IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 1463

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**HELEN JULIA MOK**
Delivered on:	20 April 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	5 and 6 December 2016
Findings of:	**IAIN TRELOAR WEST DEPUTY STATE CORONER**
Coroner's Assistant:	Leading Senior Constable Tracey Ramsay
Representation	Mr Ralph Ajzensztat appeared on behalf of the family and Ambulance Employees Australia (Victoria) Ms Roslyn Kay appeared on behalf of Ambulance Victoria
Catchwords	Fentanyl, Midazolam, Ambulance Victoria

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Helen Julia MOK

AND having held an inquest in relation to this death on 5 and 6 December 2016

at MELBOURNE

find that the identity of the deceased was Helen Julia MOK

born on 3 July 1963

and the death occurred on or about 5 April 2013

at the Doncaster branch, Ambulance Victoria, 65 High Street Doncaster, 3108 Victoria

from:

1 (a) MULTIDRUG TOXICITY

in the following circumstances:

1. Helen Mok was a 49-year-old woman who resided in Deepdene with her long-term partner, Ms Catherine Mok and their children, Maisie and Dougal. Ms Mok was a paramedic with Ambulance Victoria (AV).
2. Ms Mok's medical history included depression which was first diagnosed in 2010. There is no record of her having had suicidal ideations. She also suffered from chronic neck pain due to an injury sustained through her work. In addition, Ms Mok had suffered a variety of work related injuries over the course of her employment and had been working part time hours, due to an injury, since 2010.
3. At the time of her death, AV had wanted her to return to work full time. Ms Mok had stated to her partner on numerous occasions that the uncertainty around her work was making her feel unsettled and she was unsure about the physical toll it was taking on her. She had also previously discussed other issues including conflict with management, inadequate resources, and the struggles of dealing with abusive and aggressive patients. Ms Catherine Mok suggested that she consider leaving AV and perhaps seeing a psychologist, however, she stated that Ms Mok was concerned that if AV knew she was seeing a psychologist, she would not have a chance of gaining a higher paid position.
4. Ms Catherine Mok also stated that in the 14 months prior to her death, Ms Mok had become increasingly withdrawn. In February 2012 her friend and colleague Mr Ron McLeod committed suicide at the Reservoir AV branch. He had been very supportive of Ms Mok and his death adversely impacted on her. Shortly thereafter, Ms Mok became reluctant to venture out of the house unless for work or to see select friends. She remained social with her close friends and in that setting there was nothing untoward in her demeanour. However, at other times, Ms Mok would retreat from her family, becoming absorbed by working on projects around the house, or listening to audiobooks and not interacting.

5. Approximately a month prior to her death, Ms Mok and her partner reached a stage in their relationship where they discussed separating. The impending separation was initiated by Ms Catherine Mok as Ms Mok did not want their relationship to end.[1]The changes she observed in Ms Mok's mood and behaviour were identified as:
    a. Withdrawal from family life [2]and from domestic duties[3]
    b. Becoming reclusive[4]
    c. Lack of communication at home[5]
    d. Spending time completing unnecessary domestic projects[6] or listening to audio books[7]
    e. Impatience with the children[8]

6. On 2 April 2013, they celebrated their daughter's birthday and later, they attended to see a relationship counsellor. The counsellor suggested to Ms Mok that she may be more depressed than she realised and that she should speak with a psychologist or counsellor alone to try and work through some of her issues. A session was booked for the following week to continue counselling.

7. On 5 April 2013, the family had lunch together and attended the Melbourne Zoo. They then met their friends in the local park which was usual for a Friday evening. Upon returning home, Ms Mok was not hungry and went to lie down. After the children had gone to bed they argued over the breakdown of their relationship and Ms Mok became extremely upset. Ms Mok subsequently returned to lie down and Ms Catherine Mok continued to clean up from the dinner. After a short time, Ms Mok was heard to walk rapidly through the house, gather her wallet and keys, slam the door and leave in her vehicle. Ms Catherine Mok did not call or message her as she assumed she would go to a friend's house to calm down.

