IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 0427

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**Ms T**
Date of birth:	[redacted]
Date of death:	**Between 28 January 2016 and 29 January 2016**
Cause of death:	**Hanging**
Place of death:	[redacted] **Victoria**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms T was [redacted] years of age and residing with her husband, Mr T, and three children in [redacted] at the time of her death. Ms T was the youngest of five children born to Mrs M. She commenced drinking alcohol and smoking cannabis at a young age and continued to consume both excessively into adulthood. Those close to Ms T recognised that she experienced mental illness, in the form of ongoing substance dependence, and bouts of depression, anxiety, and rage. However, Ms T engaged minimally with mental health services.

2. On 27 January 2017, whilst attending Ms T's home in response to a report of family violence, Victoria Police members formed concerns about her mental state, particularly in relation to her allusions to suicide and uncertainty about the quantity of alcohol and prescription medications she had consumed. Ms T was subsequently transported to Box Hill Hospital, however, she was not assessed immediately due to her level of intoxication. Later that evening, prior to comprehensive psychiatric assessment, Ms T left the hospital and returned home.

3. At about 6.00pm on 28 January 2016, Mr T went to the family home in the company of police to collect property. Ms T was home, but did not answer the door and mostly remained in her bedroom whilst they attended.

4. At about 5.30pm on 29 January 2016, Ms T's brother-in-law, Mr N, contacted Victoria Police to request they conduct a welfare check on Ms T, as neither he nor his brother had had contact with her that day. Victoria Police members attended the [redacted] home and located Ms T hanging from her neck in the bathroom. Ambulance Victoria paramedics subsequently attended and confirmed that Ms T had died.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Essa Saeedi, Forensic Pathology Registrar at the Victorian Institute of Forensic Medicine (VIFM) supervised by VIFM Forensic Pathologist Dr Matthew Lynch, performed an autopsy upon the body of Ms T, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83.

6. Post mortem examination revealed a ligature mark about the neck, and multiple bruises across her chest, arms, legs and back. Dr Saeedi commented that there was no post mortem evidence that any of the injuries, other than the neck ligature mark, caused or contributed to Ms T's death.

7. Toxicological analysis of post mortem blood detected ethanol,[1] citalopram,[2] paracetamol,[3] diazepam and its metabolite nordiazepam.[4]

8. Dr Saeedi commented that toxicological analysis indicated high levels of blood alcohol (0.16g/100mL) and paracetamol (~150gm/L), therapeutic levels of citalopram and sub-therapeutic levels of diazepam. A blood alcohol level in excess of 0.15% can cause considerable depression of the Central Nervous System (CNS) affecting cognition and can produce adverse behavioural changes.

9. Dr Saeedi formulated the medical cause of death as hanging.

Police investigation

10. Upon attending the [redacted] premises after Ms T's death, Victoria Police members observed Ms T hanging from what appeared to a be an electrical extension cord in the bathroom.

11. In the loungeroom, police located a bottle of wine and a mobile phone. A review of the phone revealed that it was last used at 6.53pm on 28 January 2016 to send a message to her husband to advise that he had left behind one of their children's school bags, and she would leave it at the door.

12. Police also located the Affected Family Member's copy of a Family Violence Safety Notice (FVSN) and a handwritten note dated 28 January 2016. The note was a folded piece of paper, covered with writing. It was unsigned, but on reading was clearly authored by Ms T. It included an apology and a statement that she was to blame,

[1] Alcohol is the common name for ethanol.

[2] Citalopram is a selective serotonin reuptake inhibitor with antidepressant activity.

[3] Paracetamol is an analgesic drug.

[4] Diazepam is a sedative/hypnotic drug of the benzodiazepine class.

appearing to refer to the events on 26 January 2016. There were also references to organ donation, a funeral, and financial information within the body of text.

13. Acting Detective Senior Sergeant (A/DSS) Graeme Savage was the nominated Coroner's investigator.[5] At my direction, A/DSS Savage investigated the circumstances surrounding Ms T's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ms T's husband, Mr T and brother-in-law Mr N, General Practitioner Dr Louise Nguyen, Eastern Health clinicians Dr Homira Bashari and Dr Richard Barnes, and Victoria Police members Constables Michael Aparo, Heath Williams, Nicholas Fletcher, Brett Weisner, Andrew Watts, Stuart Williams, Ferdi Cokelek, Senior Constables (SC) Luke Penhalluriack, Andrew Sloane, Megan McNicol, Penny Gray, Leading Senior Constables (LSC) Andrew Nickson, Paul Angove, and Sergeant David Griffiths.

Mental health and alcohol dependence

14. During the investigation, police learned that Ms T had a history of anxiety, depression and alcohol dependence. Her general practitioner (GP) Dr Louise Nguyen referred her to multiple psychologists and psychiatrists between 2011 and 2015, however Ms T either did not attend, or attended only a single session before disengaging. Ms T trialled several antidepressant medications and had taken citalopram since February 2015 with reported positive effect on her depression. Whilst Ms T acknowledged previous suicidal ideation and attempts, she denied current suicidal thoughts in her consultations with Dr Nguyen and described her family and children as protective factors.

