FINDINGS, COMMENTS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

DAMIAN LUKE SUMMERS

Contents

Hearing Dates 3

Representation 3

Introduction 3

Evidence in the investigation 4

Background 5

Events between 31 October and 2 November 2019 6

Mr Summers' period of hospitalisation 8

Circumstances of death 14

Comments 15

Mr Summers' state of mind at the time of his death 16

Police actions and dealings with Mr Summers 16

Root Cause Analysis (RCA) report 17

What more could have been done for Mr Summers at discharge? 21

(a) Earlier engagement with Suzanne and provision of relevant information 21

(b) A telephone call by a treating medical practitioner to Mr Summers' general practitioner on the day of his discharge 22

(c) Notification of the Treatment Order and its terms 23

(d) Discharge on a Friday 23

(e) Step-down facility 23

Recommendations 24

Formal findings required by section 28(1) of the *Coroners Act* 1995: 24

Acknowledgements 24

Exhibit List 25

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the family by direction of the Coroner pursuant to s57(1)(c) of the *Coroners Act* 1995)

I, Olivia McTaggart, Coroner, having investigated the death of Damian Luke Summers, with an inquest held at Burnie in Tasmania, make the following findings:

Hearing Dates

20, 21, 22 July 2021

Representation

Counsel Assisting the Coroner: D Earley

Introduction

1. Damian Luke Summers, aged 42 years, died between 29 and 30 November 2019 at his home on King Island. He died as a result of hanging, an action taken by himself alone and with the apparent intention to cause his own death.

2. Four weeks before his death, Mr Summers suffered a severe deterioration in his mental state with the onset of psychosis. His condition necessitated an admission to the King Island Hospital and then a 26-day inpatient admission to the Spencer Clinic in Burnie for treatment. He was discharged from the Spencer Clinic on 29 November 2019. He immediately returned to King Island and died later that day or the following day. Upon discharge, he was subject to a Treatment Order under the *Mental Health Act* 2013. This order required him to take anti-psychotic medication as directed and permitted his detention in an approved mental health facility.

3. Certain issues arose in the investigation concerning Mr Summers' discharge from the Spencer Clinic, including:

    (a) Whether his death by suicide so soon after his admission could have been reasonably foreseen or prevented;

    (b) Whether his discharge was premature in light of his diagnosis and level of insight; and

(c) The adequacy of discharge planning, arrangements and follow-up, particularly in light of the level of support and services available to him upon returning to King Island together with the knowledge that his partner and children had left the home.

4. I determined pursuant to section 24(2) of the *Coroners Act* 1995 (the Act) that it was desirable to hold a public inquest in order to examine these issues. It is also arguable, perhaps likely, that I was mandated to hold an inquest pursuant to section 24(1)(b) of the Act as Mr Summers may have been, by virtue of the Treatment Order, a 'person held in care.' This is because the treatment order may have rendered him "a person liable to be detained in an approved hospital within the meaning of the *Mental Health Act* 2013." Alternatively, whilst Mr Summers was complying with his treatment in the community and no decision had been taken to detain him, he might not satisfy the definition of a person 'held in care.'

5. This question will arise in upcoming inquests and I intend to make a determination on the point with the benefit of full submissions from both counsel assisting and the State. In the present case, I do not need to determine the issue and note that this finding, in any event, satisfies the requirement pursuant to section 28(5) of the Act to comment on the care, supervision, and treatment of Mr Summers at the relevant time.

Evidence in the investigation

6. The documentary evidence tendered at inquest comprised exhibits C1 to C44. The exhibit list is annexed to this finding.

7. At inquest, the following witnesses provided oral testimony:

- Ms Belinda Joan Tyler – Mr Summers' partner;
- Ms Suzanne Summers – Mr Summers' sister;
- Ms Vikki Norton – Mental Health Nurse visiting King Island;
- Sergeant Stephen Shaw – Investigating Officer, stationed on King Island;
- Dr Temi Metseagharun – Psychiatric Registrar at the Spencer Clinic;
- Dr Lana Lubimoff – Consultant Psychiatrist at the Spencer Clinic;
- Dr Ann Buchan – General Practitioner on King Island;
- Dr Ben Elijah – Medical Director – Statewide and Mental Health Services;

- Ms Adie Gibbons – Clinical Executive Director – Statewide and Mental Health Services;
- Ms Joanne Beswick – Clinical Nurse Consultant and Root Cause Analysis panel member; and
- Dr Christopher Robinson – Clinical Director of North West Mental Health Services.

Background

8. Mr Summers was born in Currie, King Island on 10 June 1977. At the time of his death, he had been in a significant relationship of six years with Ms Belinda Joan Tyler. There are two children of the relationship. He worked as a self-employed kelp harvester and lived at 18 Meech Street in Currie.

9. Mr Summers was raised on King Island with three siblings - Andrew, Max and Suzanne. He remained close to Suzanne, who is ten years older than Mr Summers. His family were well-known and established on the island. In her affidavit, Suzanne stated *"As a kid growing up Damian was full of life and energy. We thought he was a really funny kid with loads of energy. Damian was pretty much a normal teenager, a little rebellious but nothing too out of the ordinary."*

10. Mr Summers moved to South Australia in his early twenties and worked long hours on a fishing trawler. He would occasionally return to King Island for family functions. In early 2012 he moved back to King Island to live.

11. Later in 2012, at a family wedding, Mr Summers had been consuming alcohol and experienced a psychotic episode. His behaviour was uncharacteristic and frightening to the younger members of the family. At the time of this episode, there was a family meeting and advice was taken from the local general practitioner and police officers. As a result, Mr Summers was taken involuntarily to the King Island District Hospital by police with the assistance of family members, including his brother, Max. After an assessment at the hospital, he was flown from the island and spent a very brief time away for treatment. The action taken by his family members at that time impacted upon Mr Summers' relationships with them, particularly between himself and Max.

12. Subsequently, Mr Summers commenced his relationship with Ms Tyler. He worked as a self-employed kelp harvester and was an active volunteer with the Currie State Emergency Service (SES) Unit. He was a respected member of the community,

including being a significant contributor to the ANZAC day proceedings as the resident bugler.

13. After his psychotic episode in 2012, Mr Summers did not display any alarming signs regarding his mental health and functioned well in the community.