8. At 8.30pm, Ms Mok attended the Doncaster AV branch where she used her key to access the facility and her security 'fob' to gain entry to the drug safe. Over a period of time she removed 10 vials of Fentanyl (600mcg/2ml) and 13 vials of Midazolam (5mg/1ml) which were mixed into an IV drip and hung from the window frame in the sleeping quarters of the facility. Ms Mok subsequently lay down on the bed and placed the IV drip into the back of her left hand.

9. At 7.15am on 6 April 2013, AV member Ms Petrina Adams arrived at the Doncaster facility to commence work. She noticed a vehicle in the driveway that she had not seen before and presumed that AV had run a night shift crew. Upon entering the building, Ms Adams observed someone lying on the bed in a rear room and assumed the person was sleeping. She commenced the audit of drugs in the drug safe and noticed discrepancies. Shortly thereafter, a second AV member, Ms Erin Rankins arrived and joined Ms Adams in auditing the drug safe. Ms Rankins observed some empty vials on the bench in a plastic jug. They walked into the rear room and located Ms Mok deceased, with the IV drip in situ.

10. An autopsy examination was subsequently performed by Forensic Pathology Registrar Dr Melissa Holmes from the Victorian Institute of Forensic Medicine. A written report of her

---

[1] Transcript p10
[2] Transcript p24
[3] Inquest Brief p9
[4] Inquest Brief p8
[5] Ibid
[6] Transcript p22
[7] Inquest Brief p8
[8] Transcript p31

findings indicates there was no evidence of natural disease causing or contributing to the death. There was no evidence of any offensive or defensive type injuries. Toxicological analysis revealed the presence of Ethanol (alcohol) at 0.05mg/100mL, Fentanyl at 18ng/mL, Midazolam at 0.4mg/L, Desmethylvenlafaxine at 0.1mg/L and Paracetamol at 3mg/L.

11. Dr Holmes commented that toxicity to Fentanyl can result in severe respiratory depression, muscle rigidity, seizures, coma and hypotension. The concentration of Fentanyl in 4 fatalities following excessive use of transdermal patches had blood concentrations averaging 23ng/mL. In a series of Fentanyl fatalities, the Fentanyl blood concentrations ranged from 3.0 to 414ng/mL. Midazolam can cause respiratory depression, apnoea and hypotension. In two cases involving Midazolam related deaths, post-mortem blood levels ranged from 0.05mg/L to 2.4mg/L. Dr Holmes stated that the combination of Fentanyl, Midazolam and alcohol may act together to cause respiratory depression through their effects on the central nervous system. Desmethylvenlafaxine may also affect the central nervous system.

Purposes of the Coronial Investigation and Standard of Proof:

12. The primary purpose of the coronial investigation of a reportable death[9]is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[10]The investigation is conducted pursuant to the Coroners Act 2008.

13. Coronial findings must be made on the basis of proof of relevant facts on the balance of probabilities. Assistance in determining the level of satisfaction required is found in the High Court decision of *Briginshaw* v *Briginshaw*.[11] The Court stated: "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences...*" [12]

14. This finding is based on the entirety of the investigation material comprising the coronial brief of evidence, including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, other than documents tendered through Counsel (including Counsel Assisting), and written submissions of Counsel following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into the death of Ms Helen Mok. I do not propose to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and where otherwise appropriate. In particular, I note that I received, and was assisted by, the written submissions from Mr Ajzensztat, Counsel for Ms Catherine Mok and Ambulance Employees Australia (Victoria) and from Ms Kaye, Counsel for Ambulance Victoria.

---

[9] Section 4 of the Coroners Act requires certain deaths to be reported to the coroner for investigation.
[10] Section 67 of the Act.
[11] (1938) 60 CLR 336
[12] Ibid at 362

Uncontentious Matters:

15. The identity[13] of the deceased is not in dispute. Her name was Helen Julia Mok (nee McManus). Her date of birth was 3 July 1963.

