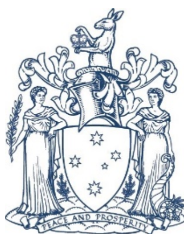

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6072

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	Marlene Sako
Date of birth:	12 January 1990
Date of death:	1 December 2015
Cause of death:	1(a) Self-immolation
Place of death:	Alfred Hospital, 55 Commercial Road, Melbourne, Victoria

CONTENTS

INTRODUCTION 4

THE CORONIAL INVESTIGATION 4

Previous hearings 4

Request for inquest 5

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE 5

Identity of the deceased 5

Medical cause of death 6

Circumstances in which the death occurred 6

Ms Sako's background 6

The months preceding Ms Sako's death 7

Hospital presentation on 18 April 2015 7

Hospital presentation on 25 August 2015 8

Hospital presentation on 31 August 2015 8

Hospital presentation on 29 September 2015 8

Hospital presentation on 3 November 2015 9

Events on 29 November 2015 10

Events on 30 November 2015 13

CONCERNS FROM MS SAKO'S FAMILY 15

Expert reports from Dr Michael Giuffrida, forensic psychiatrist 15

Expert report from Dr Jacqueline Rakov, forensic psychiatrist 17

MEDICAL AND MENTAL HEALTH TREATMENT PROVIDED ON 29 AND 30 NOVEMBER 2015 21

Northern Health 21

Discharge from hospital on 30 November 2015 21

Expert report from Professor Anne-Maree Kelly, emergency physician 22

Response to Dr Giuffrida's report 23

NorthWestern Mental Health 24

Report from Associate Professor Peter Burnett, director of clinical governance 26

Relevant sections of the Mental Health Act 2014 26

How the Mental Health Act 2014 applied to Ms Sako 27

Response to Dr Giuffrida's report 28

Independent expert report by Professor Richard Newton, consultant psychiatrist 28

VICTORIA POLICE RESPONSE ON 30 NOVEMBER 2015 33

The events of 29 November 2015 33

Relevant procedures and practices **35**
Whether Victoria Police complied with procedures and practices in responding to emergency calls regarding Ms Sako **36**
First call – 10.33pm on 30 November 2015 ..... ***36***
Second call – 11.18pm on 30 November 2015 ..... ***37***
AMBULANCE VICTORIA RESPONSE ON 30 NOVERMBER 2015 ..... **38**
EMERGENCY SERVICES TELECOMMUNICATIONS AUTHORITY RESPONSE ON 30 NOVEMBER 2015 ..... **38**
Relevant procedures and practices **39**
Whether ESTA complied with procedures and practices in responding to emergency calls regarding Ms Sako **39**
First call – 10.33pm on 30 November 2015 ..... ***39***
Second call – 11.18pm on 30 November 2015 ..... ***40***
Ambulance dispatch *41*
Police dispatch *41*
Whether these missed opportunities led to a missed opportunity to prevent Ms Sako's death **42**
Screening by the Inspector General for Emergency Management **43**
COMMENTS **43**
The adequacy of Ms Sako's medical assessment on 29 November 2015 ..... **44**
The adequacy of Ms Sako's mental health assessment on 29 November 2015 ..... **45**
Relevant provisions of the Mental Health Act 2014 ..... ***45***
Comprehensiveness of Ms Sako's mental state examination ***48***
Whether the mental state examination was sufficiently comprehensive *48*
Whether collateral information should have been obtained from Ms Sako's family *49*
Previous finding regarding the importance of collateral information *52*
Whether Ms Sako had a mental illness as defined by the Mental Health Act 2014 ..... *53*
Whether Ms Sako's blood alcohol level should have been measured for the purposes of mental state examination *55*
Whether Ms Sako should have been referred to additional supports *57*
Royal Commission into Victoria's Mental Health System ***58***
The manner of Ms Sako's discharge from hospital on the morning of 30 November 2015 ..... **60**
Emergency Services Telecommunications Authority response on 30 November 2015 ..... **60**
Victoria Police response on 30 November 2015 ..... **62**
Requests for welfare checks and delay in police response ***63***

Ambulance Victoria response on 30 November 2015 64
Victorian Suicide Register 64
FINDINGS AND CONCLUSION 65

INTRODUCTION

1. On 1 December 2015, Marlene Sako was 25 years old when she died from extensive burns. At the time of her death, Ms Sako lived at Westmeadows with her mother and siblings.

THE CORONIAL INVESTIGATION

2. Ms Sako's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

3. 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.

4. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Sako's death. The Coroner's Investigator conducted inquiries on the coroner's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. During the coronial investigation, the coronial brief was updated several times with written submissions filed by the interested parties, further statements, and expert reports.[2]

Previous hearings

7. Mention hearings were held on 7 May 2018 and 17 December 2018 to discuss the conduct of the investigation. These were presided over by Coroner Rosemary Carlin and Coroner

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

[2] The current version is Version 6, dated 7 September 2020 (**CB**).

Michelle Hodgson respectively before the investigation was eventually transferred to Deputy State Coroner Caitlin English, who had carriage of this investigation until her appointment to the County Court on 5 April 2022.

Request for inquest

8. By way of written submissions dated 2 March 2019, Ms Sako's family requested an inquest to hear evidence regarding the events preceding Ms Sako's death, including the question as to whether her death could have been prevented.[3]

9. During the course of the coronial investigation, the interested parties submitted extensive material to which I have referred in this finding. The material traversed a number of Ms Sako's hospital presentations. While this information was important for contextual background, for the most part the scope of inquiry has been limited to the circumstances immediately before Ms Sako's death.[4]

10. On 24 February 2021, Ms Sako's family withdrew their request for inquest and requested Deputy State Coroner English hand down written findings based on the material before her. Following her Honour's appointment to the County Court, I have taken carriage of this matter for the purposes of finalising this finding.

11. This finding therefore draws on the totality of the coronial investigation into Ms Sako's death, including evidence contained in the coronial brief. 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

12. On 1 December 2015, Marlene Sako, born 12 January 1990, was visually identified by her cousin, Salwa Abelahad.

13. Identity is not in dispute and requires no further investigation.

[3] CB 466-478.
[4] This was accepted by Ms Sako's family: CB 572.

Medical cause of death

14. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 2 December 2015 and provided a written report of his findings dated 8 December 2015.[5]

15. The post-mortem examination revealed extensive burns to Ms Sako's body and upper airways.

16. Toxicological analysis of post-mortem samples[6] identified the presence of ethanol (0.10 g/100mL), free morphine,[7] midazolam,[8] carbamazepine,[9] and ketamine.[10]

17. Dr Bedford provided an opinion that the medical cause of death was *"1(a) Self-immolation"*.

18. I accept Dr Bedford's opinion.

Circumstances in which the death occurred

Ms Sako's background

19. In 1992, Ms Sako migrated from Iraq with her older sister, Lara, and parents, Fahmi and Tereza. Her younger siblings, Vanessa, Lisa, David, Michael, and Martin were born thereafter.[11]

20. In 2010, Ms Sako commenced her nursing degree at La Trobe University, which she completed in 2012.[12] Ms Sako's family described her as intelligent and compassionate and it is evident that Ms Sako was much loved, and she is dearly missed by her family.

21. In 2011, Ms Sako married. Her family's description of the marriage indicates it was initially happy but later became turbulent – marred by abuse and an expectation that Ms Sako be the sole income earner in addition to cooking and cleaning at home.[13] Ms Sako's family subsequently noticed a change in her personality.[14] She later disclosed to her family that her husband had physically assaulted and abused her.[15]

---

[5] CB 70.
[6] CB 74.
[7] Morphine is a narcotic analgesic.
[8] Midazolam is a short-acting benzodiazepine
[9] Carbamazepine is an anti-convulsant.
[10] Ketamine is an anaesthetic.
[11] CB 38.
[12] CB 31.
[13] CB 39, 43.
[14] CB 31.
[15] CB 33, 40.