Events between 31 October and 2 November 2019

14. On 31 October 2019, Ms Tyler and the two children attended the Currie Police Station in a state of concern about the behaviour of Mr Summers. She spoke to Constable Wayne Stanley, who was acting in a relief capacity on King Island. She told Constable Stanley that, over the preceding two or three days, Mr Summers was behaving in a way that she had never seen before, that he needed help, and that she had booked a flight for herself and the two children that afternoon with the intention of staying with her mother in Launceston. She further stated that, as she was packing the suitcases, she saw Mr Summers pull an unusual face at the children which scared them. His behaviour was such that she left the house with the children without the suitcases and then contacted the police to check on Mr Summers and collect her suitcases.

15. At the time of this incident, Ms Tyler had actually been seriously assaulted by Mr Summers who tried to strangle her. However, as discussed below, she did not disclose this to Constable Stanley at the time. After leaving the island, she disclosed the assault to persons treating Mr Summers and made a formal complaint of assault at the Launceston Police Station on 9 November 2019. In her affidavit for the coronial investigation regarding 31 November 2019, she stated that Mr Summers had squeezed her throat for about five minutes before he let her go. She said that she was able to take the children out of the house and drive straight to the police station for help. I accept her evidence that this event occurred and was a most frightening experience for her.

16. Following Ms Tyler's presentation to the police station, on 31 October 2019 Senior Constable Fiona Russell attended 18 Meech Street at the request of Constable Stanley. Senior Constable Russell said that, upon her arrival, she found Mr Summers to be calm and lucid. She said that he looked tired and appeared to have lost weight. Mr Summers told her that he was sad that Ms Tyler was leaving with his boys but he thought he might get some sleep. He told Senior Constable Russell that he had not slept in days and was extremely tired. He helped her carry the suitcases to the police vehicle parked outside on Meech Street. Senior Constable Russell formed the opinion

that Mr Summers had decision-making capacity and therefore his mental state did not meet the criteria under the *Mental Health Act* 2013 to be taken involuntarily into protective custody for assessment. At this time, Senior Constable Russell said that there was no indication, evidence or report of family violence having occurred.

17. That day, 31 October 2019, Ms Tyler and the children left King Island as planned.

18. The following day, 1 November 2019, Senior Constable Russell made contact with Suzanne to obtain help for Mr Summers, particularly as Ms Tyler and the children had left. That same afternoon, Senior Constable Russell and Constable Stanley were called to a disturbance in Meech Street. Once at the scene, they ascertained that Mr Summers had caused minor damage to parked vehicles in the area before returning to his house. He had previously been heard that day by a neighbour shouting and swearing in his home. When the officers questioned him at his home, he admitted being responsible and was very sorry for his actions. The officers found him to be lucid but he looked exhausted. He repeated his wish to be left alone to sleep. Senior Constable Russell suggested that he see the doctor and encouraged him to speak with his sister. Mr Summers indicated that he would do so after he had slept. Again, Senior Constable Russell formed the view that Mr Summers did not meet the criteria for being taken involuntarily into protective custody for assessment.

19. The evidence indicates that between 31 October and 1 November 2019, the police officers had multiple contacts with family members of Mr Summers, primarily to understand the nature of his issues, to discuss his ongoing well-being, and to ensure that he had medical and family support.

20. On 2 November 2019, police officers again were called to Mr Summers' house due to reports of his erratic behaviour. On this occasion, Sergeant Stephen Shaw attended with Constable Stanley. Sergeant Shaw described in his affidavit the events that followed:

> *"I spoke with the deceased for some time at his front door. The deceased presented as delusional, he spoke of people taking control and of him having two separate beings. I spent considerable time trying to convince the deceased that he should attend hospital which he was unwilling to do. I observed that he had some blood on his hand and he told me he had smashed a mirror in the house. He was unable to be reasoned with and was acting completely out of character, being a person who I knew well.*
>
> *I formed the view that his mental condition and exhibited behaviour satisfied the requirements under the Mental Health Act for me to take him into protective custody*

for assessment purposes. I told the deceased he needed medical help immediately, however, he was insistent that he would seek it later. I informed the deceased we were taking him to the hospital as his need for medical assistance was right now. Constable Stanley and I conveyed him to the King Island District Hospital."

Mr Summers' period of hospitalisation

21. Mr Summers was admitted as a patient to the King Island Hospital on 2 November 2019. Throughout his admission, he continued to be delusional, speaking about being controlled by an *"eye on Mars"* and that aliens would be coming to blow up the planet. He was diagnosed by the treating medical practitioner as having *"psychosis of unknown cause."* He was prescribed diazepam and olanzapine and remained as an inpatient on a voluntary basis. I am satisfied upon the evidence that the treatment in the King Island Hospital was of a very good standard.

22. On 4 November 2019, Mr Summers was flown from the King Island Hospital to the North West Regional Hospital (NWRH) by the Royal Flying Doctor Service. He was then admitted to the high care unit of the Spencer Clinic for treatment. The Spencer Clinic is a mental health inpatient unit operated by Mental Health Services and is located within the NWRH. His care and treatment was overseen by a multi-disciplinary team (MDT) headed by consultant psychiatrist, Dr Lana Lubimoff. The MDT coordinated his care, made medication decisions, and liaised with his family members. The MDT comprised the consultant psychiatrist, psychiatric registrar, a member of the nursing staff, and the ward social worker. I will deal more specifically below with the individual evidence regarding three of these treating practitioners.

23. On 5 November 2019, Mr Summers was initially assessed by experienced psychiatrist, Dr Christopher Robinson, who was of the view that Mr Summers had very poor insight and lacked decision-making capacity. He was observed to be responding to unseen stimuli and was anxious and restless. He was noted to have disordered thoughts and delusions and no insight into his situation or illness. Dr Robinson recorded his impression of Mr Summers as *"acutely psychotic, but not typically manic."* On the basis of Dr Robinson's assessment, an Assessment Order and an Urgent Circumstances Treatment Order, (both involuntary orders under the *Mental Health Act* 2013) were made on this date. These orders expired on 9 November 2019, although Mr Summers willingly remained as an inpatient in the Spencer Clinic and accepted treatment.

24. On 7 November 2019, Mr Summers was commenced on paliperidone (an anti-psychotic medication) in addition to his existing medications of sodium valproate, diazepam, and olanzapine. An application for a Treatment Order was made by the treating psychiatric registrar, Dr Temi Metseagharun, on the basis that he lacked decision-making capacity. It was also stated in the application that he required immediate and long-term treatment and, without treatment, he would present as a risk to himself and others, notably his partner and children. I add that, by this stage, his treating team were aware of his episode of violence to Ms Tyler on 31 October 2019.