16. The medical cause[14] of Ms Mok's death is not in dispute with the cause being multi drug toxicity as a result of the intentional self-administration of intravenous Fentanyl and Midazolam.

The Inquest:

17. The circumstances in which the death occurred[15]became the focus of the inquest with two issues examined:
    a. Storage and management of medications at AV branches; and
    b. Whether there was any causal connection between Ms Mok's employment with AV and her suicide.

18. The following witnesses gave evidence:
    - Ms Catherine Mok (Partner of the deceased for 17 years)
    - Dr Michael Epstein (Consultant Psychiatrist who had been engaged by the family in their quest for dependency compensation)
    - Mr Anthony Carlyon (Regional Director, Metro West Region, AV)
    - Mr Steven McGhie (General Secretary, Ambulance Employees Australia (Victoria) (AEA))

Evidence:

A. Storage and Management of Medication

19. The evidence is clear that Ms Mok was able to enter the Doncaster AV branch after 8.30pm on 5 April 2013 when she was not rostered for work and the premises were unmanned. Over a period of forty minutes[16] she was able to access the drug safe six times and remove the medications with which she took her life. This information was subsequently available from the AV computer system which automatically logged the date and time of access as well as the identity of the person to whom the security 'fob' had been issued. The access log, however, was not monitored in real time.[17]

20. Mr Carlyon stated that the requirement for a greater level of security in respect to accessing the drug safe had not been recognised until Ms Mok's death.[18] Shortly after the incident AV introduced an after-hours system requiring two AV members to swipe their cards in order to gain access to medication safes[19]for non 24-hour branches. Subsequently, access was further restricted to allow access at AV branches only during a member's rostered operational shift.[20]

21. No evidence was presented at the inquest of any AV policies in force at the time of Ms Mok's death that dealt with access to medication as an aspect of paramedic mental health risk. It was conceded by Mr Carlyon and Mr McGhie that it is not possible to safeguard

---

[13] Section 67(1)(a)
[14] Section 67(1)(b)
[15] Section 67(1)(c)
[16] Transcript p105
[17] Transcript p131
[18] Transcript p156
[19] Transcript p98
[20] Ibid

completely against the misuse of drugs where staff require quick and efficient access to medications for patient care.[21]Nevertheless, as will be seen, measures have been implemented in an attempt to minimise this risk.

B. Was there any connection between Ms Mok's employment and her suicide?

22. Mr Ajzensztat, counsel appearing on behalf of Ms Catherine Mok and AEA, submitted that there was a causal connection between Ms Mok's employment and her suicide. In support of his submission he relies on the evidence of Ms Catherine Mok and the evidence of Dr Epstein.

23. Dr Epstein was of the opinion that at the time of her death, Ms Mok was suffering a major depressive disorder[22] with suicidal ideation and that the condition was a cause of her suicide.[23] He further believed there was a causal connection between Ms Mok's psychiatric condition at the time of her death and her employment. In his opinion, four aspects of AV employment provided the connection with the psychiatric condition:

    i. Impact of work related injuries;
    ii. Suicide of work colleague Mr Ron McLeod;
    iii. Negotiations over working arrangements; and
    iv. The culture within AV at the time.

(i) Impact of work related injuries.

24. Ms Catherine Mok told the inquest that during the course of her employment with AV, Ms Mok sustained numerous injuries, resulting in pain[24]and that she was concerned she would not be able to return to work full time because of the physical toll on her.[25]There is no dispute that Ms Mok did sustain injuries and her medical records[26]indicate she was prescribed pain relief medication on a number of occasions from 2009 to 2013. However, whilst Dr Epstein's evidence was that "*pain in and of itself makes people feel miserable and frustrated, often irritable,*"[27]I cannot determine to the required standard what, if any, influence the pain and ensuing concerns had on her decision to take her life.

(ii) Suicide of work colleague Mr Ron McLeod.

