



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Maria Rebekah Wright

Find, pursuant to section 28(1) of the Coroners Act 1995, that:

- a) The identity of the deceased is Maria Rebekah Wright;
- b) Mrs Wright died in the circumstances set out below;
- c) The cause of death was drowning, an action taken by Mrs Wright alone and with the intention of ending her life; and
- d) Mrs Wright died on 14 August 2017 at Howrah in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Wright's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Life extinct and identification affidavits;
- An opinion of the Forensic Pathologist who conducted the autopsy;
- Toxicological analysis of Mrs Wright's blood samples;
- Numerous affidavits of police officers involved in the air, land and sea search for Mrs Wright upon her being reported missing;
- Affidavits of Aaron Wright, Mrs Wright's husband;
- Affidavit of Caroline Riseley, Mrs Wright's friend;
- Affidavit of Catherine Wright, Mrs Wright's sister-in-law;
- Affidavit of David Millington, Mrs Wright's brother;
- Affidavit of Bernard Cane, Minister at Mrs Wright's church;
- Affidavits of Alana Betzold and Sabina Rainer-Smith, who found Mrs Wright's body;
- Affidavits of Forensic Services officers, with accompanying photographs;
- Letter from Grant Millington, Mrs Wright's father;
- Tasmania Police information reports concerning Mrs Wright;
- Tasmania Police missing persons documentation relating to Mrs Wright;
- Forensic analysis of text messages from Mrs Wright's mobile phone;
- Documentation from Advocacy Tasmania;

- Royal Hobart Hospital (RHH) records relating to Mrs Wright;
- Root Cause Analysis Report relating to Mrs Wright's final admission to the RHH;
- Hobart Clinic records for Mrs Wright;
- Reports and opinions from Mrs Wright's treating psychiatrists; and
- Letters and notes authored by Mrs Wright.

Background

Mrs Maria Rebekah Wright was born Claire Pamela Annette Millington in Hobart on 12 December 1985 to parents Grant Millington and Rosemary Millington (now deceased). She has an older brother, David Millington, who currently resides in Estonia. Mrs Wright was aged 31 years at the time of her death. She was married to Aaron Wright and has a son, Jeremy, born in 2011.

Mrs Wright grew up on a hobby farm near Kettering where she lived with her mother, father and brother. Mrs Wright and her brother were home schooled by their mother, Mrs Millington, who was a qualified primary school teacher. Mrs Millington was diagnosed with breast cancer in 1994, became very ill and was no longer able to home school the children. When she became unwell, Mrs Millington applied for, and won, a scholarship for her daughter to attend Collegiate school. Mrs Wright therefore commenced at Collegiate in Grade 5 and attended until she graduated in Year 12 with a very high Tertiary Entrance Rank (TER) score of 94.

Mrs Millington is described in the evidence as having severe physical and mental health issues, although there was no formal mental health diagnosis. Her behaviour was described as erratic and unpredictable at times and she believed in the physical punishment of her children. Between the time of Mrs Millington's diagnosis and her death in 1996, the children were cared for by various members of their family. As a result, their lives became unstable as they were being passed between the houses of those that were able to care for them. The evidence indicates that Mrs Wright had idolised her mother, and her brother described her as being 'no longer the same' after her mother's death when she was 10 years of age.

At the conclusion of Year 12, Mrs Wright took a gap year and moved to England. She obtained employment in a disabled care home. It was during this period that she first attempted suicide by overdosing on substances. She sought medical and psychiatric help whilst living in England. She returned to Australia at the age of 19 years, and moved to Canberra where she enrolled at the Australian National University. Within the first week of attending university, Mrs Wright alleged that she was raped but did not wish to report the matter to police at the time as she

was too ashamed to talk about it. Subsequently, her mental health further declined and she sought professional help.

Mrs Wright was a very intelligent woman and, although her mental health was deteriorating, she was still able to complete her first year at university with excellent results. However, due to struggling with the incident and her mental health issues, she moved back to Tasmania at the conclusion of her first year of university. She did not hold any regular employment due to her illness for the remainder of her life.

During 2006 Mrs Wright met Aaron Wright who had also been a patient at the Hobart Clinic where Mrs Wright had been admitted and treated. In 2008 they began a relationship and, after a break in that relationship, they married in April 2010. Mr Wright also suffers from ongoing mental health issues, however, he remained, for the duration of their marriage, very supportive of his wife.

