IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2215

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	**AS**
Date of birth:	1970
Date of death:	12 May 2017
Cause of death:	Combined drug toxicity in a woman found in a bath
Place of death:	Ballan Victoria 3342

INTRODUCTION

1. AS was a 46-year-old woman who lived at Ballan Victoria 3342 at the time of her death.

2. Ms S was found deceased from combined drug toxicity in the bath at her place of residence on 12 May 2017.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Ms S' death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. The Coroner's Investigator, Sergeant Paul Menz prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Ms S treating clinicians and investigating officers.

7. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless

9. In considering the issues associated with this finding, I have been mindful of Ms S' basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

10. Ms S father left when she was approximately 12 years old, and her mother remarried a man who assumed the disciplinary role.[2]

11. Ms S was married to BS, with whom she shared two daughters. The couple had been in a relationship since 1991. Mr S details that his relationship with Ms S had often been plagued by Ms S' insecurities, including her perception of the love and support being afforded to her and her weight control issues.[3]

12. When Ms S became pregnant, her behaviour grew increasingly erratic. After the birth of their children, the relationship was subject to many incidents involving yelling, arguing and 'public scenes'.[4]

13. Mr S states that Ms S told him in general conversation that she had thought about suicide. Throughout the course of their relationship, Mr S states that he received approximately 50 suicide threats from Ms S. The majority of these were due to Ms S accusing Mr S of not loving her or over her family 'not wanting her'.[5]

14. Around 1995, Ms S began using prescription anti-depressant medication. She would go through periods where she would spend 'huge amounts of time in bed' after taking sleeping tablets.[6]

15. Around 2012, Ms S started her own business. Initially she was very enthusiastic and things went well. After several issues with customers, Ms S lost enthusiasm, which resulted in her only doing business with a small group of friends. Around the same time, Ms S was suffering emotional issues pertaining to her step-father. Ms S 'took some

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the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Statement of BS dates 26 September 2017, Coronial Brief.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Ibid.

pills'. Mr S states that this was not a 'serious attempt' but that the ambulance was called and she went to hospital and saw a psychologist.[7]

16. Ms S 'did something similar' three months later but did not receive the treatment she had expected from her last attendance at hospital. Namely, she was told that her behaviour while admitted was unacceptable.[8]

17. From this point onwards, Ms S was on a significant amount of medication. Mr S states that Ms S would do her own research and 'badger' doctors for certain types of medication. During this period, Ms S' relationship with her husband grew increasingly strained and was subject to several court orders. It was around this time that Mr S commenced divorce proceedings.[9]

18. Mr S states that Ms S was significantly distressed by the pending divorce and commenced drinking heavily. Her behaviour grew increasingly erratic, resulting in their children staying with Mr S.[10]

19. Her friend, Tina Jackson, details that Ms S was 'always sad' in the two years prior to her death. She spoke about her family 'not liking her' and not being able to get on a disability pension. Ms S spoke to friends frequently about suicide, detailing that the more she tried, the more likely it would be that she could get on a disability support pension.[11]

Medical Treatment

General Practitioner

20. Ms S attended with general practitioner, Gaye Souter of The Ballarat Group Practice. Dr Souter details that Ms S' mental health issues included borderline personality disorder[12] and bipolar affective disorder- type 2. Medical notes detail that Ms S had resolved insomnia- anxiety related (2005) and depression (2001).[13]

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[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Statement of Tina Jackson dated 11 October 2017, Coronial Brief.
[12] Borderline personality disorder is a debilitating disorder characterised by rapid and extreme mood changes, including depressive aggressive and anxious states, intense fears of abandonment and rejection and a pattern of unstable and intense interpersonal relationships.
[13] Statement of Dr Gaye Souter dated 14 September 2017, Coronial Brief.

