CITATION: *Inquest into the death of Paula Michele Schubert* [2018] NTLC 020

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0178/2016
DELIVERED ON:	25 July 2018
DELIVERED AT:	Darwin
HEARING DATE(s):	25 – 27 June 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Employee with mental health issues, treated inappropriately by employer, bullying behaviour, Mental Health Service poor note keeping and stakeholder engagement**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Territory Families	Miles Crawley SC
Counsel for Top End Health Service	Stephanie Williams

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0178/2016

In the matter of an Inquest into the death of

PAULA MICHELE SCHUBERT

Between 16 and 17 NOVEMBER 2016
AT 47 Flametree Circuit, ROSEBERRY

FINDINGS

Judge Greg Cavanagh

Introduction

1. Paula Schubert was born 21 September 1963 in Bordertown, South Australia to Margaretha and Brian Schubert. She was the middle child in a family with five children. She went to school in Darwin and obtained employment with the Department of Children and Families. She worked for the same department for the next 32 years. She worked as a personal assistant. She was known to be a meek, quiet and compliant worker who tried her best and was always willing to please.

2. Her parents and siblings live in Darwin. They are a close family. Paula spent time with family every day and with the whole family once a week. She had a daughter in the year 2000 during the course of her marriage to Jason Grant. Her marriage ended in 2008.

3. In 2014 at the age of 50 years she suffered a mental breakdown. She began hallucinating. She smelt gas and burning rubber (olfactory hallucinations). Her lungs hurt. Her anxiety levels increased. She became fearful of losing her job and made frequent approaches to other staff seeking reassurance. Her employer referred her for a medical assessment under the provisions of the *Public Sector Employment and Management Act*.

4. Shortly thereafter (and for reasons unrelated to the medical assessment), she was admitted to the mental health ward (Cowdy Ward) where she was diagnosed with Schizophreniform Psychosis and stabilised on medication. She thereafter completed 21 sessions with a psychologist.

5. During that period she was transitioned back into the workplace. She continued to improve and commenced a Diploma in Child, Youth and Family Intervention. On completion (and she did complete it) she could have become a case support worker.

6. She was discharged from the Mental Health Service in March 2015. Her own assessment was that she was functioning at 98% by that time. She gained a promotion to an AO4 position as Executive Assistant, Greater Darwin Region on 19 October 2015.

7. However in December 2015 some of the symptoms returned. She began to smell the gas again, although only while at work. She became anxious, believing she may be headed for another mental breakdown and that she might be sent to Cowdy Ward again. Due to her anxiety she was reticent to re-engage with the Mental Health Service and did not do so until 26 April 2016.

8. When she contacted the Mental Health Access Team (Mental Health) she said she was fearful that she was headed for another full scale breakdown. However later that day she felt better and indicated that she would self-monitor and said she did not need further assistance.

9. The following month she was referred to the Mental Health Service by her General Practitioner (GP).

Feelings of Abandonment

10. According to Dr Chapman, Paula's Psychiatrist, Paula had a combination of personality traits and mental health issues that sensitised her to feelings of

"abandonment". He said it was a core feature during her illness. She feared that she was not undertaking her tasks adequately at work, she felt she was being pushed out and would lose her job. Her response was to seek frequent reassurance. She sought it from her manager and work colleagues.

11. Mental Health were aware when they sought to transition her to another service or back to her GP it would engender the feelings of abandonment. However, they believed that if managed gradually and with support she would soon adjust. She had done so on the previous occasion in 2014 – 2015.

The Workplace

12. It was noted in the workplace that Paula was struggling. Her manager, Ms Patricia Butler, and other team members began to talk about how Paula's health was deteriorating. By the end of August 2016 her manager had a meeting with Paula and made a file note. The file note indicates that Paula was asked how she was going with the extra workload she had taken on. Paula said that she was "going okay". She said she had been unwell but "was handling it". She later said that she had some personal issues and currently had medical support to help her manage.

13. On or about 6 October 2016 Paula told her manager she had schizophrenia. In telling her psychologist about that conversation she said her manager was very understanding. She said she was relieved she had told her manager as she didn't have to worry about her finding out some other way.