Over the years leading up to her death, Mrs Wright had multiple psychiatric inpatient treatment at the Hobart Clinic at Rokeby, Spencer Clinic in Burnie, St Helens Private Hospital and the Royal Hobart Hospital. In some instances she presented back to hospital less than 24 hours after discharge.

On 28 July 2011, Mrs Wright gave birth to a son, Jeremy. Both Mr and Mrs Wright continued to struggle with their mental illnesses, and they were unable to provide adequate care for Jeremy. Additionally, they were living in Ulverstone at the time and did not have any family locally to assist them. When Jeremy was four weeks old Mrs Wright took him to her mother-in-law to care for him. Jeremy remained in the care of his paternal grandparents until it was decided that he should be cared for by Mr Wright's sister and her fiancé, who reside in Sydney. Jeremy continued to have regular telephone contact and visits with his parents. Mrs Wright last saw her son several days before her death.

Before her death, Mrs Wright lived with her husband in Howrah. Both were in receipt of a disability support pension.

During the 20 years before her death, Mrs Wright was diagnosed with and treated for the following:

- Depressive Anxiety Disorder (1997);
- Major Depression, Borderline Personality Disorder and Dissociative Disorder (2003);
- Adjustment Disorder with repressed mood and Bulimia (2006);
- Recurrent Depressive Disorder (2011);

- Bipolar Disorder (2013);
- Post-Traumatic Stress Disorder (PTSD), Recurrent Depressive Disorder and Bipolar Affective Disorder (2014); and
- Schizoaffective Disorder and Borderline Personality Disorder (BPD) (2015).

Her most recent diagnosis before her death was that of severe Borderline Personality Disorder (BPD). She struggled with chronic suicidality, self-harm behaviours, impulsivity, anxiety, sensitivity and self-esteem issues, dissociative and quasi-psychotic features, suggestive of significant affective and identity dysregulation. Mrs Wright was also diagnosed with asthma, dyslipidaemia, an eating disorder and co-existing polycystic ovarian syndrome, and chronic pain. These conditions exacerbated her other psychological conditions and vice versa.

Over the years, Mrs Wright's extensive treatments included pharmacotherapy and electroconvulsive therapy as well as psychotherapeutic approaches aimed at reducing her levels of anxiety. Unfortunately, despite treatment, there was little improvement in her condition and she remained a very high risk for suicide. She was a very difficult and complex patient, resistant to much of her treatment.

For a number of years, until the beginning of 2016, Mrs Wright was seen as a private patient by psychiatrists Dr Douglas Carter and Dr Johanna Bakas. Both doctors felt that although they had worked closely with Mrs Wright over a long period of time, they were no longer able to provide the amount and frequency of treatment that she required for her own protection. Additionally, Mrs Wright no longer had private health insurance and Dr Carter was approaching retirement. She was subsequently seen in the public health system by psychiatrist, Dr Richard Benjamin, psychologist Dr Meredith Oldmeadow and a team at Eastern Shore Mental Health Services.

Mrs Wright had been referred to experts at the Belmont Clinic in Queensland and most recently to the Spectrum Mood Disorder Clinic in Victoria (experts in BPD). It appears that she resisted the attempts of these clinics to engage her. The Spectrum Mood Disorder Clinic had confirmed her diagnosis of BPD. Mrs Wright did not agree with this diagnosis and believed that she should have been diagnosed with schizoaffective disorder, a disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms, and post-traumatic stress disorder. She also felt that her medication regime was unsuitable and in the months leading to her death, she strongly advocated to treaters to be medicated for that specific condition, including to be trialled upon clozapine.

Mrs Wright presented to the RHH on multiple occasions. In 2016 Mrs Wright presented to the RHH on 25 occasions and was admitted on 18 of those occasions. According to RHH

records, in 2017 (until her death in August) Mrs Wright had presented at the RHH on 19 occasions and was admitted on 14 of those occasions. Generally, her presentations to the RHH were related to deliberately inflicted self-harm, attempted suicide or other issues related to her psychiatric conditions.

