Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 2/19

I, Sarah Helen Linton, Coroner, having investigated the death of ***Melanie (Mel) Reanna TREGONNING*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *on* ***22, 23 and 30 January 2019*** *find that the identity of the deceased person was* ***Melanie Reanna TREGONNING*** *and that death occurred between* ***12 and 13 May 2014*** *at* ***55 Collins Road, Willeton****, as a result of* ***incised wounds to the neck and arms*** *in the following circumstances:*

Counsel Appearing:

Ms F Allen assisting the Coroner.
Ms R Hartley (State Solicitor's Office) appearing on behalf of South Metropolitan Health Service, Dr Kung, Dr Arasu and Ms Warren.

TABLE OF CONTENTS

INTRODUCTION

1. Melanie (Mel) Tregonning was a talented illustrator who was a published cartoonist from the age of 16 years. Her early success meant that when she died at only 31 years of age she was still able to leave behind a significant body of work as her legacy. Her last work was a graphic novel called *Small Things*,[1] that tells through illustration the story of a little boy who feels worried and alone but learns that help is always close by.

2. Like the boy in her story, Ms Tregonning became overwhelmed with anxiety and depression. Sadly for Ms Tregonning, when she needed help most, she did not receive it. With the support of her family, she had sought help for her mental health issues from several different health professionals in the 48 hours leading up to her death. Despite her cries for help escalating, she was ultimately sent home from Fremantle Hospital without appropriate psychiatric assessment on the afternoon of 12 May 2014. She took her life in her studio overnight on 12 to 13 May 2014.

3. Ms Tregonning's family, with the help of highly regarded Perth artist and writer Shaun Tan, went to some lengths to arrange for *Small Things* to be published after her death in order to ensure that her last work was shared with the community and to spread awareness about mental illness.

4. Ms Tregonning's sister also asked the State Coroner to consider holding an inquest into her death to explore further the reasons why Ms Tregonning was not admitted for psychiatric care at Fremantle Hospital despite being taken there by ambulance on her GP's referral. Ms Tregonning's sister emphasised her belief that the mental health service failed her sister and her family's concern that this could continue to happen to other families who place their trust in medical professionals.[2]

5. The State Coroner decided that it was desirable to hold an inquest to investigate possible communication problems between the health professionals that had been identified during the initial coronial investigation, as well as the psychiatric assessment process at Fremantle Hospital.

6. I held an inquest at the Perth Coroner's Court on 22, 23 and 30 January 2019. Oral evidence was heard from a number of doctors and other medical staff who had contact with Ms Tregonning in the days before her death. Dr Adam Brett, a Consultant Psychiatrist, provided an expert opinion on the standard of the mental health care provided to Ms Tregonning prior to her death by these medical professionals and others. In addition, evidence was provided about the current mental health services available in the relevant area.

7. At the conclusion of the inquest I indicated that I was satisfied that there were systems failures on the night that meant that important information was not before the hospital staff involved in Ms Tregonning's care. However, I

[1] *Small Things* by Melanie Tregonning, published 2016 by Allen & Unwin.
[2] Letter from Ms Violet Tregonning to the State Coroner received 12 February 2015.

also indicated that although important information had not been communicated to the staff at Fremantle Hospital, there was still sufficient evidence before them to have prompted a more thorough psychiatric assessment than was performed. I invited counsel appearing on behalf of the South Metropolitan Health Service and the individual health professionals, to file submissions addressing the areas of concern I had highlighted, and to provide any additional information that might assist me in reaching my findings. Submissions were filed with the Court in due course in April 2019.[3] I have considered those submissions in reaching my findings.

8. I note at this stage that the Fremantle Hospital Emergency Department has closed since Ms Tregonning's death and been replaced by a new Emergency Department (ED) at Fiona Stanley Hospital (FSH). Therefore, any suggestions for changes looking forward necessarily relate to the FSH ED.

BACKGROUND

9. Ms Tregonning was born with a genetic condition, 5-alpha-reductase deficiency (5ARD), that affected her physical sexual development and led to issues regarding her gender identity. I am told that Ms Tregonning was very private about her condition, keeping information even from her family, so I don't propose to go into too much detail about it in order to respect her privacy. In brief, Ms Tregonning had a male (XY) genotype but was phenotypically female. Ms Tregonning always identified as female. She had some surgery as a child to remove her gonads and received hormone therapy in later years to maintain her hormonal balance as a woman.[4]

10. Ms Tregonning was described by her family as a normal teenager who was very intelligent and artistic. After finishing school she completed graphic design at Curtin University and was a finalist in the 2005 international 'Illustrators of the Future' competition. In early 2006 Ms Tregonning began working as an in-house illustrator for R.I.C. Publications. She remained working for the company until shortly before her death.[5]

11. For many years Ms Tregonning was under the care of Consultant Physician and Endocrinologist, Dr Bronwyn Stuckey. Dr Stuckey is a Medical Director at the Keogh Institute for Medical Research, with a special interest in the crossover between sex hormones and metabolism. Ms Tregonning had been referred to Dr Stuckey for further management of her hormonal status.[6]

12. Ms Tregonning had expressed concern to Dr Stuckey about mild hirsutism and loss of scalp hair. She attended a dermatology specialist clinic and was prescribed a medication to promote hair growth.

[3] Outline of Submissions filed on behalf of South Metropolitan Health Service, dated 18 April 2019; Outline of Submissions filed on behalf of Dr Dewan, dated 18 April 2019.
[4] T 22.
[5] Exhibit 1, Tab 8.
[6] T 20.

13. Ms Tregonning had also questioned whether the genetic condition, Androgen Insensitivity Syndrome (AIS) she had originally been diagnosed with (prior to seeing Dr Stuckey) was correct, or whether she had a different genetic condition. Dr Stuckey found Ms Tregonning was well-informed about conditions of intersex and had clearly researched the subject. Further investigations found Ms Tregonning was correct to question her diagnosis, and she was eventually diagnosed with 5ARD. This was a different genetic condition, but had similar outcomes.[7] Dr Stuckey considered Ms Tregonning's symptoms to be fairly mild compared to some of her patients and her clinical state was said to be pretty stable.[8]

14. Over the time that Dr Stuckey was treating Ms Tregonning she had never expressed symptoms consistent with major depression, thoughts of self-harm or suicidal intent, and had shown no sign that she was in need of psychiatric care. Dr Stuckey saw only a few signs that Ms Tregonning might have had some conflicted emotions about her gender, and it was mostly related to her appearing overly concerned about any skin or hair problem that might arise from androgen effect, which were not uncommon concerns. Dr Stuckey noted in her evidence that most of the patients with this type of genetic condition are not terribly comfortable in their own skin, so Ms Tregonning being somewhat conflicted about these issues was not surprising.[9]

15. Dr Stuckey had seen Ms Tregonning fairly regularly when she was first referred, but with less regularity as time went on, with the frequency eventually reducing to a once a year review. Dr Stuckey last saw Ms Tregonning for review on 11 October 2013, more than six months before her death. At that time, Ms Tregonning seemed to be satisfied with the effect of her treatment and was very positive about her professional life.[10] Ms Tregonning had been prescribed the same ongoing medications since 2009, which were Dianne–35, cyproterone acetate 25mg daily and spironolactone 100mg daily, and no change was made to these medications.[11]

16. For several years prior to her death Ms Tregonning was drawing her graphic novel in her spare time. It was a long process. Ms Tregonning was described as a perfectionist, which also slowed the process as she was only satisfied when her work was of the highest quality.

17. Prior to her death, Ms Tregonning took leave from her job in order to spend more time working on her book. She had considerable savings so financially she was still able to manage, but looking back Ms Tregonning's sister now feels the lack of routine and isolation may have exacerbated her depressive symptoms. However, as she had taken extended leave for a period of about 3 months on a previous occasion to solely work on her book and had coped well on that occasion, there was nothing at the time to set off alarm bells.[12]

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[7] T 20.
[8] T 21.
[9] T 22 - 23.
[10] T 20; Exhibit 1, Tab 10.
[11] Exhibit 1, Tab 10.
[12] Exhibit 1, Tab 8 and Tab 26.

18. Ms Tregonning remained living with her parents, as she had always done, and worked from a shed in their yard that had been converted into a studio. Although she had a bedroom in the house, it was not unusual for Ms Tregonning to sleep on a bed in the studio when she was working.[13]

19. Ms Tregonning had no history of mental health issues prior to the events leading up to her death. She had always appeared balanced and stable and generally kept to a simple domestic routine. She did not take illicit drugs and rarely drank alcohol.[14]

20. Ms Tregonning was described as very intelligent and self-contained. She was happy to spend a lot of time on her own drawing, reading and exploring the Internet, although she also had a group of artistic friends who she met with weekly. As well as her art, she was very interested in science fiction and human intelligence.[15]

EVENTS LEADING UP TO FREMANTLE HOSPITAL PRESENTATION

21. Prior to her death Ms Tregonning became very upset about a theory she had read that suggested humans were not as intelligent as often portrayed in science fiction and that we had largely plateaued as a species and were unlikely to continue our learning and innovation in leaps and bounds. She believed this theory to be true and said she felt that she was mourning the loss of what humans will never become. Ms Tregonning rarely cried but she was crying on the telephone when she spoke of this realisation with her sister. Ms Tregonning's sister believed Ms Tregonning had trouble sleeping after this. Ms Tregonning's family explored the possibility of Ms Tregonning accessing some counselling but it does not appear to have come to fruition before her death.[16]

22. Ms Tregonning's father reported that he had noted a sudden change in her mental state in the week or two prior to her death. He noticed she was going for walks and couldn't sleep. She also seemed tired and said she felt numb at times. She was also getting headaches and expressed concern that she was developing some kind of neurological disease, such as motor neurone disease. Mr Tregonning noticed that Ms Tregonning seemed increasingly reliant on her mother for company, which was unusual as she was usually happy spending time on her own.[17]

23. Early in the morning on Sunday, 11 May 2014, Ms Tregonning self-presented to the ED of St John of God Hospital in Murdoch. Her father understood she was going there to get some advice about her medical condition. Ms Tregonning told the nurse she had driven herself to the hospital from home and wanted someone to talk to but didn't want to see a doctor. She mentioned she felt her medications were "not doing anything for her" and she intended to speak to Dr Stuckey.[18] Ms Tregonning told the

[13] Exhibit 1, Tab 8.
[14] Exhibit 1, Tab 8.
[15] Exhibit 1, Tab 8 and Tab 26.
[16] Exhibit 1, Tab 26.
[17] Exhibit 1, Tab 8.
[18] Exhibit 1, Tab 23.

nurse she was feeling better after speaking to her and she intended to go home. After Ms Tregonning left the nurse obtained Ms Tregonning's home telephone number and rang and spoke to her father. The nurse told Mr Tregonning that Ms Tregonning had been at the ED and was on her way home. He indicated he would ring Ms Tregonning if she was not home in 15 minutes.[19]

24. After speaking to the nurse Mr Tregonning rang Ms Tregonning on her mobile. Ms Tregonning answered the phone and said she was at the Esplanade Beach in Fremantle. He asked her to come home, which she did. This event at the beach is significant as Ms Tregonning later spoke of being at the beach and entering the water with a plan to commit suicide, but then changing her mind when she thought about her family and was interrupted by a call from her father. When talking about this incident later, she referred to it being on the Friday, so it may have been a different event, but it seems more likely that the dates/days were perhaps mixed up when the later history was given.

25. When she returned home from the hospital visit, Ms Tregonning reportedly told her father that they had taken $70 from her and then told her no one could see her, which had upset her.[20] This does not accord with the notes written by the triage nurse and seems to be inconsistent with the nurse taking her conduct seriously enough to follow-up with her family at home when she left, which was unusual. However, it is certainly clear that Ms Tregonning did not see a doctor at the hospital and this affected her mood.

26. Mr Tregonning indicated this was the first time he realised that something was seriously wrong with his daughter and they had a talk about it, although it's not clear what in particular they discussed.[21]

27. Later that day Ms Tregonning and her parents went to Ms Tregonning's brother's house for a Mother's Day lunch. Ms Tregonning came to the lunch, even though she was reluctant to attend. She was noted to be quiet during the visit but this was not unusual so her family were not overly concerned.[22]

28. The following morning, being Monday, 12 May 2014, Ms Tregonning was at home with her parents. She was watching television when she began to say some dark things to her mother, such as, "A parent shouldn't have to bury their child."[23] Some other statements she made to Mrs Tregonning seemed irrational. Ms Tregonning's parents became concerned about her state of mind and decided to drive her to Sir Charles Gairdner Hospital to see Dr Stuckey, which was also what Ms Tregonning requested.[24]

29. Ms Tregonning was driven by her father to the Keogh Institute at Sir Charles Gairdner Hospital, where Dr Stuckey works. They arrived at approximately

[19] Exhibit 1, Tab 23.
[20] Exhibit 1, Tab 8.
[21] Exhibit 1, Tab 8.
[22] Exhibit 1, Tab 8.
[23] Exhibit 1, Tab 9[9].
[24] Exhibit 1, Tab 8 and Tab 9.

