms Subramaniam. I note this was also acknowledged as the likely outcome in submissions made on behalf of RPH at the conclusion of the inquest.[182]

154. This inquest has focussed upon understanding why some option for supervising Justine and limiting her ability to leave the hospital, were not considered. As noted above, the EMHS initiated its own review, which initially suggested that part of the problem arose from an inadequate handover from the Mosman Park Home, while acknowledging that RPH staff could have also followed up on the missing information. Counsel appearing on behalf of RPH submitted at the conclusion of the inquest that after hearing the evidence of the witnesses, it is clear that the transfer form was not considered by RPH staff at the critical time of the admission, so any lack of information in the transfer form was really irrelevant. It was acknowledged that the "real issue in relation to this inquest is communication or miscommunication within the Ward 8A at RPH".[183]

155. This recognition on behalf of RPH that the real failures lay internally, rather than placing the blame externally on the Mosman Park Home, was appropriate and I am grateful that the instructions were given in a timely manner to save wasted effort having to explain why I have reached the same conclusion.

156. I do, however, highlight that it is apparent from the medical records that Justine's risk of absconding had been raised before when she was admitted to the Gastroenterology Ward at RPH. On 20 June 2018, a discharge summary following her more than two week inpatient stay recorded that psychiatry had been consulted regarding Justine's ongoing chronic schizophrenia and they had been advised to keep her as an inpatient as she was "a high risk of absconding".[184] It was also noted at the time that she lived in a nursing home and had a public guardian.[185] Planning for her final admission had begun in February 2020, when Ms Warner had a conversation with a doctor at RPH who confirmed he was able to access the discharge summary from Justine's recent admission to Selby Lodge in June 2019. Justine was placed on the waitlist, which eventually resulted in her admission in May 2020.[186] All of this information was available, quite separate to any documentation or information provided from the Mosman Park Home, and it is for this reason that I have stated below that I believe the first step in highlighting Justine's risk should have been taken at the time her admission was booked by a staff member at RPH.

157. That does not mean that the handover process between agencies could not be improved, and I note that in this case it was acknowledged by the Mosman Park Home staff that the information included on the transfer form was brief and could have been a little more fulsome. Mr Hitchcock, the Corporate Services Manager for Hall & Prior, gave evidence at the inquest and agreed that, although it was unusual, based on what occurred in this case there was scope for the Mosman Park Home to amend its transfer policy to

[182] T 320.
[183] T 318.
[184] Exhibit 5, Tab 12.
[185] Exhibit 5, Tab 12.
[186] Exhibit 1, Tab 14A and 14A.7.

include a transfer that does not occur by ambulance. The policies are nationwide and affect a large number of facilities, so it needed to be considered at a higher level but I am informed it is currently being considered by management. Consideration is also being given by the Mosman Park Home's management in relation to handover procedures.[187]

158. I mention these proposals, not as any kind of criticism of the Mosman Park Home, but rather to indicate that the management of the Mosman Park Home has been proactive in considering whether there could be any improvements from their end, in terms of the transfer procedure. Ms Subramaniam expressed her understandable frustration that they provide significant documentation when transferring patients to hospitals, but it often seems the documentation is not read and they then have to provide the same information over the telephone. It goes without saying that if the transfer form is changed and more information is added, it still has to get over the hurdle of hospital staff being able to access it and take the time to read it, which is out of the control of the nursing home.[188]

159. It was acknowledged by Ms Nanthakumar and Ms Brearley on behalf of the hospital that the RPH staff should have read the transfer form and CMA patient summary when admitting Justine and sought more information if they were unclear about what her absconding risk entailed.[189] Therefore, the focus moving forward is for the hospital staff to identify red flags such as this and then seek more information if it is unclear. If that had occurred in Justine's case, it is possible that the outcome could have been different.

160. I understand that the RPH staff involved were traumatised by this very sad events and will remember Justine's case for the rest of their lives.[190] Hopefully, this very real example of what can happen when these communication gaps are allowed to exist will drive all off the RPH staff to embrace the changes that are now being implemented.