25. Dr Epstein stated that the impact of suicide on friends of the deceased "*can be really profound and can be long lasting*"[28]and that the symptoms are likely to fluctuate over time.[29]Ms Catherine Mok gave evidence, however, that following a period appropriately described as "lingering darkness" after the suicide, Ms Mok stabilised and was "more back to where she had been."[30]This appears to be confirmed by her General Practitioner, Dr Chong, given her entry in Ms Mok's medical record for 25 May 2012:[31]

---

[21] Statement of Mr Carlyon, Inquest Brief p22.23 and evidence of Mr McGhie, Transcript pp175-176
[22] A review of Ms Mok's medical history reveals that in October 2010 she was prescribed the antidepressant Prisitq. Whilst the drug is used to treat major depressive disorder, it is also prescribed to treat mood disturbance symptoms in menopausal women. As it is not clear for which of these purposes it was prescribed, its probative value is limited.
[23] Inquest Brief p22.10
[24] Transcript p34-35
[25] Statement of Ms Catherine Mok, Inquest Brief p6
[26] Exhibit 3, Dr Jessica Chong, Kew General Practice
[27] Transcript p87
[28] Transcript p86
[29] Ibid
[30] Transcript p21
[31] Exhibit 3

Has no depressive sx (symptom history). *Paramedic friend recently committed suicide and while sad and misses him, she does not have the lingering 'blackness.'*

26. Dr Epstein stated that this entry would not be a good basis from which to predict the likelihood of future deterioration and hence it was not possible to say that Mr McLeod's suicide ceased to have significance for her.[32]It must follow that it's not possible to say that it did have significance for her.

27. In these circumstances it cannot be concluded that the suicide of Ms Mok's work colleague was connected to her decision to take her life.

(iii) Negotiations over working arrangements.

28. In February and March 2013, Ms Mok was involved in negotiating her return to work arrangements with AV. Negotiations centred on her hours of work as part of her flexible work arrangement and granting of an entitlement to a temporary reserve paramedic allowance (TRP allowance). Ms Catherine Mok stated that the negotiations were a source of frustration and distress that left Ms Mok with a feeling of inequity[33]and uncertainty regarding the outcome.[34]Despite an apparent acceptance of the work hours component,[35] Ms Catherine Mok believed the negotiations had not been finalised in Ms Mok's mind[36]as her accepting of the hours was contingent on a twelve month review and no TRP, which she would not agree to.[37]

29. Ms Kay of Counsel, submitted on behalf of AV that the negotiations had been resolved in so far as related to her hours of work.[38]It was further submitted that it was highly unlikely the potential loss of the TRP allowance ($6500 per year) would have played a role in her decision to take her life, a view that was shared by Dr Epstein.[39]In addition, Ms Mok was an active and experienced union member who was capable of advocating for herself and others in an employment setting.[40] Mr McGhie, from the AEA, stated there was no question she would have known the grievance procedure and how to enact it and that she 'probably had a pretty good case' for obtaining the allowance.[41]It was submitted that in these circumstances, the unresolved TRP allowance issue would be highly unlikely to cause sufficient distress for her to take her life.

30. Mr Ajzensztat submitted that I should 'infer' that AV's interpretation of the AV Enterprise Agreement[42]during these negotiations added to Ms Mok's anxiety. However, a finding based on drawing an inference from the evidence is not appropriate. The evidence is insufficient to determine to what degree, if any, the negotiations over working arrangements added to her mental state.

---

[32] Transcript pp86-87
[33] Transcript p6
[34] Transcript p29
[35] Letter from Ms Mok to AV dated 7 March 2013, Inquest Brief pp161-162
[36] Transcript pp28-29
[37] Ms Mok's letter 7 March 2013
[38] AV Briefing Note, Inquest Brief p163 and statement of Alicia Doreian p22.19
[39] Transcript p74
[40] Transcript p163
[41] Ibid
[42] Inquest Brief p 236

(iv) The culture within AV at the time.