25. By 13 November 2019, Mr Summers' condition appeared to have settled to a degree and he was moved from the high care unit to the 'open' ward. Mr Summers continued to make improvements in his mental state, although he had poor insight into his illness. Mr Summers regularly told treating staff that his problem was post-traumatic stress disorder (PTSD), although this was at odds with his diagnosis of psychosis. He continued to maintain throughout his admission that he suffered only from PTSD and not any other condition.

26. On 15 November 2019, the Mental Health Tribunal made a Treatment Order in respect of Mr Summers under section 39 of the *Mental Health Act* 2013. The order was of six months duration, and was stated to expire on 14 May 2020. Relevantly, the Treatment Order specified as follows:

> *"This Treatment Order:*
>
> *(a) is authority for the patient to be admitted and if necessary to be detained in an approved facility for the purposes of receiving treatment; and*
>
> *(b) authorises a combination of treatment settings and for the admission or readmission of the patient to those settings, this includes treatment in the community.*
>
> *Mental Health Tribunal authorised treatment:*
>
> *1. The patient is to take the following medication (depending on clinical indication);*
>
> *(a) Antipsychotic medication*
>
> *(b) Mood stabilising medication*
>
> *(c) Anti-anxiety medication*

(d) *Anti-cholinergic medication for treatment of any extrapyramidal side-effects from taking antipsychotic medication.*

All medication is to be taken either orally and/or by intramuscular injection and/or by depot injection as prescribed by a treating psychiatrist within clinical guidelines, with dosages adjusted according to clinical response and tolerability.

2. *The patient is required to undergo standard medical and/or blood, and/or urine tests, as well as radiological examinations as clinically indicated and as directed to by the treating team.*

3. *When in the community, the patient is required to attend appointments at Adult Community Mental Health and including home visits from the Adult Community Mental Health Service team and/or Case Manager."*

27. On 19 November 2019, Sergeant Andrew Smith served a Police Family Violence Order upon Mr Summers as a result of Ms Tyler having attended the Launceston Police Station on 9 November 2019 alleging that Mr Summers had tried to strangle her on 31 October 2019, just before she left King Island. The terms of the protective order, amongst other protective conditions, prohibited Mr Summers from being at her Launceston residence to ensure that Ms Tyler and the children had a place of safety. Upon receiving the order he became teary and said that he knew he had done the wrong thing. Sergeant Smith formed the opinion that he had full knowledge of the meaning of the conditions in the order. He told Sergeant Smith that he needed to be in the Spencer Clinic to assist his recovery.

28. On 27 November 2019, there was a meeting of the MDT where Mr Summers' discharge was discussed. It is recorded that upon review by the team, Mr Summers did not have any complaints, was eating and sleeping well, and was able to talk about the separation from Ms Tyler. He indicated he would be in touch with his brother and attempt to work through their difficulties. It is clear that he still had issues with his family members and became teary when speaking of them. It was noted that he was calm and cooperative with no obvious abnormal movements, had normal speech and was displaying appropriate emotions. He did not have any formal thought disorder and did not have delusions. His perception was normal and cognition and orientation were intact. His insight relating to his condition remained poor as Mr Summers was emphatic that he suffered from PTSD.

29. The MDT did not perceive that he was at any immediate risk and that he was suitable for discharge back to King Island with depot injection of paliperidone and olanzapine

medication, which Mr Summers was content to accept. Specifically, Mr Summers emphatically denied suicidal thoughts and it was recorded that, when questioned on this topic, he said *"I'll go down fighting and that's what's required."* The social worker had already attempted to make contact with a number of Mr Summers' close family members and was successful in contacting Suzanne, who had indicated that she would be able to *"pop in"* and check on Mr Summers. This represented at least a degree of informal family support. However, Suzanne was in employment and was unable to care for him on any substantial basis. It is also evident that there were difficulties between Mr Summers and his family members, likely of Mr Summers' own making. However, Mr Summers said that he intended to *"mend fences"* with his family members on King Island. Nevertheless, he was to be discharged to his home without his partner and children and the limited support from family was likely to be insufficient in the immediate period post-discharge from a lengthy admission.

30. I comment that the course of Mr Summers' inpatient admission at the Spencer Clinic was well-documented in the medical records. It can be seen from the records that his condition was regularly assessed and monitored, his medication was managed carefully, and he was provided good nursing and counselling services. The quality of his treatment was of a good standard.

31. Importantly, Mr Summers' suicide risk was monitored regularly and Mr Summers was assessed as not being at any significant risk of suicide using the Clinical Risk Assessment Threshold Assessment Grid (TAG). In fact, most of the TAG risk assessments returned very low suicide risk ratings. These assessments correspond with his denials of suicidal ideation. Specifically, he told the psychiatric team on 27, 28 and 29 November 2019, being his final three days at the Spencer Clinic, that he was not experiencing suicidal thoughts.

32. It is appropriate, at this point, to discuss the evidence of those involved with the treatment and care of Mr Summers during his admission.

33. Dr Metseagharun was the ward doctor and Mr Summers' most regular treating doctor. He was trained in the United Kingdom and had psychiatry qualifications equivalent to those of a senior registrar. He was involved in the initial ward assessment, subsequent reviews of Mr Summers with the consultant psychiatrist, and in the discharge of Mr Summers following an MDT review. Dr Metseagharun gave evidence at inquest describing the gradual resolution of Mr Summers' psychotic symptoms over the course of his admission to the point of being relatively stable but remaining with poor insight into his condition. He described Mr Summers as a risk to

others when psychotic but in the absence of an acute mental illness or psychosis, he was of the opinion that there was no discernible mental health related risk to himself or others close to him.

34. He considered that, upon discharge, Mr Summers had settled from his psychotic condition and he did not identify any acute risk factors for suicide. He stated that, in light of the low scores on the suicide risk assessments and his own professional opinion, he did not consider it could be foreseen that Mr Summers would take his own life upon returning to King Island. Dr Metseagharun, in giving evidence, displayed good knowledge of Mr Summers' admission and illness. He was questioned by counsel assisting at some length about Mr Summers' suicide risk post-discharge and was adamant that there was no reason to consider that he would be at particular risk of suicide, no reason to consider that he would not comply with his medication regime, and no reason to think he would relapse into psychosis in the short-term. I accept his professional opinion on these matters.