14. The problems Paula was having appeared to be impacting the work environment. Paula's inability to complete her tasks meant others in the office at the AO3 level had to take on more work. Ms Butler was of the view that it was not fair on those persons who were being paid an AO3 wage when she was being paid a higher wage. Ms Butler also believed that if

Paula went back to her old job it would relieve some of her anxiety. Ms Butler said that she felt it was the "only option and avenue" she had.

15. On 19 October 2016 Ms Butler had another meeting with Paula. Again she made a file note. Paula did not have and was not given the opportunity to have a support person at the meeting. The "subject" was said to be "revised workload". Ms Butler asked how Paula was managing. Paula said she was receiving medical support and advice. Ms Butler told her there was a possibility of changing roles to relieve some of the stress she may be experiencing and doing so may be beneficial to her health and wellbeing. The alternative role offered was a demotion. Paula responded that she would be happy to move to the other position. Ms Butler told her to consider the impact on her take home pay as it was an AO3 position. Paula said she would think about it.

16. During the period until the next meeting Ms Butler said that Paula would come to work each morning with a cup of coffee. Ms Butler, referring to Paula's impending change of roles (and less pay), said to her that she would have to bring a plunger to work.

17. Paula spoke to her psychiatrist, her doctor and psychologist about the suggested transfer to the AO3 position. They were in agreement that it may help reduce her anxiety levels.

18. On 1 November 2016 Ms Butler once more met with Paula. Again there was no support person. She asked Paula how she was feeling and whether she had made a decision regarding the changes to her workload. Paula said that she would like to transfer to the AO3 role but wanted clarification that she was not relinquishing her AO4 position. It was agreed that the new arrangement could be reviewed in 3 months or sooner if desired. The terms of the meeting were reduced to a file note and Paula asked to sign it. She did.

19. Ms Butler then spoke to the Human Resources (HR) section of the Department to determine how that might be achieved. She was told it could be accomplished if there was consent to a pay reduction or through performance management. HR seemingly did not understand that there was anything inappropriate with what management sought to achieve.

20. For reasons that are not altogether clear, Ms Butler then spoke to her manager Ms Marnie Dillon (aka Marnie Couch), the then Acting Executive Director of the Out of Home Care Division. Ms Butler had previously told Ms Dillon that Paula was suffering from schizophrenia. Ms Butler said she spoke to Ms Dillon on this occasion because she felt uncomfortable performance managing Paula.

21. Ms Dillon said that the conversation with Ms Butler was about Ms Butler having difficulties with regular workplace conversations about Paula's duties. Ms Dillon said that Paula took things to heart. Ms Dillon told Ms Butler that they would have a meeting with Paula. Ms Dillon described the meeting as a "formal" meeting. A reasonable inference is that the meeting was designed to be a step toward the potential commencement of inability proceedings.

22. At that time Ms Dillon had known Paula for about three years. Ms Dillon described her this way:

> "Paula has always been an anxious type of character. I can see it in her body language and behaviour. She would always apologise for things several times. Paula tried so hard to please people … Paula presented meek, quiet, softly spoken. Paula presented as reasonably happy and calm all the time."

23. Ms Dillon said that she and Paula had a number of conversations about personal issues that had affected Paula in the past. The suggestion was that calling the meeting with her would not therefore be intimidating.

24. It was decided that Paula should not be given too much notice of the meeting as it may make her anxious. About half an hour before the meeting Ms Butler told Paula she was to attend the meeting. She did not tell her what the meeting was to be about. She did not tell her she could bring a support person.

25. At the meeting were Ms Dillon, Ms Butler and Paula. They sat around a table in Ms Dillon's office. The door was closed and the blinds drawn. The file note of that meeting states that it began with Ms Dillon saying that the meeting was to discuss Paula's diagnoses and how she could be supported in the workplace. Paula said that the meeting was making her feel anxious.

26. Ms Dillon then asked Paula if she would like a support person and said that the meeting was to work toward a support plan. Paula said that she would forego the support person. Paula was told that she could stop the meeting at any time if she wanted a support person.