31. It was submitted on behalf of Ms Catherine Mok and the AEA that there was a culture in AV at the time of the death, of unwillingness by staff to seek psychological assistance. The evidence of Ms Catherine Mok's is that Ms Mok had told her that to seek such assistance would be held against her, if she disclosed the fact in any future application for promotion or advancement.[43]

32. The evidence indicates there was a time at AV when psychological injury was accepted as being part of the job.[44]Nevertheless, AV had a number of support services available to staff at the time of the Ms Mok's death that included the Peer Support program, a 24 hour hotline to access a registered psychologist[45](VACU) and the opportunity to have a mental health assessment undertaken by a registered psychologist.[46]There is no evidence of Ms Mok engaging in counselling or assessment sessions with a registered psychologist, however, she did access the Peer Support program on five occasions, with the last occasion being a month before her death.[47]

33. AV does not accept the assertion that a paramedic accessing any of the available counselling services would be putting at risk their prospects of promotion or advancement. Mr Carlyon stated that only the VACU director, a psychologist, had access to information revealing which paramedics accessed the service and that AV managers could not access that information.[48]The director's knowledge of staff who access the counselling program is necessary for billing purposes. Mr McGhie confirmed that assurances had been given by AV regarding access to the VACU data and that the Union was involved in appeasing its members' concerns.[49]

34. Ms Catherine Mok stated that Ms Mok felt that even though they were assured of confidentiality, she didn't feel comfortable about attending a counsellor or psychologist provided by AV.[50] However, it appears she was not agreeable to obtaining assistance from outside AV either. Ms Catherine Mok stated;

> *"She wasn't up for that. I think in general, perhaps she felt there was a stigma about seeking psychological help because to seek help meant that you had a problem, an internal problem. That the problem might have been her, not circumstances."*[51]

35. The evidence does not support a finding that a lack of support or psychological assistance from AV contributed to the death.

Conclusion:

36. There is no doubt that Ms Mok's employment with AV gave her an understanding of drugs and access to the toxic combination by which she took her life. However, any connection between her employment and suicide, beyond that, is far from clear.

37. Whilst Dr Epstein believes there was a causal connection between Ms Mok's psychiatric condition at the time of her death and her employment, he had never met Ms Mok and

---

[43] Transcript p33
[44] Inquest Brief p166, Transcript p137
[45] Victorian Ambulance Counselling Unit (VACU)
[46] Stress Management and Resilience Tools Program (SMART)
[47] Inquest brief p22.14
[48] Inquest Brief p23.34
[49] Transcript p166
[50] Transcript p9
[51] Transcript p10

hence had no opportunity to assess her mood and affect in the course of private consultations, nor have her communicate information directly to him. He appropriately acknowledged that he was significantly disadvantaged in having to rely on documentation and accounts from others.[52]

38. Arguably, the four aspects of her employment Dr Epstein refers to are merely background circumstances[53] and not causative of her death. He stated that in his opinion, employment was not the precipitating factor in Ms Mok's decision to take her life. *"I don't think at the time of her death, her employment as such was the precipitating factor in her suicide. I think that probably the impending breakdown of her relationship was the major factor precipitating her suicide. What I'm saying is that's in the background, as I understand it, of deterioration in her relationship that in my opinion related to factors in her mood coming from her employment."*[54]

39. To what extent, if any, Ms Mok's employment was a materially contributing factor in her death, cannot be determined on the evidence before me. There is no evidence of her having had discussions in which she foreshadowed reasons that at some point might compel her to take her life, nor was a 'suicide note' found explaining the reasons for her actions. In the absence of such evidence, to attribute reasons to her, can only be speculative and therefore inappropriate, as speculation cannot be the basis for making findings of fact. In addition, I do not find the clinical records of the Kew General Practice of assistance in resolving this issue.

40. I find that Ms Helen Mok died following the administration of multiple drugs at toxic levels. I further find that she intended the tragic consequences of her actions.

AV initiatives to prevent the misappropriation of medications:

41. The evidence is clear that AV acknowledges work needs to be done to improve all aspects of paramedic wellbeing, by better understanding how ambulance work can impact mental health. Occupation specific reasons as to why paramedics might be at an elevated risk of suicide can include access to means, exposure to traumatic events, shift work and a reluctance to seek help.