22. Ms Sako eventually separated from her husband toward the end of 2013 and returned to live with her mother and siblings in Westmeadows. Over the following months, Ms Sako's family observed her physical and mental health begin to deteriorate in the context of excessive alcohol use. At some point during this time, she was not longer able to work.[16] Her sister, Lara Sako, noted that Ms Sako did not have any issues with alcohol before her relationship breakdown – it was only after the end of her marriage that Ms Sako began to experience depression and she began using alcohol to self-medicate.[17]

23. While her family attempted to find Ms Sako the assistance she clearly needed, Ms Sako consistently refused psychiatric and pharmaceutical treatment.[18]

24. In approximately November 2015, Ms Sako's husband filed for a divorce, which appears to have triggered further deterioration.[19] Ms Sako expressed to her family she still loved her husband and could not cope with this rejection. She later stated to family members that she no longer wished to live.[20] Lara Sako stated that after some time, Ms Sako made clear that she was not simply drinking to medicate, she was instead drinking in an effort to induce her own death.[21]

The months preceding Ms Sako's death

25. Between 18 April 2015 and 3 November 2015, Ms Sako presented to the Northern Hospital on five occasions, each in the context of having consumed excessive amounts of alcohol.[22]

Hospital presentation on 18 April 2015

26. Ms Sako presented to hospital during the late evening in the context of a generalised tonic-clonic seizure in the context of possible alcohol withdrawal and beginning a new medication (duromine). A CT scan of her brain was clear, and she was subsequently referred to her general practitioner for follow-up and further outpatient investigations.[23]

[16] CB 31, 44.
[17] CB 423-424.
[18] CB 40.
[19] CB 39.
[20] CB 34.
[21] CB 424.
[22] CB 26-27.
[23] Northern Health medical records, Discharge summary, 19 April 2015.

Hospital presentation on 25 August 2015

27. On the evening of 25 August 2015, an ambulance transported Ms Sako to the Northern Hospital after family members reported to the Crisis Assessment and Treatment Team that she was suicidal.[24] She had been discharged from Austin Hospital that morning after attending in the context of alcohol abuse and possible seizures.[25]

28. Ms Sako presented with a reduced conscious state of GCS 7[26] and her blood alcohol level (**BAL**) was recorded at 0.410. She remained in hospital overnight in the Short Stay Unit. Ms Sako declined contact with the hospital's social worker the following morning. She was discharged the next day after being assessed as being medically fit.[27]

Hospital presentation on 31 August 2015

29. Ms Sako was taken transported to Northern Hospital on the morning of 31 August 2015. The documentation regarding this presentation is limited but it appears it was in the context of alcohol intoxication. She was reported to be verbally aggressive to ambulance paramedics and witnessed to have two seizures that were relieved with pain stimuli. Restraints were used in the ambulance.[28] She was observed in the emergency department for several hours before being discharged in the late afternoon.

Hospital presentation on 29 September 2015

30. On the evening of 29 September 2015, Ms Sako's family contacted emergency services in the context of her threatening self-harm with a knife in the setting of intoxication.[29] She was subsequently taken to the Northern Hospital pursuant to section 351 of the *Mental Health Act 2014* (Vic).[30]

31. At the time of clinical assessment, Ms Sako reported having had an argument with her mother and claimed not to have remembered threatening herself due to her alcohol intake but said that the incident would never have occurred if she had not been intoxicated.[31] She was described

[24] CB 775.
[25] CB 773.
[26] CB 771. The Glasgow Coma Scale (GCS) is a scoring system used to describe the level of consciousness.
[27] CB 782, 784.
[28] CB 762-770.
[29] CB 749, 815, 820.
[30] Section 351 of the *Mental Health Act 2014* (Vic) allows a police member to apprehend a person if the person appears to have a mental illness and serious and imminent harm needs to be prevented. The police officer must then take the person to a health practitioner or hospital for mental assessment.
[31] CB 749.

as settled, compliant, and denied suicidal ideation when questioned. She was noted as being forward thinking as she talked about plans to return to study the following year. Her judgement was assessed as being intact and it was documented that she had refused contact with her general practitioner or drug and alcohol services. Ms Sako refused consent for clinicians to contact her family for collateral information during this period of assessment.[32]

32. Ms Sako's presentation was discussed with the Emergency Department Consultant who was happy for her discharge, but in the meantime her BAL was recorded to be 0.371 and she agreed to be transferred to the Short Stay Unit overnight for a period of further observation and rest, with a plan for Clinical Liaison[33] and Alcohol and Other Drug (**AOD**) worker reviews the next morning.[34]

33. The next morning Ms Sako was medically reviewed. She denied current suicidal ideation and told medical staff that her mother was over-reacting. She declined to be seen by AOD and was discharged home.[35]

34. An Emergency Mental Health clinician made contact with Ms Sako's general practitioner after her discharge by way of follow up, who indicated that he would be happy to refer Ms Sako for services if she presented.[36]

Hospital presentation on 3 November 2015

35. At approximately 11.00am on 3 November 2015, police members responded to a report that Ms Sako was intoxicated and threatening suicide. A family disagreement had occurred during which Ms Sako used a knife to harm herself.[37]

36. She was subsequently apprehended pursuant to section 351 of the *Mental Health Act 2014* and transported to the Northern Hospital Emergency Department.[38]

37. Ms Sako was medically assessed and a BAL of 0.264 was recorded.[39]

---

[32] CB 751-752.
[33] This is a team of consultant psychiatrists and registrars who work closely with a consultation liaison psychiatric nurse to assist with the assessment and treatment of cooccurring medical and psychiatric illnesses.
[34] CB 753.
[35] CB 823-824.
[36] CB 756.
[37] CB 735, 739, 742.
[38] CB 742.
[39] CB 27.

38. Mental health clinicians subsequently assessed Ms Sako at which time she spoke about ongoing arguments with her mother regarding her alcohol use. She claimed that her mother had threatened to get a court order against her. It was noted that Ms Sako had not followed through with drug and alcohol counselling, however she had a drug and alcohol counsellor and would continue to engage. Ms Sako denied suicidal ideation and agreed to see her general practitioner about getting a mental health plan for further support in the community.[40]

39. The psychiatry registrar offered voluntary admission to the psychiatry unit because of Ms Sako's domestic circumstances, which Ms Sako said were contributing to her stress, but Ms Sako declined the offer of admission.[41]

40. A clinician spoke with Ms Sako's mother who indicated that her daughter was welcome to return home. It was documented that she was however reluctant to collect her from hospital and refused to have other family members collect her. Ms Sako's mother also declined to pay for a taxi. Ms Sako stated that she would make her own way home and was discharged at 8.48pm that evening.[42]

Events on 29 November 2015

41. Ms Sako's mother reported that her daughter exhibited unusual behaviour on the evening of 29 November 2015 as follows:[43]

> *At about 8.00pm on the Sunday night Marlene was calling out to me from her room. Marlene told me to take the demons from all around the walls as they are trying to kill me.*
>
> …
>
> *At about 9.30pm Marlene called out to me and she was crying and saying there are things on the wall trying to kill me. She was very scared. I tried to help her with a rosary a [sic] bible but she pushed these things away and said there is no god because I feel like this. I held her close to me and told her everything was ok. She then had a lighter she had pulled out of [her] bra and she tried to light her t-shirt and she said 'I want to kill myself'. I said why? She said I don't want to live. I then called Lara to*

[40] CB 730-734.
[41] CB 27, 733-734. Ms Sako later accepted the voluntary admission when told the hospital would not pay for a taxi home, but the psychiatric registrar advised the voluntary admission was no longer warranted and referrals were in place.
[42] CB 27, 731.
[43] CB 34-35.

come help. I took the lighter off her. I said please Marlene don't do this to yourself. I pleaded with her. I said you will find yourself a good man.

I searched through her bag and I found an empty bottle of vodka. I then ask her why you drink so much. She just say 'mum I don't like to live'. I asked Lara to call the police for me. I thought she is going to kill herself. She had said this several times before that she wanted to kill herself. She also had a knife and she said she would cut herself. She has cut herself twice before on her wrists.