15. In October 2015, Ms T saw Dr Nguyen with her husband. Mr T expressed concerns about Ms T's relapse into alcohol abuse and changes in her behaviour when intoxicated. Ms T had attended St Vincent's Hospital the week prior for treatment and alcohol withdrawal management. Dr Nguyen thought Ms T appeared optimistic and hopeful as she agreed to continue seeing the psychologist the hospital had referred her to, and to attend relapse prevention sessions. They had planned that Mr T would keep the

[5] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

prescribed diazepam to administer as needed to manage her alcohol withdrawal symptoms.

16. Ms T returned to Dr Nguyen the following month and continued to appear optimistic and positive about her sustained abstinence. Ms T was scheduled for review in two weeks, but did not attend. This was Ms T's last consultation with Dr Nguyen.

17. On 13 January 2016, Ms T attended her regular GP clinic whilst Dr Nguyen was on leave. Ms T saw another GP and explained she had recommenced drinking alcohol but wanted to stop. She was provided a prescription for her antidepressant medication and diazepam for alcohol withdrawal.

Family Violence Incident

18. On 26 January 2016, following a verbal argument about her alcohol consumption, Ms T and her husband had an altercation which caused them both minor injuries. Mr T went next door to his brother's home. Mr T's brother, Mr N, then went to see Ms T who appeared intoxicated and said that Mr T had grabbed her by the neck.

19. Mr T left the house the following morning and thought things between him and his wife seemed fine and amicable.

20. At about midday on 27 January 2016, Ms T telephoned the Boroondara Police Station. She stated she had been assaulted by her husband however, was reluctant to reveal her name or address. She refused to attend the police station to report the matter and declined the need for medical attention. Ms T stated she was fearful of her husband and that he had a number of firearms registered to him and the call taker, SC Penhalluriak, encouraged her to take up the police assistance on offer. SC Penhalluriak became more concerned when Ms T suddenly questioned him about the penalty she might receive if she killed her husband in self-defence. Ms T quickly followed up these comments suggesting she may as well kill herself. SC Penhalluriak made further enquiries about her mental state and Ms T said that she was suicidal the day before, but not at the time of the call, noting her three-year-old son was at home with her. She advised she had tried to overdose on medication before, but not recently. Before the call ended, Ms T eventually revealed her surname and the name of her street, and SC Penhalluriak encouraged her to contact police if she needed any assistance.

21. After ending the call, SC Penhalluriak discussed the presenting situation with his supervisor, and a member from the Box Hill Family Violence Unit. They agreed it was appropriate to request police attendance at Ms T's home for a welfare check and two divisional van members were briefed.

22. At about 1.20pm on 27 January 2016, Victoria Police members, LSC Nickson and SC Aparo, attended Ms T's home. She had visible bruises on her arms and scratches on her neck. Ms T refused to provide a formal statement but conceded that there had been an incident the day before during which she had punched her husband in the face, and she inferred that her husband had caused her injuries. When asked directly, Ms T denied any intention to suicide or self-harm. Police observed that Ms T appeared to have been drinking, but they did not consider her excessively intoxicated. LSC Nickson and SC Aparo left with the intention of locating and arresting Mr T for interview.

23. At about this time, Mr T was contacted by a neighbour, who notified him of the police attendance at his home. Mr T contacted his wife, and she said words to effect of *"they're going to take away your shooter's licence"* but told him not to go to the police station, and to come home. Mr T drove to the Boroondara Police station where he was arrested and interviewed by LSC Nickson and SC Aparo in relation to the events of the day before. Mr T told Police that Ms T experienced mental illness and had problems with substance dependence, particularly alcohol. He explained that the altercation the day prior occurred in the context of him confronting her about her drinking and pouring alcohol out. At the conclusion of the interview, Mr T was released without charge, but was issued with a FVSN directing him not to commit family violence against Ms T.

24. Mr T then accompanied LSC Nickson and SC Aparo back to his home so that they could seize firearms from the property and serve Ms T with a copy of the FVSN. Ms T appeared intoxicated and had white substance on her lips. Mr N was also present and expressed concerns to police that his sister-in-law required psychiatric help. Police observed an almost empty bottle of wine and approximately 50 white tablets scattered on a table. Ms T sounded groggy and incoherent and was equivocal when questioned about the quantity of alcohol and medication she had consumed. When asked if she felt suicidal, Ms T replied stating she wished she was dead, but refused medical attention. Eventually, Ms T acquiesced and was transported to Box Hill Hospital under s351 of the *Mental Health Act*.