35. Dr Lubimoff was the consultant psychiatrist at the Spencer Clinic who saw Mr Summers on about eight occasions, the last being 27 November 2019. Like Dr Metseagharun, she gave evidence of the resolution of Mr Summers' psychotic symptoms, his lack of acknowledgement of his illness, and his lack of suicidal ideation. She gave evidence that Mr Summers was ready for discharge and did not consider that it could have been predicted that he would end his life.

36. Dr Robinson, consultant psychiatrist at the Spencer Clinic and currently the Clinical Director of the North West Mental Health Services, saw Mr Summers on one occasion for assessment at the commencement of his admission. Dr Robinson commented in evidence at inquest that Mr Summers had been admitted for psychosis and the aim of relieving the psychosis was achieved by the conclusion of the admission. He gave evidence that the discharge occurred at an appropriate time and emphasised that the fact of subsequent suicide post-discharge was not able to be predicted.

37. In summary, the three psychiatrists gave good, credible evidence concerning; diagnosis, treatment, suicide risk, and Mr Summers' readiness for discharge. They also gave evidence that Mr Summers' insistence on denying the correct diagnosis of his psychotic condition was not as important as his willingness to take medication and comply with treatment. I have no hesitation in accepting this expert evidence. I find that, with the resolution of his psychosis, his willingness to take medication and the

follow-up arrangements, it could not have been predicted that Mr Summers would end his life very shortly after discharge.

38. Mr Summers was seen by experienced mental health nurse, Ms Vikki Norton, on three occasions as an inpatient. Ms Norton was the regular clinician visiting King Island and case manager of selected patients. She confirmed that, as a case-managed patient, the relevant guidelines specified that Mr Summers was to be seen within a week of discharge. Ms Norton explained in evidence that not all patients are case-managed after discharge from the Spencer Clinic, but due to Mr Summers being in a rural area and under a Treatment Order he was under case management. Ms Norton arranged to see Mr Summers during her next scheduled visit to King Island on 4 December 2019, five days after his discharge from Spencer Clinic.

39. Ms Sharon Bartlett, qualified mental health nurse and experienced ward social worker at the Spencer Clinic, saw Mr Summers on a number of occasions. However, her main involvement focused upon supporting discharge planning, providing psychosocial education, and arranging family support. In evidence at inquest, Ms Bartlett described her observations of Mr Summers and his marked improvement in mental state during his stay. She stated that Mr Summers was not seen as a risk of suicide and the fact that the case manager would be there in a week was, in her view, an appropriate interval to provide specialised mental health assistance. She said that Mr Summers' behaviour on the ward leading up to discharge was very settled.

40. Ms Bartlett last spoke to Mr Summers in his room at 4.30pm the day before he was discharged. On this occasion, he was anxious about his return to King Island but told Ms Bartlett that he was looking forward to discharge and getting his life back on track. He was worried about how he would be received by his family, and particularly the King Island community as a whole, due to his behaviour before his admission. He said he wanted to reconnect with family and find work. Ms Bartlett said, in terms of a mental status examination, there was nothing extraordinary in his presentation. She said that she had reservations in respect of Mr Summers' *"ambivalent and superficial"* presentation generally during his admission, which she voiced to members of the treating team, but acknowledged that her impression in this regard was not based upon clinical evidence. She stated in her report that she would have expected a low mood and anxiety on his part in the context of impending discharge in such circumstances. She gave Mr Summers twenty-four hour helpline numbers, printed information regarding his diagnosis and his case manager's contact details.

41. Ms Bartlett stated that her role in the discharge process was also to approach family members regarding support. She spoke with Suzanne, Max and Mr Summers' father. She said that Suzanne was open to providing low care follow-up. Max said he was unable to assist given the estranged relationship. Mr Summers' father said he was old and unwell but could be of limited assistance. Ms Bartlett noted that there was considerable discord within the family brought about by Mr Summers' past behaviour. Ms Bartlett said that the family situation was less than ideal but there was not much more that could be done in this regard. In her statement for the inquest, she said *"Considering the family dynamics, I felt that requesting the family to support Mr Summers was somewhat inappropriate although I did voice my opinion.... Mr Summers was keen to be discharged and there seemed no reason for him to remain an inpatient."*

42. Ms Bartlett specifically commented that Mr Summers' ongoing social situation, namely his wife and children having left King Island and the issuing of the Police Family Violence Order against him, presented social situational risks. She outlined her contact with Ms Tyler and, through the admission, her role in mediating between Mr Summers and his wife regarding future plans, assuring him that she had no intention of keeping his sons from seeing him and providing supportive counselling. She said that his primary risk was the limited support, complicated by discharge to a small community in a rural area.

Circumstances of death

43. At 7.00am on 29 November 2019, Mr Summers was discharged from the Spencer Clinic and returned to King Island by plane that same day. Mr Summers' father collected Mr Summers from the airport and delivered him home to 18 Meech Street.

44. At about 1.00pm, or shortly thereafter, on 29 November 2019, Suzanne visited Mr Summers at his home. She said *"he looked exhausted and pale but was calm and lucid."* She said that Mr Summers told her that he may be suffering PTSD due to an incident in his SES role just before he left the island. She said that he was emotional at times but mostly he was *"beaten."* He told Suzanne that his head was *"broken"* and he did not think he could fix it. Suzanne encouraged him to sleep before she left. It was Suzanne's intention to check upon her brother on a daily basis.

45. Between about 4.00pm and 5.00pm the same afternoon Mr Patrick Johnson, the next door neighbour of Mr Summers, observed Mr Summers in the driver's seat of his red Holden Rodeo utility with a trailer attached. Mr Johnson watched Mr Summers attempt to roll start his vehicle down Meech Street. He later observed the same

vehicle parked around the corner in George Street as it had apparently not been able to start. Mr Johnson was the last person to see Mr Summers alive.

46. About 7.30pm that night, Suzanne sent Mr Summers a text message but it was not answered.

47. At about 2.30pm the following day, 30 November 2019, Suzanne went to visit Mr Summers at his home. There was no answer to the door. She entered the unlocked house but could not find him inside the house. She went to the backyard and saw that the shed door was unlocked and ajar. On entering the shed, she saw Mr Summers hanging by the neck and clearly deceased. She did not touch his body.

48. Suzanne did not have her phone and drove to the house of her uncle, Gary Morgan, in Currie. Emergency services were notified and Mr Morgan attended the scene with Suzanne. He also saw Mr Summers hanging by the neck with the rope attached to the roof supports of the shed. He touched his hand and felt it was cold. He was clearly deceased.