42. At 9.59pm on 29 November 2015, Ms Sako's sister, Lara Sako, telephoned emergency services to request police assistance. Lara reported that her sister was assaulting her brothers and making threats of suicide. Lara told the operator Ms Sako was threatening to light herself on fire, had a cigarette lighter in her hand, and was currently being restrained by her brothers.[44]

43. During the call, Lara reported her sister was trying to get a kitchen knife and trying to hurt herself and *"everyone in the house".* Lara informed the operator her sister was affected by alcohol and had previously attempted suicide. She expressed concern that Ms Sako had been taken to hospital previously, but she had been released and without mental health treatment.[45]

44. Victoria Police members attended a short time later. They observed Ms Sako to be extremely upset and crying. Family members informed police she had a knife and was threatening to kill herself and was attempting to cut her stomach. She had also attempted to set her shirt on fire with a cigarette lighter, which was forcibly removed from her. Ms Sako reportedly had to be physically restrained by family members to stop her harming herself.[46] Ms Sako disclosed to police that she had been trying to hurt herself and that she wanted to die.[47]

45. According to police, the multiple family members present appeared to be quite resentful that Ms Sako was at the address and wanted her removed. It appeared there was a tense family dynamic – Ms Sako's family stated they were sick of her behaviour and did not want her to return to the home and requested an intervention order.[48]

---

[44] CB 2.
[45] CB 2.
[46] CB 18, 21.
[47] CB 19, 21.
[48] CB 18-19, 21.

46. Concerned about Ms Sako's mental health, the police members exercised their powers under section 351 of the *Mental Health Act 2014* and transported her to the Northern Hospital Emergency Department, arriving at approximately 10.50pm.[49]

47. Lara Sako followed the police van to hospital and waited in the reception area. After an hour, she left her name and telephone number with reception staff and requested that she be called when her sister was ready for discharge so that she could collect her. In her statement, Lara Sako noted that when she did not receive a telephone call that night, she assumed that her sister had been compulsorily detained in hospital.[50]

48. Blood alcohol testing was not undertaken at this presentation.[51] A medical assessment concluded there were no medical issues requiring treatment.[52]

49. During Ms Sako's mental health assessment, a psychiatric nurse read an *In Depth Assessment* completed on 4 November 2015 when Ms Sako had presented in in similar circumstances. The psychiatric nurse thereafter conducted a mental status examination,[53] which was not demonstrative of any significant disturbance in thought, mood, perception, or memory and not suggestive of a psychiatric illness. Ms Sako denied suicidal ideation when asked. She denied threatening herself with a knife or that she was trying to set fire to herself (explaining that she was going for a smoke and was checking if her lighter was working).[54]

50. Despite her disclosure that she had consumed five glasses of wine throughout the day, she did not appear intoxicated. She noted that she had reduced her alcohol intake and sought help for this in the past. She did not want to stop drinking.[55]

51. The psychiatric nurse enquired about Ms Sako's previous instances of self-harm. Ms Sako noted she had engaged in this behaviour in the context of increased drinking and going through a divorce, and to demonstrate her frustration to her family about her divorce from an abusive person and her family's disproval of her lifestyle.[56]

---

[49] CB 27, 491.
[50] CB 387, 423.
[51] CB 27, 392-393.
[52] CB 390.
[53] The MSE (mental status examination) is a structured way of observing and describing a patient's current state of mind under domains of appearance, attitude, behaviour, mood and affect, speech, thought process thought content, perception, cognition, insight, and judgement. Transition/ Discharge Summary completed by the psychiatric nurse appears at CB 722-724.
[54] CB 24, 723.
[55] CB 24, 723.
[56] CB 24, 723.

52. The psychiatric nurse concluded that Ms Sako did not require a psychiatric inpatient admission and an admission was not offered nor requested. A plan was made to refer her to her general practitioner for further input. Ms Sako said she would go home and apologise to her family and was giving some thought to leaving the family home. She was referred to her general practitioner.[57]

53. She was discharged home to her family at 12.45am on 30 November 2015.[58]

Events on 30 November 2015

54. According to Ms Sako's family, she arrived home at approximately 3.00am the next morning. They had not been contacted regarding her discharge from hospital.[59]

55. Upon her return home, Ms Sako's mother observed that she was not wearing any shoes and her feet were bleeding. It appeared that Ms Sako had left the hospital without any money or phone and had walked home alone.[60]

56. At about 10.00am, Ms Sako remained upset and stated she wanted to die. Her mother pleaded with her to stop drinking and see a doctor.[61] At some point during the day, Ms Sako obtained alcohol and spent the day in her room drinking.[62]

57. At about 10.00pm, Ms Sako's two sisters, Vanessa and Lara, became concerned for her wellbeing and pleaded with her to get help.[63]

58. At 10.33pm, Lara Sako contacted emergency services and reported Ms Sako was intoxicated, threatening suicide, and wanted to drink herself to death. Lara stated was there was blood on her bed although she had not seen any injuries, Ms Sako had wet herself, but she was conscious and breathing.[64]

59. At 11:19pm, Lara Sako telephoned emergency services again and reported Ms Sako now had a knife and was still threatening suicide. Lara stated they were trying to prevent Ms Sako from leaving the house and she was currently outside in the backyard holding a knife. Lara stated to the call-taker she had seen blood all over Ms Sako's bed but could did not think she needed

---

[57] CB 24, 723.
[58] CB 414.
[59] CB 35, 45, 388.
[60] CB 35.
[61] CB 35.
[62] CB 45.
[63] CB 46.
[64] CB 98-101, 359-365, 385, 424.

an ambulance as she was walking. Lara indicated she had called police earlier regarding her sister wanting to suicide, and now her sister was *"taking it to another level"*.[65]

60. At approximately 11.45pm, an ambulance arrived at the Sako family residence. However, just as it drove into the street, it was diverted to a more urgent case. The paramedics stopped to talk to Ms Sako and one of her sisters (presumably Lara Sako) who reported that an ambulance was not required, that they had in fact requested police attendance. Ms Sako's sister replied that she family would stay with Ms Sako until other authorities arrived at the scene.[66]

61. Sometime after this, Ms Sako made her way to the backyard and into a small, concreted area next to the bungalow. There, she poured a container of fuel over herself and used a cigarette lighter to ignite the fuel and her clothing. Ms Sako subsequently fell to the ground in an unresponsive state. At about this time, her family exited the house and observed Ms Sako on fire and acted to extinguish the flames.[67]

62. At 11.57pm, a neighbour telephoned emergency services and expressed concern for the screams coming from the Sako family home and requested urgent police attendance.

63. At 11.58pm, Lara Sako again contacted emergency services, screaming that her best friend had been burnt.

64. A further nine calls were made to emergency services for urgent police, ambulance, and fire brigade attendance at the Sako family home in Westmeadows. The calls were regarding hysterical screams, fire, a possible deceased person, and an attempted suicide.[68]

65. Just after midnight, the Metropolitan Fire Brigade arrived, being the first emergency service on scene. The crew immediately provided first aid and intubated Ms Sako in order to provide oxygen. Ambulance Victoria paramedics arrived at the scene a short time later and continued first aid treatment. At approximately 1.15am, Ms Sako was transported to the Alfred Hospital Emergency Department.[69]

[65] CB 366-370.
[66] CB 332, 342-343, 345-346, 385-386.
[67] CB 46, 386.
[68] CB 29, 59, 354.
[69] VACIS electronic Patient Care Report, 1 December 2015, page 6.