21. Dr Souter further details that Ms Shad a history of overdoses, including 'a few' over the preceding months prior to her death. Since her overdose attempts earlier in 2017, medications were being dispensed to her on a seven day supply basis. Dr Souter had hoped to organise a Webster pack however, Ms S refused on the basis that there was an additional cost involved.[14]

22. In the months prior to her death, Ms S had been prescribed Mobic 15mg[15], Lovan, Stilnox, Lorazepam (diazepam prior to Lorazepam), Endep and Rhinocort. All scripts were issued for controlled supply.[16]

23. Ms S' last attendance with Dr Souter was on 9 May 2017. Dr Souter states that Ms S was 'experiencing a number of social stressors and was quite despondent at that visit, but was forward planning, including planning podiatry visits, documentation for Centrelink, and referral for a new psychologist'.[17]

24. I note here that I am satisfied with the level of care afforded by Dr Souters.

Australian Mental Health Services (private psychiatrist)

25. Ms S attended with consultant psychiatrist, Praveen Thottappilil of the Australian Mental Health Services Ballarat. Ms S was under Dr Thottappilil's care from 25 May 2016 to the time of her death.[18]

26. Dr Thottappilil details that Ms S had a diagnosis of bipolar affective disorder type 2 with borderline personality traits/ disorder. Ms S presented with multiple situational stressors, including ongoing interpersonal relationship and employment issues. In addition to diagnosis and medication adjustments, Dr Thottappilil linked Ms S with his practice nurse, Morag Wheeler for ongoing psychological treatment.[19]

27. Ms Wheeler details that she saw Ms S several times to prepare mental health care plans on behalf of Dr Souter. Ms Wheeler further states that Ms S did not engage with the psychologists Ms Wheeler had referred her to and would present to her following interpersonal relationship crises.[20] She has been described as having had a tenuous level of

[14] Ibid.
[15] For recurrent low back, knee and ankle pain.
[16] Statement of Dr Gaye Souter dated 14 September 2017, Coronial Brief.
[17] Ibid.
[18] Statement of Dr Praveen Thottappilil dated 12 October 2017, Coronial Brief.
[19] Ibid.
[20] Statement of Morag Wheeler dated 12 October 2017, Coronial Brief.

engagement and commitment to her treatment. Mr S would regularly miss appointments and later make unrealistic demands to be seen 'immediately if she presented without a scheduled appointment.'[21]

28. Dr Thottappilil details that Ms S' treatment continued with ups and downs in her mood. He notes that there were no *major* self-harming episodes in 2016 however, the continuation of personal stressors resulted in a decline in her symptoms in 2017.[22]

29. From January through to March of 2017, Ms S self-harmed multiple times.[23] These included several attempts that resulted in Intensive Care Unit (ICU) hospitalisation. She was assessed by the Ballarat Mental Health Services (BMHS), who notified Ms Wheeler of their involvement on 9 March 2017. Ms Wheeler told BMHS that her clinic was not a crisis service and that they could not manage Ms S at present because she could not guarantee her own safety.[24]

30. Despite the BMHS involvement, Ms S continued to experience poor coping responses to stress. Dr Thottappilil states that he considered Ms S' risk and vulnerability to have been high during this period. He organised a Webster pack to prevent overdose however, Ms S continued to abuse her medication.[25]

31. Ms S last attended with Dr Thottappilil on 7 April 2017. She presented with ongoing conflict regarding her interpersonal relationship issues. She denied having any acute thoughts of self-harm. Dr Thottappilil advised Ms S to continue with her medication via the Webster pack.[26]

32. I note here that I am satisfied with the level of care afforded by Australian Mental Health Services.

Ballarat Mental Health Services

33. Ms S had a history of involvement with the BMHS. She was assessed on 5 January 2017, following an overdose of her prescribed medication. 'A risk management plan outlining coping strategies and important contact phone numbers was provided…' Feedback