Mrs Wright was also under the regular care of her general practitioner, Dr Karen Sargent at the Hopkins Street Medical Clinic. She last saw Dr Sargent on 14 June 2017 when she told Dr Sargent that she was feeling suicidal and could not stop thinking of self-harm. Dr Sargent organised an appointment with her psychologist and wrote a referral letter to Dr Benjamin.

Circumstances Surrounding Death

On 21 July 2017, Mrs Wright presented to the Emergency Department of the RHH with abdominal pain. She was not admitted to hospital. She was advised to use her regular analgesia and was provided with a script for a nonsteroidal anti-inflammatory drug.

On 30 July 2017, Mrs Wright again presented to the Emergency Department stating that she had taken an overdose of paracetamol and lamotrigine. She was voluntarily admitted overnight and monitored. Early the next morning, she asked to go home as she had things to do.

On 5 August 2017, Mrs Wright took an overdose of paracetamol and lamotrigine, requiring urgent treatment for the paracetamol overdose. She claimed to have ingested 60 x 500mg tablets with the intention of suicide. She refused to attend the RHH voluntarily and was placed under a Protective Custody Order and taken to the hospital by police officers. She was admitted to the hospital at 9.25pm and given an N-acetylcysteine (NAC) infusion to try and reverse the likely fatal toxicity of the paracetamol. During this time she became agitated, removed her cannula and refused medical treatment.

At about 1.30pm on 6 August, by reason of Mrs Wright's agitated state and refusal of medical treatment, physical restraints were authorised by the admitting doctor on consultation with Dr Benjamin. The restraints were authorised for 24 hours commencing at 2.00pm after which they would be reviewed. Mrs Wright was to be provided with "one-on-one" care and be in the line of sight of staff at all times, with regular checks of the restraints and pressure points. A code black was to be called at least every two hours to assist in removing the restraints and to assist in helping Mrs Wright to eat and visit the toilet. The cannula was replaced and the NAC infusion continued.

At 6.55am on 7 August, whilst Mrs Wright was in restraints and receiving the NAC infusions, she tried to release the restraints and again attempted to remove her intravenous line. The restraints were again applied and at 9.30am she was medically cleared, although awaiting a

psychiatric admission. The restraints remained in place, however, the chest restraint was removed at 12.10pm after a visit to the bathroom. At 1.50pm, Mrs Wright again attended the bathroom and the restraints were removed by staff. The code black team were in attendance, however, Mrs Wright attempted to abscond. She was relocated back to bed and restraints applied again. The two-hourly code blacks were still in place as were the 15 minute checks on the restraints. She also still had one-on-one care.

On 8 August at 4.45am, Mrs Wright escaped from her restraints. She was located in the staff toilet a short time later. At this time she had assaulted a nurse. She had taken hold of the nurse's lanyard and then grabbed hold of both of the nurse's arms tightly. A code black was called and Mrs Wright was returned to her bed and the restraints again placed on her arms and legs.

At 2.30pm, Mrs Wright again attempted to undo the restraints. They were, again, placed on her correctly. 25 minutes later Mrs Wright had the restraints removed and she was transferred to ward 3J where her psychiatric treatment could be continued. During her time on the medical ward, for a substantial amount of that stay, she was non-communicative and refused to accept any medication and food or water. Although the restraints had been removed a "one-on-one" sitter was to remain with Mrs Wright, and the bathroom remained locked. Two nurses were to accompany her if she needed to use the bathroom.

On 9 August, during the evening, Mrs Wright made two attempts to escape the secure ward. Both times a code black was called and she was escorted back to the ward by nursing staff and security. Earlier that day, she had managed to lock herself in the bathroom with a broken pen, and superficially scratch her wrist with it. There was continued one-on-one care during that evening.

On 10 August, Mrs Wright refused her medications, and initially also refused her breakfast. After some coaxing from staff, Mrs Wright agreed to eat breakfast, and at 9.00am was handed a breakfast tray. She took the knife from the tray and threatened to stab herself with it before hiding it amongst the bed clothes. The knife was subsequently recovered by staff.

At 10.30am on 10 August 2017, a discharge order for Mrs Wright was made with the intention of follow-up with the Crisis Assessment Team (CAT). Mrs Wright was discharged into the care of her husband.