66. Ms Sako was found to have full thickness burns to 87 percent of her body, including her airway. These injuries were considered non-survivable. Ms Sako received palliative care until she passed away at 5.35am that morning.[70]

CONCERNS FROM MS SAKO'S FAMILY

67. Ms Sako's family made submissions[71] outlining their concerns about the events leading to her death as follows:

   (a) whether appropriate medical and mental health assessments were conducted on 29 November 2015. This included a concern that collateral information was not obtained from Ms Sako's family and Victoria Police and there was limited importance placed on her repeated presentations to hospital;

   (b) whether Ms Sako was discharged in an appropriate and safe manner on 30 November 2015. While the family noted that the manner in which Ms Sako was discharged had not directly contributed to her death, walking 14 kilometres in the middle of the night without shoes and bleeding feet would have had a negative effect on her mental health;

   (c) whether Victoria Police took appropriate actions in responding to the first call to emergency services on 30 November 2015; and

   (d) that the Emergency Services Telecommunications Authority (**ESTA**) failed to properly prioritise the first and second call to emergency services.[72]

Expert reports from Dr Michael Giuffrida, forensic psychiatrist

68. In determining whether Ms Sako was appropriately assessed, treated, and discharged, Ms Sako's family relied on expert reports obtained from Dr Michael Giuffrida, forensic psychiatrist practising in New South Wales.[73] I note that Dr Giuffrida provided advice regarding Ms Sako's presentations from February 2014 until November 2015, however I will only refer to his opinion regarding Ms Sako's most recent presentation on 29 November 2015.

---

[70] E-Medical Deposition, 1 December 2015.

[71] CB 466-500, 568-573, 872-874.

[72] In relation to the first call, the Sako family identified an inconsistency in the transcripts of this call at CB 99 and 361. It was submitted that a statement by Lara Sako that her sister was trying to attack her should have escalated the call to a higher priority as it indicated a threat to safety or a potential for violence: CB 660. Further submissions regarding the ESTA response are at CB 717-720.

[73] CB 425-440, 479-488. Notes of a conference between legal representatives for Ms Sako's family and Dr Giuffrida were also relied upon at CB 489-490.

69. In summary, Dr Giuffrida provided the following opinions:[74]

(a) the assessment on 29 November 2015 should have taken into consideration Ms Sako's pattern of escalation over preceding months and not just her presentation that evening.[75] Dr Giuffrida was critical that there was no evidence of a mental health assessment and it appeared limited medical history, including a review of Ms Sako's background from the medical records, had been obtained. Dr Giuffrida concluded that the psychiatric nurse's conclusion that Ms Sako did not have evidence of a mental illness and posed no risk was *"grossly ill-judged"*;[76]

(b) Ms Sako's threats of self-harm and acts of self-harm indicated mental illness and risk;[77]

(c) Ms Sako satisfied the treatment criteria under the *Mental Health Act 2014* and her care should have been escalated to a senior psychiatrist on call;[78]

(d) collateral information should have been obtained from Ms Sako's family;[79]

(e) hospital staff should not have accepted Ms Sako's denials of self-harm or suicidal ideation – it is common for people with mental illness or who have self-harmed to deny that fact;[80] and

(f) a BAL reading was essential on 29 November 2015 as alcohol use greatly increases the risks of self-harm and suicide and had been a contributing factor in her previous threats of and actual self-harm. He could not see any reason as to why this had not occurred;[81]

(g) had the BAL indicated a high level of intoxication, Ms Sako should have been offered a stay in the Short Stay Unit as had occurred previously.[82] Further, a liver function test should have been ordered;[83] and

---

[74] CB 471.
[75] CB 487.
[76] CB 437-438.
[77] CB 487.
[78] CB 483, 487.
[79] CB 437-438, 488-489.
[80] CB 489-490.
[81] CB 489-490.
[82] CB 438.
[83] CB 438.

(h) Dr Giuffrida also criticised the way in which Ms Sako had been discharged from hospital, noting that if it was known that she required family or a friend to collect her and had no money to make her own way home, staff should have contacted her family.[84]

Expert report from Dr Jacqueline Rakov, forensic psychiatrist

70. In May 2020, Ms Sako's family submitted a report by Dr Jacqueline Rakov, consultant psychiatrist at Mercy Mental Health (in Victoria).[85]

71. Similarly, I note that Dr Rakov's report traverses Ms Sako's previous presentations from February 2014 until November 2015 – I will only refer to her opinion regarding Ms Sako's most recent presentation on 29 November 2015.

72. In relation to whether a BAL should have been taken, Dr Rakov noted tests had been undertaken during Ms Sako's previous presentations and it would not have been an unreasonable action during the last presentation. However, the test was not necessary to determine the next stages of her assessment. Dr Rakov was also critical that observations did not appear to be taken while Ms Sako was observed in the emergency department.[86]

73. However, Dr Rakov noted a BAL test would have indicated Ms Sako's degree of intoxication and the period in which she would likely remain intoxicated. This would have informed staff regarding whether she should have been offered a stay in the Short Stay Unit – she believed it would have been appropriate to offer the stay while Ms Sako sobered. In addition, she noted that ideally a mental health assessment should be conducted on a non-intoxicated person.[87]

74. In regard to the mental health assessment conducted, Dr Rakov noted that the only available documentation was the *Transition/ Discharge Summary*. A more comprehensive *NWMH Assessment* form had been completed during a previous presentation – this was preferred as it prompted the assessor to address broad issues, including drug and alcohol assessment, risk assessment, and a short-term plan. Use of that form may also prompt the assessor to gather collateral information from family or escalate to more senior staff.[88]

---

[84] CB 439.
[85] This report was provided subsequent to the last version of the coronial brief.
[86] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 12.
[87] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 12.
[88] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 12.

75. Dr Rakov was critical of the mental health assessment performed for the following reasons:[89]

(a) it was not reasonable to conduct the assessment while Ms Sako presented as intoxicated and without having established her BAL;

(b) it did not appear the assessment involved a consideration of Ms Sako's previous presentations;

(c) given Ms Sako's family had contacted police about their concerns regarding her risk of self-harm, the assessment should have included a discussion about the reasons for not contacting her family or details about any discussion held with her family;

(d) it was not appropriate to accept Ms Sako's denials of self-harm. In a sober person, it would have been appropriate to determine what had occurred by contacting Ms Sako's family. In the absence of a BAL assessment, Ms Sako may not have been a reliable historian; and

(e) if the assessment had occurred while Ms Sako was sober, it would have allowed the assessor to determine whether Ms Sako should be offered a voluntary psychiatric admission.

76. While Dr Rakov noted the psychiatric nurse determined that Ms Sako did not present with evidence of mental illness, she referred to Ms Sako's disclosure that she had experienced a depressed mood for two weeks (that is, an appearance of mental illness). This, combined with the consideration that she presented with an immediate risk to self, and that care was unable to be provided in a less restrictive context (that is, she was not accepting it voluntarily), meant she could have been *considered* for an Assessment Order pursuant to the *Mental Health Act 2014*. The making of an Assessment Order would have triggered a psychiatrist review within 24 hours.[90]

77. In regard to whether Ms Sako should have been referred to other services, Dr Rakov indicated it would not have been unreasonable to re-refer Ms Sako to those supports. There did not appear to be a consideration to drug and alcohol services in the assessment, nor was follow-up from the Crisis Assessment and Treatment Team provided.[91]

---

[89] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 13.
[90] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 13.
[91] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 14.

78. Dr Rakov was further critical of the failure to obtain collateral information from Ms Sako's family. In the context of reports of that her family members had wrestled a knife from her, and they had held her on the ground, it would have been appropriate to contact them to discuss not only details of her presentation prior to hospital but also discharge planning and any associated concerns. She noted that it appeared Lara Sako was willing to be contacted.[92]

79. Dr Rakov further noted: [93]

> *Given her intoxication, and the time of day, especially in light of previous presentations, the hospital would in my opinion have acted reasonably to have considered ... at least an admission to [the Short Stay Unit]; to assist her to sober up and implement adequate management, or if appropriate, discharge planning.*

80. In answer to a question as to whether Ms Sako's death was preventable, Dr Rakov answered:[94]

> *Had Ms Sako been appropriately assessed whilst not intoxicated, at any of her presentations, including the final one, there would have been an opportunity to assess and intervene such that on the balance of probabilities, her death would not have occurred on 30 November 2015.*

81. She went on to add that there were departures from a reasonable standard of care, which included:[95]

    (a) a psychiatrist was not involved in her assessment;

    (b) the absence of drug and alcohol services and the offer and implementation of detox or counselling;

    (c) there was lack of follow-up, such as a telephone call or outreach by the Crisis and Assessment Treatment Team;

    (d) poor documentation;

    (e) no BAL testing; and

    (f) minimal contact with family, including for collateral information.