49. At 3.05pm, Sergeant Shaw attended the scene and observed Mr Summers' body to be cold and stiff. He made observations of the rope configuration and saw that the whole weight of Mr Summers was taken by the rope around his neck. He noted that there was a milk crate directly under Mr Summers' feet, which he had used as a step. Sergeant Shaw saw no other marks upon Mr Summers' body or signs of violence at the scene.

50. Ambulance Tasmania Volunteer Officer, Robert Jordan, attended the scene. He checked the deceased for signs of life and confirmed that he was deceased. Life extinct was formally pronounced by Dr Richard Giese at King Island Hospital.

51. The house was unlocked at the time, there was no sign of a disturbance in the house, and there was no sign of theft. The house was searched, as were his vehicles. No suicide notes were located. There was no sign of illicit drug use in the house. The scene was photographed and Mr Summers was released from the rafter. Medication and a discharge medication list were seized. Sergeant Shaw formally identified Mr Summers and he was conveyed to the King Island Hospital mortuary. Subsequent autopsy in Launceston revealed that he had died as a result of hanging. His blood sample was tested and showed only the presence of appropriate levels of his prescribed medications.

Comments

Mr Summers' state of mind at the time of his death

52. I find that Mr Summers specifically intended to end his life by taking the action of hanging himself. I find that he was not in a psychotic or delusional state at the time. He was calm and lucid with Suzanne when she visited him but she observed that he appeared *"beaten."* There is no other evidence of behaviour suggesting psychosis upon his return to King Island. I find that Mr Summers was in a state of mental anguish and, because of that anguish, he ended his life. He did not indicate to any other person, including Suzanne, that he was likely to do so. It would appear that his return to King Island caused him significant distress. His depressed state of mind, humiliation within the community regarding his previous behaviour, and absence of his partner and children were likely contributing factors in his decision.

Police actions and dealings with Mr Summers

53. Ms Tyler said that she disclosed to police on 31 October 2019, before leaving King Island, that she was strangled by Mr Summers. The weight of evidence is against such disclosure. The police officers involved maintained that her complaint did not involve an assertion that Mr Summers had perpetrated family violence. The transfer of care letter from Dr Cox, (the treating doctor at the King Island Hospital) to the Spencer Clinic does not refer to that serious allegation, which would be expected if it had been disclosed at that time.

54. Ms Tyler instigated a complaint about inaction of the King Island police officers in responding to her allegation of family violence and how a different response may have contributed to preventing his death. I determined before the inquest that the police dealings with Mr Summers before his lengthy hospital admission did not bear any connection to his death one month later. Nevertheless, the evidence tendered at inquest shows that Ms Tyler's complaint was investigated thoroughly and confirms that whilst the officers on King Island had no knowledge of the assault, Ms Tyler did state to a Radio Dispatch Operator on 1 November 2019 that Mr Summers had *"attempted to kill"* her. This information was not passed on to the King Island officers.

55. I make comment generally about the actions of the three police officers in dealing with Mr Summers before his admission to King Island Hospital with psychosis. As will be apparent from the description of events involving Mr Summers in the days before his hospitalisation, the three police officers were most diligent in their response to the incidents. They showed kindness to Mr Summers as well as being appropriately protective of the community. They also disclosed a good working knowledge of the

issue of decision-making capacity and transported Mr Summers to the hospital for assessment and treatment when it was clear that he did not have such capacity by virtue of his state of mind. They communicated well with Suzanne and managed the matter sensitively.

Root Cause Analysis (RCA) report

56. Following Mr Summers' death, a Root Cause Analysis (RCA) report was prepared by the Tasmanian Health Service (THS). The report examined Mr Summers' admission at, and discharge from, the Spencer Clinic as outlined in his clinical file. In particular, the report considered the issues of diagnosis, medication, discharge plan and follow-up, relationship issues, preparing Mr Summers for his return home and risk management. Ultimately, the panel was unable to identify any root causes or contributing factors in Mr Summers' death that related to his care or treatment, nor did the panel identify any gaps in service delivery.

57. In this inquest, it was relevant to examine the process of the creation of an RCA report. Coroners investigating deaths occurring in THS facilities or after recent discharge regularly, and helpfully, receive these reports but, at least from my perspective, are unaware of the process by which they are created and the identities, expertise or independence of the authors of the report. Without such knowledge, the evidentiary value of the report is affected.

58. The evidence at inquest indicates that the RCA process is a well-established internal tool used by the THS to inform itself about contributory factors in a death or serious event and to improve systems and service delivery. The 'RCA Tool Kit,' an information and guideline document for the RCA process, was tendered in evidence. This document provides helpful instruction for a panel member in respect of investigation and analysis of a particular incident. It emphasises the requirement for independence and open-mindedness in the process, as well as providing information concerning the determination of causation. Also tendered in evidence was a useful document setting out the numerous steps in the 70-day process from the decision to commence the RCA until the report is tabled at relevant committees. A number of witnesses were also called to give evidence at inquest to inform me about the RCA process in this case.

59. In Mr Summers' case, THS processes required an RCA report be prepared as his death occurred within 28 days of his discharge from the service.

60. The report was authored by three clinicians: Ms Joanne Beswick, Clinical Nurse Consultant - Quality and Patient Safety Services; Ms Marlene Cronin - Registered Nurse; and Dr Surinder Johl – psychiatrist and former Clinical Director of Statewide Mental Health Services North).

61. Following Mr Summers' death being 'logged' with THS, a 'team huddle' was held to commence the preparation of the RCA. The huddle included Dr Ben Elijah (Medical Director - Statewide Mental Health Services), Ms Adie Gibbons (Clinical Executive Director - Statewide Mental Health Services), the Director of Nursing, the relevant Nurse Unit Manager, Dr Lubimoff, allied health staff and Ms Beswick.

62. Ms Beswick assumed a coordinating role on the panel. Following the huddle, she identified Ms Cronin and Dr Johl from a pool of practitioners as suitable candidates to form the panel with her to furnish the report. Ms Beswick aimed to select panel members who worked in different practice areas and geographical locations than the matter in question. The evidence revealed that where suitable panel members cannot be identified from within the THS pool due to these preclusions, practitioners may be sourced from other states in Australia. It is intended that, in doing so, panel members will be free of bias. Ms Beswick said that typically, an RCA panel will be made up of three panel members but the size of the panel may vary depending on the case being considered.