[21] Statement of Kirby Moerth dated 21 September 2017, Coronial Brief.
[22] Statement of Dr Praveen Thottappilil dated 12 October 2017, Coronial Brief.
[23] Ibid.
[24] Statement of Morag Wheeler dated 12 October 2017, Coronial Brief.
[25] Statement of Dr Praveen Thottappilil dated 12 October 2017, Coronial Brief.
[26] Ibid.

was provided to Dr Souter and Dr Thottappilil with the recommendation for limited supply of medications and consideration of medication review.[27]

34. Ms Swas under the care of the BMHS for the last time from 24 February to her date of death. Triage information indicates that this last review was due to Ms S admission to the Ballarat Health Services, emergency department (ED) following a hanging attempt. Ms S attempted to overdose while being treated in the ED. She was subsequently admitted to the ICU.[28]

35. On 27 February 2017, BMHS psychologist, Kirby Moerth, conducted an assessment of Ms S. On the same day, Ms S threw herself at a window. An inpatient admission to the Adult Acute Unit (AAU) was facilitated for longitudinal assessment, diagnostic clarification and containment risks.[29]

36. Ms S remained a patient in the AAU until 1 March 2017. Her discharge diagnosis was situational crisis on a background of borderline personality disorder. Ms S expressed the preference to remain in treatment with Dr Thottappilil and Ms Wheeler.[30]

37. Dr Thottappilil states that he received a discharge summary from the BMHS in March of 2017, detailing that Ms S 'continued to have situational crisis[31] and continued to have personality problems'. BMHS advised that due to this, they would continue to case manage her.[32]

38. Ms S was reviewed by Ms Moerth at her residence on 2 March 2017. She did not present with any 'features suggesting a major mood or psychotic disorder, and she appeared euthymic[33] and expressed remorse over her overdose'. Ms S informed Ms Moerth that she had appointments in place to attend with Dr Thottappilil and Ms Wheeler and declined further BMHS intervention.[34]

39. Ms S presented again to the ED on 5 March 2017, following another overdose.[35] She was discharged home by the Western Health, Enhanced Crisis Assessment Treatment Team

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[27] Statement of Kirby Moerth dated 21 September 2017, Coronial Brief.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Situational crisis begins with a precipitating event and intensifies into feelings of fear and emotional disequilibrium.
[32] Statement of Dr Praveen Thottappilil dated 12 October 2017, Coronial Brief.
[33] A normal and/ or tranquil mental state or mood.
[34] Statement of Kirby Moerth dated 21 September 2017, Coronial Brief.
[35] Statement of Dr Linda Danvers dated 16 October 2017, Coronial Brief.

(ECATT), with plans for an urgent psychiatrist appointment being offered for 8 March 2017.[36]

40. On 7 March 2017, Ms S was taken to the ED by Ambulance Victoria after threatening to kill herself with a knife. The following day, Ms S did not attend the urgent psychiatrist review mentioned above. A further appointment was made for the following day, 9 March 2017.[37]

41. During the evening of 8 March 2017, Ms S suffered an overdose at a pharmacy. She was subsequently admitted to the ICU for two days, before being transferred to the AAU. On 9 March 2017, Ms Moerth held a telephone consultation with Ms Wheeler. After discussing Ms S' pattern of self-harm and high-risk behaviours, it was decided that more assertive intervention was required than what could effectively be managed in the private sector. BMHS subsequently accepted Ms S for short-term intervention 'to develop a comprehensive risk management plan (RMP Type II) and to manage her current crisis, with the ultimate view to transfer her back into the care of her private team six to eight weeks later'.[38]

42. Ms S was reviewed by Ms Moerth in the ICU on 10 March 2017. Her medications were on a weekly pick up regime with the Ballan Pharmacy. 'ICU staff indicated that there was a high-risk of lethality with further overdoses, and the on-call psychiatrist... recommended that Ms S be readmitted to AAU.... This was facilitated.' Ms S had a RMP Type II completed. She was noted as being hostile, disruptive, argumentative, unwilling and dismissive.[39]