161. Ms Nanthakumar suggested that in the future, when a patient like Justine, who has a long history of mental health issues, is coming in for a planned admission to a general medical ward, the best way to ensure that the nursing staff are aware of her particular risks would be for the doctor who is arranging the admission to contact the residential care facility and find out what her present mental health problems are, and determine if she needs a psychiatric review or at least put some of that information in the booking form. In Justine's case, there was insufficient information in the electronic bed management system to alert the Nurse Shift Coordinator, Nurse Meakes, and Nurse Unit Manager, Ms Nanthakumar, to Justine's particular risks and assist them to communicate them to the other staff. Ms Nanthakumar very sensibly suggested that this case highlights the importance of treating someone like Justine "as a whole patient"[191] rather than focussing on the one issue linked to this admission. which all need to be managed together. The first step was the doctor who arranged the booking providing the information about Justine's complex mental health and physical health issues and

[187] T 307 – 308; Closing Submissions of Fresh Fields Aged Care Pty Ltd t/a Mosman Park Aged Care Home filed 22 April 2022, [42] – [43].
[188] T 304 – 305.
[189] T 238, 243.
[190] T 240.
[191] T 242.

contacting the various specialty areas that might be involved in her care, rather than simply focussing on the gastroenterology side of her treatment.[192]

162. I agree with Ms Nanthakumar that the booking of Justine for admission was the right time for her risk to be flagged from the hospital's perspective, even before the nursing home sent in their information. Justine was a regular patient who had a known, well-documented, history of mental health issues that had been treated regularly within the public health system. All of the relevant information was available in her medical files, if anyone took the time to look. There were some very clear warnings documented in relation to Justine and smoking in the discharge summary following her admission to Bentley Hospital in early 2018. She had also been to Selby Lodge much more recently, and they had liaised with RPH to ensure her physical care could be coordinated there at the one hospital [193] There is no good reason why RPH medical staff could not have flagged that history as part of her booking.

163. Ms Brearley agreed that in the future, the best option would be for the risk to be electronically flagged on a patient's record, so that it is immediately apparent to any staff, but she indicated that RPH is still many years away from being able to implement an electronic medical record. This is because of the older infrastructure at RPH, as compared to some of the newer hospitals.[194]

164. There was another opportunity for that information to be flagged for nursing staff when Justine was transferred to the hospital with the written documentation provided by the Mosman Park Home staff and Dr Sudbury. However, there was evidence from the RPH nursing staff that they would not necessarily read that documentation and would expect key information to be communicated to them verbally. Nurse Meakes, who was the shift coordinator, gave evidence that it would require a trigger to prompt her to read the transfer form, rather than doing so as a matter of course, and that seems to be the case for the other nursing staff.[195] It seems fairly clear in this case that very few, if any, of the RPH staff actually did read the transfer form or CMA, and certainly no one followed up with the nursing home staff about her level of risk. The only follow-up call was made by Dr Tan to talk about Justine's physical treatment needs, which was obviously his focus as a doctor formulating a treatment plan for her admission to the gastroenterology ward.

165. Ms Nanthakumar gave evidence that since Justine's death and the SAC1 review recommendations, all nurses now seek a very thorough handover when a patient comes in from a residential facility, consider the written information and contact the facility by telephone to discuss the patient and ascertain any risks or concerns. This information is then communicated to all of the nursing staff on the ward. In a case like Justine's, the information obtained would likely then prompt a referral to the psychiatric liaison nurse for review.[196] Ms Brearley also confirmed this was the current recommended procedure.

[192] T 242.
[193] T 206; Exhibit 8.
[194] T 260.
[195] T 136.
[196] T 226 - 227.

166. As mentioned above, on behalf of the Mosman Park Home, submissions were filed at the conclusion of the inquest suggesting a number of possible recommendations that might be made to improve the care provided to patients with a history of psychiatric illness who are admitted to RPH in the future. I note these are suggested in the context of Ms Brearley's evidence that RPH now sees a significantly increased prevalence in patients of combined general physical health and mental health issues as compared to the past. Ms Brearley gave evidence this places "an enormous amount of pressure on the system and nurses",[197] so any recommendations that might be made to assist in this area may be helpful to alleviate some of that pressure.