A Treatment Plan was updated for Mrs Wright on 8 August 2017. The primary aim of the Plan was to provide the best possible care for Mrs Wright and to move the focus of care from hospital to community, and from seeking help after self-harm/suicide activity to seeking it before such activity. The goal was to help her understand her condition, to teach her the skills

to manage her symptoms and psychological distress so that she did not feel the urges to attempt self-harm/suicidal behaviours. The Treatment Plan also noted that the Tasmanian Health Service (THS) and Spectrum both had an understanding that Mrs Wright had the potential to recover from her psychiatric illnesses, but that she also remained an ongoing risk of death by misadventure. Both organisations also believed that repeated and/or lengthy psychiatric admissions were unlikely to reduce that risk, and paradoxically could increase the risk.

Amongst other points, the Plan also outlined the following:

- Regular psychotherapy with Dr Meredith Oldmeadow;
- Regular consultations with Dr Richard Benjamin;
- Mrs Wright was able to present to the Hospital for admission for mental health care. She was to present to the Emergency Department for assistance when concerned about self-harm, suicide, or internal distress and 48-72 hour admissions would be provided to assist Mrs Wright to manage the difficulties. These admissions were to be limited to 10 per year with a maximum duration of 72 hours. To help Mrs Wright retain control over her care, all admissions were to be on a voluntary basis and to an open ward. This was designed to help Mrs Wright manage her distress and to avoid self-harming behaviours through the provision of a place of safety, and validation of Mrs Wright's concerns;
- Should self-harm behaviour or suicidal activity occur, Mrs Wright was to be discharged once medically fit to leave. That was because the indication of admission was to avoid self-harm. There were also restrictions around the time of discharge (i.e. she was not to be discharged during the evening);
- Anti-psychotic medication, in particular, was to be avoided; and
- Treatment services and agencies were to liaise and collaborate together in providing the Treatment Plan, and advice in relation to the Plan was available seven days per week.

The Plan provided for 9 signatories, however, all parties had not signed the document at the time of Mrs Wright's discharge from hospital.

During her stay on the medical ward, Mrs Wright complained about her treatment with regard to being held in restraints. She made the complaint to hospital staff and was advised to seek legal advice. As a result of this, she sought guidance from Advocacy Tasmania and drafted a letter of complaint to the Hospital. This was sent to the Complaints Department of the Tasmanian Health Service. In that letter, she described her pain and distress as a result of the

restraints, and the fact that the experience was “highly detrimental” to her already fragile mental health. She sought from the RHH an apology for her treatment.

On the morning of 14 August 2017, Mrs Wright woke in, what was described by her husband as, a quite settled and good mood. She went to Eastlands and returned around 10.00am. During the day, her behaviour and mood deteriorated and by early afternoon Mr Wright was becoming concerned about her. She avoided directly answering questions and refused to return the house and car keys to Mr Wright, who generally locked the keys and medication away to keep Mrs Wright safe. As a result of this, Mr Wright was unable to lock the doors to prevent Mrs Wright from leaving.

At 4.00pm, Mrs Wright indicated to her husband that she was going for a walk. She had left the location services on her mobile phone on, and Mr Wright could see that she was headed towards Howrah Beach. Mr and Mrs Wright exchanged text messages, and Mrs Wright wrote of the voices in her head and the fact that they were directing her to do certain things and that she could not resist them. She did not specify the actions that they were directing her to take. Mr Wright asked Mrs Wright to ignore the voices and to concentrate on something else. It was at this time that Mrs Wright realised the location services on her phone were switched on, and she turned them off. Mr Wright attempted to convince Mrs Wright to return home. Mrs Wright’s last location on her phone was Howrah Beach at the end of Silwood Avenue.

Mr Wright called Tasmania Police at 6.16pm and police officers attended Silwood Avenue Howrah and spoke with Mr Wright. He explained his concerns and pointed out on his phone where Mrs Wright’s phone was showing as being located.

Police conducted a search of the beach and area around the rocks of the bluff between Bellerive and Howrah beaches. A pair of shoes and a pile of clothing, neatly folded and stacked, were located on the rocks approximately 10 metres from the water’s edge on the cliff area of the bluff. Mrs Wright’s phone was located in the pocket of the trousers.

A helicopter was deployed to the area and arrived at the area at 7.35pm. An aerial search of the area with night vision goggles took place. During the search, a pale object was spotted submerged just below the surface and, as a result, the marine section of Tasmania Police was notified and dispatched to the area. Whilst the vessel was on route, the object in the water appeared to be sinking and after several passes over the area the police were unable to find the object. The police vessel and helicopter searches concluded at approximately 8.05pm.