43. Ms S was discharged on 14 March 2017. She had an existing appointment booked in with Dr Thottappilil and arrangements for her medication to be collected on alternative days.[40]

44. Ms S cancelled her post-discharge appointment on 15 March 2017. A subsequent appointment was conducted the following day, during which she expressed her dissatisfaction with having been discharged. Ongoing vague suicidal ideation without a clear

[36] Statement of Kirby Moerth dated 21 September 2017, Coronial Brief.
[37] Ibid.
[38] Ibid.
[39] Ibid.
[40] Ibid.

plan or intent was noted. Ms S also requested a letter for Centrelink in support of her disability support pension application.[41]

45. Ms S had several reviews throughout March, including appointments with psychiatrists. During these reviews, Ms S' focus alternated between expressing that death was her only option, to forward planning for the future. She had several other incidents involving suicide threats, Victoria Police involvement and ED admission. During these episodes, she was reviewed by ECATT, found to be presenting consistently with her RMP Type II and discharged home with a plan for community follow-up.[42]

46. On 25 March 2017, Ms S attended a session with Ms Moerth. Ms Moerth states that during this session there was some indication that Ms S' 'crisis period was gradually abating'. She was well engaged with the interventions during the session, her mood and mental state was described as being more settled, and that her 'narrative suggested improved insight and recognition of impacts of her actions'.[43]

47. Ms S had several reviews throughout April. In early April she presented with ongoing improvement in her mood and mental state. She reported, between 5 and 10 April 2017, that she had attempted suicide but that her daughter had found her unconscious in the bath and put her to bed.[44]

48. From late April into early May, Ms S had several interactions with BMHS. After an appointment confusion that resulted in Ms S' psychiatrist review being rescheduled from 9 May 2017 to 11 May 2017, she became very aggressive and demanding on BMHS. Much of Ms S' angst during this period appears to have been linked to her request that BMHS write a Centrelink letter in support of her disability support pension. It was not the treating team's opinion that Ms S would be eligible. Ms S had raised several concerns over her diagnosis. Namely, whether her diagnosis should be bipolar affective disorder[45] and not borderline personality disorder.[46]

49. On 6 May 2017, BMHS received a call detailing that Ms S was 'hysterical and suicidal'. When the BMHS duty worker contacted Ms S, she described dissatisfaction

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[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Ibid.
[45] File review indicates that Ms S was previously treated by a private psychiatrist, Dr Dominic Green, under the diagnosis of bipolar disorder (around 2011). BMHS determined that there was no evidence of bipolar illness and that her clinical presentation and history was better reflected with the diagnosis of borderline personality disorder.
[46] Statement of Kirby Moerth dated 21 September 2017, Coronial Brief.

at her psychiatrist review being postponed, the pharmacy destroying her medications and her medications being on a limited supply.[47] Later that same evening, Victoria Police found Ms S outside Mr S' house. Ms S expressed a desire for Victoria Police to shoot her.[48] She was subsequently taken to the ED. It was found that she had again overdosed.[49]

50. Ms S was reviewed by ECATT and described her overdose as 'only a small OD' and that she had no ongoing thought, plan or intent of self-harm or harm others. Ms S also denied having a stockpile of medications. She was discharged home.[50]

51. Ms Moerth reviewed Ms S at home on 7 May 2017, as per her risk management plan following her admission to the ED the night before. Ms S denied any recollection of the events the day prior. She described her self-perception as 'critically ill and suicidal'. She expressed dissatisfaction with being on weekly supply with her medications and grew increasingly agitated and irritable. The review was terminated due to her increasing aggressiveness. Ms S was provided with an appointment card for the next available non-urgent psychiatrist review on 6 June 2017.[51]

52. On 10 May 2017 at approximately 11.25pm, Ms S contacted ECATT and reported ongoing distress and alcohol use. She reported several social stressors and detailed a desire to be euthanised. She disclosed that she had a stockpile of diazepam, lorazepam and over the counter medications.[52]