6.45 am. Given the early hour, Dr Stuckey was not yet at work. The Keogh Institute laboratory manager rang Dr Stuckey at home and told her that Ms Tregonning and her father were sitting in the waiting room and Mr Tregonning was very concerned about his daughter as there had been a significant change in her mental state.[25]

30. Dr Stuckey agreed she was very surprised to receive the call, not only because of the time of the morning and the fact she had not seen Ms Tregonning for some time, but also because she was exhibiting symptoms that Dr Stuckey had not seen in her before.[26] Dr Stuckey recalled she spoke to Mr Tregonning on the telephone but also agreed she may have spoken to Ms Tregonning herself, although she could not be sure.[27] Dr Stuckey recalled being told that Ms Tregonning had expressed sentiments about life being worthless. Mr Tregonning said the change in her state of mind was relatively recent and wanted to know if any of the medications she was taking could have put her in this state. Dr Stuckey observed that cyproterone acetate can be associated with depression but since Ms Tregonning had been on the medication for so long without this effect Dr Stuckey doubted that it could be causative of Ms Tregonning's changed mental state, and this was agreed by another expert.[28] Ms Tregonning had not had any recent medications added, having been on the same medications prescribed by Dr Stuckey since 2009.[29]

31. Although Mr Tregonning did not expressly state it, Dr Stuckey's impression was that Ms Tregonning was severely depressed and at risk of suicide. Dr Stuckey was unaware what might have precipitated this change as she had not seen Ms Tregonning since October 2013. Dr Stuckey thought it sounded like Ms Tregonning was at risk and considered it urgent that Ms Tregonning be assessed by someone that day. She said in her report she felt that a GP was the best person to make a referral to a psychologist or psychiatrist, which she suggested they do as soon as possible.[30]

32. Mr Tregonning recalled that Ms Tregonning appeared reassured after the conversation with Dr Stuckey so he took her home. Following Dr Stuckey's advice, Mr Tregonning took Ms Tregonning to see a general practitioner, Dr Freeman at the Glenmoy Medical Centre, in order to get a psychological referral. During the consultation a GP Mental Health Care Plan was completed and Ms Tregonning was referred to a psychologist. It appears that Ms Tregonning mistakenly thought she would be able to see the psychologist that day, but when they drove to the psychologist's office they found the psychologist had moved locations and, when she was contacted by telephone, the earliest available appointment was on 17 May 2014.[31]

33. When they returned home Ms Tregonning said she wanted some anti-depressants and didn't feel she could wait until 17 May 2014. At this stage Mr Tregonning described Ms Tregonning as having "been cycling through

[25] T 21.
[26] T 21.
[27] T 21 - 22.
[28] T 113; Exhibit 1, Tab 10 and Tab 24 [5], p.6.
[29] Exhibit 1, Tab 10.
[30] T 21, 23; Exhibit 1, Tab 8.
[31] Exhibit 1, Tab 8.

various states of crying, being fatalistic and calm. She had been distressed and upset but hadn't talked of self-harm as such."[32] Mr Tregonning said at that stage Ms Tregonning believed that she had something linked to motor-neurone disease and "said she wanted me to kill her but I said I wouldn't do that and that she shouldn't try to self-diagnose herself."[33]

34. They returned to the Glenmoy Medical Centre that afternoon. This time Ms Tregonning saw another GP, Dr Elena Vysotskaya, as Dr Freeman was not available. Dr Vysotskaya could see Dr Freeman's notes, indicating Ms Tregonning had been in that morning and now returned, which was an immediate red flag to her. Ms Tregonning told Dr Vysotskaya that she had returned as she couldn't wait to see the psychologist she had been referred to, and felt like she needed to be prescribed antidepressants in the interim. Concerningly, when Dr Vysotskaya asked her why she wanted antidepressants, Ms Tregonning said that "she would like to sleep forever."[34]

35. Mr Tregonning had come in for the start of the consultation but Dr Vysotskaya had the feeling Ms Tregonning was not comfortable speaking of these things in from of her father. Accordingly, at Dr Vysotskaya's suggestion, Mr Tregonning agreed to leave the room so they could speak face to face privately.[35]

36. Dr Vysotskaya said that Ms Tregonning opened up after Mr Tregonning left. Ms Tregonning mentioned that she had a genetic condition, 5ARD, and wrote it down for Dr Vysotskaya. Ms Tregonning didn't want to discuss it but did indicate she was in pain and had been taking medication for the condition. In her report, Dr Vysotskaya said Ms Tregonning described suicidal thoughts related to her genetic condition.[36]

37. Dr Vysotskaya asked her a number of questions to elicit whether she had active suicidal ideation, and Ms Tregonning answered positively to these questions, saying that she was having persistent suicidal thoughts that were hard to shake off. Ms Tregonning told Dr Vysotskaya that she had made an appointment with the psychologist for a few days' time but didn't want to wait three to four days given her persistent suicidal thoughts. Ms Tregonning also spoke of previous suicide attempts and said she had been very close to going ahead with a plan but cited her mother and other relatives as protective factors stopping her from completing the act. Ms Tregonning told Dr Vysotskaya she was concerned that she might go through with it, so she had come back to the GP practice for help as she didn't want to do that to her family.

38. Dr Vysotskaya explained to Ms Tregonning that starting an antidepressant in this setting was not the best choice as it will take time to start working and it could also cause a further deterioration in her symptoms and increase

[32] Exhibit 1, Tab 8 [34].
[33] Exhibit 1, Tab 8 [35].
[34] T 24; Exhibit 1, Tab 15.
[35] T 24 – 25.
[36] T 25; Exhibit 1, Tab 14.

her suicidal ideation in the short term.[37] This position was supported by other doctors who gave evidence at the inquest.

39. Dr Vysotskaya suggested that if Ms Tregonning wanted to see a psychiatrist or psychologist urgently, she could call an ambulance and transfer her to Fremantle Hospital. Dr Vysotskaya said that "surprisingly she actually agreed with that"[38] proposal. This decision underscored the sincerity of Ms Tregonning's desire to seek help and her willingness to follow medical advice as to the best way to get that help.

40. Ms Tregonning gave Dr Vysotskaya permission to inform her father, so Dr Vysotskaya spoke to Mr Tregonning separately to inform him that Ms Tregonning was going to be sent to hospital by ambulance for psychiatric assessment. She suggested that Mr Tregonning should go home and refresh himself before going to the hospital, as it might take some time.[39]

41. While waiting for the ambulance, Dr Vysotskaya rang Fremantle Hospital and spoke to ED Consultant Dr Arasu to advise of Ms Tregonning's impending presentation. Dr Vysotskaya was under the mistaken impression that she was talking to a Consultant Psychiatrist as she had explained to the switchboard that it was a psychiatric presentation and had been put through to Dr Arasu on that basis.[40] In fact, Dr Arasu is a Consultant Emergency Medicine Physician. He was working in the Clinical Decisions Unit that day, and his role included receiving phone calls as the 'admitting consultant' in the ED. It was Dr Arasu's usual practice to complete a 'Patient Expects' paper slip and provide it to the ED liaison clerk, who would then check the computer system to determine if the patient had any previous medical records that should be brought up. The clerk would also entered into the ED Information system an entry that the patient was expected and the clinical information that had been provided to them by the admitting consultant.

42. Dr Vysotskaya gave evidence that when she spoke to Dr Arasu she said she had a patient with high suicidal ideation and then asked him what information she should put in her referral letter. Dr Vysotskaya recalled that Dr Arasu told her that she could make the referral letter brief as she had already passed on the relevant information.[41]

43. Dr Vysotskaya doublechecked with Dr Freeman, who was her supervisor and had seen Ms Tregonning that morning. He agreed with the plan. An ambulance was then arranged to take Ms Tregonning to Fremantle Hospital.[42]

44. Following Dr Arasu's instruction, which suited her as she had limited time due to the ambulance coming soon, Dr Vysotskaya kept her referral letter very brief, simply indicating that Ms Tregonning had been referred "for an

[37] T 25.
[38] T 25.
[39] T 25; Exhibit 1, Tab 8.
[40] T 28.
[41] T 26.
[42] T 25 - 26.

opinion and management in relation to her depression and suicidal ideation,"[43] with her past history of 5ARD noted. She addressed the letter to Dr Arasu.

45. Regrettably, it does not appear that the verbal information Dr Vysotskaya provided to Dr Arasu made its way onto the ED information system. A search of the records found an entry made at 3.18 pm on the 'patient expect' screen to show that Ms Tregonning was expected to come into the ED and that she was suicidal but no other information was included. Dr Arasu does not believe he was in the main ED when Ms Tregonning arrived at the ED at 4.10 pm as he was not based in that area. As the Consultant on duty in CDU, he would not have had any contact with her. He also did not have any discussion with the ED doctor who eventually examined her.[44]

46. This was a missed opportunity at the hospital for critical information to be provided to the person assessing Ms Tregonning's mental state. Dr Vysotskaya said she had assessed Ms Tregonning's suicide risk as very high. She thought Ms Tregonning needed urgent assessment and arranged the transfer by ambulance as she felt uncomfortable to let Ms Tregonning make her own way there.[45] Evidence was given by various witnesses that if the information about Dr Vysotskaya's assessment of Ms Tregonning when she saw her at the GP practice had been passed on to them, it would have changed their assessment of the urgency of Ms Tregonning's situation and the decisions they made on that night.

47. As well as telephoning Fremantle hospital and speaking to Dr Arasu, Dr Vysotskaya also spoke to the ambulance officers when they arrived and explained the situation to them.[46]

48. Dr Vysotskaya had a reasonable expectation, based upon the steps she had taken, that Ms Tregonning would be assessed by a psychiatrist or mental health professional when she reached Fremantle Hospital. She gave evidence that she was shocked when she received a letter a few days later from the coroner and found out about later events.[47]

FREMANTLE HOSPITAL ED PRESENTATION

49. The ambulance arrived at the medical centre at 3.28 pm, and after she was safely in the ambulance Mr Tregonning went home as suggested. The St John Ambulance (SJA) Patient Care Record indicates they arrived at Fremantle Hospital at 4.06 pm.

50. The SJA Patient Care Record described Ms Tregonning as having presented to the GP that day with acute depression and suicidal ideations for the past 6 days. She had no prior psychiatric history before that time. Ms Tregonning told the ambulance officers that she had "found out some truth" 6 days ago,

[43] Exhibit 1, Tab 22, GP Referral.
[44] Exhibit 1, Tab 25.
[45] T 26.
[46] T 27.
[47] T 30.

which might have been the cause of her current symptoms. She said she felt numb and that her body was giving up. They observed she had very flat affect and, although willing to answer questions, she was talking slightly jumbly. She told them she had considered walking into the water to drown and, en route, Ms Tregonning went on to say she had been thinking about suicide and stated she should "just go and do it." She denied any psychotic symptoms but did admit to poor sleep and bad nightmares when she did sleep, as well as daydreams and bad thoughts when awake. The ambulance officers recorded that Ms Tregonning was "reassured++++en route."[48]

51. Ms Tregonning arrived in the ED at 4.10 pm and the Triage Assessment Form was filled in by a nurse at 4.25 pm. Ms Tregonning was given a Triage Score of 4 out of 5. Her presenting history was recorded as acute onset of depression 6 days prior when she had a breakdown. She reported thoughts of suicide and said she had gone to the beach two days before but had been distracted by a call from her father.[49]

52. Ms Tregonning was seen relatively quickly afterwards by a resident medical officer (RMO), Dr Zhi Kung, who was completing a shift in the Fremantle Hospital ED that afternoon. Dr Kung did not regularly work in the ED but rather was working as an RMO Reliever. He was assigned to different areas in the hospital as required.[50] As an RMO, which is a more junior doctor position, Dr Kung was supervised by senior doctors, in the sense that they were available in the ED for him to consult when required.[51]

53. Dr Kung explained that it was his role to review a patient, take a history, do an assessment and consider any medical conditions that may explain their symptoms. If he deemed the patient to have a psychiatric issue, he would contact the Psychiatric Liaison Nurse (PLN), who was based in the ED, for advice. If the PLN deemed it appropriate, they would then take over the care of the patient.[52]

54. At the time Dr Kung saw Ms Tregonning for his initial assessment, there was very little documentation available. He recalled seeing Dr Vysotskaya's referral letter,[53] which did not contain the extra information she had told Dr Arasu. Dr Kung did not recall the triage notes being present in the file, which could have shown that Ms Tregonning came in by ambulance as there was a note made to that effect.[54] He also indicated that the St John Ambulance Record was not present, and Dr Kung explained that he would not always be aware that the patient had come in by ambulance unless he was told by a nurse or the record was on the file.[55] Dr Kung gave evidence that if he was aware a patient who required psychiatric assessment came in by ambulance he would highlight that fact to the psychiatric team, but in

[48] Exhibit 1, Tab 16.
[49] Exhibit 1, Tab 22, Adult Triage Assessment Form.
[50] T 14.
[51] T 6.
[52] T 6.
[53] T 14.
[54] Exhibit 1, Tab 22, Adult Triage Assessment Form.
[55] T 7.

this case he did not know that was how Ms Tregonning arrived at the hospital.[56]

55. Dr Kung's evidence was that the ED is a busy place and it was not unusual to be missing documentation, so he often found he had to assess patients without the benefit of the paperwork.[57]

56. When Dr Kung first saw Ms Tregonning she appeared quite calm and did not look distressed. She was well groomed and spoke clearly. Her presentation did not suggest to him she represented any immediate threat to herself at that time. However, Ms Tregonning did mention experiencing suicidal thoughts.[58]

57. Ms Tregonning told Dr Kung that she realised the previous Tuesday that "life is unfair"[59] and "she is not suited to this world."[60] She had been having difficulty sleeping and concentrating since then. Ms Tregonning said she had "realised the 'truth', that she has been searching for since young"[61] and words to the effect that the human race was dying. Ms Tregonning reported having suicidal thoughts for the previous three days, being from the previous Friday. She had contemplated suicide on the Friday at the beach, and had taken one step into the water before realising that she did not want to go further. Ms Tregonning said she had been crying occasionally and described anhedonia (loss of pleasure or enjoyment in normally pleasurable activities). Ms Tregonning was noted to have no prior psychiatric history and no history of drug or alcohol abuse. Her vital signs were fine and all physical examinations were normal, including no evidence of prior self-harm or injury.[62]

58. Dr Kung's assessment at that time was that Ms Tregonning was physically well and her main issue was psychiatric. He felt she was at risk of suicide and at risk of absconding from the hospital as she had mentioned wanting to leave the hospital to catch a show later that evening.[63]

59. As mentioned earlier, where an ED patient's main issue was psychiatric, the usual practice at the Fremantle Hospital ED was to contact the PLN to request that they conduct an assessment of the patient.