167. To keep things brief, I note that some of the proposed recommendations, while entirely sensible, are probably not feasible given the limited resources with the public health system. The first suggested recommendation is an example of this, as while I consider it would be ideal for all patients with any psychiatric history to be reviewed immediately upon admission by a clinical staff member of the psychiatric department and determine whether they require any additional level of supervision. I know from previous inquests that this simply isn't possible given the prevalence of patients with mental health issues and the already stretched mental health resources. There are currently often long wait times for even acutely psychotic and suicidal patients to be reviewed by a psychiatric liaison nurse in emergency departments.

168. In relation to recommendation two, suggesting RPH considering implementing an audit regime, I understand from Ms Brearley's evidence that this is currently already being undertaken by RPH, at least in relation to the key aspects arising from the review into Justine's death.

169. In relation to recommendations four, five and six, I consider that they are all very sensible suggestions. In particular, I consider it imperative that there needs to be improved communication where a patient is transferred from an external facility to RPH, particularly when it is a nursing home, to ensure that there is a good understanding of why the patient has been transferred and whether there are any particular risks associated with that patient's behaviour or risk profile. This would apply to dementia patients and elderly patients who are at risk of falls, as well as patients with a psychiatric history like Justine. It seems obvious that a patient who needs to live in such a facility will have different risks than the average patient.

170. I note that in Justine's case, a lot of that information was very helpfully provided by the Mosman Park Home staff in a written form, but the impression I formed from hearing the evidence is that there is rarely time for that documentation to be read and processed by busy nursing staff. Therefore, the suggestion that RPH consider amending its policies to require that, where a patient is received from an external facility, contact be made immediately upon the patient's admission with the external facility to confirm relevant information about the patient, seems the best solution.

171. However, I also note Ms Nanthakumar's evidence that since Justine's death and the SAC1 review recommendations, all nurses in Ward 8A now seek a very thorough handover when a patient comes in from a residential facility, communicate the

[197] T 262.

information to all of the nursing staff on the ward and consider referral to the psychiatric liaison nurse for review, where required.[198] Ms Brearley also confirmed this was the current recommended procedure.

172. The fifth suggested recommendation fits within the comments I made earlier about the best time for information about known risks with a patient, based upon their previous medical records held by the hospital, is at the time of booking the patient.

173. Counsel appearing on behalf of the EMHS provided detailed information to the Court in April and May 2022 on the policy changes that have been made at RPH (and Bentley Hospital) since Justine's death and the inquest into her death. The changes are as follows:

- All admissions and transfers of patient care are to be accompanied by an appropriate clinical handover. Clinicians are responsible for reviewing transfer records and ensuring relevant information is captured in the appropriate documents and electronic systems AND communicated to other staff as per the Clinical Handover Policy. This same policy applied at the time of Justine's death, but I understand that there is a greater emphasis placed on the policy being followed carefully and thoroughly.

- Clerical staff are to provide interfacility transfer records to the admitting nurse for review so that information can be transferred into the RPH admission documentation/iSoFT handover before filing in the patient's health record.
- Discharge transfer letters will be retained in the medical record.

- Several changes have also been made specifically in regard to inter-facility transfers, namely:

    i. For multi-day admissions, receiving staff must contact the facility to seek a verbal clinician to clinician handover (even if a written transfer is provided) to very information and identify risks or concerns;

    ii. Day units/procedural units may utilise written transfer information if there are no concerns. Where there are questions/concerns about assessment findings or changes in the patient condition, staff should clarify information with the referring facility; and

    iii. When patients convert from a day admission to a multiday admission, a change in the patient's condition is inferred and this warrants a re-assessment of risk that needs to guide care planning. Hospital staff must contact the external facility for a verbal handover to guide re-assessment.[199]

[198] T 226 - 227.

[199] Attachment to Letter to Counsel Assisting from SSO dated 6 May 2022 – Admission, Discharge and Transfer SOP – Scope, p.4.