53. 'Ms S was more settled by the end of the call and reported that she had a psychiatrist appointment in place for' 11 May 2017.[53]

54. Ms S did not attend the appointment on 11 May 2017. BMHS did not initiate contact because Ms S had a regular pattern of missing appointments. Ms Moerth did not consider that there were immediate concerns raised at review in the days prior.[54]

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[47] Ibid.
[48] Statement of Kirby Moerth dated 21 September 2017; Statement of Senior Constable Warren Birthisel dated 19 September 2017, Coronial Brief.
[49] Ibid.
[50] Ibid.
[51] Statement of Kirby Moerth dated 21 September 2017; Statement of Anoop Raveendran dated 20 March 2019, Coronial Brief.
[52] Statement of Kirby Moerth dated 21 September 2017, Coronial Brief.
[53] Ibid.
[54] Ibid.

55. On 12 May 2017, Dr Thottappilil contacted BMHS wanting to know if Ms S had attended her psychiatrist appointment the previous day or if there had been further contact overnight. The duty worker confirmed that there had not been any further contact.[55]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

56. On 12 May 2017, Mr S drove around to Ms S' residence and used a spare key to enter. Upon entering the house, Mr S found Ms S in the bath. In his statement, Mr S details that there 'were pills everywhere on the floor and were razor blades on the vanity next to the sink'.[56]

57. Mr S called emergency services who attended shortly after.

IDENTITY AND CAUSE OF DEATH

58. On 12 May 2017, BS visually identified the body of his wife, AS, born 1970. Identity is not in dispute and requires no further investigation.

59. On 15 May 2017, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Ms S' body and reviewed a post mortem computed tomography (CT scan) and the Police Report of Death for the Coroner. Dr Burke provided a written report, dated 24 August 2017, in which he formulated the cause of death as *'I(a) Combined drug toxicity in a woman found in a bath'.*

60. Toxicological analysis of post mortem samples taken from Ms S identified the presence of phentermine[57], diazepam and its metabolite nordiazepam[58], lorazepam[59], zolpidem[60], amitriptyline and its metabolite nortriptyline[61], fluoxetine[62], haloperidol[63], quetiapine[64] and promethazine[65].

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[55] Ibid.
[56] Statement of BS dates 26 September 2017, Coronial Brief.
[57] Phentermine is a drug chemically related to amphetamines and is available as Duromine in 15mg, 30mg and 40mg strengths. Duromine is prescribed for weight reduction but also has stimulant properties related to amphetamines.
[58] Diazepam is a sedative/ hypnotic drug of the benzodiazepines class.
[59] Lorazepam is a benzodiazepine drug belonging to the same family of drugs such as Valium, Serepax and Rohypnol.
[60] Zolpidem is an imidazopyridine derivative used since 1986 in European countries and since 1993 in the USA as an hypnotic agent.
[61] Drugs such as amitriptyline are used to treat depression.
[62] Fluoxetine is a substitute propylamine indicated for the treatment of major depressive disorders and obsessive compulsive disorders.
[63] Haloperidol is a butyrophenone derivative used therapeutically as an anti-psychotic agent.
[64] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.
[65] Promethazine is an anti-histamine.

61. Dr Burke commented that the postmortem CT scan showed no injuries, that there was a large amount of fluid in Ms S' stomach and that the external examination showed no injuries.

62. Dr Burke further commented that Ms S' death may relate directly to an overdose or a combination of overdose and drowning however, notes that there were no diagnostic signs of drowning at postmortem.

63. I accept Dr Burkes' opinion as to cause of death.

Intent

64. On the basis of the available evidence, taking into account Ms S' history of reoccurring overdoses without intent to end her life, I am not satisfied to the requisite standard that she intentionally ended her life on this occasion. I consider Ms S' overdose to be in keeping with previous episodes however, on this occasion resulted in her death.