60. Dr Kung unsuccessfully attempted to contact the ED PLN via pager. He was eventually told by the ED Nurse Coordinator that the PLN was not on duty at the time. Dr Kung then contacted the Psychiatric Duty Medical Officer (DMO), Dr Rajat Dewan.

61. Dr Dewan was a Psychiatric Registrar, so above Dr Kung in the hierarchy of doctors at the hospital, and he had more specialised training and experience in psychiatry. Dr Dewan was based at the Alma Street Centre, which is a

[56] T 7 – 8, 15 - 16.
[57] T 16.
[58] T 8.
[59] Exhibit 1, Tab 11 [11].
[60] Exhibit 1, Tab 11 [11].
[61] Exhibit 1, Tab 22, Emergency Department Clinical Record.
[62] T 8; Exhibit 1, Tab 22, Emergency Department Clinical Record.
[63] T 8; Exhibit 1, Tab 11 [14], [16].

specialised psychiatric treatment facility. It was located in a separate building, approximately 10 minutes' walk from the ED.[64] Dr Dewan was doing the after-hours shift that night in the duty medical officer role, which he explained primarily involved attending to calls from the mental health inpatient ward, that might involve charting of medications or request for review of a patient on the ward. In addition, calls would be received to provide advice to fellow colleagues, and could require attendance at the ED to review patients.[65]

62. Dr Dewan described a general night as a DMO doing the after hours shift as constantly attending to calls until about 2.00 or 3.00 am, often with multiple pagers going off at once time. He said there was "essentially zero downtime"[66] and he would have to prioritise different work. As part of that, he would try to determine whether it was simply a request for assistance over the telephone or whether the request required in-person assistance, and he would then try to appropriately triage the various demands.[67]

63. Dr Dewan was in the Psychiatric Registrar Office in the Alma Street Centre when he received a page to return Dr Kung's call at about 5.40 pm. He returned the call from the office. Dr Dewan recalled that Dr Kung immediately started to present Ms Tregonning's psychiatric history. Dr Dewan interrupted him and told Dr Kung that he should go through the PLN. Dr Kung advised the PLN was not present. He was told by Dr Dewan that the PLN should be available. The call was ended and Dr Kung went off to make further enquiries.[68]

64. Nursing notes made at 5.35 pm record that Ms Tregonning had absconded from the ED. Dr Kung spoke to the ED Consultant and informed her that he considered Ms Tregonning to be a suicide risk requiring psychiatric assessment. He was advised by the ED Consultant to follow the usual departmental escalation practice and contact police and Ms Tregonning's next of kin and try to arrange for Ms Tregonning to be psychiatrically reviewed when she returned to the ED.[69] However, it seems Ms Tregonning had only gone to the toilet and she returned to the ED at 5.56 pm. Ms Tregonning's father had attended the ED around this time so he was with her from that time. There was a note made at that time by a nurse that the PLN was unavailable until 7.00 pm so a formal review by a doctor was being requested.[70]

65. There was evidence that Ms Tregonning had started to become quite anxious because of the ED environment, as there was a patient in a bed next to her who was in a lot of pain and experiencing a lot of distress. Dr Kung asked the bed manager if they could move Ms Tregonning to a quieter environment but he was told there was no other bed available and Ms Tregonning needed

[64] T 10.
[65] T 36.
[66] T 54.
[67] T 54 – 55.
[68] T 37; Exhibit 1 Tab 12, Statement of Facts 26.5.2014.
[69] Exhibit 1, Tab 11 [20].
[70] Exhibit 1, Tab 22, Adult Triage Assessment Form.

to be kept within eyeshot of the main area so staff could be aware if she absconded again.[71]

66. Dr Kung tried paging the PLN again without success and made further enquiries with the ED Nurse Coordinator. Dr Kung then contacted Dr Dewan again to tell him that he had still been unable to contact the PLN. Dr Dewan made enquiries and established that the PLN was supposed to have been on duty until 7.00 pm but had unexpectedly left at 3.30 pm (which I understand was due to a family emergency).[72] The next PLN was not due to arrive until 7.00 pm, which left the ED with no PLN for a few hours. Dr Dewan clarified with the After Hours Clinical Nurse Manager that where there was no ED PLN, he was required to respond to and address any psychiatric related requests from the ED in the meantime.[73]

67. Dr Dewan indicated that he had considered suggesting that the ED staff wait until the next PLN arrived at 7.00 pm but decided this was not suitable given ED pressures.[74] Instead, Dr Dewan said he decided to hear the history first from Dr Kung, "to see what he was requesting of me,"[75] and then decide on a course of action.[76]

68. I pause at this stage to indicate that from this time the evidence of Dr Kung and Dr Dewan as to events diverges at times. Accordingly, I have tried to highlight the discrepancies in their accounts where they appear, so that I can then make findings where possible as to what occurred.

69. Dr Kung's evidence was that Dr Dewan called him back and confirmed that the PLN was not available.[77] Dr Kung's evidence was that he asked Dr Dewan if he could come down to the ED to see Ms Tregonning, but this did not occur. Instead, Dr Dewan asked him for more information, so they discussed Ms Tregonning's history and findings and Dr Dewan came to the conclusion that Ms Tregonning sounded like she was at low risk of suicide and he advised Dr Kung that he could discharge Ms Tregonning and ask her to come back to the outpatient clinic.[78]

70. Dr Dewan was adamant that he was not asked to attend the ED to complete a psychiatric assessment of Ms Tregonning. Dr Dewan maintained that a request for a review "formal or otherwise, verbal or written, was not received at any point."[79] Dr Dewan was asked if he considered going to the ED to see Ms Tregonning himself at that time, but he said that from the information provided and the impression he had formed, he did not consider it would need his attendance.[80]

[71] T 11.
[72] T 77.
[73] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[74] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[75] T 38.
[76] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[77] Exhibit 1, Tab 11 [23].
[78] T 10.
[79] Exhibit 1, Tab 12A [17].
[80] T 41.

71. Dr Dewan recalled he was told that Ms Tregonning had no previous psychiatric history but reported she had been suicidal the previous night and had been open to the idea of death as "everyone dies anyway."[81] He recalled mention of Ms Tregonning going to the beach but did not understand she had made a suicide attempt.[82] He understood Ms Tregonning had then gone to a GP and received a referral to mental health services, which she had presented to the ED. Dr Dewan said he was told she had experienced low mood, insomnia and anhedonia for the past week but was eager on this night to leave hospital so that she could attend a comedy show that evening. Dr Dewan was also informed of her medical history of 5ARD, but admitted he did not know what that diagnosis entailed at the time.[83]

72. Dr Dewan said he asked Dr Kung to elaborate on the suicidal ideation of the night before and the symptomatology of Ms Tregonning's current presentation, which didn't add much to the clinical picture. He then asked some specific questions, which confirmed that Ms Tregonning had not had a definite suicidal plan the previous night, nor put her thoughts into action and did not show any current psychiatric symptoms and denied any current suicidal plan or intent.

73. Dr Dewan's evidence was that he then asked Dr Kung if it was accurate to say in summary that the patient had some fleeting passive death ideation the night prior to presentation with no self-harm or suicide intent, plan or action, had consulted a GP, attained a referral, and had essentially presented to ED with the referral and no current acute emergency psychiatric symptoms. In response, Dr Kung agreed with the summary.[84]

74. Dr Dewan's evidence was that at that stage he formed the impression that the night prior to presentation Ms Tregonning had developed passive death ideation with no actual plan, and had been given a GP referral and presented to the ED "to essentially hand in the referral."[85] Given he also understood Ms Tregonning was keen to leave hospital to attend an event, he decided it would be appropriate to direct the referral to the Mental Health Outpatient Department and discharge Ms Tregonning from the ED. Dr Dewan said he conveyed his impression to Dr Kung and his view that it was appropriate, "given the non-emergency nature of the presentation,"[86] to take the referral and forward it to the Mental Health Outpatient Department for routine community follow up, but to allow him to confirm and call him back, as it was an unusual situation.[87]

75. As part of this chain of conversation, Dr Kung also believed Dr Dewan had said he would discuss the case with his Consultant, and Dr Kung made a

[81] T 39.
[82] T 49.
[83] T 39; Tab 12, Statement of Material Facts 26.5.2014.
[84] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[85] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[86] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[87] T 40.

note of this at the time.[88] It seems Dr Dewan was suggesting he would confirm it with the A/Hours Clinical Nurse Manager, not his Consultant.[89]

76. Dr Dewan said he spoke to the A/Hours Clinical Nurse Manager, who advised him to call the Alma Street Centre and speak to a Mental Health Triage Nurse to confirm. Dr Dewan called and spoke to Senior Mental Health Triage Nurse Carrie Merrick. I will return to Nurse Merrick's evidence later, as it differs somewhat from Dr Dewan's recollection. At this stage, I will simply focus upon Dr Dewan's recollection of their exchange.

77. Dr Dewan recalled Nurse Merrick confirmed that the Alma Street Centre could take the referral to forward appropriately, but asked him to check the patient's address.[90] Dr Dewan called Dr Kung to clarify the address and when told Ms Tregonning lived in Willetton, he advised Dr Kung that the suburb did not fall within the Fremantle Hospital catchment area and the referral would likely need to be faxed to Bentley Hospital. Dr Dewan confirmed this was correct with Nurse Merrick. Dr Dewan's recollection was that Nurse Merrick suggested either Dr Kung could fax the referral to Bentley Hospital himself or alternatively Ms Tregonning could come to the Alma Street Centre and the triage staff would fax the referral to Bentley Hospital on her behalf.[91]

78. Dr Dewan's evidence was that he then called Dr Kung back and advised that the best course of action was to ask Ms Tregonning to go to the Alma Street Centre and hand in the GP referral. Dr Dewan recalled that Dr Kung seemed hesitant and he "requested reasoning for the hesitancy."[92] Dr Kung replied "she has suicidal ideation."[93] Dr Dewan said he then specifically asked about, and confirmed, the lack of any current suicidal/self-harm ideation and that the suicidal ideation Dr Kung was referring to was from the previous evening. Dr Dewan said he requested Dr Kung to

> *"be sure" and "be confident" on the accuracy of these aspects of the presentation.*[94]

79. Dr Dewan said that Dr Kung confirmed the accuracy of these aspects and Dr Dewan then requested Dr Kung to direct Ms Tregonning to present to Alma Street Centre.[95]

80. I asked Dr Dewan whether Dr Kung's hesitancy and his impression that Dr Kung wasn't sure or confident raised a red flag that might have suggested he should go down and see the patient himself. Dr Dewan said it didn't occur to him at the time that he should go down and see the patient himself. He felt it was appropriate to request clarification from Dr Kung given his apparent hesitancy, but felt Dr Kung should have been in a position to make an assessment of her symptoms himself. Dr Dewan did not recall Dr Kung

[88] T 11; Exhibit 1, Tab 11 [24] and Tab 22, Emergency Department Clinical Record.
[89] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[90] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[91] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[92] T 51; Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[93] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[94] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[95] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.

mentioning anything along the lines that he was not feeling competent to assess Ms Tregonning, although he did understand Dr Kung was hesitant about the proposed plan in relation to Ms Tregonning.[96] Dr Dewan accepted that the internal referral Dr Kung completed after their conversation was consistent with Dr Kung understanding that a psychiatric assessment would be done, but at no stage did Dr Dewan believe he had been requested to conduct such an assessment.[97]

81. Dr Kung's recollection of events is not dissimilar to Dr Dewan's account on some of the events. However, the important difference is that Dr Kung says he made it clear to Dr Dewan he felt Ms Tregonning required psychiatric assessment, and he understood that an assessment was going to be conducted at the Alma Street Centre.