---

[92] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 14.
[93] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 14.
[94] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 14.
[95] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 15.

82. Dr Rakov was also critical that there was no comprehensive management plan given Ms Sako had expressed depressed mood, and repeatedly presented with alcohol intoxication, in distress and either threatening, gesturing, or having completed self-injurious behaviour.[96]

83. In conclusion, Dr Rakov noted the following relevant statistics and guidelines:[97]

> *Given that 1 in 25 patients presenting to hospital for self-harm proceed to kill themselves within 5 years and treatment of deliberate self-harm in hospital is the strongest predictor of death by suicide,[98] improving emergency department care after a suicide attempt is a public health priority.*
>
> *Predating the RANZCP clinical practice guideline,[99] the Department of Health also introduced a clinical practice guideline for emergency departments and mental health services.[100] This too supports development of a treatment plan, with consideration given to the patient's home environment and potential stressors.*
>
> *In Australasian Psychiatry, the 2015 publication of consensus guidelines[101] for presentations such as Ms. Sako's note that clinicians should be respectful and reassuring. They determine that clinicians should review old notes, conduct a full history and examination, and talk to friends, family and any practitioners already involved in the patient's care. They conclude by noting "every negotiated management plan and its rationale should be carefully documented." …*

84. She explained that the consensus guidelines also set out that there was no use in conducting a detailed interview with a heavily intoxicated patient.

---

[96] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 15.
[97] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 15.
[98] Carroll, R., Metcalfe, C. & Gunnell, D. (2014). Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. PloS One. 9(2): e89944.
[99] Carter, G., Page, A., Large, M., et al. (2018) Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm [correction] Jan; 52(1):98-99. Aust N Z J Psychiatry doi:10.1177/0004867416661039.
[100] Victoria Government Department of Health (2010) Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services Mental Health, Drugs & Regions branch, Melbourne, Victoria.
[101] Ryan, C. J., Large, M., Gribble, R., Macfarlane, M., Ilchef, R., & Tietze, T. (2015). Assessing and managing suicidal patients in the emergency department. Australasian Psychiatry, 23(5), 513-516. https://doi.org/10.1177/1039856215597536.

MEDICAL AND MENTAL HEALTH TREATMENT PROVIDED ON 29 AND 30 NOVEMBER 2015

85. Ms Sako presented to Northern Hospital on the evening of 29 November 2015. I note that medical services are provided by Northern Health and mental health services are provided by NorthWestern Mental Health (which is a part of Melbourne Health).[102]

86. Northern Health[103] and NorthWestern Mental Health[104] made submissions regarding Ms Sako's treatment and discharge as follows.

Northern Health

Discharge from hospital on 30 November 2015

87. After medical and mental health staff assessed Ms Sako and concluded she did not require any further in-hospital treatment, she was discharged.

88. Northern Health noted that Ms Sako was calm and cooperative during her presentation at all times and was considered capable of making her own decisions. There was no evidence that she was intoxicated at the time or that she did not have capacity to make her own decisions.[105]

89. Ms Sako expressed a wish to leave hospital. The only way that staff would have been able to keep her in hospital would have been if she satisfied the criteria under the *Mental Health Act 2014* or the *Severe Substance Dependence Treatment Act 2010* and there was no evidence that she satisfied those criteria.[106]

90. It is unclear from the evidence as to whether Ms Sako was wearing shoes at the time or how she intended to return home.[107]

91. Northern Health noted that there were no policies in place that dealt with what clothing a patient was wearing upon discharge. While Northern Health acknowledged that it would be morally inappropriate to discharge a patient in the early hours of the morning in the knowledge

---

[102] CB 390.
[103] CB 443-465.
[104] CB 503-515, 554-555.
[105] CB 443, 458. I note the submission from the Sako family that there were other references to Ms Sako being affected by alcohol and not acting cooperatively: CB 572.
[106] CB 444.
[107] CB 414-415, 444.

that the patient hand no means of getting home other than walking, and the patient had no footwear, there was no evidence to suggest that staff were in possession of that information.[108]

92. However, Northern Health intended to amend its relevant policies to include considerations to be taken into account when discharging patients from the emergency department. These would include the time of day, means of getting to a safe location, appropriateness of clothing, weather conditions, availability of public transport, and ability to contact family and friends.[109]

93. In January 2022, Northern Health provided the Court with an update regarding the implementation of these amendments.[110] A new procedure titled *ED – Patient Management in the Emergency Department*, last reviewed on 23 November 2021 requires a senior decision maker to determine whether a patient is safe for discharge and to consider undertaking a risk assessment. Such an assessment involves consideration of social circumstances that may impact upon a patient's readiness for discharge. If a patient is identified as high risk, they are referred to the Discharge Planning and Support Services during working hours. Importantly, the procedure advises that discharge should be delayed until the level of support has been confirmed.

Expert report from Professor Anne-Maree Kelly, emergency physician

94. Northern Health submitted an expert report from Professor Anne-Maree Kelly, senior emergency physician at Western Health, who reviewed the assessment and treatment provided to Ms Sako during her presentations to the Emergency Department.[111] While Professor Kelly provided advice regarding Ms Sako's multiple presentations to Northern Health, I will again only refer to her opinion regarding the most recent presentation on 29 November 2015

95. Professor Kelly concluded that the clinical management was consistent with widely accepted peer professional practice and noted:[112]

    (a) there was a focussed history and examination after which Ms Sako was referred for mental health assessment;[113]

[108] CB 415, 444.
[109] CB 415.
[110] Email from Minter Ellison, dated 12 January 2022.
[111] CB 448-465.
[112] CB 444, 464.
[113] CB 464.

(b) there was nothing in Ms Sako's presentation that mandated blood tests. A specific level of blood alcohol would not have altered the clinical management;[114] and

(c) there was no clear indication for Ms Sako to be admitted to the Short Stay Unit, which is different to a psychiatric short stay unit (known as a Psychiatric Assessment and Planning Unit).[115]

96. Professor Kelly also generally noted:

(a) it would be unusual for an emergency department doctor to overrule a mental health worker's assessment;[116]

(b) while an emergency doctor has the power to detain a patient, this would not happen where there is an absence of a significant mental health issue and where the patient is capable of making their own decisions; and[117]

(c) the *Mental Health Act 2014* is not used to detain persons who exhibit chronic risk-taking behaviour, such as dangerous drinking, in the absence of mental health issues.[118]

Response to Dr Giuffrida's report

97. In its submissions, Northern Health discounted Dr Giuffrida's expert opinion for reasons including:[119]

(a) his comments regarding treatment of liver disease and seizures were beyond his expertise and there was no acute medical need for Ms Sako to remain in hospital;

(b) Dr Giuffrida failed to take into account Ms Sako's pattern of refusing treatment options open to her, including review by her general practitioner to obtain a mental health plan, or drug and alcohol services;

(c) (referring to his first report) he had not referred to Victorian mental health legislation and did not address whether Ms Sako required a compulsory psychiatric admission;

[114] CB 464.
[115] CB 444, 464.
[116] CB 459.
[117] CB 459.
[118] CB 464.
[119] CB 445. Based on Professor Kelly's expert report.

(d) Ms Sako was assessed as being capable of making her own decisions when she expressed a wish to leave hospital during 29 and 30 November 2015;

(e) given Ms Sako did not satisfy the criteria to be detained at the hospital, further options were limited – there was no way to force Ms Sako to undergo treatment; and

(f) every intoxicated patient cannot be admitted to the Short Stay Unit due to limited resources.