63. After Ms Gibbons approved the panel members selected by Ms Beswick and they were notified of their selection, at their first meeting, the panel members met face to face and examined Mr Summers' clinical file. Ms Beswick gave evidence that, in doing so, they were looking for any issues or 'flags' or any actions or inactions that needed to be addressed in the report. She said that, at this point, the panel will typically begin to group relevant themes for discussion and reporting, for example; medication, diagnosis, mental state, discharge and past history. If more information is needed at this stage, it may be requested. This can include panel members making contact with family members of patients. In this case, Ms Beswick said that the panel did not contact Mr Summers' family. She gave evidence this was not necessary given that the panel's significant focus was upon Mr Summers' time within the unit immediately prior to discharge.

64. Following the first meeting, Ms Beswick created a first draft of the report. She gave evidence that, at this stage, the other panel members then have the opportunity to edit the draft, describing this process as a 'partnership.' Ms Beswick explained that once all panel members were content with the draft report, it was sent to Dr Elijah

and Ms Gibbons as well as Mr Summers' treating team for input. Any feedback or input is provided in writing to the panel who will then reconvene to discuss it. However, that does not mean the panel will always receive feedback from these stakeholders or that they will make changes as a result of their input. In giving his comprehensive evidence, Dr Elijah was clear that his role in the independent RCA process is not to make changes to a report. Ms Beswick gave evidence that any issues taken with the report by any person consulted in this process that are not adopted by the panel can be attached to the final draft in the interests of transparency.

65. In the RCA relating to Mr Summers, the panel agreed upon a final draft. This was provided to Dr Elijah and Ms Gibbons who endorsed it on 7 May 2020.

66. Final RCA reports are uploaded onto THS systems where recommendations and outcomes can be accessed. The inquest did not focus on the processes within THS of implementing any recommendations or how the report is used by the various internal committees or as an educative tool. Dr Elijah commented in evidence that the reports are supplied willingly to coroners and he recognises their value in the coronial process.

67. It is noted that in this case, the RCA did not, on its face, disclose the names of the panel members. The inquest heard that this is standard practice and that the panel members are provided with anonymity to ensure they can carry out their review free of influence or fear of ramifications if they were to make adverse findings or comments. Ms Gibbons gave evidence that this is particularly important in a small state such as Tasmania.

68. In her evidence, Ms Beswick said she stood by the conclusions of the RCA process regarding Mr Summers' care and treatment. In this case, it is clear that the panel members, like the treating psychiatrists and health professionals who provided evidence, did not consider that Mr Summers was at risk of ending his life shortly after discharge and did not consider that there were any deficits in his treatment at the Spencer Clinic or in the discharge or follow-up arrangements. I set out below the concluding paragraphs of the RCA report exposing the reasoning of the panel:

"Preparing the client for his return home

- *The panel discussed what could have been done differently to prepare the client for what he faced on his return home. It was identified that the service could not have predicted the degree of distress he felt when he returned home to an empty house. The panel considered the changes to*

the family home would have been a major contributing factor to the final moments, that might have contributed to his suicide. It was noted that even the social worker and the case manager who had prior regular contact with the client and his family, did not have knowledge of the gravity of what he was to face on returning home, and the level of impact it may have had on him.

- *The panel considered that SMHS* (Statewide Mental Health Services) *provided the appropriate level of intervention and support for this client's presentation based on the information available to them.*

Risk Management

- *The TAG was completed in accordance with the SMHS Risk Management Protocol and the client was reviewed regularly with documented MSE's* (Mental State Examinations). *It was noted the client denied any suicidal ideation or plans when he was questioned. Prior to discharge the client had commented that he wanted to return home and reconnect with his family (parents & siblings) and to get on with his life i.e. he was future focused. The client has been transparent about his feelings and the level of adjustment required to live without his family. The client had not presented as risk on the Open Unit and he was compliant with leave restrictions. In the 12 days prior to discharge, the TAG risk rating was a consistent 3, with a mild score being rated for intentional and unintentional self-harm, risk to others and survival. The client's family did not have concerns related to intentional self-harm and without a prior history of suicidal intent or action, it was difficult to predict the outcome. The panel is satisfied that the client's level or risk was appropriately managed, and the follow-up arrangements would have been able to mitigate and [sic] new or emerging risks."*

69. I comment that I was assisted considerably by the evidence of Ms Gibbons, Dr Elijah, and Ms Beswick, and the documents provided by them in respect of the RCA process.

70. I accept that the RCA report in Mr Summers' case represented a detailed and independent review of the main aspects of his treatment and care. As I have noted above, the treatment and care in the Spencer Clinic was of a very good standard. I also accept the opinions of the panel members and the experienced psychiatrists, that Mr Summers' psychosis had resolved and there was no indication that he was at

particular risk of suicide. I also find that Mr Summers was ready to be discharged and it was appropriate to do so.

71. A comprehensive discharge summary had also been sent to his general practitioner by email at about 7.45pm on the evening of his discharge, well within the recommended time for preparing and supplying the discharge summary. Within the discharge summary was a request for the general practitioner to review Mr Summers' valproate levels. Further, a case management appointment with Ms Norton had been scheduled for five days post-discharge on 4 December 2019, shorter than the time specified in the applicable protocol. Finally, a telehealth review with a psychiatrist was scheduled for 12 December 2019. The evidence at inquest indicates that the plan for monitoring Mr Summers' condition in the short-term was adequate.

72. Therefore, I accept the conclusions set out in the RCA report as being considered and reasonable. I do not find that there was any issues with the decision-making or care in respect of Mr Summers that could be said to have contributed to his death.

73. However, there are some comments to be made surrounding discharge, which I set out below. It is to be noted that these comments are made with the benefit of hindsight knowing that Mr Summers died unexpectedly by suicide.

What more could have been done for Mr Summers at discharge?

(a) Earlier engagement with Suzanne and provision of relevant information

74. It was known to Mr Summers' treating clinicians for the duration of his admission that his partner and children did not plan to return to King Island, and that he had little family support. It should also have been apparent that Suzanne was the only realistic support for Mr Summers, although even her ability to assist was limited. It was certainly important that the clinicians engaged Ms Tyler and Mr Summers' mother, as they did, in the early stages of his admission to obtain collateral history for diagnosis and general liaison, but those persons could not perform a support role upon discharge.

In her affidavit, Suzanne stated:

> *"I was quite surprised and worried when Spencer Clinic rang me to arrange his discharge on about the 27th or 28th of November.......*

Spencer Clinic told me that they would mail some information on Damian's diagnosis and the things to help us support him. They released him and he flew home on the morning of the 29th of November. This information turned up approximately four days after he died."