82. Dr Kung's evidence was that when he was told by Dr Dewan to refer Ms Tregonning to the outpatient clinic, Dr Kung told Dr Dewan that he believed Ms Tregonning was a possible suicide risk and felt she needed to be assessed by a member of the psychiatric team.[98]

83. In his statement, Dr Kung said he then recalled Dr Dewan specifically asked him to clarify his opinion on Ms Tregonning's presentation, and whether he felt she was a high or low risk. Dr Kung said he told Dr Dewan he agreed with Dr Dewan's assessment that Ms Tregonning could be classified as at low suicide risk, but felt that because she had presented with suicidal ideation she should be seen by a member of the psychiatric team, and he noted that Ms Tregonning and her father had both requested a psychiatric review (although it is not clear if he communicated this request to Dr Dewan).[99]

84. Dr Kung said he communicated to Dr Dewan that he felt, as a junior RMO, that he was not adequately trained to fully assess the patient and as there was no PLN available in the ED to assess her, he needed Dr Dewan to see her.[100] Dr Kung said that he communicated that he didn't feel comfortable being the only person to have seen the patient and assessed her from a psychiatric point of view as he didn't have sufficient psychiatric training.[101]

85. After this discussion, Dr Kung believed Dr Dewan directed that Ms Tregonning should present to the Alma Street Centre Triage to be seen by staff there.[102] Dr Kung said that based on his conversation with Dr Dewan, his expectation was that she would be seen at the Alma Street Centre by a member of the psychiatric team for completion of a psychiatric assessment.[103] Dr Kung's contemporaneous note was that the plan was that Ms Tregonning could "present to Psychiatric Department Triage for assessment and referral," and her ongoing management was to be with the Psychiatry Department, which was consistent with his later evidence.

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[96] T 52.
[97] T 53.
[98] T 10 - 11; Exhibit 1, Tab 11 [25].
[99] Exhibit 1, Tab 11 [26].
[100] Exhibit 1, Tab 11 [27].
[101] T 12, 18.
[102] Exhibit 1, Tab 11 [27].
[103] T 12, 18.

86. Dr Kung's conversation with Ms Tregonning and her father at this time also supports Dr Kung's evidence that this was at least his understanding of what was going to occur.

87. Dr Kung said he considered whether he needed to get security officers to escort Ms Tregonning to the Alma Street triage area, but was informed by the nursing staff that in the absence of a PLN, Ms Tregonning's father could accompany her to Alma Street and act as her chaperone.[104] Dr Kung spoke to Ms Tregonning and her father and told them that they were to go to the Alma Street Centre Triage, where Ms Tregonning would be seen by a doctor.[105]

88. Dr Kung prepared a piece of paper relating to Ms Tregonning, which was an internal referral form. He explained that it was his understanding the form was required when transferring the care of a patient from one department to another.[106] Dr Kung also understood that Ms Tregonning's medical file would move with her, although there is evidence from another witness that this was not the case unless the patient was escorted by a staff member.[107]

89. The internal referral form completed by Dr Kung had a notation that he had discussed the patient with Dr Dewan and indicated Dr Kung's intention that it be a referral to Psychiatry from the ED. Dr Kung did not tick the box on the form, but clarified in his evidence that he intended it to be an inpatient consultation request, not an outpatient clinic referral.[108]

90. The internal referral included information that Ms Tregonning's last suicide attempt had been three days prior and she had experienced low mood and anhedonia for one week. I will return to this information later, but I note at this time that Dr Dewan was adamant he was not told of the prior attempt, nor the history of a week of low mood, which was information he described as markedly different to the information he was told by Dr Kung over the phone.[109] However, in his notes Dr Dewan does refer to a week long history.[110]

91. There was some evidence from Dr Dewan that the internal referral used by Dr Kung was not the correct form to be used in such circumstances, as internal referral forms are typically used by hospital ward doctors for patients who are already admitted to a ward, in order to request review of the patient by another speciality.[111] It was clear that Dr Kung was unfamiliar with the ED and was adapting his knowledge of other specialty areas to the ED, so it seems to me it was not unreasonable for him to use the form for that purpose. Dr Dewan accepted he had seen it used in such circumstances occasionally, although it was incorrect procedure.

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[104] T 11; Exhibit 1, Tab 11 [28].
[105] T 13; Exhibit 1, Tab 11 [28].
[106] T 13.
[107] T 13; Exhibit 1, Tab 13B.
[108] T 16; Exhibit 1, Tab 22, Internal Referral form.
[109] T 48.
[110] Tab 12, Statement of Material Facts 26.5.2014.
[111] T 46 - 47; Exhibit 1, Tab 12A [18].

92. The other difficulty with the internal referral form is that it was apparently not faxed to the Alma Street Centre by ED staff until 7.47 pm that evening, after Ms Tregonning had gone home, and no one at the Triage appears to have been aware of it that evening.[112] It is unfortunate, as it may have triggered a response from the Alma Street staff, or at least Nurse Merrick believes it would have prompted some action on her part. In the end, the referral was forwarded onto Mill St Clinic the following day, before the hospital was notified of Ms Tregonning's death.[113]

93. Dr Kung said he did not have any contact with Dr Dewan or anyone else from the Alma Street Centre after Ms Tregonning left the ED, and he had no further contact with Ms Tregonning or her father.[114]

94. Dr Kung was clear in his evidence that he did not think he was sending Ms Tregonning to the Alma Street Centre merely to hand in a referral. Dr Kung pointed out that if all she had needed to do was drop in a referral letter, he could have helped her to do that at the ED. Dr Kung said that he was "quite adamant"[115] at that point in time that he was uncomfortable letting Ms Tregonning go without someone else assessing her. He said that if he had understood that was Dr Dewan's plan, he would not have let her go and would have considered alternative options.[116] I considered Dr Kung to be a genuine and reliable witness and notes and actions on the night were consistent with his evidence.

95. Later in the shift, after Ms Tregonning had left, Dr Kung said he was asked by the ED Consultant if everything was okay and what had happened with Ms Tregonning. He informed the Consultant that, after discussing the case with the DMO, he had referred Ms Tregonning to the Alma Street Centre for psychiatric assessment and she had gone there in the company of her father.[117]

96. Dr Dewan, on the other hand, was firm in his position that Dr Kung did not request his attendance in the ED or request a psychiatric review during any conversation, either formally or informally, directly or indirectly. He maintained there "were no words around asking me to come or review or anything along those lines."[118] I asked Dr Dewan whether he would concede the fact Dr Kung had called him after repeatedly trying to find a PLN suggested that he was looking for psychiatric input. Dr Dewan replied this was not necessarily the case, as it was also consistent with him simply seeking some advice as part of a collaborative approach between doctors, in the sense that Dr Kung was simply wishing to "obtain [his] perspective on different things."[119] When pressed on whether he may have misunderstood Dr Kung's request, Dr Dewan said more than once that he wanted "to be

[112] Exhibit 1, Tab 13A and Tab 13B [11] – [12].
[113] Exhibit 1, Tab 17A.
[114] T 13.
[115] T 12.
[116] T 18.
[117] T 12; Exhibit 1, Tab 11 [29].
[118] T 41.
[119] T 41.

perfectly clear that [he] was not asked to review the patient"[120] and there was nothing said along those lines at all.

97. Dr Dewan also disagreed that what he was doing over the phone was, in effect, making an assessment of Ms Tregonning's psychiatric presentation. Dr Dewan's evidence was that he took a conscientious approach to his work and was asking questions in an attempt to ascertain if there was any current risk present. In that sense, he was not attempting to assess the patient over the phone but simply trying to see if he needed to challenge Dr Kung's proposed plan of receiving the referral.[121]

98. Dr Dewan's evidence was that if he had been requested to attend the ED and make an assessment of Ms Tregonning, he would have made time to do so. He acknowledged it was his duty and responsibility as the Psychiatry Registrar to attend such calls for assessment and he was not in a position to refuse.[122] However, he said he did not do so as his understanding was that at no point was that request for a review made.[123]

ALMA STREET PRESENTATION

99. Once again, there is a slight divergence between the evidence of Dr Dewan and a witness. This time, the divergence arises between the evidence of Dr Dewan and Nurse Merrick.

100. Carrie Merrick is a Clinical Nurse Specialist who has had a long career in mental health care. Nurse Merrick has been an Authorised Mental Health Practitioner since 2003. She worked at the Alma Street Centre for approximately 16 years and then moved to FSH when it opened at the start of 2015, where she still works. Prior to moving, Nurse Merrick was the Coordinating Duty Officer in the Alma Street Centre Triage and had direct line management responsibility for the Alma Street Centre Triage clinical nurses. In her current role, Nurse Merrick is responsible for the provision of a Mental Health Consultation & Liaison Service at FSH, which involves both clinical care and training and development of staff and standards of practice.[124]

101. Nurse Merrick impressed me with her knowledge of the systems and procedures in place at Fremantle Hospital, both in the ED and at Alma Street Centre, for dealing with patients presenting with a psychiatric issue. She also showed she had reflected at length on the events, and her involvement in Ms Tregonning's care that night. Nurse Merrick gave evidence that this was probably the case that stood out more to her than any other case in her career, and she believed she had a very strong recall of events.[125] I found her to be a very credible and reliable witness as to the events in which she was involved.

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[120] T 42.
[121] T 42.
[122] T 62, 65.
[123] T 65.
[124] T 74; Exhibit 1, Tab 13.
[125] T 75.

102. One disparity between Nurse Merrick's evidence and that of Dr Dewan was an issue in relation to a conversation about where Ms Tregonning lived. Dr Dewan said he discussed with Nurse Merrick over the telephone the need to check with Ms Tregonning where she lived.[126]

103. On the night in question, Nurse Merrick was on a period of maternity leave and had been called in to provide casual Clinical Nurse cover in Triage. Nurse Merrick recalled that she received a call from Dr Dewan in the late afternoon/early evening informing her that there was a female patient in the ED with a GP referral for a mental health assessment, but that there was no emergency medical rationale for the patient to be in the ED as there were no acute risk issues warranting immediate assessment.[127] Nurse Merrick recalled she was told that the patient had come voluntarily to the ED with her father on the basis of the GP referral but did not want to wait for assessment as they had tickets to a comedy show. Nurse Merrick recalled it was made clear to her by Dr Dewan that the patient did not require an assessment, but rather was seeking to submit a referral for processing.[128] Nurse Merrick said Dr Dewan specifically inquired about the GP Liaison clinic, and whether her handing in a referral might exclude her from that clinic.[129] Nurse Merrick confirmed it would not exclude her from that clinic and she agreed it was fine for the person to bring the referral to her in order for them to be able to leave and attend their event.[130] Nurse Merrick said she was not told where Ms Tregonning lived. Nurse Merrick said she didn't say this, and in hindsight wishes that she had asked about the address, as set out below.

104. Nurse Merrick explained in her oral evidence her understanding from her conversation with Dr Dewan was, in effect, that the patient had mistakenly gone to the wrong end of the hospital (the ED rather than Alma Street) and was seeking direction on what they needed to do with the GP referral. She agreed that they could bring it to her and she would sort it out.[131] Nurse Merrick said that, in retrospect, she wished she had asked more specific questions at the time of Dr Dewan, as she was not aware that Ms Tregonning had been seen by Dr Kung. Nurse Merrick said this knowledge would have significantly altered what occurred next, as the clear processes in place would have required Ms Tregonning to remain in the ED for her management and follow a linear management pathway, rather than diverting to the Alma Street Centre.[132]

105. Nurse Merrick said that she regretted not calling the ED herself to clarify the information that Dr Dewan passed on, but explained that calling the ED is not actually a very easy thing to do as it is often hard to find the person who can provide the relevant information. It would usually occur in reverse, as the ED triage nurse would call Nurse Merrick and ask for permission to send the patient. In such circumstances, Nurse Merrick's usual practice was then to ask a series of questions around demographics and risk to determine

[126] T 44.
[127] Exhibit 1, Tab 13 [12].
[128] Exhibit 1, Tab 13 [12], [15].
[129] T 75.
[130] Exhibit 1, Tab 13 [15].
[131] T 76.
[132] T 76 - 78.

whether they met the Alma Street Centre criteria and the transfer of the patient was appropriate. Nurse Merrick said that even if it was an RMO calling her, she would follow a similar practice of questioning, as she would assume they would not be very good at triaging a mental health presentation. However, in this case, as it was a Psychiatric Registrar calling her, Nurse Merrick did not adopt her usual practice and did not ask a lot of questions.[133]

106. Sometime prior to 7.00 pm a female patient arrived in the Alma Street reception. The female patient proved to be Ms Tregonning. Nurse Merrick approached her and confirmed that she was the patient from the ED that they had been expecting and that she was dropping in a referral. The reference to a referral was the GP referral, not Dr Kung's internal referral. Ms Tregonning did not have the GP referral with her and said she may have left it with the ED staff.[134]

107. Nurse Merrick noted Ms Tregonning did not appear to be a typical patient that they would normally see at Alma Street. She was well groomed, bright and very pleasant. She was not distressed, but did appear to be a bit frustrated, particularly about not having been given back the GP referral.[135] Nurse Merrick said at the inquest that her belief at the time, which she now realises was very wrong, was that Ms Tregonning had been kept waiting and effectively given the runaround at the hospital, and she wanted to be helpful and assist her to get out.[136]

108. Nurse Merrick told them she would chase up the missing referral from the GP and she asked for the GP's name and Ms Tregonning's home address. When she was told Ms Tregonning lived in Willetton, Nurse Merrick was surprised as it was not a suburb falling within the Alma Street catchment areas. Nurse Merrick's explained that the normal procedure in such circumstances for a patient who resided outside the catchment area would be to remain in the ED for assessment rather than come to the Alma Street Centre. Nurse Merrick explained that usually the only patients sent through from ED to the Alma Street Centre were patients who were already known to, or active with, Alma Street Centre and also fit within some other criteria.[137]

109. Nurse Merrick said she had felt frustrated with herself at the time that she had not asked Dr Dewan where Ms Tregonning lived, as this would ordinarily be the first question she would ask a triage nurse. Instead, because she had not asked, Nurse Merrick had to be the next person to tell her she was in the wrong place and she felt embarrassed having to give this news to Ms Tregonning.[138]

