

20 April 2026

Coroners Court of Victoria  
65 Kavanagh Street,  
Southbank, Victoria, 3006  
By email to: [cpuresponses@coronerscourt.vic.gov.au](mailto:cpuresponses@coronerscourt.vic.gov.au)

Dear Coroner Giles

**RE: Ms NXA (COR 2021 004243)**

On behalf of the Royal Australian and New Zealand College of Psychiatrists (the College), I acknowledge the findings into the death of Ms NXA and extend my sympathies to her family, friends and community. I respond to the recommendations as made.

I note The Coroners Court of Victoria's Recommendation (i)

*"That the Royal Australian and New Zealand College of Psychiatrists promote awareness to its members of the significant psychosocial impacts of tinnitus and tinnitus-related distress, including the risk of suicide."*

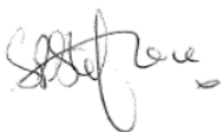
The College acknowledges this recommendation. The College's remit includes professional standards, education and training, clinical guidance, and policy and advocacy on issues relevant to psychiatric practice and mental health. Within that remit, the College's primary role is to support psychiatrists through broader clinical, educational and policy frameworks, rather than to promote awareness of individual conditions in isolation.

The College notes that its existing curriculum and [position statement on suicide prevention](#) directly address the underlying clinical principles the recommendation seeks to promote: comprehensive biopsychosocial formulation, assessment of psychosocial stressors, and suicide risk in the context of comorbid physical health conditions.

Psychiatrists are medical specialists trained to assess and manage suicide risk within a comprehensive biopsychosocial framework. The College recognises that conditions such as tinnitus may, in some individuals, be associated with significant psychological distress and elevated suicide risk. The College's curriculum addresses suicide prevention and risk assessment across the training continuum, including the impact of chronic physical health conditions on mental wellbeing, comorbid illness, disability, pain and psychosocial stressors, with an emphasis on person-centred care and clinical formulation.

The College will consider opportunities to reinforce awareness of the psychosocial impacts of chronic physical health conditions, including tinnitus-related distress, through its existing communication and education channels.

Yours sincerely,



A/Prof Simon Stafrace  
**Chair, RANZCP Victorian Branch**

To discuss this further, please contact Jo Balmforth, Branch Lead, at [ranzcp.vic@ranzcp.org](mailto:ranzcp.vic@ranzcp.org)

## Internal Briefing on COR 2021 004243 Ms NXA

### **Incident Summary:**

- On 9 August 2021, Ms NXA was admitted to Northern Hospital ED following an overdose of medication and alcohol with a note indicating self-harm intent. Ms NXA told the hospital staff that her actions were related to her tinnitus and the desire to end her life. Following a multidisciplinary team meeting and reviews from social workers, nurses and a Consultant Psychiatrist, Ms NXA was discharged from Northern Hospital on 10 August 2021 and died by suicide on 11 August 2021.

### **Coroner's Findings: (pg 17 & 25-26)**

- The coroner found that Ms NXA had significant and pervasive mental health conditions that she suffered for many years prior to her passing, including chronic suicidal ideation and suicide attempts.
- The coroner accepted The Coroners Prevention Unit (CPU) conclusions that the care provided by the Consultant Psychiatrist and the social worker was not in line with the modern principles of mental health care. The clinicians focused heavily on tinnitus as the primary driver of Ms NXA's suicidality and did not adequately explore the impact of her significant psychosocial stressors.
- The CPU accepts that Northern Health is operating in a significantly different environment, particularly with respect to the mental health service it provides, compared with the service it offered in 2021 and therefore the coroner has not recommended further action.

### **Coroner's Recommendation to the RANZCP: (pg 26)**

- *The Royal Australian and New Zealand College of Psychiatrists promote awareness to its members of the significant psychosocial impacts of tinnitus and tinnitus-related distress, including the risk of suicide.*

### **Further items for consideration**

- The coroner noted Ms NXA had additional significant stressors and risk factors for suicide, including caring for her unwell father, a family history of suicide, social isolation and alcohol abuse.
- Ms NXA is originally from Tasmania and did not have a GP in Victoria at the time of discharge, but her treatment plan directed her to receive follow-up care from a GP.
  - o The report identified notable operational issues in Ms NXA's care. Before Northern Health separated from Melbourne Health on 1 July 2022, the Northern Health SSU was not a designated mental health service, and the staff were not designated mental health service clinicians. It was unclear to what extent EMH staff expected SSU staff to address safety and treatment planning specific to Ms NXA's mental health. Therefore, the CPU stated that the EMH staff were required to assist with the discharge process. Ms NXA discharge was guided by the opinions of the consultant psychiatrists and social worker.
- In response to the CPU's concerns Northern Health stated that it intends to explore education for mental health staff on the link between tinnitus and mental health in conjunction with the ENT team, consistent with the growing body of clinical evidence.
- The Consultant Psychiatrist and the social worker indicated in their statements to the Court that they believed that discharge planning was the responsibility of the medical team, with input from the mental health staff as needed.

### **Psychiatrist Engagement Timeline: (pg 4-6)**

1. 9 August 2021 Ms NXA admitted to Northern Health Emergency on due to an overdose of medication and alcohol.
  - Ms NXA indicated she could not sleep due to her chronic tinnitus and the primary reason for the overdose. She also stated her family history of suicide and current extreme stress. Ms NXA reported feeling unsafe to go home of fear of another overdose. Ms NXA was admitted to the SSU overnight for crisis containment, and for further EMH review in the morning.
2. 10 August 2021 a multidisciplinary meeting was held where clinicians determined that the steps were to re-review, discharge and consider a referral to the Goulburn Valley Area Mental Health Service for follow-up.
  - A social worker began the re-review and consulted an EMH Consultant Psychiatrist after Ms NXA indicated if she did not receive medical support for her tinnitus, she would take her own life.
  - The EMH Consultant Psychiatrist reviewed Ms NXA and advised that her distress was due to tinnitus, an inpatient admission was not appropriate. The Consultant Psychiatrist also advised that Ms NXA should receive GP follow-up to obtain a mental health care plan.
  - A few hours later Ms NXA told a medical intern she wanted to go home to re-attempt suicide, and the medical intern raised concerns to the social worker who stated there was no concern. It was deemed by the SSU no escalation was needed.
3. 10 August 2021 Ms NXA was discharged and died by suicide on 11 August 2021.

### **Next Steps:**

- Review Vic Branch Letter response to coroner's Recommendation to RANZCP
- Provide any recommendations for the Vic Branch Response