Mental Health Admission to Box Hill Hospital

25. On arrival to hospital at about 7.55pm, Ms T was medically reviewed and denied current suicidal ideation. She admitted to taking five 10mg diazepam tablets and three 30mg citalopram tablets with alcohol. Ms T spoke with the Police, Ambulance and Clinical Early Response (PACER) clinician Geoffrey Ahern and was assessed to be unsuitable for a comprehensive mental health assessment at that time due to intoxication. A plan was developed for her to receive a comprehensive mental health assessment later in the evening when her level of alcohol intoxication had reduced.

26. At about 8.52pm, Ms T attempted to leave the hospital, reportedly to have a cigarette. A code grey[6] was called. Mr Ahern requested that Ms T remain in the hospital, informing her that she may be placed under an assessment order if she attempted to leave. She complied with the request and stayed.

27. At about 9.30pm, Ms T asked the emergency department (ED) doctor, Dr Homira Bashari, if she could leave for a cigarette. Dr Bashari asked Ms T to remain in the hospital and again she complied with this request and remained in the ED.

28. At about 10.00pm, Ms T was documented to have a blood alcohol content (BAC) of 0.179 and again denied suicidal ideation.

29. At approximately 10.25pm, Ms T left the hospital for a cigarette. She had asked the ED nurse, Mercy Bobby, for permission to leave, which was granted under the belief that Dr Bashari had already granted such permission. About 5 minutes later, ED nursing staff requested security check on Ms T outside, however mental health clinician Andrew Morgan requested they wait 5 minutes. At 10.35pm security went to check on Ms T and could not locate her.

30. Mr Morgan unsuccessfully attempted to contact Ms T twice, and Mr T once. He eventually spoke to Ms T on the phone at about 11.30pm. During the phone call, she denied suicidal ideation and engaged partially in a telephone assessment. Ms T told Mr Morgan that she would go and see GP. However, she declined to provide information about her family/significant others, GP, substance use and family history. Mr Morgan

[6] A code grey is a hospital wide coordinated clinical and security response to actual or potential aggression or violence (unarmed threat). A code grey activates an internal alert or emergency response.

noted Ms T was superficially engaged but did not present as intoxicated. She refused mental health follow up, and poor engagement in follow up was identified as a risk factor.

Following self-discharge from Box Hill Hospital

31. That evening, Mr N contacted police, concerned about a possible burglary after he heard banging at Mr and Ms T's home. LSC Angove and Constable Weisner were tasked to attend the property and were briefed that Ms T had been transported to hospital by police earlier in the evening under s351 of the *Mental Health Act 2014* (Vic).

32. At about 11.45pm, they arrived at the home and identified no signs of forced entry. They found Ms T in the rear yard attempting to gain access to the house. She explained that she had been to hospital and been released but had locked herself out. Police assisted her to gain entry to the home and left.

33. At about 6.00pm on 28 January 2016, Mr T met Sgt Griffiths and SC Cokelek at the family home to collect some belongings. Ms T did not answer the door, but when they entered the property, she emerged from her bedroom. Mr T's sister also entered the home to assist him. Sgt Griffiths explained to Ms T that her husband was collecting some items and they would leave shortly. Ms T otherwise did not engage in conversation with her husband, sister-in-law, or the attending police members.

34. Whilst collecting items, Mr T picked up a piece paper from a table. He looked at it briefly and recalled it said something to the effect of *"I'm really sorry, it's my entire fault"* with a love heart or something similar drawn. He handed it to SC Cokelek who looked at it and placed it back on a table.

Family concerns

35. In his statement provided for the coronial brief, Mr N outlined concerns about the actions of Box Hill Hospital staff and the Victoria Police members who attended the T home on the afternoon of 28 January 2016. In particular, he articulated concerns that:

    a. Police should have acted on the note that was left by Ms T, that was observed by Mr T and brought to the attention of the attending police members; and

b. Box Hill Hospital had failed to appropriately care for Ms T, as she was able to abscond when she was a compulsory patient who had recently taken an overdose of prescription medication.

Review of Police Actions

36. Ms T had multiple interactions with Victoria Police members in the days before her death. During one of these interactions, two police members were made aware of a handwritten note. It was later recognised that this note was authored by Ms T, and alluded to suicide. Mr N expressed concerns that police did not act on this note. Considering these interactions, I requested the court's in-house legal service assist me to review the actions of police.

37. During a previous coronial investigation[7], Assistant Commissioner Luke Cornelius gave evidence at inquest that included discussion of police attendance at property exchanges in the context of family violence. In his evidence he rejected the notion that property exchanges were a community service and described his expectation that Victoria Police members exercise a professional sense of curiosity, or a 'duty to inquire'. The duty to inquire appeared to encompass a requirement for police members to actively, rather than passively engage with a situation to assess risk.

38. I wrote to the Chief Commissioner of Police (CCP) to request submissions in relation to policy, practices and expectations concerning property exchanges and the 'duty to inquire' described by Assistant Commissioner Cornelius.