110. Nurse Merrick advised Ms Tregonning and her father that Willetton was in the catchment area for the Mills Street Centre at Bentley Hospital.[139] Nurse Merrick noticed that Mr Tregonning looked understandably frustrated at

[133] T 80.
[134] Exhibit 1, Tab 13 [20] – [21], [26].
[135] T 81.
[136] T 81.
[137] Exhibit 1, Tab 13B.
[138] T 84.
[139] Exhibit 1, Tab 13 [22] – [24].

having been incorrectly redirected to the Alma Street Centre. Nurse Merrick told Mr Tregonning that they could either get Ms Tregonning's GP to send a referral to Mills Street Centre or self-present at the Mills Street Triage.[140] Nurse Merrick says that she asked Ms Tregonning if she was okay to self-present to Mills Street Triage or if she would prefer to stay and be assessed by her that evening. Nurse Merrick's evidence was that she offered to see Ms Tregonning herself at that time, but Ms Tregonning said she had plans.[141]

111. Nurse Merrick recalled that Ms Tregonning said she would present to Mills Street Centre the next day and have her GP redirect the referral.[142] Ms Tregonning then left with her father. Ms Tregonning also reportedly said she was planning to attend work the following day.[143]

112. Although not formally assessed, Nurse Merrick says her practice as a mental health nurse is to constantly be assessing people in an informal way, and Ms Tregonning appeared warm and bright and did not appear distressed.[144] However, Nurse Merrick said that in hindsight, if she had known that earlier Ms Tregonning had been distressed, her sense of calm would have been a red flag to her.[145]

113. At the time, without that knowledge, Nurse Merrick believed Ms Tregonning seemed relaxed, showed evidence of future orientation and was in the company of a supportive parent. Based on these factors, Nurse Merrick said she was comfortable at the time with a decision to send Ms Tregonning home.[146] Nurse Merrick did recall saying to Ms Tregonning that her father did not look happy and Ms Tregonning reiterated that they were just frustrated as they had had a long day and been moved around, which reinforced Nurse Merrick's belief at the time that the best thing to do was to get her out quickly.[147]

114. Another difference between Nurse Merrick's evidence and Dr Dewan's was in relation to a purported conversation later that night, although this was resolved to a large extent during the inquest.

115. Dr Dewan's original recollection of events, as set out in the Statement of Material Facts he prepared a few days after the events and finalised on 26 May 2014, was that later that evening, at about 6.50 pm he came across the PLN who was due to start the next shift at 7.00 pm. The PLN asked Dr Dewan if there were any patients or issues that she needed to be aware of, and Dr Dewan said he replied that there was a young lady who had presented with a GP referral, for previous death ideation, that just had to be handed in.

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[140] Exhibit 1, Tab 13 [24].
[141] T 82.
[142] Exhibit 1, Tab 13 [26].
[143] T 82; Exhibit 1, Tab 13 [20] – [21], [26].
[144] T 82; Exhibit 1, Tab 13 [19].
[145] T 84.
[146] T 83 - 84; Exhibit 1, Tab 13 [27].
[147] T 82.

116. Dr Dewan recalled that Nurse Merrick was also present at the time and she said, "it was a bit more complicated than that, she came in an ambulance with her dad, but I've sorted it."[148] Dr Dewan said that he had been unaware that Ms Tregonning had come in by ambulance or was accompanied by her father until that time. Dr Dewan's initial account was that Nurse Merrick then informed him that the matter had been appropriately dealt with by her, with no immediate concerns, and that Ms Tregonning had been eager to leave to attend a comedy event with her father and had done so. Dr Dewan's evidence was that if he had not been told that the matter had been dealt with appropriately, he would have been concerned at finding out Ms Tregonning had come in by ambulance, but he had confidence that the mental health triage nurses are extremely competent and he respected their judgment.[149]

117. Nurse Merrick was adamant that that this conversation did not occur that night. Nurse Merrick indicated she did not have any contact with Dr Dewan on the night following her interaction with Ms Tregonning. Nurse Merrick's evidence was that she did not become aware that Ms Tregonning had been brought in by ambulance until after her death. Her testimony was that if she had found out that evening that Ms Tregonning had come in by ambulance, she would have called her and if she couldn't get hold of her, she would have called Mr Tregonning. There were also two community nurses who could have been sent to her home address if neither of them answered the telephone. Nurse Merrick said she would also have adopted a similar course if she had seen the internal referral prepared by Dr Kung that night.[150]

118. After hearing Nurse Merrick's testimony on 23 January 2019, Dr Dewan wrote to the court that evening to indicate that he had reflected on the matter and believed that he had made a mistake when identifying 12 May 2014 as the time when he became aware that Ms Tregonning came to the hospital by ambulance. Dr Dewan still believed a conversation took place between himself and Nurse Merrick, as part of an informal debrief, but felt the conversation may have occurred in the days following 12 May 2014, rather than on that date. Dr Dewan had a recollection he saw Nurse Merrick in his Consultant's office several days after and during that conversation he heard the phrase "it was a bit more complicated than that, she came in an ambulance."[151] Dr Dewan apologised for any confusion caused by his error, and indicated that he remained confident as to the accuracy of the rest of his evidence.

119. Nurse Merrick also provided some supplementary information, after hearing the evidence at the inquest. Nurse Merrick again confirmed her recollection that she had no contact with Dr Dewan on the night of Ms Tregonning's presentation other than the brief phone call.[152] She did recall having briefly met Dr Dewan for the first time in his Consultant's office, but said it was some weeks later and after the Root Cause Analysis meeting. Nurse Merrick

[148] T 56; Exhibit 1, Tab 12, Statement of Material Facts, dated 26.5.2014.
[149] T 56 – 57.
[150] T 83.
[151] Exhibit 1, Tab 12B.
[152] Exhibit 1, Tab 13B [1].

accepted that at that time she may have made a statement to the effect that Ms Tregonning's presentation had been "more complicated."[153]

120. Based on Dr Dewan's concession, and Nurse Merrick's supplementary information, there appears to be less of a divergence between the two witnesses' accounts. What it makes clear is that Nurse Merrick did not know Ms Tregonning had come in by ambulance on the night in question. As discussed later in this finding, Nurse Merrick's evidence is that if she had known Ms Tregonning had been brought to the ED by ambulance, it would have significantly altered her decision-making on the night.

121. Nurse Merrick was also clear that she did not speak to Dr Dewan about Ms Tregonning living in Willetton, in the Bentley the catchment area, over the telephone,[154] although Dr Dewan recalled having this conversation.[155] Nurse Merrick recalled the first time she became aware of where Ms Tregonning lived was when she was told by Ms Tregonning in the Triage area. She was certain that if she had been told this by Dr Dewan earlier, she would have not agreed to Ms Tregonning attending Alma Street and certainly not for the purpose of faxing her referral to Bentley. Nurse Merrick described such a plan as "ludicrous"[156] as there was no reason why the ED couldn't do that.[157]

122. As to communication of information from Dr Kung, as noted earlier, the internal referral and the medical file did not travel with Ms Tregonning as she was unescorted. Nurse Merrick's evidence was that if she had called for the file from the ED, once Ms Tregonning was in attendance, it would have taken about an hour to get to her.[158]

123. Nurse Merrick was asked whether she told Mr Tregonning there was not a doctor available to perform a mental health assessment that evening. She did not recall making such a statement and said that they always had a psychiatric registrar on duty to make such assessments, which would have been Dr Dewan that evening.[159]

LAST KNOWN EVENTS

124. After leaving hospital it seems Ms Tregonning went home and did not attend the show as planned.

125. At about 9.30 pm Ms Tregonning told her parents she was going to sleep out in the studio/shed, which she did from time to time.

126. At about 7.30 am the next morning Ms Tregonning's father went out to check on her. She did not respond when he knocked on the door so he forced the door open. Upon entering he found Ms Tregonning lying in a pool of blood near the door. She was fully clothed and had a large kitchen knife in

[153] Exhibit 1, Tab 13B [3].
[154] Exhibit 1, Tab 13B [4].
[155] T 50.
[156] T 84.
[157] T 84; Exhibit 1, Tab 13B [4].
[158] T 82.
[159] T 87.

her hand and obvious wounds to her body. It was apparent to Mr Tregonning that she had died.

127. Police officers attended and observed Ms Tregonning had a deep laceration across her throat underneath her chin and wounds to her left and right forearms. The kitchen knife was still in her hand. There was no sign of any disturbance at the scene and Ms Tregonning had no other injuries to her body apart from the wounds to her arms and neck.[160]

128. Police officers viewed Ms Tregonning's mobile telephone and found a draft text message, date and time stamped 12 May 2014, 5.35 pm, reading "I've had a very good life." Police did not find any note left by Ms Tregonning in her room but an undated and unsigned note was found later that indicated Ms Tregonning had an intention to end her life when she wrote the note.[161]

129. Police officers concluded there were no suspicious circumstances and the evidence at the scene supported the conclusion Ms Tregonning's injuries were self-inflicted.[162]

CAUSE AND MANNER OF DEATH

130. A post mortem examination was performed by Forensic Pathologist Dr Daniel Moss on 15 May 2014. The examination revealed an incised wound to the neck, which showed underlying arterial and venous injury, and incised wounds to the wrists and forearms that were superficial venous wounds only. The absence of internal genitalia was also noted, consistent with Ms Tregonning's medical history.[163]

131. Toxicology analysis was undertaken. It showed a therapeutic level of the antidepressant venlafaxine and spironolactone, one of Ms Tregonning's prescription medications, was also detected.[164]

132. It is not clear where Ms Tregonning obtained the venlafaxine as there is no record of Ms Tregonning being started on the medication by her GP and a search of the Pharmaceutical Benefits Scheme did not return any PBS prescriptions for venlafaxine. Although there was a therapeutic level of venlafaxine detected, it did not necessarily indicate she had been taking it for any length of time.[165]

133. Dr Dewan expressed some concern at the inquest about the presence of venlafaxine in Ms Tregonning's bloodstream, as it is known that in the initial period of starting an antidepressant patients often feel worse rather than better and there is an increased risk of suicide, which is why patients are usually kept under close clinical supervision when commenced on antidepressants.[166]

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[160] Exhibit 1, Tab 4.
[161] Exhibit 1, Tab 4.
[162] Exhibit 1, Tab 4.
[163] Exhibit 1, Tab 6.
[164] Exhibit 1, Tab 7.
[165] T 112 – 113.
[166] T 66 – 67.

134. A Consultant Psychiatrist, Dr Brett, who I refer to below, also noted that it takes 4 to 6 weeks for venlafaxine to have its full effect and in the first week of starting it, there can be an increase in anxiety, agitation and suicidality. It is Dr Brett's clinical practice to warn patients about this issue, so they can better manage it. In Ms Tregonning's case, if she had recently started taking venlafaxine, it may have caused a change in her mental health and presentation. If she had not been warned, she would not have realised that it could actually exacerbate some of the symptoms she was experiencing.[167]

135. At the conclusion of all investigations Dr Moss formed the opinion the cause of death was incised wounds to the neck and arms. I accept and adopt the conclusion of Dr Moss as to the cause of death.

136. Given the known circumstances, indicating the injuries were self-inflicted, I find that the manner of death was by way of suicide.

COMMENTS ON THE MEDICAL CARE

137. From the perspective of Ms Tregonning and her father, they had sought help first from Dr Stuckey, who had directed her to her GP, who had directed her to the hospital ED, and from there she had been sent to Alma Street Centre. Ms Tregonning had dutifully gone to each of these places but at no stage did anyone conduct a full psychiatric assessment. Neither Ms Tregonning nor her father had any experience in the mental health system, so they needed help to navigate it. Instead of receiving help, they were lost in a labyrinth of miscommunication and redirection. This inquest has been directed towards understanding how and why this occurred. I have been assisted in that endeavour by reviews by hospital staff and a court-appointed expert, as set out below. The evidence has identified individual and system failures.

Clinical Incident Investigation

138. After the hospital became aware of Ms Tregonning's death, a Clinical Incident Investigation was undertaken at Fremantle Hospital. The purpose of such an investigation is to identify system errors rather than focus upon errors in individual actions or decision-making. It outlined a number of contributing factors and root causes and made follow-on recommendations.

139. Two of the recommendations identified staffing issues with the PLN role, which had led to increased pressure on the Psychiatric Duty Medical Officer and had reduced the likelihood of timely and appropriate assessment of mental health patients in the ED. The need to obtain accurate information from the referring GP and the ambulance officers when a mental health patient is brought in by ambulance on a GP referral was also emphasised, which the evidence indicates could have made a real difference to the course of events.

140. I note that the Clinical Incident Review suggested that the GP should have done more in this case. In my opinion Dr Vysotskaya did everything she

[167] T 112 – 113; Exhibit 1, Tab 24 [6], p. 6.

could reasonably be expected to do. This was accepted by the expert witness, Dr Brett and a witness from FSH, Ms Warren, at the inquest.

141. There were some other criticisms made of the hospital incident review, which I detail below.

142. As noted at the start of the finding, a considerable period of time has passed between Ms Tregonning's death and this inquest, and in the intervening period Fremantle Hospital ED has closed. It has been replaced by the new FSH ED. Therefore, looking forward it is relevant to consider how mental health patients are dealt with at FSH ED.