27. Ms Dillon and Ms Butler said they would like to meet with her medical providers to understand how they could support her. Paula said that she didn't need support and everything was in hand. Ms Dillon then said that she was concerned about Paula displaying some anxiety and uncertainty when dealing with change or additional tasks. She said "all parties needed to be able to speak frankly" to work toward a solution. Paula said she did get anxious at times.

28. The discussion was then had about Paula changing "roles and levels" and how she was anxious about losing her job and being pushed out. Ms Dillon said that was not the case and that her supervisor "needs to be able to talk to her and delegate tasks without her feeling apprehensive". Paula said she wasn't feeling pushed out now and was happy to change to the lower level. They agreed to meet again in eight weeks.

29. Two days later on Wednesday, 9 November 2016 Paula and her manager signed a file note related to that meeting. Ms Dillon then sent it to HR.

30. Paula attended the workplace that same week on the Thursday (10th) and the Friday (11th).

31. On Monday, 14 November 2016 it was noted that Paula appeared to have an anxiety episode. She appeared to be in a "zombie like state". At 11.00am she went to see her General Practitioner. He gave her a medical certificate.

32. On Tuesday 15 November 2016 she sat in a team meeting and apparently did little else other than draw a picture. At the end of the meeting Ms Butler said, "Paula will share her minutes with everyone". Paula looked surprised. Ms Butler said it was a good drawing and she should share it with everybody.

33. On Wednesday 16 November 2016 Paula rang Ms Butler to say she needed two days off to take her parents to appointments. Ms Butler thought she sounded "down".

34. That night Paula went to her parent's house for dinner. After dinner her mother asked her to stay, however she said she'd go home.

35. The next evening was a pre-planned dinner with the family. It was usual for Paula to go to her mother's house and from there go out with the family. When she didn't arrive and didn't answer her phone, her mother asked that her brother go to her home and check on her.

36. When he arrived the television was on and he could hear her phone ringing inside the house. He reported that to the family and rang the Police. Police found her body in her bedroom. She had hung herself from the bedroom door.

37. She was 53 years of age.

Treatment

38. Her General Practice of choice was the Palmerston Medical Clinic. There was no one particular doctor she always saw, although from the end of August 2016 the main General Practitioner (GP) she saw was Dr Wasana Ratnayake.

39. On 12 May 2016 she was referred to Mental Health by Dr Bandi Samarasena of the Palmerston Medical Clinic. The doctor recorded that she was complaining of flu like symptoms for the last three months, associated with smells of which she was becoming more conscious. She thought that her past problems were recurring and she was anxious and depressed with frequent crying spells.

40. Paula contacted Mental Health to make an appointment on 13 May 2016. She said that she wasn't as bad as indicated in the GP's referral and was worried that if she saw Mental Health they might lock her up again. However later that same day she sought an urgent appointment. She said her symptoms were escalating. She was at work and having the olfactory hallucinations and her chest was burning. That night at 9.30pm she presented to the Emergency Department. She was given Risperidone and discharged home. Three days later she reported that the smells had almost disappeared.

41. On 22 June 2016 her GP also referred Paula to Wisemind Psychology. He said that the Top End Mental Health Team had suggested psychological counselling to improve her anxiety symptoms. She attended the psychologist on a weekly basis thereafter.

42. Paula saw the consultant psychiatrist, Dr David Chapman of the Top End Mental Health Service on 4 July 2016. She took her mother with her. Dr Chapman prescribed 2mgs of Risperidone to be taken at night. However, at 2.30am the following day (5 July 2016) Paula phoned the mental health line

and expressed concern about her “restless hands and feet”. She said she thought it was more to do with her anxiety than with the medication.

43. On the afternoon of that same day just before 3.00pm she phoned again while in the midst of a panic attack. There is no further entry in the Mental Health records as to what transpired after that call in the following nine days. However on 14 July 2016 Dr Chapman commenced Paula on Paliperidone 6mg to be taken in the morning.

44. On 1 August 2016 Paula rang and advised that she was having another panic attack. She mentioned that she had discontinued taking the Paliperidone and was taking Risperidone 2mg at night.

45. On 8 August 2016 Paula saw Dr Chapman again. She took her mother. Her mother said that her restless hands and feet were absent or much less when on Risperidone. Dr Chapman prescribed Paliperidone 3mg and commenced Paula on Escitalopram 5mg in the morning for her anxiety.

46. Two days later Paula phoned at 2.45pm in a panic. She said she felt weird in her body and her head. She was asked to come into the Tamarind centre. On arrival she said she was anxious, shaking, restless and couldn’t talk properly. She felt she was going to die. The clinician had a brief discussion with Dr Chapman and Paula was restarted on Risperidone. Paula said that she was also taking Serequel 25mg at night, prescribed by her GP to calm her.

47. On 12 August 2016 Dr Chapman saw Paula again. Paula took her mother with her to the appointment. Dr Chapman prescribed Risperidone 2mg at night and a further 1mg if needed due to stress. He also continued the prescription for Escitalopram 5mg.

48. On 26 August 2016 she told her psychologist that she was feeling panicked. She said a colleague at work had said that she did not seem herself that day. Paula immediately thought the colleague could tell that she was on

medication. Later that day she rang her psychologist saying that she was “at the end of her tether”.

49. On 27 August 2016 Paula rang Mental Health. The notes state that she reported having poor sleep for the past few days and was “angry and irritable, seeking Temazepam and stating that Paliperidone is causing her not to sleep”. There is no indication as to why or when she went back onto Paliperidone.

50. On 28 August 2016 she phoned Mental Health again. She wanted to see Dr Chapman. She said she wanted to decrease the Paliperidone. It was decided she would talk to her GP about it that afternoon.

51. Paula saw her GP at 2.50pm. She told him she was on Paliperidone 3mg but that she did not like to take Paliperidone and had not taken it that day. She said that she was having suicidal thoughts and had razor blades in her hand bag. She said she wanted to cut herself. The GP rang the Mental Health CAT Team. They advised that Paula should hand over the razor blades to the GP and a referral was made to the Tamarind Centre for review of her medication. The doctor provided the referral and prescribed Temazepam 10mg daily.

52. Paula saw Dr Chapman on 5 September 2016. In his note of that consultation he indicated that Paula was currently on Paliperidone 3mg at night because although Risperidone had helped her with sleep she had ceased it due to daytime cloudiness of thought. The plan at the end of that consultation was to consider reverting to Risperidone 2mg at night.

53. Four days later on 9 September 2016 Paula phoned Mental Health. She wanted to change her medication. She said Paliperidone was keeping her awake. She had a crisis that day and the following day and threatened to kill herself on a number of occasions.

54. She sent a text to her sister:

> "Being on medication for psychosis is fucked barbara. So many side effects I don't know what to do barbara. I really just want to die quickly and painlessly but I still cant decide how"

55. Her sister, Barbara, called Mental Health to tell them that she was concerned about Paula. She told them that Paula had been threatening suicide in front of family and had purchased a straight razor.

56. The following day, 10 September 2016, Paula was told by Mental Health that she could change her medication to Risperidone. On 12 September 2016 she called Mental Health seeking to reduce the Risperidone from 2mg to 1mg. She was told to wait until her next consultation. However on 23 September 2016 Paula indicated that she reduced the dose to 1mg "a couple of nights ago".

57. On 4 October 2016 Paula said she felt better on the reduced dose of Risperidone but that the smells were returning while she was at work. She saw Dr Chapman the next day. There is no note in the Mental Health Community Care Information System (CCIS)[1] relating to that consultation. However Dr Chapman also made "personal" notes in an old diary. The notes include an indication that Paula was prescribed Risperidone 1mg twice a day and Seroquel 75mg at night.

58. Just over a week later on 12 October 2016 Paula told a Mental Health Clinician that she couldn't tolerate Risperidone 2mg twice a day and so her dose had been reduced to 1.5mg twice a day. She said the smell was there all the time. There is no indication in the notes if and when that dose was prescribed.

[1] The electronic system for note keeping and document storage used by the Mental Health Service.

59. When she saw Dr Chapman on 20 October 2016 Paula told him that there was an improvement in her smell hallucinations while on Risperidone 1.5mg twice a day. She said the only time she got the smell was in the middle of the day. Dr Chapman noted that she looked much less stressed. She told him that she had been invited to step down from the Administration level 4 to level 3 to reduce workplace stress. She said she was considering it. Dr Chapman added an additional Risperidone 0.5mg to 1mg to be taken in the middle of the day.

60. On that same day, 20 October 2016, she met with her psychologist. They discussed the "pros and the cons of going down one level, reducing stress to reduce vulnerability". Paula told the psychologist that she looked at a website on how to hang one's self almost every day. She said she did so to remind herself that there was another option should her anxiety become severe again.

61. On Sunday, 23 October 2016 Paula rang Lifeline and told the call-taker that she had a rope and intended to hang herself. Lifeline notified Police. They attended and she showed them a rope hanging on her bedroom door. They organised an ambulance and she was taken to hospital. At the hospital she said she was confused and had a panic attack. She said she had no intention of killing herself. The following day she said she was "Okay now", that her symptoms were under control and that she had no thoughts of self-harm.

62. In speaking to her psychologist later that week she said those events happened because she had a panic attack. She went on to say that she continues to have thoughts of suicide because she does not see a way out of the anxiety and does not know how else to get rid of it (28 October 2016).

63. On Thursday, 3 November 2016 Paula saw Dr Chapman. She told him that her hands and legs had been "doing something" constantly since last Sunday. She said she also felt spaced out. Dr Chapman reduced her dose of Risperidone to 1mg morning and night with 0.5mg in the middle of the day.

He noted that it may need to be increased to a total of 3mg per day. He discussed with Paula that she was now on a stable dose and her care needed to be transitioned to her GP. He told her that the Adult Team had declined to take over her care.

64. That afternoon Paula phoned the Mental Health Team. She said she didn't understand the plan after seeing Dr Chapman. She said she still had concerns about the smell hallucinations. The call-taker discussed the issue with Dr Chapman and her case manager and told Paula they would refer her to the Palmerston Mental Health Team. Paula appeared happy with that.

65. On 8 November 2016 Mental Health phoned Paula to tell her the referral to Palmerston Mental Health Team had been declined and that the transition would be back to her General Practitioner. The caller said the case was now closed with Mental Health.

66. On the Sunday (13 November 2016) Paula contacted the Mental Health Service. She sounded weepy. She said she was feeling suicidal because of the "tremors" in her hands. She said the tremors had started two to three weeks ago and that she couldn't concentrate. She said she had seen the psychiatrist and her medication had been reduced, but the tremors had not stopped. She said she was feeling abandoned by her psychiatrist and that her case was being closed by Mental Health.

67. There were no further notes on the Mental Health file from that date until she killed herself three or four days later.

Issues – Mental Health

68. There were two major issues noted in relation to her treatment by the Mental Health Team:

    a. The note keeping in the Community Care Information System (CCIS) was inadequate; and

b. The team did not seek information from Paula's family, her GP or her psychologist.

Note keeping

69. The psychiatrist had eight consultations with Paula. On each of those he made a few notes in an old diary. Often, but not always, those notes were transferred to the CCIS system and not always contemporaneously:

a. 4 July 2016 – diary notes not transferred to CCIS. No notes in relation to consultation in CCIS.

b. 13 July 2016 – no notes in diary but entry in CCIS on 14 July 2016. No indication as to why consultation on that date (previous entry on 5 July 2016), but the "plan" included commencement of Paliperidone 6mg in morning and review 25 July 2016.

c. 8 August 2016 – diary notes transferred to CCIS 9 August 2016. Trial Paliperidone 3mg and commence escitalopram 5mg.

d. 12 August 2016 – diary notes transferred to CCIS 12 August 2016. Remain on Risperidone 2mg nocte with 1 mg PRN.

e. 5 September 2016 – diary notes transferred to CCIS 7 September 2016. Consider reverting to Risperidone 2mg nocte.

f. 5 October 2016 – diary notes not transferred to CCIS. No notes in CCIS.

g. 20 October 2016 – diary notes transferred 20 October 2016. Increase dose Risperidone 1.5mg morning and night and .5 – 1mg midi.

h. 3 November 2016 – diary notes transferred on 9 November 2016. Risperidone 1mg morning and night, .5 - 1mg midi, quetiapine 75mg nocte.

70. Of those issues Dr Parker stated Mental Health had a policy related to documentation:

> "The Top End Mental Health standard is that all consultations should have a contemporaneous written record of that consultation. So a contemporaneous record at the time of the consultation."

71. The evidence establishes that Dr Chapman did not adhere to the Top End Mental Health standard.

72. Paula also attended on a clinician or "case manager" each week. Notes of those meetings are not contained within CCIS or elsewhere.

73. In all cases the consultation notes are relatively brief. On 3 November 2016 one of the clinicians wrote, "Awaiting CCIS notes from Dr Chapman". There was however no note until 9 November 2016, despite the note (when it appeared) including "Referral to Adult declined. Transfer care to GP". There was no noted plan for the transfer.

74. On 8 November 2016 one of the clinicians made a note stating:

> "P/c to Paula to inform her of decline of referral from Palmerston Mental Health Team and referral to GP will be done. Paula accepted this very well and gave verbal consent for history of this current referral. Author advised Paula that this case is now closed. Paula accepted this."

75. Dr Chapman considered the potential perception that Paula may have taken from that communication. He said: "That would have been quite anxiety provoking".

76. Mental Health claimed that Paula was still being "assertively managed" during that period, by the Mental Health Team.[2] However it is unlikely that Paula understood that. There were only two further contacts from Paula after that phone call. Both occurred on 13 November 2016.

[2] Statement by David Chapman dated 15 June 2018, paragraph 9

77. On 13 November 2016 the call-taker noted that Paula sounded "weepy". Paula said that she had tremors for the last three weeks and couldn't concentrate. She said that she was feeling suicidal. She said her medication had been reduced but the tremors wouldn't stop. She said she felt abandoned as she had been told by Dr Chapman that Mental Health was closing their file. Paula said she thought that she needed ongoing mental health management. The call-taker told Paula she should go to her GP. Paula is said to have "begrudgingly terminated the call".

78. Paula rang back five minutes later and spoke to another clinician. She said she was still having the tremors and asked "what can I do?" She was advised to use relaxation techniques to calm and distract herself. Paula thanked the clinician and said she had to go. She had no further contact with the service.

79. It appears from Paula's perspective and perhaps from some of the clinicians' perspective also that the transfer of Paula to the GP was complete. Whether that was due to a lack of the notes or planning it was certainly not in accordance with the claim that Paula was being "assertively managed".

Failure to obtain information from other sources

80. Mental Health appears to have made no real effort to obtain information from other sources. Their only source was Paula and they were aware that Paula downplayed her symptoms.

81. Initially, Dr Chapman said that he sought consent from Paula to contact others and she declined. He didn't make a note of that. However, there is no suggestion that any real effort was made to either explain to her the benefits of including her family in the discussion or taking the opportunity to talk to her family and employer.

82. Her sister Barbara is recorded as calling Mental Health on at least two occasions worried about her. Her mother attended consultations with her on three occasions.

83. Dr Parker told me that there had to be care taken to ensure the therapeutic alliance was not broken. However he indicated that effort should be put into discussing with a patient the benefits of talking to family:

> "…what I would do if I was looking after someone, if the family had raised issues, I would usually bring the subject up with the patient and discuss it with them at depth about the benefit of family being involved and why they, if they've got fears about the family, discuss those explicit fears and explore that with them … I am very supportive of family members being involved … if there's a perceived problem with that, I think it is important to explore it with the patient … the problem is that they may have unfounded fears. The role of the therapist is then to work with them on those unfounded fears to try and get them to accept that it may be better to involve family."

84. Dr Chapman recognised that there should have been contact with her GP, if for no other reason than to know what drugs were being prescribed. He said they were unsure of the identity of the GP:

> Q. Did you have any knowledge of the expertise or experience of her GP?
>
> A. We weren't even sure who the GP was because we weren't able to identify them at the end.

85. However, the General Practice was always the Palmerston Medical Clinic. It was that Clinic that referred Paula to the Mental Health Service. Similarly there was no attempt to contact the psychologist who saw Paula each week. Dr Chapman said:

> "I have to be honest and say I don't remember whether or not we knew about that psychologist at that stage."

86. In relation to the reticence to seek additional information from other sources, such as employers, Dr Chapman stated:

> "…we, as a set of clinicians, often feel that we're caught between a rock and a hard place in that on the one hand, we have people that say, you know, you should gather information, you should be more

willing to go and ask for information even though you don't have consent, versus situations where, if we do that, we will get severely criticised by other groups of people. And that's a constant tension that - and we tend to be conservative. We tend to err on the side of caution rather than be adventurous and step outside our comfort zone."

Issues – Department of Territory Families

87. There are a number of issues that bedevilled the Department of Territory Families' handling of Paula's health issues. However, the primary one was seeking to demote Paula. It seems that the Department thought it appropriate because they gained the consent of Paula. However, it is difficult to understand how that view could have been held given that it was obvious that Paula was overly anxious, desperate to please, afraid of losing her job and had known mental health issues.

88. Obtaining Paula's consent through a process that did not involve support persons, where she was given no adequate notice of meetings, and where no advance notice was given of the agenda must have been known to be inappropriate.

89. Leaving aside the obvious lack of fairness, the treatment of Paula by her employer was not consistent with the *Anti-Discrimination Act*. Section 24 states:

> *24* ***Failure to accommodate special need***
>
> *(1) A person shall not fail or refuse to accommodate a special need that another person has because of an attribute.*

90. The definition of "attribute", includes "impairment". Impairment is defined to include:

> *"psychiatric or psychological disease or disorder, whether permanent or temporary"*

91. Prior to commencement of the inquest it was recognised by the Department of Territory Families that seeking to demote Paula was inappropriate. The Deputy CEO (Operations), Jeanette Kerr provided an additional statement that indicated that in like circumstances there would be a support plan and that while a reduction in work activities or responsibilities may be needed or agreed to as part of such a plan, it would not include a reduction in remuneration. I am grateful for that acknowledgement and indication.

92. However, it did little to prepare me for the evidence of Paula's manager Ms Butler. In short, it was shocking. The most extraordinary part of the evidence was the recitation of the events on the morning of 15 November 2016.

93. Those events happened in the context of Paula having agreed for the benefit of her anxiety issues to move to the AO3 position.

94. It was clear from the beginning of that working week that Paula was having significant health issues. According to Ms Butler, just the day before (the Monday), Paula had an "anxiety episode". Thereafter Ms Butler saw her sitting at her computer in a "zombie like state". At 11.00am Paula went to see her GP and didn't return that day.

95. The very next day (the Tuesday), Paula participated in a team meeting. There is no indication of what was discussed, but clearly in Paula's mind she was no longer the AO4 but was being demoted to an AO3 similar to the other team members at that meeting.

96. It was at the end of that meeting that Ms Butler having seen that Paula was not concentrating and doodling on a piece of paper said, "Paula will share her minutes with everyone". Ms Butler referred to it as a "joke". Paula is said to have looked surprised.

97. Paula's psychiatrist, Dr Chapman sat through the whole of the inquest. He heard that evidence. When he gave evidence he said that was likely to have been a "critical event". He went on to elaborate:

> "To expose somebody who was already under a degree of stress … to then have a public – effectively a public humiliation in the workplace, given the fear that she would lose her job, that's critical."

98. At the conclusion of the inquest I said to Senior Counsel for Territory Families:

> "Just in that regard, Mr Crawley, it might be beneficial, when the transcript of all the evidence is available, for more than the Deputy CEO but the other people you've talked about from the Department and Mr Davies to have a read through the line manager's evidence … which, from the facial expressions, if I could read them of the Deputy CEO, shocked her and it might be said, shocked me too.
>
> That would be something that might be considered. Just read the evidence, HR managers and other managers in the Department."

Departmental Responses

Territory Families

99. Territory Families sought an external consultant to review the support or lack thereof given to Paula by Territory Families staff.

100. The review recommendations included:

a. The 2010 Australian Human Rights Commission: *Workers with Mental Illness – a Practical Guide for Managers* be sourced and distributed to managers;

b. Beyond Blues National Workplace program be investigated to determine whether it could be delivered to managers;

c. Implementation of an Unplanned leave reporting system;

d. Employees with non-work related injury or condition are provided with a reasonable adjustment plan and monitored appropriately.

101. A statement by Ms Jeanette Kerr dated 19 June 2018 set out the response of the Department to those recommendations. In short, the *Workers with Mental Illness – a Practical Guide for Managers* has been made available on the Departmental website. The Australian Red Cross had provided their *Mental Health Matters* training offered to all Territory Family Senior leaders (SAO1/SP1 and above). Reports relating to unplanned leave are monitored on a monthly basis and Territory Families developed the Framework that has modules that include a Care Plan and a "conversations model" to foster a 'culture of conversations'.

Top End Health Service

102. The Top End Health Service provided a further statement during the inquest by The General Manager of the Top End Mental Health Service, Mr Richard Campion. In that statement it was said:

a. There will be a complete review of the way in which supervision is provided to all Medical Officers inclusive of consultants. The Director of Psychiatry will oversee the provision of the supervision;

b. The existing processes for auditing case notes will be reviewed;

c. The audit tool will be reviewed to more specifically focus on areas around communication with other stakeholders such as GPs and family members. It will also monitor compliance with record keeping around matters relating to consent, escalation of care and medications.

d. Top End Health Service will introduce a process by which each and every team member will have one of their cases reviewed in depth each month.

e. There will be educational sessions arranged to provide clinicians with the opportunity to receive training and advice around matters such as record keeping and communication with family and stakeholders.

Comment

103. Paula was a well-respected and liked employee of the Department of Children and Families/ Territory Families. She gave to the Department the benefit of her working life. Thirty two years in total.

104. In the last few years she developed a mental health condition that exhibited itself in the workplace as anxiety and panic attacks. When especially severe it led to olfactory hallucinations where she felt afflicted by gas and burning smells.

105. Her employer was aware of those issues in 2014 and took appropriate action to identify how Paula could be supported and in her return to the workplace. In 2016 her employer took a different course. They showed no empathy and no awareness of appropriate managerial practice. Rather they sought to obtain the agreement of Paula to a temporary demotion.

106. There might be a tendency to wonder how a scheme to demote an employee because of mental health issues could operate in a modern government department. The HR unit should operate to prevent such actions. However, far from counselling against the scheme to demote Paula, HR supported the managers in that endeavour. That is a damning indictment on the organisation.

107. Paula had discussed the financial impact that might have on her. It was clear that the financial impact would cause anxiety. However, her employer proceeded in a manner that took advantage of Paula's meekness, willingness to please and fear of being pushed out of her workplace.

108. To do that to any employee would have been insensitive and inappropriate. Doing so to an employee with 32 years of service and suffering a health episode magnified the inappropriateness of the conduct.

109. The conduct of the managers in holding meetings without providing appropriate information about the agenda, without giving appropriate notice or a reasonable opportunity to have a support person present, the teasing about not being able to afford coffee and the humiliation in front of fellow workers was not reasonable management action. In my opinion it was bullying.

Formal Findings

110. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Paula Michele Schubert born 21 September 1963 in Bordertown, South Australia.

(ii) The time of death is unknown but occurred sometime between 16 and 17 November 2016. The place of death was 47 Flametree Circuit, Rosebery in the Northern Territory.

(iii) The cause of death was self-inflicted hanging.

(iv) The particulars required to register the death:

1. The deceased was Paula Michele Schubert.

2. The deceased was not of Aboriginal descent.

3. The deceased was employed at the time of her death as Executive Assistant, Greater Darwin Region, Department of Territory Families.

4. The death was reported to the Coroner by the brother of the deceased.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother is Margaretha Maria Schubert and her father is Brian Benjamin Schubert.

Recommendations

111. That the Chief Executive Officer of the Department of Territory Families do all things required to ensure the managers and HR personnel within the Department are aware of their responsibility toward employees and in particular to refrain from bullying behaviour;

112. That the Chief Executive Officer of the Department of Territory Families continue the training of all managers and HR personnel to ensure a sound understanding of the appropriate supportive behaviours and accommodation of persons suffering impairment (as defined in the *Anti-Discrimination Act*);

113. That the Top End Health Service ensure that the Mental Health Services keep proper patient notes and undertake all appropriate communication with stakeholders such as families, General Practitioners and other treating professionals.

Dated this 25th day of July 2018.

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GREG CAVANAGH
TERRITORY CORONER