39. The subsequent submissions received on behalf of the CCP confirmed that all police members who interacted with Ms T in the days before her death had complied with the relevant Victoria Police policies and procedures in place at the time. It was noted that some of these policies have since been updated. Nevertheless, it appeared the attending police members' actions would also have also complied with the updated policies.

40. The submissions received on behalf of the CCP suggested that the relevance of Assistant Commissioner Cornelius' evidence in relation to 'the duty to inquire' was somewhat limited due the different circumstances of the two cases. The prior investigation

[7] Coronial Investigation into the Death of Kelly Thompson COR 2014 0824.

concerned a death caused by further family violence perpetrated against an affected family member (AFM) following police attendance at a property exchange. That is, Assistant Commissioner Cornelius' comments concerned the failure of police to anticipate further violence towards an AFM, to specifically assess the risk of that violence occurring following the property exchange, and to take more proactive steps to prevent that violence occurring. The CCP submitted that this should be distinguished from the circumstances in Ms T's case, where police did not identify a risk of self-harm by the AFM during a peaceful property exchange.

41. It was submitted that Sgt Griffiths and SC Cokelek were not aware of the contents of the handwritten note. In his statement, Mr T recalled that the two police members looked at the note together before placing it down. However, both police members denied having read the note. SC Cokelek stated that Mr T handed the note to him and mumbled something, whilst Sgt Griffths stated that Mr T had said something to the effect of *"I don't want to read that".* SC Cokelek acknowledged he looked at the paper when handed to him and noticed messy writing, but said that he did not read it. Both police members noted that Mr T's attention was then drawn away by his sister who had pointed out a broken window, and SC Cokelek placed the note on a table.

42. Save for the note, of which Sgt Griffiths and SC Cokelek said they were not aware of the contents, the CCP submitted that there was nothing in the circumstances of the property exchange that ought to have triggered a 'professional curiosity' in the minds' of Sgt Griffiths and SC Cokelek to inquire further about the possibility that Ms T was likely to make a further self-harm attempt.

43. In consideration of the statements obtained for the coronial brief, and the submissions on behalf of the CCP, I was satisfied of the following circumstances:

    a. On 28 January 2016, two police members attended Mr and Ms T's home to facilitate a property exchange in the context of a family violence situation. The duration of the visit appeared to be short (approximately 5 minutes).

    b. The attending police had information available to them about activities at the household in the preceding days, particularly about Ms T, as well as information from LEAP such as a 2009 'person warning' flag for suicide, and recent family violence incidents.

c. Neither Mr T, nor the attending police officers read the note in full, though all were aware of its existence. Without reading the note in full it is possible that it may not be recognised as evincing Ms T's intention to end her own life. It appeared that Mr T did not recognise that this may be a suicide note, and did not draw the police member's attention to it as such.

d. Both Mr and Ms T were cooperative during the property exchange. Ms T appeared indifferent and engaged minimally with the attending police members. Her and her husband's behaviour did not trigger any elevated level of concern for her safety either from family violence or from self-harm.

I determined that no further investigation into police action was required.

Coroner's Prevention Unit investigation

44. In light of the concerns noted in Mr N's statement and the proximity of police and medical contact to Ms T's death, I requested the Coroners Prevention Unit (CPU)[8] review the care and management provided to Ms T by Box Hill Hospital.

45. CPU obtained further material from Eastern Health, including further statements from Dr Bashari, Nurse Mercy Bobby, Mental Health Clinician Mr Morgan, Dr Barnes and Eastern Health Policy documents.

46. The CPU confirmed that Ms T was not treated as a compulsory patient during her admission to Box Hill Hospital on 27 January 2016. CPU agreed with the assessment that on arrival to the ED, Ms T did not satisfy the criteria under the *Mental Health Act 2014* (Vic) to be treated as a compulsory patient. Therefore, it was appropriate to treat her a voluntary patient while encouraging her to remain for a comprehensive mental health assessment.

47. However, the CPU identified that elements of the care provided to Ms T by Eastern Health were suboptimal. In particular, CPU outlined deficiencies relating to:

[8] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

a. lack of assessment and treatment for nicotine dependence;

b. miscommunication within the ED; and

c. insufficient follow up provided after Ms T left hospital.

Assessment under the Mental Health Act 2014 (Vic)

48. The *Mental Health Act 2014* (Vic) specifies that the purpose of police detention under s351 is to enable a person to be examined in accordance with s30 of the Act. Upon handing over care of the patient to a hospital, the patient is no longer subject to s351. At this point, an examination must be completed by a registered medical practitioner to determine whether the person satisfies the criteria for an assessment order under s29. If the person does not satisfy the criteria for an assessment order, they may remain voluntarily for a mental health assessment.

49. For a person to be made subject to an Assessment Order they must meet the following criteria, per s29 of the Act:

    a. the person appears to have a mental illness; and

    b. because the person appears to have mental illness, the person appears to need immediate treatment to prevent;

        i. serious deterioration in the person's mental or physical health; or

        ii. serious harm to the person or to another person; and

    c. if the person is made subject to an Assessment Order, the person can be assessed; and

    d. there is no less restrictive means reasonably available to enable the person to be assessed.