On 15 August, the search for Mrs Wright continued. A search was conducted on foot of both Bellerive and Howrah Beaches as well as the bluff walking tracks and cliffs. The marine and dive

sections of Tasmania Police were also tasked to search the water in and around those areas. These searches did not produce any results.

On 16 August at 3.08pm, Tasmania Police received a telephone call from a member of the public who was driving along the South Arm Highway on the neck at South Arm. The caller observed a deceased body washed up on the foreshore. Police officers attended and based on the circumstances of the discovery, and the resemblance to the driver's licence photo, believed the body to be that of Mrs Wright.

Members of the Criminal Investigation Branch and Forensic Services attended and examined the scene. The examination involved a search of the beach and the body, which concluded that there were no suspicious circumstances.

A full autopsy was conducted by Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey concluded, based on autopsy findings and toxicological examination, that in his opinion the cause of death of Mrs Wright was drowning.

A note was found by police officers in the pocket of Mrs Wright's clothing, which I am satisfied was written by her. The note was a three-page typed document dated 12 August 2017. In the note, Mrs Wright stated that she had experienced psychotic symptoms since she was 17 years of age but had not spoken to her treating professionals about these until 2017, at which time she alleged that these were "dismissed" by her psychiatrists and psychologists, who she stated found it easiest to account for her mental health issues by reference to her past trauma. She stated in the note that she heard voices constantly and these voices controlled her actions. Relevantly, this note does not criticise her recent treatment or restraints at the RHH, and does not indicate an intention to end her life.

I am satisfied that Tasmania Police engaged in a thorough search for Mrs Wright once her disappearance was reported. I find that Mrs Wright, upon leaving her home, went to Howrah Beach and, during this time, exchanged text messages with her husband. Once at Howrah Beach, Mrs Wright removed all items of her clothing, folded them and left them in the location they were found, together with her phone, before deliberately entering the water at the bluff area between Howrah and Bellerive beaches. She then deliberately submerged herself in the water with the intention of ending her life by drowning. Her body was located two days later, washed ashore in Speaks Bay, just east of South Arm and about 16 km from the point of her entry into the water. I am satisfied that there were no suspicious circumstances surrounding Mrs Wright's death and that no one could have prevented her from ending her life. In particular, Mr Wright took all steps that he was able to take to attempt to keep her safe and prevent her suicide.

Comment on Mrs Wright's Mental Health Treatment

I have set out above in detail the treatment of Mrs Wright at the RHH, including the lengthy admission between 5 and 10 August 2017 in which she was subject to involuntary, life-saving treatment with mechanical restraints being applied to her for a total period of 47 hours 55 minutes. I feel compelled to make comment about this issue, not only because of the involuntary nature of the treatment but because Mrs Wright herself made a formal written complaint about it on the day following her discharge. I have also had regard to the submission and supporting documentation by Mrs Wright's close friend, Caroline Riseley, provided to the Coroner's Office. In her documentation, Ms Riseley included comprehensive, typed written material she had received from Mrs Wright during the months before her death. In that material, Mrs Wright repetitively alleged, giving detailed reasons, that she had been misdiagnosed, as she did not have BPD but did suffer schizophrenia. She also indicated that she was therefore not treated or medicated correctly.

In the first instance, I do not accept the proposition that Mrs Wright had received an incorrect diagnosis. I accept the correctness of the diagnosis by her many experienced treating professionals, including the specialist consultants from Spectrum in Victoria, that Mrs Wright suffered severe Borderline Personality Disorder, including dissociative and quasi-psychotic features, but did not suffer from any primary psychotic or affective disorders (including schizophrenia).

I am not required in this investigation to make any detailed finding upon the correctness of Mrs Wright's stated experience of hallucinations and delusions. Many of her treating professionals did not accept that she was truthful about the extent of her psychosis. In a piece of writing dated 21 June 2017 (seemingly to her psychologist) she indicated, for example, that she had the experience of aliens controlling her for a malevolent purpose and causing her to be "extremely suicidal". Mrs Wright may well have experienced auditory and visual hallucinations and may have suffered these for a lengthy period of time, however, I am satisfied on the basis of the expert opinion that the psychotic episodes suffered by her were consistent with BPD rather than schizophrenia.