42. The evidence of Mr Carlyon is that since April 2013 the following changes have been made in relation to access to medication safes at AV branches:[55]

    a. AV introduced a system of after-hours dual swipe card access to medication safes for peak period units (i.e. non 24 hour AV branches). This meant that two AV members had to swipe their access cards at peak period branches in order to access the safe at times other than during their shifts. This measure remains in place despite restricting access as set out in (b).[56]

    b. From about 22 November 2016, AV members' swipe cards only allow them to access medication in an AV branch safe during their rostered operational shift and for a limited period of time either side of the rostered shift, to allow for overtime. In

[52] Transcript p45
[53] Keown v. Khan [1999] 1 V.R.69 at 76
[54] Transcript pp78-79
[55] Exhibit 6 p2
[56] Supplementary statement of Mr Carlyon, Exhibit 7

the event a member tries to access a medication safe outside of their rostered shift, an automatic email is generated to an AV regional director.

c. AV members' swipe cards do not allow them access to medication safes while they are on leave. Again, if a member attempts access at that time, an automatic email is generated to an AV regional director.

d. AV is also to introduce a further restriction, whereby members will only be able to use their swipe cards to access medication safes at the branch at which they are working and at a small number of branches in their geographical vicinity.

43. AV's Professional Standards Manager, Mr Colin Grant, in correspondence to the Court expanded on the implemented security controls aimed at reducing misappropriation of drugs.[57] He refers to:

a. Replacing Fentanyl vials with ampoules. The new Fentanyl cartridges contain a lower concentration of drug, thus reducing the amount of residual;

b. Reviewing the medication imprest levels at branches. There are now new minimum and maxim holdings with a new methodology regarding terms of use;

c. Swipe cards being implemented state wide with dual card drug safe access wherever practical;

d. CCTV being installed at all branches;

e. Eliminating afterhours access to drug safes for peak period units and;

f. Upgrading the drug safe locking mechanism. The drug safes have been changed from a single solenoid to a three point locking mechanism. AV have also installed more advanced alarm systems within the AV storerooms to enhance the drug security.

Training/programs/support regarding mental health and suicide prevention:

44. Mr Carlyon gave evidence of the AV Mental Health and Wellbeing Strategy for 2016 to 2019 which was launched on 10 October 2016. It is based on comprehensive research including the Beyond Blue 'Good Practice Framework for Mental Health and Wellbeing' as well as extensive consultations with staff, unions, families and the AV psychological health and wellbeing consultative group. The Strategy includes;

a. Compulsory suicide prevention training being provided to all members as part of a new package of mental health awareness training and is being provided in partnership with Beyond Blue. The training will consist of a combination of online learning and face to face sessions and will be facilitated by appropriately skilled and qualified external facilitators.

b. AV engaging Phoenix Australia who are experienced in dealing with trauma to review AV's current mental health support services available to the AV workforce and to make recommendations. Also Phoenix Australia have conducted a number of focus groups with AV members' families in order to obtain input from them as to the adequacy of mental health services provided by AV to its staff.

[57] Inquest Brief p 50

c. AV running ongoing leadership development programs. Part of those programs aims to assist managers and directors to identify and deal with mental health issues or problems experienced by those working under them.

d. In addition to training and surveying its staff, AV also makes available the counselling and support services including:

   i. Providing extended access to counselling with external professionals (the VACU program). VACU provides psychological support services to AV staff and their immediate families on both work related and non-work related issues.

   ii. Peer counselling

   iii. Chaplaincy services

   iv. The Stress Management and Resilience Tools (SMART) program which assesses members' mental health.

   v. 24 hour telephone counselling and crisis support services which provides AV employees and their immediate families with access to peer support, chaplaincy and psychological services. A registered psychologist is available 24/7 to provide telephone counselling and crisis support as well as consultation and advice for managers on matters relating to managing mental health issues in the workplace or other psychological health matters.