50. For the purposes of s29, a person is not considered to have a mental illness because they have consumed drugs or alcohol, or because they have previously been treated for a mental illness. Disinhibition, impulsivity, impaired decision making, and impaired judgment associated with alcohol intoxication contribute to a highly changeable level of risk and therefore impacts the validity of a comprehensive mental health assessment with an individual affected by alcohol. The Chief Psychiatrist's Assessment of Intoxicated

Persons guideline[9] states that the presence of alcohol intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated.

51. A Mental Health Disorder Transfer form was completed for Ms T at 7.55pm, indicating that a handover was provided to Mr Ahern. The presence of a mental illness was unable to be determined at that time due to Ms T's intoxicated state. CPU considered that Mr Ahrern appropriately determined that further assessment was required when Ms T was no longer intoxicated.

52. Although Ms T's level of risk remained somewhat uncertain and changeable due to her relatively brief period of observation and her level of intoxication, she was no longer expressing suicidal ideation and agreed to remain in hospital where she would be monitored and accept a mental health assessment. As such, she was not considered an imminent risk of harm to herself or others, and Eastern Health staff determined that Ms T did not satisfy the criteria of the *Mental Health Act 2014* (Vic) to be made subject to an assessment order. With this determination, Ms T became a voluntary patient. CPU considered this appropriate.

53. When a code grey was called at 8.52pm, Mr Ahern advised Ms T that she may be made subject to an assessment order if she tried to leave the hospital for a cigarette. The code grey appeared to have been called not in response to actual aggression, but rather in response to the potential for aggression on asking Ms T to remain in the ED. There was no evidence this potential aggression eventuated, and Ms T agreed to remain in the ED. CPU considered it was appropriate to a call a code grey at this time in consideration of potential aggression, but not to place her under the *Mental Health Act 2014* (Vic) when she agreed to remain.

54. CPU noted that when Mr Ahern advised Ms T that she may be made subject to an Assessment Order if she attempted to leave again, it was unclear whether he thought that her risks may change if she left the hospital, or it was an attempt to convince Ms T to remain in the ED. Given the present risk factors and the uncertainty of Ms T's ongoing

[9] Office of the Chief Psychiatrist, Assessment of Intoxicated Persons, available at https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/assessment-of-intoxicated-persons

level of risk, continued consideration of an Assessment Order when Ms T's presentation changed (for example, when trying to leave the hospital) was appropriate. Nevertheless, she did not appear to satisfy the criteria for an Assessment Order at that time.

55. Ms T continued to comply with requests to remain in the ED when asked and throughout her ED admission, there was no evidence that she presented as aggressive, agitated or at imminent risk of harm to herself. As such, it was appropriate that she remained a voluntary patient.

Communication of treatment plan

56. ED Nurse Mercy Bobby stated that she believed ED Registrar Dr Bashari had approved Ms T leaving the hospital for a cigarette and therefore did not encourage Ms T to remain when she requested to leave for a cigarette at about 10.25pm. Documentation and statements provided by Dr Bashari indicate that she had not approved Ms T leaving the hospital.

57. It appeared that Nurse Bobby was unaware of the treatment plan to encourage Ms T to remain in the hospital until the completion of a comprehensive mental health assessment. Ms T was a voluntary patient and was unable to be prevented from leaving. However, she had complied with previous requests to remain in the hospital as a voluntary patient. There was no evidence to suggest that she would not comply with the request again at 10.25pm, had Nurse Bobby been aware of the treatment plan.

58. Mr Morgan was also under the impression or assumed that Ms T had been given permission to leave the ED at the time she left. This explained his suggestion that security allow Ms T another five minutes to smoke, as he considered 10 minutes, as opposed to 5 minutes, a more reasonable time to allow a person to smoke a cigarette.

Management of nicotine withdrawal

59. Nicotine withdrawal symptoms can begin within two hours of last smoking. As such, it is likely that Ms T was experiencing nicotine withdrawal symptoms during her ED admission. Ms T requested to leave the ED on three occasions, all in the context of wanting a cigarette. There was no record of an assessment of nicotine dependence and

nicotine withdrawal, or an offer of nicotine replacement throughout Ms T's three and a half hour ED admission.

60. Eastern Health's Tobacco Free Health Service Practice Guideline states that patients admitted to Eastern Health who are smokers will be offered nicotine replacement therapy and upon discharge will be offered referral to the Eastern Health Tobacco Free Clinic or Quitline along with nicotine replacement therapy on prescription for one month.

61. The CPU considered the Department of Health and Human Services (DHHS) Working with the Suicidal Person: Clinical Practice Guidelines for Emergency Departments and Mental Health Services (2010).[10] The Guideline states that when a person is identified at triage as a risk of harm to themselves, duty of care indicates that all efforts should be made to prevent self-discharge pending further assessments and that proactive steps can be taken with every person who presents with suicidal behaviour or mental health problems. The Guideline does not explicitly state whether it applies to voluntary or compulsory patients, but CPU considered that it should apply regardless of a person's legal status under the *Mental Health Act 2014* (Vic).