Dr Brett's Review

143. Dr Adam Brett is a very experienced Consultant Psychiatrist, who works both within the public health system and privately in Western Australia. Dr Brett holds a number of clinical positions at the Start Mental Health Court, Stirling Mental Health Service, Busselton Community Mental Health Clinic and the Autism Association of Western Australia. He has provided expert reports for courts in Western Australia for a number of years, including the Coroners Court.

144. Dr Brett was asked by this Court to provide a report on the psychiatric treatment provided to Ms Tregonning at Fremantle Hospital prior to her death.

145. Dr Brett noted that Ms Tregonning had complex medical issues and medication that may have complicated her mental health presentation.[168] After reading all the materials, Dr Brett concluded that Ms Tregonning probably had a depressive disorder with possible psychotic symptoms (related to her belief that she had motor neurone disease). Dr Brett's expert opinion was that what Ms Tregonning needed "was a comprehensive psychiatric review with a clear formulation of what was going on for her."[169] It was apparent that she had sought help from a number of sources but no one gained a comprehensive picture of what she was experiencing. Dr Brett commented that, as in many cases, there was poor communication that led to relevant information being overlooked.[170]

146. Dr Brett noted Professor Stuckey appropriately suggested psychological or psychiatric treatment and her GP duly referred her for psychological treatment. When she represented at the GP clinic, Dr Vysotskaya performed what Dr Brett considered to be a good assessment and she appropriately called the ED and an ambulance. The ambulance service made good notes and documented significant risk issues. Unfortunately, the information from the GP and ambulance staff does not appear to have been communicated through to the relevant clinicians dealing with Ms Tregonning at Fremantle Hospital.[171] This meant that they made decisions about Ms Tregonning's care without knowing important information.

[168] Exhibit 1, Tab 24 [1], p. 5.
[169] Exhibit 1, Tab 24 [1], p. 5.
[170] Exhibit 1, Tab 24 [3], p. 6.
[171] T 106; Exhibit 1, Tab 24.

147. Dr Brett acknowledged that there was some conflict between the accounts of Dr Kung and Dr Dewan and Nurse Merrick, and noted that the clinical files do not always reflect all the interactions that occurred at the time.[172]

148. Based on his review of the records and statements, Dr Brett considered that Dr Kung performed a competent review of Ms Tregonning, took a competent history and it was apparent he had some concerns about her and took steps to have her undergo a mental health assessment.[173] Dr Brett noted that this would normally be done by a PLN, but there was no PLN available at the critical time.[174]

149. Although Dr Kung appeared to ask the DMO, Dr Dewan, for a review, this did not occur, and Dr Brett noted this appeared to be because Dr Dewan was satisfied that Ms Tregonning did not have acute mental health issues requiring assessment (although Dr Dewan also denies being asked to do an assessment). Dr Brett commented that this decision was made on inadequate information and in his opinion, Ms Tregonning should have had a face to face mental health assessment.[175] Dr Brett, who had worked at Fremantle Hospital and the Alma Street Centre himself as a junior doctor, said it would be his expectation that, given the ED doctor believed Ms Tregonning needed specialist assessment, Ms Tregonning should have been kept in a safe place until that assessment occurred.[176] In this case, Dr Brett believed Ms Tregonning should have been kept in the ED for that purpose, and Dr Dewan should have attended the ED to do the face-to-face assessment.[177]

150. In Dr Brett's expert opinion, Ms Tregonning's overall care and management at Fremantle Hospital and the Alma Street Centre was inadequate. This opinion was based on the information provided to Dr Brett, and as noted, for various reasons none of the clinicians involved on the relevant day had all the necessary information. Dr Brett considered the errors in Ms Tregonning's management to be multiple and reflected systemic issues.[178]

151. The information available to Dr Brett, after Ms Tregonning's death, showed what he described as a number of 'warning flags' that made her a risk of suicide. These included:

- her attempt on a beach a few days before;
- the significant change in her mental state noted by her family;
- the fact that she had been seeking help;
- her indication that she didn't feel she could wait to see a psychologist and wanted more urgent assistance;
- the fact she had complex medical issues; and
- the fact she was on regular medication that could cause mental health issues.[179]

[172] Exhibit 1, Tab 24 [31], p. 5.
[173] T 107; Exhibit 1, Tab 24.
[174] Exhibit 1, Tab 24.
[175] Exhibit 1, Tab 24.
[176] T 107 – 018.
[177] T 108 – 109.
[178] Exhibit 1, Tab 24, p. 8.
[179] T 109 - 110.

152. As already noted, much of this information was not before Dr Kung, Dr Dewan or Nurse Merrick, and in Dr Brett's experience this lack of communication of essential information is unfortunately not unusual.[180] Dr Brett believes that the fundamental issue is that mental health isn't seen as a specialty which deserves as much care and attention as other specialties. Dr Brett expressed the opinion that what is needed is clinicians who have got the time and facilities to be able to sit down with clients who are suicidal, take a full history, get as much history from other people as possible where the client consents, formulate a very clear plan and then move forward from there. As Dr Brett explained, until someone has done a proper assessment, you can't do a proper management plan.[181]

153. Dr Brett noted the issues Ms Tregonning faced while waiting in the ED, where she was witness to other patients in pain. This added to the distress she was already experiencing. Dr Brett agreed that an ED is not an ideal place to assess people with mental health issues as they are noisy and busy. Dr Brett expressed his belief that all EDs should be designed so there is a safe and therapeutic place where people with mental health presentations can be assessed. He noted the Mental Health Observations Area in Sir Charles Gairdner Hospital appears to be a good model.[182] Dr Brett also suggested that other options should be considered, such as a drop-in centre model of mental health care that operates outside of working hours, to avoid people having to come into the ED at all.[183]

154. Dr Brett also noted that the hospital initiated a root cause analysis (or SAC1 investigation), which he believed was of poor quality. The report included factual errors and, in his view, the key conclusion should have been that Ms Tregonning failed to have a comprehensive mental health assessment. If this had occurred, the clinicians who saw her would have got all the information and "most importantly, they could have been compassionate and given her hope that her issues would resolve and that she would get better."[184] Dr Brett suggested that the reasons behind the failure to provide a proper review potentially included systemic issues such as pressure on junior staff and a lack of resources.[185] Dr Brett also suggested that, for a root cause analysis to be done properly, it should include people from the coal face, who can provide information beyond what is included solely in the records.[186]

155. Dr Brett also highlighted the issues with the transfer of information, noting the more hands that information goes through the more likely there are going to be mistakes, and that is what occurred here.[187]

156. Dr Brett expressed the opinion that a "good therapeutic interview, with a clear formulation and feedback to Ms Tregonning and her father may have

[180] T 110.
[181] T 110.
[182] T 111, 117; Exhibit 1, Tab 24, p. 9.
[183] T 116 - 117.
[184] Exhibit 1, Tab 24, p. 9.
[185] T 115 – 116.
[186] T 123.
[187] T 118.

been sufficient to alter her trajectory and avoid this tragedy."[188] The plan may have involved hospital admission, but Dr Brett did not think this was necessarily required.[189] The plan could have involved formulating only a community plan, but this still could have provided reassurance. What Ms Tregonning really needed was to talk to someone, and Dr Brett felt that a "compassionate engaged interview may have given her the hope that it appears that she needed."[190] Dr Brett emphasised that hope is a key thing in cases such as these, and being able to say to someone, "This is 100 per cent treatable. You will get better from this,"[191] gives people reassurance when they go home.

157. Overall, Dr Brett commented that this was "an extremely sad review" [192] because he believed Ms Tregonning's death was probably preventable, as there were a lot of opportunities for intervention that could have changed the trajectory.[193] In Dr Brett's view, the main thing that was needed, and what was missed in this case, was for someone to sit down with Ms Tregonning and her father and listen to their story and formulate a plan to help them look ahead.[194] Dr Brett acknowledged that suicide is difficult to predict, but felt that she was primarily looking for reassurance. If that had been given, Dr Brett felt it may have changed everything, but instead she was really given the opposite response.[195]

158. Dr Brett's main conclusions in terms of recommendations, were that the systems need to be set up where people with mental health issues can be appropriately assessed and managed, preferably in a therapeutic environment staffed by properly trained mental health staff.

Fiona Stanley Hospital Review

159. Ms Lynne Warren is the Service Director of Mental Health for the Fiona Stanley Health Group. Ms Warren was not involved in the care of Ms Tregonning, but provided a report based upon her review of the materials relating to Ms Tregonning's presentation to Fremantle Hospital. The report canvassed whether Ms Tregonning received an adequate mental health assessment at the time and also provided advice on the relevant current policies, procedures and guidelines at FSH.[196]

160. Ms Warren had reviewed the report of Dr Brett prior to preparing her own report, and she indicated that she agreed with Dr Brett's opinion that Ms Tregonning did not receive an adequate assessment when she attended the Fremantle Hospital.[197] Ms Warren also agreed with Dr Brett's comments about the internal hospital investigation. Ms Warren noted that the SAC1 investigation looks more at systems issues than the conduct of individuals,

[188] Exhibit 1, Tab 24 [4], p. 6.
[189] T 114.
[190] Exhibit 1, Tab 24 [4], p. 6.
[191] T 114.
[192] Exhibit 1, Tab 24, [21], p. 9.
[193] T 118.
[194] T 118.
[195] T 118 – 119.
[196] Exhibit 1, Tab 26.
[197] T 96; Exhibit 1, Tab 26, p. 1.

but nevertheless she felt that this internal investigation seemed to focus on the wrong things (roster, duty statements etc) whereas the main concern should properly have been about the failure to compete a comprehensive face-to-face mental health assessment.[198]

161. Ms Warren indicated that the process for reviewing patients with a mental health presentation at Fremantle Hospital were very similar to the ones currently in existence at FSH. The process at the time in Fremantle Hospital was for the ED to refer patients to the ED PLN, who would determine if a review by the DMO (Psychiatry Registrar) was necessary. A psychiatry registrar was based in the ED from 8.30 to 4.30 pm Monday to Friday and after hours and on weekends the role was covered by the Alma Street Centre DMO, who would attend the ED and review the patient.[199]

162. Ms Warren was very clear in her support of Nurse Merrick's assertion that, when the PLN was not available, the proper thing to do, in the circumstances where an RMO was seeking input from the mental health team, was for the DMO to go to the ED and conduct a face to face assessment.[200]

163. Ms Warren gave some evidence about the mental health observation area at SCGH, as referred to by Dr Brett, and described it as an area that provides a very quiet, low stimulus environment for mental health patients. It is serviced 24 hours a day by trained mental health clinicians.[201] There was originally an intention to use the assessment unit at FSH in a similar way, but Ms Warren explained that due to the lack of beds in the system, they have turned into admission beds rather than ED beds for patients waiting for psychiatric assessment. Ms Warren gave evidence that for the last four or five months there has been consideration given to the possibility of creating a "one-stop shop type facility for mental health presentations to ED" at FSH, but it is still at a very preliminary stage.[202]

164. At the conclusion of her evidence, Ms Warren reiterated her belief that there had been a system failure in the treatment of Ms Tregonning and she expressed her sincere condolences to Ms Tregonning's family.[203]

Response of the various clinicians involved

165. The accounts given by the doctors and nurse involved in Ms Tregonning's case on the night reveal there were failures in communication, both on a systemic level and between individuals. At the time they gave their evidence at the inquest they all acknowledged that there was critical information that had not been before them on the night, and which might have altered the course of events.

166. Dr Kung did not have before him the ambulance record, nor the full details of Dr Vysotskaya's assessment. Without this information, he did not

[198] T 98; Exhibit 1, Tab 26, p.2.
[199] Exhibit 1, Tab 26, pp. 1 – 2.
[200] T 96 – 97, 99.
[201] T101.
[202] T 101.
[203] T 102.

appreciate the acute nature of the risk she presented to herself at the time she entered the ED. Nevertheless, Dr Kung, who did not have specialist psychiatric training, was concerned about Ms Tregonning's level of risk and did not feel adequately trained to make a full assessment. He sought help from the specialist mental health staff at the hospital and, was initially given the runaround as Dr Dewan mistakenly believed the PLN was still in the ED. It was eventually established the nurse had unexpectedly left early due to a family emergency, which obviously could not have been predicted and left little opportunity to fill the gap until the next nurse arrived for their shift.

167. When the absence of the PLN was finally understood, Dr Dewan spoke to Dr Kung about the patient. Dr Dewan did not personally assess Ms Tregonning but simply asked for Dr Kung's assessment. In that process key information about the fact Ms Tregonning was sent to the hospital by ambulance from her GP's practice was not made clear to Dr Dewan, as Dr Kung himself was unaware of this fact. Dr Dewan says if he had known, it would have changed his approach. Without this information, Dr Dewan appears to have then formed the opinion that Ms Tregonning was at low risk, even though this did not reflect Dr Kung's preliminary assessment.

168. Dr Dewan then directed Dr Kung to send Ms Tregonning to Alma Street Centre, where Dr Kung believed Ms Tregonning was going to have a full risk assessment. However, Dr Dewan believed he was only sending Ms Tregonning there to hand in her GP referral so that arrangements could be made for outpatient follow-up.