174. It is clear from the new policy that is accepted that there is an obligation on RPH staff to take a proactive approach with inter-facility transfers to ensure that there is a comprehensive handover of information between clinicians about patient's treatment needs and risks. If such a policy had been applicable at RPH at the time of Justine's admission, it would have prompted a discussion with the Mosman Park Home staff that would have allowed them to convey what they knew about Justine's particular risks, which would hopefully have led to a different approach to RPH staff when Justine expressed a desire to leave the ward. I still consider that there is also an obligation on RPH staff to review their own medical records when someone, like Justine, is a regular patient and flag any known risks at the time of her booking, but ensuring that RPH staff seek a verbal handover from the other facility's staff is a good backstop position to ensure that important information is not missed.

175. While I acknowledge the merit in some of the submissions put forward on behalf of the Mosman Park Home in relation to potential recommendations, in my view the proactive steps taken by RPH as part of the EMHS has addressed most of those issues. I support hospitals creating their own policies where they can, and it is clear that these policies were informed by the evidence that came out of the inquest and the submissions that have been filed. Therefore, I do not consider it necessary to make any recommendations in this matter.

CONCLUSION

176. Justine Painter had a complex history of chronic medical conditions and psychiatric issues. Dr Sudbury, her GP, described Justine as a "supremely complicated lady [who] had a very disruptive illness physically and emotionally".[200] After a long admission to a psychiatric hospital, accommodation was found for her in a secure nursing home facility, namely the Mosman Park Home. While living in the facility, her risk of absconding and self-harm was significantly reduced and she was able to live relatively comfortable in that environment.

177. Justine's medical issues required regular treatment in hospital and when she left the Mosman Park Home environment, where the staff knew her well, the risk to her safety increased. Several days after Justine was admitted to RPH in May 2020, she left the ward and walked out of the hospital grounds, walked to a nearby multi-storey carpark and jumped from the roof of the carpark to her death.

178. It is apparent that there were communication issues between RPH staff and the Mosman Park Home staff, and internally between the RPH staff, which led the RPH nursing staff to underestimate Justine's risk of absconding and self-harm. Without an understanding of Justine's psychiatric history and her particular risks, the RPH nursing staff effectively treated her like any other patient who might request leave to go outside the ward. Even though concerns were raised directly by Justine's guardian and the Mosman Park Home staff a few days into her admission, the RPH staff felt reassured that she was calm and cooperative and would return to the ward each time, so they allowed the practice to continue. As a result, no one raised the alarm after she left the hospital on the last occasion, as it was assumed she had left the ward and would return as she had done

[200] T 26.

before. Tragically, this did not occur. Instead, Justine did exactly what the Mosman Park Home feared she might.

179. Justine's family and the Mosman Park Home staff were devastated at the news of her death, given the efforts that had been made by them to keep her safe. The RPH staff on Ward 8A were also deeply affected by the event, as well as other doctors and health staff who witnessed Justine's fall. Her tragic death raised many questions about how it was able to occur, and what lessons could be learnt to prevent similar deaths in the future.

180. I am confident that by the conclusion of the inquest, the EHMS (which is responsible for RPH and its staff) had come to fully appreciate the ways in which failures in communication within RPH had led to the known risks of Justine harming herself if left unsupervised being overlooked, or at least underestimated, by the relevant RPH staff. The EMHS has taken proactive steps to change policy to ensure that relevant information is obtained from external facilities when a patient like Justine is admitted, and that information is then shared with all of the health staff who are responsible for caring for the patient. Complex patients like Justine need to be cared for in a holistic manner, with all of their care needs considered and acknowledged. This is the kind of care the Mosman Park Home provided for Justine, and the EMHS has acknowledged this is the proper pathway for RPH staff to aim for the future.

181. Justine's parents attended every day of the inquest. At its conclusion, they expressed their thanks to the Mosman Park Home staff for the way they cared for Justine in the last years of her life. They expressed their hope that the inquest into her death will lead to positive change for future patients, to prevent a similar death occurring when it seems clear it might have been prevented. I hope that they have taken comfort from hearing that the hospital has listened and learned from this case and are making real efforts to change and improve the way they care for other patients like Justine.

S H Linton
Deputy State Coroner
7 October 2022