I cannot discount that, before her death, she was fully or partially reacting to auditory hallucinations directing her to end her life in the manner that she did. If this is the case, her formed intention to do so was not based upon rational thought.

Secondly, I am satisfied that the treatment at the RHH is unlikely to have played any substantial part in her death. Ironically, the application of the restraints together with the NAC infusion may well have prevented her death at an earlier time from paracetamol overdose by fatal liver injury. I am satisfied that if she had not been restrained, she would likely have removed her

intravenous cannula which provided the life-saving treatment and left the hospital. It is understandable that the restraints remained in place after the conclusion of the infusion as she had absconded from the Assessment and Planning Unit and had assaulted a member of the nursing staff.

In January 2020, I received from THS as part of the evidence a “Final RCA Report” reviewing Mrs Wright’s care from 5 August until her death. The review noted that the Chief Psychiatrist identified lapses in compliance with the *Mental Health Act 2013* provisions and made systems based recommendations in response. It appears from my own consideration of the records that appropriate assessment orders covered the whole of Mrs Wright’s admission but there may have been gaps in required documentation for Urgent Circumstances Treatment under section 55 and for authorising restraints under section 57 of that Act. After extensive inquiries, it appears that the review referred to in the RCA report was, in fact, a review by Ms Cecily Pollard (Clinical Nurse Consultant, Prevention and Incident Management, Patient Safety Unit, Tasmanian Health Service) at the request of the Mental Health Tribunal and Directors of Statewide Mental Health Services. Ms Pollard confirms in her review that there was a lack of documentary evidence regarding the extension of restraint, although there was evidence of verbal consent by the on-call Psychiatric Consultant. Ms Pollard found that, despite the lack of documentation, the restraint was necessary to continue Mrs Wright’s treatment.

Ms Pollard further found in her review that the NAC infusion was carefully monitored as per guidelines and in consultation with the New South Wales Poisons Information Centre. She also concluded that the nursing care and management of Mrs Wright was excellent, being evidence-based and in accordance with protocol and the requirements under the *Mental Health Act 2013*. I accept her conclusions.

I am satisfied that the threshold legislative requirements for an assessment order (in particular, a lack of decision-making capacity), for Urgent Circumstances Treatment and for the use of restraints were satisfied regardless of any gaps in the Hospital’s documentation.

The RCA panel found that the period of mechanical restraint may have been shortened to a degree if a bed in the Department of Psychiatry had been available after completion of the NAC infusion. Other issues were identified relating to record-keeping and follow-up procedures and documentation post discharge with recommendations to implement changes. The review noted that some of these issues arose because Mrs Wright was subject to a personalised plan, rather than the usual CAT team follow-up, which involved, initially, an appointment with her psychologist the day following her discharge.

There is insufficient connection to Mrs Wright's death to deal with these matters further. In this regard, I observe that Mrs Wright did not attend her psychologist's appointment but, in the days after discharge, engaged in extensive email correspondence with Ms Kristy Meos, an Advocacy Tasmania advocate, in relation to what she perceived as her particular needs for her ongoing care in the community - matters separate from the issue of the restraints. Ms Meos documented a phone call made by an advocate to Mrs Wright on 14 August in which she stated that Mrs Wright was upset about an email sent from Dr Carter to Dr Benjamin in which Dr Carter reinforced that he was not able to assist Mrs Wright any longer.

The RCA panel also noted the complexity of Mrs Wright's condition and her chronic high risk of death. It found that there was a thorough, personalised, multidisciplinary plan in place for her care both within the patient and community settings.

For these reasons, I am satisfied that there are no issues concerning Mrs Wright's treatment or diagnosis that contributed to her death. I am also satisfied that there were no deficits in her treatment at the RHH in her final admission that played any significant role in her death. Despite the dedicated efforts of doctors and mental health professionals over many years, Mrs Wright remained a severely ill person who was unable to recover from her illness.

The circumstances of Mrs Wright's death are not such as to require me to hold a public inquest or to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I extend my appreciation to the investigating officer, Constable Samantha Brady, for her thorough investigation and report.

I convey my sincere condolences to the family and loved ones of Mrs Wright.

Dated: 13 August 2020 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner