Submission No 580

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

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Fiona Barbieri was forced to Nepean Hospital in April 2011 by police. She was held by the hospital for 5 days. She was discharged to her 17year old son "as the person responsible". At that time both were psychotic with chronic schizophrenia. Neither was diagnosed. Neither was treated. The Carers Recognition Act required Nepean to provide Mitchell with what he needed as her carer. There was no known follow up. All these facts need to be investigated and explained. This is a straightforward example of totally preventable iatrogenic harms leading to two mentally ill people ending in gaol.

Miriam Merten died in the psychiatry unit of Lismore Hospital. She was grossly intoxicated on prescribed drugs. She died from brain injuries from repeated falls. The coroner did not make findings on the prescribing. A later inquiry set up by the Minister for Health did not look into her death at all. The coroner blamed two nurses. Both were subjected to disciplinary proceedings. One died by suicide the day after adverse findings. There should be an inquiry into the prescribing. There should be an inquiry into how the coroner could make no findings about the prescribing. There should be an inquiry into how an inquiry into her death didn't inquire into her death. There should be an inquiry into disciplinary proceedings resulting in suicide a day later.