169. Nurse Merrick saw Ms Tregonning at the Alma Street Triage and approached her on the basis of her understanding, taken from Dr Dewan, that Ms Tregonning was only there to hand over the GP referral. Nurse Merrick did not appreciate that Dr Kung had sent Ms Tregonning over to Alma Street for psychiatric assessment as he wished for someone more experienced to assess her risk of suicide. Nurse Merrick says if she had known, she would have approached Ms Tregonning very differently. Nurse Merrick had not questioned Dr Dewan more closely, as he was the Psychiatric DMO. If she had spoken to Dr Kung directly, things may have been different.

170. Nurse Merrick was also clear that if the PLN had been present in the ED, Ms Tregonning's referral to the Alma Street Centre would not have occurred, as an experienced mental health nurse would have been aware of the processes.[204]

171. Nurse Merrick said that during the root cause analysis conducted by the hospital after Ms Tregonning's death, she became aware of information which, had it been made available to her on the evening in question, would have drastically altered her actions. Nurse Merrick said if she had known Ms Tregonning,

[204] T 85.

- presented to the ED by ambulance,
- there were significant concerns about risk, and/or
- lived outside the catchment area,

any one of those factors would have prompted her to give advice that Ms Tregonning should stay in the ED and Dr Dewan should review the patient there.[205] She also indicated if she if she had known Ms Tregonning was referred to the ED by a GP for urgent assessment, she would have requested assessment by Dr Dewan immediately.[206]

172. Nurse Merrick also gave evidence that if Ms Tregonning had been accompanied to the Alma Street Centre Triage by a hospital staff member, they could have brought her medical record, which would have provided Nurse Merrick with some important information that would have made it clear Ms Tregonning was in need of assessment rather than just there to hand in a referral.[207] I note Dr Kung did explore the possibility of Ms Tregonning being escorted by hospital staff, but was apparently dissuaded by unidentified nursing staff.

173. Interestingly, Nurse Merrick gave evidence that, on the rare occasion that they need to transfer a patient from Alma Street to the ED, due to a physical health issue requiring treatment, they have a car at their disposal and she would physically put them in the car and drive them to the ED and take them to the triage window.[208] This is very different to the approach apparently recommended to Dr Kung by ED staff.

174. Nurse Merrick also spoke of recent changes under the new *Mental Health Act* that allow for greater family involvement. At the time Ms Tregonning presented that evening, there was a greater emphasis in the legislation on protecting the patient's privacy, which Nurse Merrick referred to as part of the reason why she did not speak to Ms Tregonning's father, although she also admitted that he appeared irritated and she might have avoided talking to him.[209] Nurse Merrick said at the inquest that she still regrets not talking to Mr Tregonning that evening, as she thinks that if she had spoken to him, he may have told her information that would have changed the sequence of events.[210] However, as it was, Ms Tregonning's demeanour did not flag to Nurse Merrick that she should seek permission to speak to Mr Tregonning. Nurse Merrick's evidence was that she now practices very differently.[211]

175. Nurse Merrick emphasised that, looking back in hindsight based upon all the known information, it would have been usual and appropriate practice for Ms Tregonning to have been seen by the Psychiatry DMO, Dr Dewan on that evening, in the ED for an assessment as per hospital procedure.[212] Nurse Merrick explained that the ethos behind the policy is that the "moment you move someone who's asking for help from one location to

[205] Exhibit 1, Tab 13B [2].
[206] Exhibit 1, Tab 13 [28] – [30].
[207] Exhibit 1, Tab 13B [7] – [9].
[208] T 87.
[209] T 93.
[210] T 94.
[211] T 94.
[212] Exhibit 1, Tab 13B [13].

another, you send them a very clear message … that they're not getting the help they need."[213]

176. Nurse Merrick confirmed her understanding that this is what should have occurred, in that someone from psychiatry should always go and see the patient when requested by the ED to give mental health advice. In her current position at FSH, Nurse Merrick said that there is an understanding that, even if an RMO is running something past them, in order to give advice they must go and see the patient before they give any advice.[214]

177. Nurse Merrick went on to express her great regret that Ms Tregonning saw so many people that week who were not equipped to help her. Nurse Merrick accepted that by the time she sent Ms Tregonning home, she had probably "had enough of being fobbed off" and was resigned to leaving without help. Nurse Merrick said she didn't know if she could have done anything to change what happened but she wished she had tried, and expressed how sorry she was.[215]

178. Prior to giving evidence at the inquest, Dr Dewan had an opportunity to read Dr Brett's report and he prepared some written comments in response. Dr Dewan advised that the chronology of events set out in Dr Brett's report was very different to the chronology of events as he understood them on the night Ms Tregonning attended Fremantle Hospital. In particular, Dr Dewan said there were several crucial elements of the presentation that he became aware of for the first time when reading the report, namely:

- the week long history of low mood and anhedonia (he says he understood it was only a one day history, although I note that Dr Dewan's original chronology he prepared in May 2014 details an understanding that Ms Tregonning had experienced low mood, insomnia and anhedonia "in the past week")[216];
- the psychiatric presentation to St John of God Hospital a couple of days earlier;
- the presentation to Dr Stuckey;
- the GP referral to a psychologist;
- Ms Tregonning's comments regarding wanting antidepressant medication;
- the second and separate presentation to a GP on the same day and the fact that the GP formed the impression that urgent psychiatric assessment was required;
- the ambulance transfer from the GP to Fremantle Hospital;
- the GP's discussion with Dr Arasu and the contents of the GP referral letter; and
- the fact police were called at one stage when Ms Tregonning left the ED.[217]

[213] T 83.
[214] T 86.
[215] T 94.
[216] Exhibit 1, Tab 12, Statement of Material Facts, 26.5.2014.
[217] Exhibit 1, Tab 12A.

179. Dr Dewan accepted that his questioning of Dr Kung did not elicit all of the key information, as there was critical information he was not aware of, including Ms Tregonning's attendance by ambulance. He also agreed that his understanding that Ms Tregonning was simply dropping off a referral, which he concluded based on his conversation with Dr Kung, was incorrect.[218] Dr Dewan's position, after becoming aware of all the relevant history, was that Ms Tregonning was, in fact, "crying out for help"[219] when she went to Fremantle Hospital that day.

180. Dr Dewan saw Ms Tregonning's SJA patient record for the first time at the inquest. After reading the information it contained, Dr Dewan's evidence was that it contained critical information, noting there were a lot of comments as to acute risk and current suicidal ideation.[220]

181. Dr Dewan gave evidence that since Ms Tregonning's death he has been presented with various extra information that was contrary to his understanding of the case on the night. He said he had experienced a myriad of emotions in the face of this material, including shock that the actual sequence of events was so markedly different to what he understood on the night, frustration with the system and a strong sense of sadness.[221] He expressed his deepest condolences to Ms Tregonning's friends and family and expressed a hope that they had not lost faith in the system, while acknowledging the system had failed in this case.[222]

182. Dr Dewan agreed that if he had known of the other information, that might have conveyed an acute suicide risk, Ms Tregonning would not have been sent home unless there had been a guarantee that she had a safety net of family and friends. In particular, if Ms Tregonning had been acutely voicing concerns of suicide risk, with current intent or plan, Dr Dewan said he would have advocated for an admission.[223] However, some of that was dependent on how forthcoming Ms Tregonning was at the time.

183. Dr Dewan accepted that one of the greatest concerns in this case was that Ms Tregonning had sought help but had been repeatedly turned away and sent home without a plan. Similarly to Dr Brett, Dr Dewan gave evidence that in his experience, it is often sufficient to change a patient's mental state just to engage in a discussion with them and help formulate a future plan. He noted that patients often have "a tremendous sense of calm"[224] after a conversation that includes some future focus, and he believed there was a good chance such a conversation would have helped Ms Tregonning's mental state. Dr Dewan agreed that, taking into account everything that is known now about Ms Tregonning's presentation on the night, in hindsight she should have been assessed by a PLN, or Dr Dewan in their absence, and a plan formulated for her.[225]

[218] T 43.
[219] T 43.
[220] T 61.
[221] T 65 – 66.
[222] T 66.
[223] T 67.
[224] T 72.
[225] T 73.

184. Dr Dewan made it clear in his evidence that he felt Dr Kung, as an RMO in the ED, should have been able to make an assessment of Ms Tregonning's mental health symptoms, in the same way he would assess someone for chest pain or a broken leg.[226] Dr Kung, on the other hand, made it clear he did not feel sufficiently qualified to make the assessment and was requesting a specialist's assessment.

185. Nurse Merrick, who has practised in the mental health area of hospitals for many years, in effect agreed with Dr Kung and said that she did not believe being seen by an RMO, such as Dr Kung, would provide an adequate assessment as an "RMO is not trained or equipped to do a psychiatric assessment beyond any great detail."[227] Nurse Merrick said that in her experience junior doctors are not always particularly accurate as they don't have any particular training or skill in that area. She expressed the opinion that psychiatry is not simple and can be very nuanced as there can often be very subtle symptoms.[228] Nurse Merrick said that in her experience, "RMO's tend to misdiagnose mental health conditions very easily."[229] Nurse Merrick gave, as an example, a patient who may present with what at first instance appears to be a panic attack, but can actually be showing subtle early psychotic symptoms, that an RMO may not have the skill or experience to identify.[230]

186. Therefore, Nurse Merrick indicated that the staff she works with do not decline referrals without seeing a patient, including very vague referrals. Nurse Merrick explained that at FSH, they will often have a junior doctor come to them and say, "I don't think you need to see this person. I just want to run this past you." [231] To her, this is a flag that the doctor is not feeling confident and would prompt a mental health team member to do the assessment.

187. Further, Nurse Merrick's understanding is that the PLN would usually have spoken to the RMO and possibly done their own initial assessment, but where the person was presenting with a letter from a GP, the hospital protocol was that they were still required to be seen by a Psychiatric Registrar and not just a PLN. As Nurse Merrick puts it, when a GP sends a patient to an ED, they were generally thought to be sending them for a medical opinion, not a nursing opinion.[232]

188. I am satisfied that Dr Kung behaved appropriately when he decided he was not qualified to make a proper assessment of Ms Tregonning's risk, and sought the input of more qualified health professionals. The fact that there is a specialist PLN based in the ED indicates a recognition within the health system that it is area requiring specialist knowledge. Dr Brett spoke of a need for better education of junior doctors, so they can manage mental

[226] T 52.
[227] T 79.
[228] T 86.
[229] T 93.
[230] T 93.
[231] T 93.
[232] T 79.

health emergencies better,[233] but in the meantime, referral to a person with more specialised knowledge is appropriate.

189. I am also satisfied that Nurse Merrick was unaware that Ms Tregonning had attended the ED and been referred to the Alma Street Triage for a psychiatric assessment. Nurse Merrick had been told the purpose of Ms Tregonning's attendance by Dr Dewan and she had not reason to question the instruction of the Psychiatric DMO, particularly as Ms Tregonning's presentation did not suggest she was acutely unwell or distressed.

Adverse Finding

190. At the conclusion of the inquest I indicated I was considering making an adverse finding in relation to the conduct of Dr Dewan in failing to attend the ED and conduct a face-to-face assessment of Ms Tregonning. I invited submissions from his counsel in that regard. I have since received those submissions and have given further consideration to the matter.[234]

191. As I have noted earlier, Dr Dewan and Dr Kung's recollection of events differs significantly in relation to whether Dr Kung asked Dr Dewan to come down to the ED and review Ms Tregonning.

192. Dr Kung's evidence was that he specifically made that request to Dr Dewan. Although Dr Dewan did not agree to come and perform that assessment in the ED, Dr Kung's evidence was that he eventually came to an arrangement that he would send Ms Tregonning to the Alma Street Centre Triage for a psychiatric assessment to take place and Dr Dewan would take charge of the patient. Dr Kung's version of events is supported, to a significant extent, by his contemporaneous notes, which make it clear that he had an understanding he was referring Ms Tregonning to the Psychiatric Unit for assessment and he noted Dr Dewan's name as the doctor to whom he was referring her.

193. Dr Dewan denied that any request was made to him by Dr Kung to conduct a psychiatric assessment, either directly or indirectly.[235] Dr Dewan did not have the benefit of contemporaneous notes, but he did make some notes a day or two after, once he became aware of Ms Tregonning's death. There is contemporaneous evidence that supports at least Dr Dewan's understanding that Ms Tregonning was not going to be assessed by him that night, as he told Nurse Merrick she was simply dropping in a GP referral.

194. If both witnesses are accepted to have given honest evidence as to their recollection of events, then at the very least there was a miscommunication between the two doctors on the night, as Dr Kung made it clear he was not prepared to send Ms Tregonning home without a psychiatric assessment and Dr Dewan's evidence was clear that he understood Ms Tregonning was to be sent home and dealt with as an outpatient.

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[233][233] T 125.

[234] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 18.04.2019, as amended on 26 April 2019.

[235] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 18.04.2019, as amended on 26 April 2019.

195. It was submitted on behalf of Dr Dewan that it was common practice for junior doctors to contact him to seek advice on how to deal with a particular situation, and this is how he viewed his discussions with Dr Kung on the night. Dr Dewan's evidence was that he would never have deliberately ignored another doctor's request for him to attend and perform a psychiatric review.

196. However, Dr Dewan did accept that he found his exchange with Dr Kung "to be unusual."[236] There was also evidence heard during the inquest, as I've outlined above, that Dr Dewan told Dr Kung that he needed to "be confident" and "be sure"[237] when they were discussing the patient, which suggests to me that Dr Dewan was concerned about the reliability of what Dr Kung was telling him about the presentation and his assessment of the patient.