62. CPU considered that providing Ms T with nicotine replacement therapy as per Eastern Health guidelines could have been a proactive step to reduce the likelihood of Ms T leaving the hospital prior to receiving a face to face comprehensive mental health assessment.

63. CPU acknowledged that there are challenges managing a patient who is experiencing nicotine withdrawal in an ED. These include the short-term nature of admissions and rapid turnover of patients, high acuity of illness and injury, high stimulus environments, and the physical layout and location of the ED within the hospital. However, CPU considered that implementation of nicotine replacement therapy can reduce the frustration, restlessness, and anxiety associated with nicotine withdrawal and therefore potentially reduce the risk of patients leaving prior to the completion of treatment.

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[10] Department of Health and Human Services, Clinical Practice Guidelines for Emergency Departments and Mental Health Services, available at https://www2.health.vic.gov.au/about/publications/policiesandguidelines/suicide-guidelines-working-with-suicidal-person

Follow up after leaving Box Hill Hospital

64. When a voluntary mental health patient leaves hospital against medical advice, police are unable to return the patient to hospital against the person's wishes if there are no concerns for the person's welfare allowing apprehension under section 351 of the *Mental Health Act 2014* (Vic). Based on Mr Morgan's telephone call with Ms T, he deemed that it was not necessary for police to return Ms T to the ED for a mental health assessment. This was appropriate given there was no evidence that Ms T was an imminent risk of harm to herself or others during the phone call between Mr Morgan and Ms T.

65. Ms T's presentation was discussed between Eastern Health clinicians the following day at a Mental Health Clinical Review Meeting, and the decision was made not to provide any further contact to Ms T. This was determined on the basis that Ms T declined to provide her GP details, denied suicidal ideation, reported some hope for the future during her phone call with Mr Morgan and the low lethality of her overdose without suicidal intent.

66. The CPU considered the Department of Health and Human Services (DHHS) Working with the Suicidal Person: Clinical Practice Guidelines for Emergency Departments and Mental Health Services (2010). The Guideline recommends that when a patient leaves the ED prior to a mental health assessment being completed, the local Crisis Assessment and Treatment (CAT) team should be alerted so that they can follow up with the person within 24-48 hours. The Guideline does not comment on whether a telephone risk assessment is a suitable basis to determine whether further follow up is required. However, a previous coronial investigation[11] prompted response from the Office of the Chief Psychiatrist indicating that telephone assessments are not an adequate means of assessment of a patient by CAT teams. Although no specific comments were made regarding mental health assessments by ED mental health clinicians, CPU considered it reasonable to infer that telephone assessment would not be adequate in this situation.

67. Dr Barnes, Eastern Health Consultant Psychiatrist with the Centralised Mental Health Triage Service, explained that when a patient leaves the ED prior to mental health assessment and no immediate risks have been identified, a telephone assessment is one

[11] Investigation into the death of Gay Prieto COR 2008 4272.

option that may be considered. Other options include negotiating voluntary return of the patient to hospital for assessment, or developing an alternative follow up plan (for example, follow up with a GP and relevant information being sent to the GP). If a patient declined to engage in a telephone assessment or return to hospital, an alternative follow up plan should include liaison with the patient's family or carers where possible. Dr Barnes stated that where a patient who left was intoxicated these options would remain the same, but the assertiveness of response would be informed by the additional risks associated with intoxication. CPU considered that this position on telephone assessments was inconsistent with the recommendations of DHHS and the Chief Psychiatrist.

68. The Eastern Health Assessment of Severely Substance Dependent Clients in Eastern Health Emergency Department & Other Acute Settings Guideline (2013) states that a person's level of intoxication should be assessed as objectively as possible with documentation including BAC, the presence of slurred speech, smell of alcohol, and other objective symptoms of alcohol intoxication. CPU considered that level of information available to Mr Morgan in assessing Ms T's level of intoxication during a phone call would have been limited as many symptoms associated with alcohol intoxication (for example, motor incoordination, unsteady gait, facial flushing, and the smell of alcohol) are unable to be assessed in a phone conversation.

69. Ms T's level of intoxication, reluctance to fully engage in a telephone assessment, refusal to provide her GP's details and a recognised risk of poor engagement with follow up treatment, all increased the level of uncertainty and changeability in her level of risk and thereby increased her overall risk profile. CPU concluded it would have been reasonable to refer Ms T to a CAT team to provide further contact to her in the 24-48 hours after leaving the hospital. This would have provided Ms T the opportunity to consider mental health assessment or follow up via her GP, without her judgment and decision-making being affected by alcohol.