75. Suzanne gave evidence that she only knew her brother had a particular mental health diagnosis when she met him back on King Island but did not know anything of his requirement to take medication or further support arrangements. She was of the view that more information at an earlier stage in hospitalisation would have been beneficial in order to attempt to secure proper support on the island. Her point is a good one, assuming Mr Summers agreed that staff could provide her with the necessary information concerning his condition and needs. If she had been engaged and given information about him well before his discharge, she may well have better understood his condition and made arrangements to supervise him more intensively upon his return. In hindsight, more effort should have been directed towards Suzanne and her support role in these circumstances.

(b) A telephone call by a treating medical practitioner to Mr Summers' general practitioner on the day of his discharge

76. The discharge summary sent by email to Mr Summers' general practitioner had not been read at the time of his death as it was sent to the Ochre Medical Centre email after the practice had closed on Friday night. Mr Summers may have already been deceased by that time. It would have been read and considered on the morning of Monday 2 December 2019. Therefore, no medical staff on the island were aware that Mr Summers had returned on Friday 29 November 2019, despite his serious illness.

77. I heard evidence from Dr Ann Buchan, of the Ochre Medical Centre on King Island, who said that it was crucial that a telephone call was made to the general practitioner by a treating practitioner concerning the discharge of a patient after a mental health admission. She gave evidence that it was particularly important in Mr Summers' situation, because of the severity of his illness and the fact that he was subject to a Treatment Order. Dr Buchan was not working at the practice at the time of Mr Summers' death but she said that if the practice had received a call early on the Friday regarding Mr Summers' return to the island, then a call would likely have been made to him that day and the hospital would have been advised of the situation. She gave evidence that it is rarely the case that a phone call is made to her practice by mental health facilities in which a patient has been treated. She described the issue as a communications failure and as *"very frustrating."*

78. Similarly, Dr Robinson gave evidence that Mr Summers' general practitioner should have received a call from the Spencer Clinic upon his discharge. If Mr Summers had received a call from his general practitioner on the day of his discharge, he may have benefited by the knowledge of immediate medical support.

(c) Notification of the Treatment Order and its terms

79. I note that the discharge summary did not specify that Mr Summers was subject to a six month Treatment Order. There is no evidence that a copy of the order was attached to the discharge summary or sent to the general practitioner separately. It is obviously important for the general practitioner to have immediate knowledge of the existence of such an order. If possible, Suzanne should also have been provided with a copy, or notified of the terms of the order.

(d) Discharge on a Friday

80. At inquest, the question arose about whether Mr Summers should have been discharged on a Friday because of a lack of available services over the weekend. Ms Bartlett said in her statement: *"I do not agree with discharges on Fridays particularly to areas where there is little immediate mental health support available and no strong family support as is the case with Mr Summers. I raised this issue with both the Consultant Psychiatrist and the Discharge Planning Nurse. However, Mr Summers was not voicing any suicidal ideation and was quite insistent on discharge. There did not appear to be any clinical reason to prevent him from leaving."*

81. Dr Buchan also said in evidence that patients should not be discharged on Fridays to King Island due to the inability of doctors to be armed with information concerning the patient. Dr Robinson said in evidence that there is pressure at the Spencer Clinic to make beds available on weekends. There is no evidence that a lack of beds was a factor in discharging Mr Summers and clearly he was ready for discharge. It is more likely that Mr Summers died on Friday evening, as he did not answer Suzanne's text message at that time. If this is the case, it may not have been significant that he was discharged earlier that day. Nevertheless, the issue should be considered by discharging clinicians, particularly where a patient has little or no support over the weekend.

(e) Step-down facility

82. Dr Robinson, Ms Gibbons and Ms Bartlett commented in evidence that a 'step-down facility' would be highly beneficial in the North West region. Ms Bartlett said that if

the region had a step-down unit, such as those available in the North and South of Tasmania, Mr Summers could have spent three or four days building his resilience and then discharged to King Island in the company of his case manager, Ms Norton. She explained that this may have softened his fear of return and his home environment and he could have been assessed further in this time. The inquest did not explore this in any detail, although I note that proposals for such a facility have been discussed for many years. It would appear that there is strong demand for this type of facility.

Recommendations

83. **I recommend** that when a patient is discharged from an inpatient mental health facility to a rural or remote area, a treating clinical or health professional from the facility provides immediate advice to the patient's general practitioner of the discharge and details of the admission.

84. **I recommend** that when a patient is discharged from an inpatient mental health facility and is subject to a continuing order under the *Mental Health Act* 2013, a copy of the order is provided to the patient's general practitioner with the discharge summary.

Formal findings required by section 28(1) of the *Coroners Act* 1995:

a) The identity of the deceased is Damian Luke Summers;

b) Mr Summers died in the circumstances set out in this finding;

c) The cause of Mr Summers' death was hanging, an action taken by himself with the intention of ending his life; and

d) Mr Summers died between 29 and 30 November 2019.

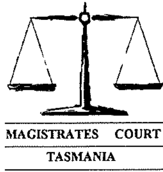
Acknowledgements

I appreciate the assistance of Ms Deanne Earley (Counsel Assisting), Sergeant Genevieve Hickman, (Coroner's Associate), and Sergeant Stephen Shaw (Investigating Officer).

I convey my sincere condolences to the family and loved ones of Damian Luke Summers.

Dated: 3 December 2021 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

LIST OF EXHIBITS

Record of investigation into the death of
Damian Luke SUMMERS
As at 25.08.2021

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH	SENIOR CONSTABLE FIONA RUSSELL
C2	LIFE EXTINCT AFFIDAVIT	DR RICHARD GIESE
C3	AFFIDAVIT OF IDENTIFICATION	SERGEANT STEPHEN SHAW
C4	AFFIDAVIT OF IDENTIFICATION	MORTUARY AMBULANCE – PETER CHIVERS
C5	POST MORTEM AFFIDAVIT	DR TERRY BRAIN
C6	TOXICOLOGY REPORT	NEIL McLACHLAN-TROUP
C6A	SUPPLEMENTARY TOXICOLOGY REPORT	NEIL McLACHLAN-TROUP
C7A	ELECTRONIC MEDICAL RECORDS	TASMANIA HEALTH SERVICE
C7B	TREATMENT ORDER 15/11/2019	MENTAL HEALTH TRIBUNAL
C7C	DISCHARGE SUMMARY	THS
C7D	MH TRANSFER	THS
C8A	AFFIDAVIT 30/11/2019	BELINDA JOAN TYLER (SNOK)
C8B	AFFIDAVIT 04/06/2020	BELINDA JOAN TYLER (SNOK)
C9A	AFFIDAVIT 27/05/2020	SUZANNE LOUISE SUMMERS (FINDER)
C9B	AFFIDAVIT 16/06/2020	SUZANNE LOUISE SUMMERS (FINDER)
C10	AFFIDAVIT	MAXWELL SUMMERS (WITNESS)
C11	AFFIDAVIT	GARY MORGAN (WITNESS)