45. In order to update Mr Carlyon's evidence, correspondence has been received by the Court from Mr Grant, addressing the following;

   a. *Providing suicide prevention training to all paramedics.* In working with Beyond Blue, this has now been delivered to all operational staff (paramedics). The program commenced in September 2016 and includes a number of online pre-learning training modules, a four hour 'face to face' training module, followed by further online training modules.

   b. *Developing a mental health training package for all new graduate paramedics.* This is being delivered to all new graduate paramedics as part of their induction program.

   c. *Introduce pre-employment psychological screening for all new recruits in an effort to mitigate significant individual suicide risk factors.* Pre-employment psychological screening and mental health assessment of all new recruits commenced in early 2017. The process includes graduate paramedics and qualified ambulance paramedics seeking employment with AV. The screening process has identified a number of individuals who were not selected for employment based on the results of their mental health assessment.

   d. *Review and expand Leadership Development Programs to better equip managers to support staff.* The review of the AV leadership development program was completed in 2016. An amended Leadership Development program is currently in design phase, with implement to commence by 30 June 2017.

46. Additional changes introduced by AV relate to increasing and improving workplace flexibility for staff, with the following arrangements put in place:

a. The introduction of a 'points system,' whereby each shift worked is allocated a number of points and paramedics must work shifts which add up to a particular number of points.[58]This is designed to provide greater transparency and equity in the allocation of shifts across the organisation.[59]

b. The introduction of shorter shifts at some branches.[60]

c. Affording staff the opportunity to enter into part-time arrangements for a much longer period of time and for reasons broader than parental responsibilities.[61]

Request for recommendations:

47. Counsel appearing for the family and for the AEU invites me to make the following recommendations:

    a. That AV make dual-swipe access mandatory for all medication;

    b. That AV investigate the viability of eliminating single member units;

    c. That AV expand the peer support program to include AV staff who are on WorkCover;

    d. That AV consider the effect of industrial negotiations on the mental wellbeing of its staff;

    e. That AV increase the level of psychological support it provides to its employees;

    f. That AV increase the resourcing of the peer support program;

    g. That AV take steps to dispel the perception amongst its staff that VACU is not independent of AV;

    h. That AV introduce a system that enables it to oversee medication access for single member branches in real time.

48. I am not satisfied, however, that the suggested recommendations are warranted.

49. Recommendation a., seeking to make all medications accessible only through dual-swipe access, may unnecessarily hinder paramedics in the performance of their job. It would not be appropriate to make a recommendation mandating a particular action without knowing whether it is impractical and unworkable.

50. Requested recommendations b. c and h, relate to issues that are outside the scope of this inquest. I have no evidence before me about the rationale for the operation of single member units. There is no evidence that Ms Mok worked at a single member branch, or that the Doncaster facility was a single member branch. In addition, there no evidence that she was under WorkCover as a result of psychological issues. Whilst she was under WorkCover for physical injuries, there is no evidence that her treatment by AV relating to her WorkCover matters, had played any role in her death. Accordingly, these matters are not sufficiently connected with Ms Mok's death to permit recommendations being made.

---

[58] Supplementary statement of Mr Carlyon, Exhibit 7
[59] Transcript pp 118-119
[60] Transcript p1119 and p169
[61] Transcript p 119

51. In regard to requested recommendations d. e. f and g, I am satisfied AV is aware of these issues and that it takes the mental health of its staff seriously. A comprehensive review of its mental health and wellbeing initiatives has already been undertaken, resulting in a number of improved services to paramedics and their families, as previously mentioned in this finding. In these circumstances, I am not satisfied that recommendations addressing these issues, are warranted.

I direct that a copy of this finding be provided to the following:

Ms Catherine Mok

Ms Emily Anderson, Maurice Blackburn Lawyers

Mr Steven McGhie, General Secretary, Ambulance Employees Australia (Victoria)

Ms Eliza Elliott, Lander & Rogers Lawyers

Mr Colin Grant, Manager Professional Standards, Ambulance Victoria

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: **20 April 2017**