MENTION HEARING

70. On 11 December 2018, I held a mention hearing to communicate my outstanding concerns about the management provided to Ms T by Eastern Health. I asked that Eastern Health:

a. Consider a summary of CPU's conclusion and provide a response.

b. Provide material that would, insofar as possible, clarify the timeline of events concerning Eastern Health's treatment of Ms T, as the times as reported in the medical notes and statements by Nurse Bobby, Dr Bashari, Mr Morgan, were inconsistent and conflicted with the times reported by police records.

c. Provide further material to clarify whether Ms T was given permission to leave for a cigarette, the reasons for inconsistencies in this understanding between staff, and any relevant policies in relation to this decision making.

Further information

71. Eastern Health provided submissions in relation to the issues identified at the Mention Hearing and supplied statements from Mr Ahern and Nurse Bobby, as well as supplying Eastern Health's Absconding or Missing Patient or Resident Procedure.

72. Eastern Health acknowledged and apologised for the inconsistencies in the times recorded in the clinical notes. Eastern Health noted that in practice, times recorded may be approximate and are often necessarily made after the events rather than during the events. I accept that clinicians are often required to make retrospective notes, which may result in some inconsistencies in the documented times. I am satisfied that this investigation has identified the sequence of events prior to Ms T's death with sufficient accuracy.

73. The further material was not able to clarify the inconsistency between the ED doctor's and nurse's statements as to whether Ms T was given permission to go outside to smoke a cigarette. That is, Dr Bashari's perspective remained that she had not given permission for Ms T to go outside to smoke, and Nurse Bobby's perspective was that she understood that the doctor had given that permission. Eastern Health apologised for this inconsistency.

74. Eastern Health acknowledged that they had no written policy that specifically detailed the process for patients to leave an ED to smoke. For a voluntary patient who is at risk, usual practice would require them to have permission of a doctor or mental health clinician to leave the hospital temporarily.

75. Eastern Health also noted that their policy in relation to nicotine replacement therapy tended to focus on inpatients, rather than persons presenting to the ED and confirmed that Ms T was not offered nicotine replacement therapy.

76. Eastern Health acknowledged that telephone assessments can be inferior to face to face assessments, however noted that most referrals received by mental health services outside of EDs are initially assessed by telephone. They further observed that the guidelines considered by the CPU were general in nature and did not stipulate that a telephone assessment was inadequate for a person in Ms T's circumstances.

77. Eastern Health reiterated that despite a recent BAC of 0.179, Ms T did not present as significantly disturbed in her behaviour and was documented several times to be *'settled'*, *'calm'*, and *'speaking in sentences'*. It was conceded that Ms T's mental state and risk could have changed as her BAC continued to drop, however at her last assessment she was not considered to require any further assessment against her wishes.

78. Eastern Health maintained that the decision that Ms T did not require further follow up after leaving the ED was a clinically appropriate decision, despite CPU's conclusion that it was not. Eastern Health noted that Ms T was a voluntary patient, and did not meet the criteria for compulsory treatment both on assessment at hospital, and during her later partial telephone assessment. Eastern Health described the factors that led to the conclusion that Ms T did not require further follow up included that she denied suicidal intent, her overdose was of low lethality, she was not assessed as high risk and she declined follow up. Eastern Health considered it would have been inappropriate to override Ms T's decision to refuse further treatment and follow up.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. I accept that Emergency Departments face significant challenges managing mental health patients and patients who are intoxicated. Eastern Health clinicians formulated an appropriate treatment plan for Ms T, that involved encouraging her to stay for a comprehensive mental health assessment once sobered. However, due to inadequate communication between staff, Ms T eventually left the department for a cigarette with the permission of an Eastern Health nurse who mistakenly believed this permission had already been granted by a doctor.

2. Ms T had requested to leave the Emergency Department several times, each time purporting to want a cigarette. Despite her continued requests to have a cigarette, Ms T was not assessed for nicotine dependence or offered nicotine replacement therapy. I accept there are challenges in implementing nicotine replacement therapy in an Emergency Department. However, in the context of a voluntary mental health patient awaiting comprehensive assessment, this would have been a proactive measure that would have avoided potential physical and/or psychological effects of nicotine withdrawal and reduced the likelihood of Ms T self-discharging prior to assessment.

3. I accept that the factors considered by Eastern Health in determining that Ms T did not require further follow up, such as apparently reduced intoxication, denial of suicidality, and participation in a partial telephone assessment, were relevant considerations. I also accept that there are no clinical guidelines specifically for voluntary patients who have self-discharged from an Emergency Department prior to a comprehensive face to face mental health assessment. However, having regard to the recommendations of DHHS and the Chief Psychiatrist, I consider it would have been reasonable for Eastern Health to plan further follow up with Ms T when she was more sobered.