C12	**AFFIDAVIT**	**ROBERT JORDAN (TASMANIA AMBULANCE)**
C13	**AFFIDAVIT**	**VINCENT HOLTHOUSE (SES)**
C14	**AFFIDAVIT**	**PATRICK JOHNSTONE (WITNESS)**
C15	**AFFIDAVIT**	**HAYLEY SMITH (WITNESS)**
C16	**AFFIDAVIT & REPORT**	**CONSTABLE WAYNE STANLEY**
C17	**AFFIDAVIT & PHOTOGRAPHS**	**SENIOR CONSTABLE FIONA RUSSELL**
C17A	**REPORT**	**SENIOR CONSTABLE FIONA RUSSELL**
C17B	**SUPPLEMENTARY REPORT**	**SENIOR CONSTABLE FIONA RUSSELL**
C18	**AFFIDAVIT & PHOTOGRAPHS**	**SERGEANT STEPHEN SHAW**
C19	**AFFIDAVIT & POLICE FAMILY VIOLENCE ORDER**	**SERGEANT ANDREW SMITH**
C20	**AFFIDAVIT & INVESTIGATION REPORT**	**SENIOR SERGEANT ADAM SPENCER**
C21	**AFFIDAVIT & LETTER OF COMPLAINT**	**ACTING INSPECTOR STEWART WILLIAMS**
C22	**POLICE COMPLAINT FILE**	**TASMANIA POLICE**
C23	**FINAL RCA REPORT**	**TASMANIA HEALTH SERVICE**
C24	**ELECTRONIC MEDICAL RECORDS**	**OCHRE HEALTH MEDICAL CENTRE**
C25	**RECORD OF PRIOR CONVICTIONS**	**DAMIAN SUMMERS**
C26	**AFFIDAVIT**	**JUSTIN THORPE**
C27	**RCA TOOLKIT**	**DR BEN ELIJAH**
C28	**KING ISLAND GP REFERRALS TO MHS GUIDELINE**	**DR BEN ELIJAH**
C29	**SMHS CLINICAL RISK MANAGEMENT PROTOCOL**	**DR BEN ELIJAH**
C30	**TAG – CLINICAL RISK ASSESSMENT**	**DR BEN ELIJAH**
C31	**TELEHEALTH PROTOCOL**	**DR BEN ELIJAH**
C32	**AFFIDAVIT**	**DR LANA LUBIMOFF**
C33	**STATEMENT**	**SHARYN BARTLETT**

C34	STATEMENT	VIKKI NORTON
C35	STATEMENT	DR METSEAGHARUN
C36	SMHS – DEATH OF A PATIENT GUIDELINE	THS (JOANNE BESWICK)
C36A	ATTACHMENT 1 – SAFETY EVENTS REPORTABLE TO THE DEPT. HEALTH	THS (JOANNE BESWICK)
C36B	ATTACHMENT 2 - STANDBY – SUPPORT AFTER SUICIDE BROCHURE	THS (JOANNE BESWICK)
C36C	ATTACHMENT 3 – POSTVENTION AUSTRALIA GUIDELINES	THS (JOANNE BESWICK)
C36D	ATTACHMENT 4 – CLINICAL COMMUNICATION (ISOBAR)	THS (JOANNE BESWICK)
C37	SMHS – EXIT & DISCHARGE PROTOCOL	THS (JOANNE BESWICK)
C37A	ATTACHMENT 1 – CLINICAL COMMUNICATION (ISOBAR)	THS (JOANNE BESWICK)
C38	RCA STEPS	THS (JOANNE BESWICK)
C39	PATIENT SAFETY MANAGEMENT PROTOCOL	THS (JOANNE BESWICK)
C39A	ATTACHMENT 1 – THS SAFETY EVENT MANAGEMENT PROCESS	THS (JOANNE BESWICK)
C39B	ATTACHMENT 2 - SAFETY EVENTS REPORTABLE TO THE DEPT. HEALTH	THS (JOANNE BESWICK)
C39C	ATTACHMENT 3 – GUIDE TO DOWNLOAD SAC 1 SAFETY EVENTS IN SRLS	THS (JOANNE BESWICK)
C39D	ATTACHMENT 4 – GUIDE TO ELECTRONIC REB AND RCA RECOMMENDATIONS IN SRLS	THS (JOANNE BESWICK)
C39E	ATTACHMENT 5 – REPORTED SAC 1 RESPONSE FLOW CHART	THS (JOANNE BESWICK)
C39F	ATTACHMENT 6 – SYSTEMS ANALYSIS OF CLINICAL INCIDENTS – THE LONDON PROTOCOL	THS (JOANNE BESWICK)

C39G	**ATTACHMENT 7 – LONDON PROTOCOL METHOD**	**THS (JOANNE BESWICK)**
C39H	**ATTACHMENT 8 – LONDON PROTOCOL REPORT**	**THS (JOANNE BESWICK)**
C39I	**ATTACHMENT 9 – INCIDENT REVIEW REPORT (IRR) SAC 2 STEPS**	**THS (JOANNE BESWICK)**
C39J	**ATTACHMENT 10 - INCIDENT REVIEW REPORT (IRR) SAC 2**	**THS (JOANNE BESWICK)**
C40	**KING ISLAND MENTAL HEALTH SERVICES – CONTACT LIST**	**DR BEN ELIJAH**
C41	**SMHS – TRANSFER OF CARE (WITHIN SMHS) - PROTOCOL**	**THS (JOANNE BESWICK)**
C41A	**SMHS – TRANSFER OF CARE INPATIENT**	**THS (JOANNE BESWICK)**
C42	**SPENCER CLINIC MANAGEMENT STRUCTURE FLOW CHART**	**THS (JOANNE BESWICK)**
C43	**SMHS STRUCTURE FLOW CHART**	**THS (JOANNE BESWICK)**
C44	**AFFIDAVIT**	**SHARYN BARTLETT**