197. There was also evidence before me from Nurse Merrick and Ms Warren that they would expect in terms of usual hospital procedure (both at Fremantle Hospital and now at FSH) that in circumstances where a junior RMO in the ED was telephoning a Psychiatric DMO asking for advice about a patient, that the Psychiatric DMO would attend and perform a face-to-face assessment.[238]

198. I accept that there was a lot of information that was not available to either Dr Kung, and therefore not available to Dr Dewan at the time they had their conversations, that would have altered the course of events. Dr Dewan indicated that if he had been aware of some of important information that was not before Dr Kung, such as Ms Tregonning's referral to the ED by ambulance, Dr Vysotskaya's belief Ms Tregonning required urgent psychiatric assessment, her earlier psychiatric presentation to St John of God Murdoch and SCGH and the multiple presentations to a GP that day, he would have formed a different view as to her level of risk and he would have acted differently. I accept that he would have done so. The point is, however, that if he had attended the ED and seen Ms Tregonning himself, there is a good chance he might have elicited some of that information.

199. In my view, taking the position most favourable to Dr Dewan and accepting that he did not understand Dr Kung was asking him to conduct a psychiatric assessment of Ms Tregonning, there was still sufficient information before him to raise a red flag as to Dr Kung's ability and confidence to perform a psychiatric assessment of Ms Tregonning. Dr Dewan was aware that Ms Tregonning had presented to the ED with a GP referral for mental health treatment. He was aware Dr Kung had been trying to find the PLN in the ED, which strongly suggests Dr Kung was seeking input from a mental health professional. When the PLN was established to be unavailable, Dr Kung persisted with making contact with Dr Dewan, and it was apparent to Dr Dewan in his conversation that Dr Kung was not entirely sure or confident when answering questions and was hesitant about the

[236] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 18.04.2019, as amended on 26 April 2019 [12].
[237] Exhibit 1, Tab 12, Statement of Material Facts 26.5.2014.
[238] T 87, T 96 – 97, 99.

proposed plan to send Ms Tregonning home for later treatment as an outpatient.[239]

200. In those circumstances, I am satisfied the proper and obvious course for Dr Dewan to have taken was to attend the ED and see Ms Tregonning for himself. I accept that if he had done so, this may not have altered the final outcome, but it was a missed opportunity that may have resulted in further and important information to be obtained from Ms Tregonning and her father and to provide both of them with reassurance that she would receive the help she was seeking and hopefully get better.

201. I accept Dr Dewan is sincere in his regret that he did not perform a greater role in assessing Ms Tregonning on the night and I understand his frustration that more information was not put before him, which would have likely altered the course of events, at least in terms of Ms Tregonning being psychiatrically assessed that evening. There were multiple communication failures on the night that contributed to the outcome and a general systems failure in terms of the relevant information being before the doctors making the decisions, which is unfortunate and certainly not the fault of Dr Dewan. However, I am satisfied there was sufficient information before Dr Dewan, as the on call Psychiatric DMO and knowing that the PLN was unavailable, to alert him to the fact that he needed to go and see Ms Tregonning and assess her for himself.

202. It cannot be said definitively that keeping Ms Tregonning in longer and conducting a full psychiatric assessment would have saved her life. I have heard evidence from expert psychiatrists often to the effect that suicide is unpredictable and the process of risk-screening is difficult and often flawed. However, it is generally agreed that what is needed for any real assessment of risk is for a properly qualified person to undertake a comprehensive assessment process, to ensure that as much information is elicited to inform the person making the assessment and help them to form a view as to whether a person represents an acute risk to themselves or others. It was agreed in this inquest that there was a real possibility that had Ms Tregonning been comprehensively assessed by an experienced mental health practitioners, she may have been provided with information that would have changed the assessment of her level of risk, or at least allowed a plan to be formulated that gave her some reassurance and hope for the future.

IMPROVEMENTS AND RECOMMENDATIONS

Ambulance Record

203. As noted above, the ambulance record provided some very important information about Ms Tregonning's mental state at the time she was brought in to the ED. Further, just the fact Ms Tregonning was brought in by ambulance was accepted by all the witnesses to have been an important piece of information that would have prompted a different course of action. The evidence at the inquest indicated that the ambulance record was not

[239] T 52.

available to Dr Kung, and indeed, was not printed out until some significant time later.

204. Given the absence of this highly relevant information on the night, and the fact it may have changed the course of events, it was important to ascertain what is the current situation with the availability of SJA records in the FSH ED. Counsel appearing on behalf of the State Solicitor's Officer undertook to make further enquiries, and helpfully provided submissions including this additional information.[240]

205. I am informed that SJA now has an electronic Patient Care Record, which is completed by the SJA officer on their electronic device and there is a portal in the ED for them to access and print the records. The Patient Care Record is then provided by the SJA officer to the ED Nurse or Clerk, and it then remains with the patient's Triage Assessment Form until the patient has been discharged. In addition, clerical staff in the ED can access the portal for patients for up to four hours after they have presented and print the record, if for some reason it has not been done by the SJA Officer.[241]

206. It was submitted that Patient Care Records are much more likely to be on the record now, although it was acknowledged that there was still not 100% compliance with this practice. I am advised SJA remind their officers to print the records and FSH ED staff are reminded to look for them. Junior doctors at FSH are also reminded to access collateral information, such as the SJA Patient Care Record.[242]

207. I am satisfied that there is greater awareness within the FSH ED of the importance of SJA Patient Care Records. Junior doctors in the ED should continue to be reminded of the importance of requesting such information, both whether the patient arrived by ambulance and the patient care record in those cases.

FSH Mental Health Assessment Unit

208. In July 2012 Professor Bryant Stokes AM published the results of his review of aspects of public mental health facilities/services in Western Australia. In the review, generally referred to as the Stokes Report, Professor Stokes noted that at the time of preparing the report the mental health system was "under considerable stress, particularly in relation to staff already stretched, endeavouring to adhere to formal policies, procedures, legislative requirements and their own professional expectations and the expectations of patients and carers."[243] Increasing demand for services meant that demand often outstripped provision of mental health resources. In addition, a key message from many carers and families was "the unhesitating opinion that the system, by virtue of not providing adequate, timely and preventative care, was a major contributing factor to a patient's suicide."[244]

[240] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 19.04.2019.
[241] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 19.04.2019.
[242] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 19.04.2019.
[243] *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Professor Bryant Stokes, AM, July 2012, Executive Summary, 3.
[244] Ibid, 5.

209. Two years on from the release of the Stokes Report, Ms Tregonning's family reached the same unhesitating opinion in relation to Ms Tregonning's experience at Fremantle Hospital.

210. The Stokes Report supported previous recommendations made by the Deputy State Coroner, including a recommendation that where a person has been referred to an authorised facility for admission by a medical practitioner, final risk assessment should be undertaken by a psychiatrist after triage and preliminary assessment by a registered mental health nurse if 'wait time' is a problem.[245] In the absence of the PLN, that role fell to Dr Dewan, but it did not occur in this case.[246]

211. Dr Brett also referred to recommendation 7 of the Stokes Report, that stated that 'patients presenting anywhere in the public health system with suicidal intent must undergo a best practice risk-screening process and, where required, a comprehensive assessment by a mental health professional. A care plan must be formulated and all decisions to discharge require medical oversight and approval.' It is also recommended a comprehensive discharge plan be given to the patient. As Dr Brett noted, neither of these things occurred in this case.[247]

212. The recommendations contained in the Stokes Review were broadly supported by the Western Australian Government and I understand implementation of the recommendations has progressively been undertaken. A further review has been initiated to review of clinical governance of public mental health services in WA, which I understand is underway. A review panel has been established and a report is due by 30 June 2019.[248]

213. In the meantime, the FSH Mental Health Assessment Unit was commissioned to be an assessment unit for patients presenting with a mental health issue. The unit is connected to the FSH ED via an underground corridor so patients can move swiftly between the two areas. It was intended that the unit would hold patients waiting for assessment for up to 72 hours, in a more therapeutic environment than the ED.

214. Unfortunately, evidence was given at the inquest that the lack of mental health beds in the system has created pressure on the unit to effectively become another mental health ward, for admitted patients with mental health issues. Therefore, patients suffering from mental health issues remain in the ED, an environment known to often be detrimental to such patients.

215. I am advised that FSH is implementing numerous initiatives with the aim of returning the unit to its original purpose, although what those initiatives are has not been expanded upon in great detail.[249] I am advised that as part of initiatives to improve the mental health service at FSH, the South Metro Health Service is currently looking at the possibility of establishing a Mental Health Observation Area attached to the ED at FSH, in a similar model to

[245] Ibid, Recommendations, 16.
[246] T 86.
[247] Exhibit 1, Tab 24 [10], p.7.
[248] https://ww2.health.wa.gov.au/About-us/Mental-Health/The-review.
[249] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 19.04.2019.

what was referred to by Dr Brett as in place at SCGH. A Mental Health Observation Area is different to the Mental Health Assessment Unit, as the Mental Health Observation Area is deemed to be an extension of the ED, is not intended for long term assessment and is also less subject to being overtaken by patients admitted under forms pursuant to the *Mental Health Act*. However, I am also told this proposal is in its infancy and further details are not available at present.[250]

216. I certainly consider such a facility is an important addition to the mental health service provided in the ED at FSH. Dr Brett's evidence was that the SCGH model is beneficial to mental health patients and provides a much more therapeutic environment for these patients who are waiting assessment, rather than the general noisy and busy ED. The evidence before me was that Ms Tregonning was adversely affected by the distress of other ED patients while she was waiting in the Fremantle Hospital ED, and this is not uncommon. I have no doubt part of the reason she agreed to leave the hospital in the end was because of the ED environment she had experienced that day.

217. There appears to be no dispute from the South Metro Health Service that creating a more therapeutic environment than the ordinary ED for patients like Ms Tregonning is important, and yet a new hospital was built at FSH, anticipating a much larger number of ED presentations, with insufficient mental health beds to accommodate demand and no mental health observation area in the ED. The Mental Health Assessment Unit, which might have served that purpose, in a few short years has been overwhelmed by the number of mental health patients requiring admission, so we are back in the position that faced Ms Tregonning at Fremantle Hospital.

218. Dr Brett gave evidence that in his early days as a trainee there were usually beds to admit patients to, but demand for mental health beds has now outstripped resources and taken away one of the significant tools available to junior doctors in the ED and mental health practitioners generally.

219. Nurse Merrick indicated that FSH has a much busier ED than Fremantle Hospital (on average seeing 300 to 400 people a day), and they have seen a marked increase in psychiatric presentations, including many children as FSH has the only youth mental health service in the state. To service those patients, there is a 24-hour PLN rostered (two 12 to 13 hour shifts), who is a clinical nurse specialist. There is also a 24 hour registrar, who is typically not a psychiatric trainee and may have only limited psychiatric experience, but is there to perform the psychiatric registrar role. Nurse Merrick explained it is not a consistent position and is often filled by a different person every day. There is also limited access to a Consultant Psychiatrist, between roughly 8.30 am to noon each day and thereafter there is a different person on call. At my prompting, Nurse Merrick acknowledged it is "not a great system" at present.[251]

[250] Outline of Submissions filed on behalf of the South Metropolitan Health Service, 19.04.2019.
[251] T 92.

220. However, on the plus side, Nurse Merrick believes there is a better team environment in the ED during the day shift, especially in the morning when the Consultant is present, and she also believes there is a much better culture at FSH and a lower threshold to involve the Consultant and seek assistance when they are on call.[252]

221. The evidence is very clear that there is a lack of resources put towards mental health treatment in this State, which translates to a lack of mental health beds, a lack of properly trained and available psychiatrists and mental health professionals, and a lack of appropriate areas in which to assess the increasing number of people presenting to hospital EDs for psychiatric assessment. The new FSH is an obvious example, with its Mental Health Assessment Unit already unable to perform the function for which it was originally commissioned. While I understand a review is underway into the clinical governance of public mental health services, I still consider it appropriate and necessary to add my own recommendation to the other materials that will no doubt be considered by the review panel, in order to avoid other preventable deaths like Ms Tregonning's.

RECOMMENDATION

I recommend the Honourable Minister for Health give priority to commissioning a Mental Health Observation Area at Fiona Stanley Hospital Emergency Department.

222. In a more general sense, I urge those reviewing the mental health service provided at public hospitals to focus on ways of ensuring mental health emergencies are treated as seriously as any other medical emergency, with appropriate resources directed to ensuring that they are treated by properly trained staff in appropriate therapeutic environments.

CONCLUSION

223. In the 48 hours leading up to her death Ms Tregonning sought help from several different health professionals. Unfortunately, due to a series of miscommunications, system problems and inadequate assessment, she did not receive the help she needed.

224. The failure in this case to conduct a comprehensive psychiatric assessment resulted in Ms Tregonning going home with no hope that she would get help and get better. As a result, the community has lost someone who had the potential to make a great contribution to society through her art. Fortunately, Ms Tregonning's work was not lost entirely and her graphic novel remains as her legacy to others who struggle with anxiety and depression.

[252] T 92 – 93.

225. Although the Fremantle Hospital ED is no longer functioning, the evidence indicates that the same types of problems that arose in this case are still faced at the FSH ED. There is a need for more resources to be invested, both at FSH, and in the mental health system generally, to ensure that systemic failures, such as occurred with Ms Tregonning, are prevented. In this way, other similar deaths can hopefully be prevented.

S H Linton
Coroner
24 May 2019