4. Ms T had five separate interactions with Victoria Police members in the 48 hours before her death. In each instance, they responded appropriately to her presentation. These responses included; initiating a welfare check following her equivocal report of family violence; issuing a Family Violence Safety Notice to protect Ms T from family violence;

transporting Ms T to hospital when she presented with suicidal ideation and having taken a small overdose, assisting her to gain entry to her home when she reported having been released from hospital; and attending a property exchange to ensure the Ms T's safety during that exchange. In this final interaction, police did not apprehend a risk of harm to Ms T from family violence. This was likely their primary consideration in assessing risk in this context. Police had information available to them that indicated Ms T's recent mental ill health, which perhaps would have heightened their concern for Ms T's risk of harm to herself. During the property exchange, Ms T did not display any overt signs of distress or mental illness and no such concerns were raised by her husband or sister-in-law who were present. However, Ms T had already penned a note that indicated that she intended to end her own life. This note was handled by her husband and at least one of the attending police members. But the note was not read in full and the gravity of its contents was not recognised. In the context of the brief property exchange, it was not unreasonable that Mr T, distressed by recent events and focussed on collecting items to care for his children, did not engage deeply with the note. Furthermore, it was not unreasonable that police members attending a peaceful property exchange did not think it was incumbent on them to read a handwritten note found amongst the property without indicators that it was of significance. However, this albeit brief exchange and encounter with Ms T was an opportunity lost to engage with her, question her about the note and if then appropriate, to implement s351 to ensure that a more fulsome assessment of her mental health at that time could be made. Nevertheless, it is not possible to definitively state that her death could have been prevented even if this opportunity had been seized.

5. The risk assessment and management tool used by Victoria Police members responding to family violence appropriately identifies perpetrator and affected family member mental illness as risk or vulnerability factors. However, how this information is engaged with from situation to situation will understandably vary. A proposed practice note on property exchanges encourages police members to use property exchanges as an opportunity for risk assessment and management if indicated by the circumstances. The question remains; what circumstances may trigger an attending police member to consider the risk posed by an affected family member's mental state, absent behaviour indicative of a mental health problem during the property exchange. The submissions received on behalf of the Chief Commissioner of Police noted Victoria Police's response

to a previous investigation that considered the phenomenon of perpetrator suicide in family violence contexts. The recognition of this trend resulted in communications to Victoria Police members encouraging them to explicitly consider and make enquiries about the mental state of a perpetrator during their risk assessments. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the Victorian Suicide Register (VSR),[12] particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

[12] The Victorian Suicide Register (VSR) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present. The VSR was designed, built and piloted by staff in the Coroners Prevention Unit (CPU) between 2011 and 2012, and became integrated into the Court's work in 2013. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations:

1. In the interests of promoting public health and safety and preventing like deaths, **I recommend** that Eastern Health review the communication processes both within the emergency department and between emergency department staff and mental health staff to improve the accessibility and reliability of clinical information used by clinicians to make decisions about patients leaving the emergency department while waiting for a mental health assessment.

2. In the interests of promoting public health and safety and preventing like deaths, **I recommend** that the Victoria Network of Smokefree Healthcare Services and Eastern Health develop and promote a guideline specific to the assessment, prevention and management of withdrawal symptoms from nicotine in patients while in an emergency department.

3. In the interests of promoting public health and safety and preventing like deaths, **I recommend** that Eastern Health review the systems for follow up of patients who leave the emergency department while waiting for a comprehensive mental health assessment, to ensure that they are in line with recommendations from the Department of Health and Human Services and the Chief Psychiatrist.

FINDINGS

1. I find that Ms T, born [redacted], died on 28 January 2016 or 29 January 2016, in her home at [redacted] Victoria.

2. I find that Ms T had a history of mental ill health and alcohol dependence which was known to precipitate irrationality and self-destructive behaviour.

3. I find that Eastern Health clinicians correctly assessed that Ms T did not meet the criteria for compulsory mental health treatment. However, I find that Eastern Health missed opportunities during her voluntary admission to prevent Ms T from self-discharging prior to comprehensive mental health assessment. Namely, she was not offered nicotine replacement therapy, and a treatment plan to encourage her not to leave the emergency department was not understood by all emergency department staff. I also find that Eastern Health missed opportunities to offer further follow up to Ms T after she self-discharged.

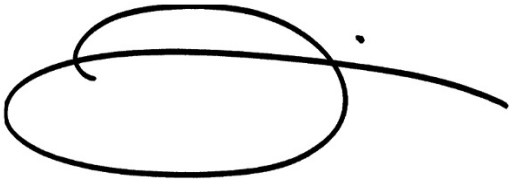
4. I find that Victoria Police members complied with relevant policy and procedures during the five interactions she had with police in the 48 hours before her death, and made reasonable assessments of the risks of harm to Ms T in the context of the presenting circumstances.

5. I accept and adopt the cause of death ascribed by Dr Essa Saeedi and I find the cause of Ms T's death was hanging.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:
Mr T
Mrs M
Eastern Health
Chief Commissioner of Police
Acting Detective Senior Sergeant Graeme Savage

Signature:



AUDREY JAMIESON

CORONER

Date: 27 May 2020