REVIEW OF CARE

65. In order to assist me with my investigation, I referred this matter to the Coroners Prevention Unit (CPU)[66] for an assessment of the health care afforded to Ms S in the period leading up to her death.

66. Specifically, I raised several issues around the telephone call Ms S made on 10 May 2017 at approximately 11.25pm to ECATT. She reported ongoing distress and alcohol use and detailed a desire to be euthanised. She disclosed that she had a stockpile of diazepam, lorazepam and over the counter medications.[67] BMHS stated that there is a notation in Ms S' clinical record indicating an intended handover to the next shift but no follow up notation to confirm this occurred.[68]

67. BMHS detail that at the time, the usual practice was that ECATT (night duty) would handover and this would be documented in the minutes from the team meeting the following day. The psychiatrist is present at this meeting and is informed via the handover process.

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[66] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[67] Statement of Kirby Moerth dated 21 September 2017, Coronial Brief.

[68] Statement of Anoop Raveendran dated 20 March 2019, Coronial Brief.

68. Ms S' call is not documented in the minutes for 11 May 2017.[69]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Overall medical care from Ballarat Health Services

69. I note that Ms S increased the frequency and severity of her self-harm following her first inpatient stay. Ms S attended the ED on nine occasions between 1 May 2017 and 6 May 2017.[70] She was evasive about where she was obtaining scripts from outside of the coordination between her known medical professionals and pharmacy.

70. I note that Ms S was also taking Duromine (for weight loss)[71], which was not prescribed by Dr Souter. Dr Priya Allencherry states that she had explained to Ms S the risks of drug interactions with Duromine and her regular medications.[72]

71. Medical statements detail that Ms S showed limited insight during treatment discussions. Psychoeducation relating to alternative treatment options, including psychological therapy and psychosocial changes (resuming her Buddhist meditation and support group, respite accommodation etc.) had all been declined by Ms S.

72. I further note that she had made several requests to be readmitted and expressed continual angst over BMHS drafting a Centrelink letter in support of a disability support pension for a period of two years. This included the insistence that her diagnosis be changed from borderline personality disorder to bipolar affective disorder type 2.[73] Ms Jackson's statement supports medical notes, detailing the Centrelink disability support pension as being an ongoing preoccupation for Ms S. Ms S had specifically said that the more she 'tried' to commit suicide, 'the more she would be able to get on the pension'. On admission to the ED, Ms S also expressed the view that her husband was trying to kill her through financial ruin.[74]

[69] Ibid.

[70] Statement of Dr Linda Danvers dated 16 October 2017, Coronial Brief.

[71] The amount prescribed to Ms S was within prescribing guidelines and not excessive. Had Ms S taken the medication as prescribed, she would not have had many left proximate to her death. It appears Ms S did not take the medication as prescribed and therefor, had an available script that she was able to fill on 10 May 2017 and consume, along with other medications.

[72] Statement of Dr Priya Allencherry dated 9 October 2017, Coronial Brief.

[73] Ibid.

[74] Various statements.

73. While in the AAU after her ED admission on 24 February 2017[75], Ms S was informed of a favourable financial settlement. After this news, she reported feeling better and denied ongoing thought, plans or intent to self-harm. She also reported that she had not intended to kill herself. Ms S was counselled over the dangers of accidental lethality with overdoses.[76]

74. Whether perceived or otherwise, I am satisfied to the requisite standard that financial concerns were a significant contributing factor in Ms S' angst and a driving force behind much of her behaviour.

75. The BMHS *Clinical Practice Guideline for Clinical Risk Assessment and Management in Mental Health of the Ballarat Health Services* (the Guidelines) detail that inpatient admissions should be brief and with predetermined goals for the admission. The risk management plan should be utilised when ongoing and persistent risk issues are identified through regular and thorough assessment. 'primarily, this would apply for a patient where there is an established pattern of risk over an extended period of time. Type II plans are ongoing in nature and reviewed at intervals of no less than six months, or earlier if clinically indicated.'[77]

76. Not to deny Ms S' evident mental health struggles in the period proximate to her death, I am nonetheless satisfied that a component of her behaviour was driven by a desire to be considered eligible for a Centrelink disability pension and not due to a worsening of her symptoms that would have required amendment to her RMP Type II or a prolonged stay in hospital.

77. I am satisfied that the treatment afforded to Ms S under her RMP Type II was appropriate and consistent with the Guidelines. I do not consider it to have been necessary nor indicated for Ms S to have repeated or prolonged inpatient admissions as part of her RMP Type II.

Failure to follow-up post-10 May 2017 call

78. I am satisfied that BMHS failed to follow-up with Ms S after her phone call on 10 May 2017. I note that Ms S seemed 'more settled by the end of the call' and reported that she had a psychiatrist appointment in place for the following day however, do not

[75] For a failed hanging 'attempt' and subsequent overdose in the ED.
[76] Statement of Dr Priya Allencherry dated 9 October 2017, Coronial Brief.
[77] Statement of Kirby Moerth dated 21 September 2017; Statement of Dr Priya Allencherry dated 9 October 2017, Coronial Brief.

consider this a valid reason as to why her call was not handed over and followed-up by the day shift staff.

79. Despite having failed to attend multiple appointments in the past, Ms S was at chronic risk of self-harm, devoid of whether these attempts had genuine suicidal intent. Her history of repeated overdoses means that there was no reasonable excuse for the failure to provide Ms S with appropriate follow-up after her call on 10 May 2017. This is especially so, given that she failed to attend her psychiatrist appointment that very afternoon.

80. I note that BMHS have stated they did not initiate contact because Ms S had a regular pattern of missing appointments and that Ms Moerth did not consider there to have been immediate concerns raised at her review in the days prior. I nonetheless reiterate that, given Ms S' history of overdoses, in addition to her call on 10 May 2017 and her failure to attend he psychiatrist appointment on 11 May 2017, follow-up should have occurred at handover.

81. The omission of this 'usual' practice has been seemingly recognised by Dr Anoop Raveendran Nair in their statement dated 20 March 2019. While not explicitly referencing a failure in protocol, Dr Nair does state that there is no notation on Ms S' clinical record to indicate a handover.

82. It concerns me that the omission of the usual practice was not discussed in the executive summary provided to the Court. I consider this omission to be a failure of communication that diminished the quality of care afforded to Ms S. Follow-up contact with Ms S would have potentially served as a preventative measure, which may have saved her life. As such, I make the following recommendation.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

83. Ballarat Health Services ensure that the 'usual practice' of handover is recorded in guidelines and that staff are educated in its importance.

FINDINGS AND CONCLUSION

84. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

85. I acknowledge the persistent difficulties faced by those who deal with mentally ill loved ones. The effects of mental illness stretch beyond the patient, oftentimes placing an enormous burden on the shoulders of family members who are at the frontline. I therefore,

acknowledge the ongoing support provided by Ms Taylor's family in what would have been incredibly frustrating circumstances and commend them on their continued efforts.

86. I express my sincere condolences to Ms S' family for their loss.

87. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) The identity of the deceased was AS, born 1970;

(b) The death occurred on 12 May 2017 at Ballan Victoria 3342 from combined drug toxicity in a woman found in a bath; and

(c) The death occurred in the circumstances described above.

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

(a) Mr BS, senior next of kin

(b) Mr Michael Mennen, Ballarat Health Services, interested party

(c) Dr Gaye Souter, treating clinician, interested party

(d) Dr Praveen Thottappilil, treating clinician, interested party

(e) Dr Neil Coventry, Office of the Chief Psychiatrist, interested party

(f) Dr Anoop Raveendran Nair Lalitha, Ballarat Mental Health Services

(g) Sergeant Paul Menz, Coroner's Investigator

Signature:

SIMON McGREGOR
CORONER
Date: 14 January 2020