NorthWestern Mental Health

98. NorthWestern Mental Health referred to the statement from the psychiatric nurse[120] regarding Ms Sako's presentation during her assessment, which referred to Ms Sako as bright and reactive. He had regard to an *In Depth Assessment* completed on 4 November 2015, which had occurred in similar circumstances. At her presentation on 29 November 2015, there was no evidence of mental illness, there was no history of mental illness, and she did not meet the criteria for compulsory mental health treatment under the *Mental Health Act 2014*.[121]

99. The only other legislation that would have allowed Ms Sako to be detained was the *Severe Substance Dependence Treatment Act 2010*, which required an order from the Magistrates' Court of Victoria, and in any case Northern Hospital was not a scheduled treatment centre for that purpose.[122]

100. It was therefore not appropriate to detain Ms Sako on 29 November 2015, which would have infringed her human rights and disregarded the mental health principles set out in section 11 of the *Mental Health Act 2014*.[123]

101. NorthWestern Mental Health considered the options available for a person who did not meet the treatment criteria for compulsory treatment were as follows:

(a) a comprehensive assessment (using a NorthWestern Mental Health Assessment form) could have been conducted in line with the *Assessment in Emergency Departments* procedure.[124] However, one had already been completed recently on 4 November 2015. Therefore, in accordance with the *Assessment Guideline*,[125] it was at the

[120] CB 24-25.
[121] CB 508.
[122] CB 508.
[123] CB 508.
[124] CB 518-523. I note the submission from the Sako family that this policy required collateral information be collected in line with the Department of Health's 2010 guideline, *Working with the suicidal person*: CB 571, 574-658.
[125] CB 524-537.

psychiatric nurse's discretion to complete a further assessment (as one had been completed within the previous six months);[126]

(b) the *Assessment and care of intoxicated persons* guideline[127] provides for a consideration of any urgent physical health concerns, an assessment of acute mental health concerns, a review of therapeutic foci if the person is a current mental health service user, and involvement of police if the person exhibits aggressive or antisocial behaviour. NorthWestern Mental Health submitted that this guideline was followed – Ms Sako did not present with significant mental health concerns and was not appropriate for an admission to an acute mental health facility, she was not a current mental health care service user and had previously been referred to drug and alcohol services and her general practitioner, and there was no required for police to assist;[128] and

(c) a guideline regarding patients who re-present to hospital within a seven-day period[129] was not triggered as Ms Sako's last presentation was 26 days earlier.[130]

102. NorthWestern Mental Health submitted that a further relevant policy was the *Assessment and Review* policy,[131] which guided clinicians to perform assessments in a manner that was sensitive to their individual circumstances and their carer (paragraph 5.1(c)). This policy was revised in October 2018[132] to include family and the policy sets out the manner in which consultation with family should occur (paragraph 5.3). NorthWestern Mental Health submitted that this was an appropriate change to the policy.[133] The Sako family, however, noted that the previous version of the policy, which referred to 'carers', already applied to Ms Sako.[134]

103. Despite the policy change regarding consultation with family noted above, NorthWestern Mental Health submitted that it could not be determined whether consultation with Ms Sako's family should have occurred in this case, because:[135]

---

[126] CB 510.
[127] CB 516-517.
[128] CB 510-511. I note the Sako family submitted that a BAL test should have been undertaken in line with this policy: CB 570.
[129] CB 546-548.
[130] CB 512.
[131] CB 538-541.
[132] CB 542-545.
[133] CB 512.
[134] CB 570.
[135] CB 512.

(a) there was documented evidence of disharmony in her family home;

(b) Ms Sako stated she would go home and apologise to her family; and

(c) she planned to move out of the family home.

104. It was submitted that it would be speculative to consider whether consultation with Ms Sako's family would have been beneficial.[136]

105. In conclusion, NorthWestern Mental Health submitted that the decision not to compulsorily detain Ms Sako as a psychiatric inpatient and to not offer her a voluntary admission, but rather to provide her with a follow up referral and advice to her general practitioner, was reasonable and within the applicable guidelines. Whether this decision was a missed opportunity that could have prevented Ms Sako's death had to be considered in light of their inability to detain Ms Sako and the intervening events that occurred during the remainder of 30 November 2015, including Ms Sako's continued alcohol ingestion.[137]

Report from Associate Professor Peter Burnett, director of clinical governance

106. NorthWestern Mental Health submitted a report from Associate Professor Peter Burnett, director of clinical governance at NorthWestern Mental Health, who provided an opinion regarding the applicable legislation and how it applied to Ms Sako.[138]

Relevant sections of the Mental Health Act 2014

107. Professor Burnett referred to the principles of the *Mental Health Act 2014* set out in section 11(1) of that Act (specifically (a), (c), (d), and (e)), explaining that when read together those principles require mental health services to provide treatment for mental illness in the least restrictive way possible (with a preference for voluntary treatment). Further, those services must be provided in a way that allows patients to make their own decisions about treatment, even when those decisions are against the advice of mental health clinicians. These principles are reflected further in the Act, which imposes a high threshold for compulsory mental health treatment. So, persons who do not have a significant mental illness are entitled to refuse or decline treatment.[139]

[136] CB 512.
[137] CB 513.
[138] CB 556-560.
[139] CB 557.

108. Professor Burnett went on to explain the definition of 'mental illness' in section 4(1), which is defined as a medical condition that is characterised by a significant disturbance of thought, mood, perception, or memory. While the Act did not give further definition to those terms, he noted they were well-known *"abnormal phenomena upon which diagnoses are made"* in psychiatry. He provided a further explanation of these terms in his report.[140]

109. He also referred to the criteria for an Assessment Order in section 29 of the *Mental Health Act 2014*. He noted that an Inpatient Assessment Order can only be made if assessment cannot occur in the community.[141]

How the Mental Health Act 2014 applied to Ms Sako

110. Professor Burnett concluded that Ms Sako did not meet the criteria for an Inpatient Assessment Order on 30 November 2015 because she did not have a mental illness.[142]

111. He referred to the multiple presentations to Northern Health in the months preceding her death, which occurred in the context of her marriage breakup, family tension, and alcohol intoxication. While there was record of threats of self-harm, Professor Burnett noted that on each presentation Ms Sako reported that she only expressed suicidal thoughts when intoxicated. There was only one instance of actual self-harm (on 3 November 2015), which Ms Sako had explained was in the context of family tension.[143]

112. Referring to the definition of mental illness, Professor Burnett noted that following about Ms Sako's presentation on 30 November 2015:[144]

    (a) she did not have a significant disturbance of thought. Ms Sako gave a clear and relational account of the evening's events. She denied experiencing persistent suicidal thoughts and non were evident during the assessment;

    (b) she did not have a significant disturbance of mood. Ms Sako did not report depression and appeared bright and reactive other than when she was talking about her ex-husband; and

    (c) she did not exhibit any evidence of significant disturbance of memory of perception.

---

[140] CB 557-558.
[141] Section 30(4) of the *Mental Health Act 2014.*
[142] CB 558-559.
[143] CB 559.
[144] CB 559-560.

113. Given that Ms Sako did not satisfy the first hurdle of appearing to have a mental illness, an Assessment Order could not be made.[145] Professor Burnett also noted that the *Mental Health Act 2014* specifically excluded alcohol consumption alone as an indication for compulsory treatment.[146] He noted that Ms Sako was appropriately offered referral to specialist services and follow-up by her general practitioner on each of her presentations.[147]

Response to Dr Giuffrida's report

114. NorthWestern Mental Health noted that Dr Giuffrida's first report should be disregarded as it did not relevantly refer to Victorian mental health legislation.[148] His further report, which did refer to Victoria mental health legislation, did not have regard to the significant developments introduced by the legislation in 2014 and did not have regard the principles of the *Mental Health Act 2014.* NorthWestern Mental Health submitted that Dr Giuffrida had sought to liberally expand on the relevant legislative definitions to support his earlier conclusions.[149]

Independent expert report by Professor Richard Newton, consultant psychiatrist

115. As part of her investigation, Deputy State Coroner English obtained an independent expert report from Professor Richard Newton, clinical director of Peninsula Mental Health Service.[150] Again, I will only refer to the part of his opinion regarding Ms Sako's most recent presentation on 29 November 2015.

116. Professor Newton noted that Dr Giuffrida did not appear to appreciate that a person who presents with alcohol and drug abuse issues needs to participate in their own treatment if that treatment is to be of use. The process to engage people as an active participant in their treatment plan is a slow process.[151] However, he agreed with Dr Giuffrida's opinion that discharge planning was inadequate, which is set out further below.[152]

117. As noted by Professor Burnett above, Professor Newton noted that the *Mental Health Act 2014* specifies that a person is not to be considered to have a mental illness only by reason

---

[145] CB 560.
[146] See section 4(2)(l) of the *Mental Health Act 2014.*
[147] CB 559.
[148] CB 508.
[149] CB 554.
[150] CB 661-664.
[151] CB 662.
[152] CB 885.

that the person uses drugs or consumes alcohol.[153] While he noted Professor Burnett's conclusion that the assessment conducted during Ms Sako's presentation was sufficient to preclude the use of compulsory treatment provisions, Professor Newton opined the assessment was deficient as set out below.[154]

118. Professor Newton noted that Ms Sako's presentation on 29 November 2015 appeared to be in the context of family disharmony. There was an awareness that her family had reported that she had attempted to set fire to herself. Ms Sako provided an explanation that she was checking if the lighter was working, and this explanation was accepted by staff. This presentation was again in the context of heavy alcohol use.[155]

119. In his supplementary statement, Professor Newton noted the assessment of Ms Newton's presentation on the night of 29 November 2015 did not mention any exploration of the risks of harm to her family, which was a significant omission. A screening document captured information communicated to police members that Ms Sako had threatened harm to her family with a knife whilst affected by alcohol.[156]

120. Professor Newton noted that the only documentation regarding this presentation he could find was the *Transition/ Discharge Summary form* and the statement from the psychiatric nurse. There was no other documentation of the assessment or treatment planning and the nurse's statement did not provide any further detail.[157] The assessment included information such as a description of Ms Sako's appearance and behaviour in the interview, a summary of her account of events leading up to her being brought to hospital, and a mental state examination reflective of her presentation at the time of interview. The psychiatric nurse appears to have been reassured that Ms Sako did not have a significant psychiatric illness, that she did not present with significant risk, and that she was able to make decisions regarding her future. Ms Sako's explanation regarding the events preceding her presentation appear to have been accepted as adequate and credible.[158]

---

[153] Section 4(2)(l) of the *Mental Health Act 2014.* Professor Newton noted that Professor Burnett's statement provided an accurate description of the *Mental Health Act 2014* and how compulsory assessment and treatment criteria should be applied: CB 885.
[154] CB 885.
[155] CB 663.
[156] CB 882. It appears that Professor Newton is referring to the *Mental Disorder Transfer* form, which is completed by an attending police member: CB 727.
[157] CB 663.
[158] CB 882.

121. However, Professor Newton opined that this was a significant gap in the documentation and, given Ms Sako's repeated presentations with escalating risk, a thorough assessment and a considered treatment plan was warranted.[159]

122. During her presentation, Ms Sako reported that she had felt depressed during the preceding two weeks. However, there was no evidence that the possibility of a depressive illness was adequately explored. Her statement that she currently felt *"good"* did not discount the need for a *"more systemic diagnostic history"* to be taken.[160]

123. The assessment was further deficient in that it did not explore the risks of harm to Ms Sako's family – this is despite threats of harm to her family being documented and the discharge plan noting she would return home to her family. Professor Newton explained:[161]

> *In particular the family was not contacted to obtain their account of the risks and discuss how safe it was for Ms Sako to return to them. The family were aware of her presentation to the ED even though in the past Ms Sako had refused permission for the family to be contacted there is no evidence that such a contact was considered or permission requested on this occasion. Given the circumstances of harm to the family and the plan for Ms Sako to return to the family home contacting the family should have occurred even if Ms Sako did not give permission.*

124. While a mental state examination was conducted in regard to how she appeared at the time of her presentation, it did not appear that recent signs of significant illness preceding her presentation were obtained. It appears that this meant the probability that Ms Sako may have been underplaying the events or history that brought her to hospital was not considered or explored further. Professor Newton also noted that the exploration of Ms Sako's alcohol use also lacked important detail.[162] He noted:[163]

> *This was a repeated presentation with threats to harm self and her family in the context of alcohol use and her denials of risks required a more careful and curious exploration that should have included collateral history from her family. If the family had been consulted then they may have also informed the clinician that Ms Sako had reported demons in the walls of her room this being suggestive of visual hallucinations and or*

[159] CB 663, 882.
[160] CB 882.
[161] CB 882-883.
[162] CB 883.
[163] CB 883.

delusions and a sign of potentially very serious psychiatric illness of sequalae of alcohol abuse. I note a Family member had left their details at the front desk of [the emergency department] to facilitate communication.

125. Professor Newton noted that it was recognised it was extremely difficult to predict the risk of completed suicide. Most people who do end up taking their own lives are actually rated at low risk of suicide at the time of their death. And most people who are assessed as being at high risk of suicide do not go on to take their own lives. Professor Newton explained that assessment of suicide risk is therefore quite nuanced:[164]

> *Assessment of suicide risk requires a careful exploration of the person['s] negative thoughts about themselves, the world around them and their future. Identifying what gives the person hope, makes life worth living and how they see their future are as important as exploring whether the person has made plans or has imminent intent to kill themselves. It does not appear that these issues were addressed in the assessment.*

126. Similarly, there was insufficient information regarding Ms Sako's discharge arrangements. He noted that it appeared from statements from the Sako family that they were not contacted prior to her discharge. Professor Newton opined that as Ms Sako presented in the context of relationship difficulties and arguments within the family, an appropriate course of action would have been to contact her family and obtained collateral history from them to ensure that there was a shared understanding of how Ms Sako would return home. He stated:[165]

> *Discharging Ms Sako from the Emergency Department in the middle of the night, intoxicated, without any apparent plan of how she would get home, without any apparent discussion with the family, does not seem appropriate. I agree with Dr Giuffrida that in the context where threats have been made to the family, it becomes even more important that contact with the family be made before a discharge plan back to that family, is put in place.*

127. He went on to describe the lack of contact with her family and the lack of discussion about how a young and intoxicated woman would find her way safely home was a significant gap.[166] Professor Newton opined that an adequate discharge plan should have included consideration

[164] CB 883.
[165] CB 663
[166] CB 663.

as to how Ms Sako would be making her way home given she had been compulsorily transported by police in the middle of the night. Professor Newton was critical:[167]

> *The documentation contains no indication that this occurred and the statements from the family of how Ms Sako's eventually go home are disturbing and consistent with an absence of adequate discharge arrangements being made from Northern [emergency department].*

128. In Professor Newton's opinion, an adequate discharge plan should have included:[168]

    (a) an explicit exploration with Ms Sako about how she would be returning home;

    (b) checking that Ms Sako's plan was safe and adequate;

    (c) contacting Ms Sako's family to ensure they were accepting of her returning home and taking up their offer of arranging transport for Ms Sako; and

    (d) given Ms Sako had a number of repeated presentations, it would have also been appropriate to follow up with North West Area Mental Health Services to provide an opportunity to longitudinally assess Ms Sako outside of a 'coerced' setting.

129. In regard to Professor Kelly's report, Professor Newton described it as a comprehensive summary of medical care as evidenced in the clinical notes and her response were reasonable and appropriate.[169]

130. In conclusion, Professor Newton described that the care provided to Ms Sako appeared to be consistent with the principles of the *Mental Health Act 2014* and within the standards of care to be expected within emergency departments and in public mental health services for somebody presenting with recurrent intoxication. Ms Sako consistently denied or refused to consider treatment or therapy for alcohol abuse. She consistently played down her risk to self and continually framed her issues as being in the context of relationship issues rather than clear mental illness.[170] Professor Newton noted that even if a more detailed assessment had been undertaken, Ms Sako may not have met the criteria for compulsory assessment and treatment under the *Mental Health Act 2014* if she was willing to accept voluntary treatment, that she preferred this to be in the community, and if the risk issues were not confirmed as

---

[167] CB 883.
[168] CB 883.
[169] CB 663.
[170] CB 664.

more severe and imminent.[171] However, as Ms Sako did have a repeated pattern of presenting to hospital:[172]

> *... she would have benefited from a considered approach to treatment planning and did not necessarily require immediate intervention. It also seems very likely to me that Ms Sako would have been willing and able to negotiate treatment in a less restrictive environment. The information we have available is not sufficient to make an absolute determination as to the applicability of the [Mental Health Act 2014].*

VICTORIA POLICE RESPONSE ON 30 NOVEMBER 2015

131. On 9 June 2017, the Chief Commissioner of Police informed the Court that the circumstances surrounding Ms Sako's death were the subject of an oversight investigation by Professional Standards Command and provided the Court with a copy of an Interim Report.[173] The Chief Commissioner also made submissions as outlined below.[174]

The events of 29 November 2015

132. At 10.39pm on 29 November 2015, Acting Sergeant Luke Colquhoun received a request from Police Communications regarding direction on a call to attend the Sako family home in Westmeadows. The call was in relation to a female threatening suicide who is going to drink herself to death.[175] Available information also included that Ms Sako's family was present.[176]

133. Acting Sergeant Colquhoun advised the Operator that no police units were available to attend, and the task would be passed onto the Broadmeadows nightshift unit (NBS311). As the nightshift had yet to comment, the original dispatch was allocated by ESTA via the Mobile Data Terminal (**MDT**), but an on-air broadcast was not made.[177]

134. Acting Sergeant Colquhoun's shift ended at 11.00pm; he provided a handover to the incoming night shift supervisor, Acting Sergeant Ben Cornish, who was performing patrol supervisor duties in the Hume Police Service Area, working from the Craigieburn police station with

---

[171] CB 884.
[172] CB 885.
[173] CB 113-120.
[174] CB 102-105.
[175] CB 441.
[176] CB 104.
[177] CB 104, 118-119.

responsibility for supervision of the Sunbury, Broadmeadows, and Craigieburn police stations.[178]

135. According to Acting Sergeant Cornish, while they did not speak about any specific jobs, he became aware of a report of suicidal female when he logged on; this job had been given to Broadmeadows 311.[179] Conversely, Acting Sergeant Colquhoun stated that he informed Acting Sergeant Cornish of a number of jobs placed on hold, including a job involving a female threatening to drink herself to death.[180]

136. In regard to the discrepancy regarding the content of the handover, the Chief Commissioner submitted that the nature and fullness of Acting Sergeant Colquhoun's handover was not pertinent as any information provided to Acting Sergeant Cornish would have been limited to the information Acting Sergeant Colquhoun had at the time, that is, the same information Acting Sergeant Cornish would have received when logging on.[181]

137. While Acting Sergeant Cornish was unable to provide a further statement regarding his knowledge of the delay in responding to the first call, the Chief Commissioner noted that usual practice for an incoming night shift supervisor would be to assess available resources.[182]

138. When the Broadmeadows nightshift divisional van (unit NBS311) commenced duty at 11.00pm, there was a total of nine outstanding tasks/ events that required police attendance. This unit immediately attended a Priority 2 family violence incident involving a serious assault with the perpetrator remaining in the area. The unit remained in attendance at this job at the time of Lara Sako's second call.[183]

139. After Lara Sako's second call at 11.18pm during which she reported that her sister was now in possession of a knife (and still threatening suicide), the ESTA operator added the updated detail to the event already created, which had previously been allocated to the Broadmeadows divisional van (NBS311). There was no alteration in the priority ESTA had assigned for the dispatch of the job and an on-air broadcast regarding the updated details was not made. While the updated information was available on the unit's MDT, the relevant members were still at

[178] CB 420, 441.
[179] CB 29.
[180] CB 126, 441.
[181] CB 551.
[182] CB 420.
[183] CB 185, 420.

the family violence incident involving a serious assault and were unable to see it or respond to the update.[184]

Relevant procedures and practices

140. While the Victoria Police Manual Policy Rules set out minimum standards to which police members are required to comply, there are no rules or guidelines that are directed solely towards how police respond to a request for a welfare check nor the priority to be given to welfare checks. When conducting a welfare check, police members should use their own judgment based on the information received and their experience with the individual and/or generally.[185]

141. The Resource Management and Patrol Supervision Guideline specifies priority categories for Police Communications to dispatch calls as follows:[186]

    (a) Priority 1 calls indicate the need for an urgent response by police and would cover situations where persons are seriously injured or in danger, life threatening situations, and where offences are violent;

    (b) Priority 2 calls indicate the need for police to attend as soon as possible and covers situations where a person is injured but not life threatening and offenders are present but not violent or have left the scene; and

    (c) Priority 3 calls indicate police should attend when they are able to do so.

142. The Patrol Supervisor is responsible for overseeing and coordinating jobs.[187] Either the ESTA or the supervising sergeant will allocate tasks to general duties patrol uniform units. Allocation of units depends on the resources available and the balancing of priorities and risk assessments.[188]

---

[184] CB 104, 118.
[185] CB 103.
[186] CB 305-306.
[187] CB 316-319.
[188] CB 103-104.

Whether Victoria Police complied with procedures and practices in responding to emergency calls regarding Ms Sako

143. The Chief Commissioner concluded that police members had acted in accordance with Victoria Police policy and procedures based on the information to them at the time. The following was noted.[189]

First call – 10.33pm on 30 November 2015

144. There were no available units to attend the first call. Acting Sergeant Colquhoun therefore triaged and prioritised the job based on the information provided and the resources available at the time. The information available at the time included that Ms Sako wanted to drink her herself to death *but* there was family present. The information received did not result in a risk assessment that required a priority response by police and decisions were made on this information. Acting Sergeant Colquhoun therefore decided to hold over the job until the nightshift. The Chief Commissioner concluded that this was a reasonable decision. As the nightshift had not commenced, ESTA allocated the job via the MDT.[190]

145. In regard to response times for welfare checks, the Chief Commissioner generally noted:[191]

> *Unfortunately, it is not unusual for police to take some time to respond to requests for welfare checks when the job is triaged as not requiring an urgent response and in the absence of updated information that leads to a revision of the earlier risk assessment. Demand for police services often exceed available resources and triaging decisions need to be made. ... There is no requirement to advise callers of ESTA of delays in police attendance.*

146. And further:[192]

> *Ideally, police would be able to respond to all requests for assistance in the shortest possible time, however this is not always possible with the resources available. Priorities must be balanced and risk assessments undertaken and managed by those it command. Out of necessity, this will always involve balancing numerous factors including the number of patrol units working in a division at any given time.*

[189] CB 104.
[190] CB 104, 420-421.
[191] CB 422-423.
[192] CB 104.

Second call – 11.18pm on 30 November 2015

147. During the second call to emergency services, Lara Sako indicated her sister was now in possession of knife and still threatening suicide. While the ESTA operator updated the MDT with this information, there was no change to the priority category originally assigned – it remained a Priority 2 job. The ESTA operator did not advise of the update via air broadcast.[193]

148. While the Broadmeadows 311 unit had been dispatched to attend to the first call following shift changeover, they were occupied with an earlier job and were not in a position to respond to or see the update via the MDT (which would have required them to refresh the entry).[194]

149. The Chief Commissioner submitted that if the update had been provided over air, Acting Sergeant Cornish would have become aware of it and he may have decided to dispatch a different unit to attend. It was submitted:[195]

> *The method of dispatch of information directly to the MDT to Broadmeadows 311 meant the information which indicated an increase in priority was not able to be considered and the priority adjusted.*

150. It was therefore the Chief Commissioner's conclusion that Victoria Police members acted in accordance with policy and procedures that were available to them at the time – they were not provided with updated information that would have allowed them to reassess the urgency of the job and take action.[196]

151. I note that Timothy Madigan, Executive Manager of Operations for Word Trade Centre and Police/SES services, ESTA, explained that Victoria Police were in the process of introducing the BlueConnect Program to improve connectivity of police out in the field by providing a more mobile approach to receiving information. This would mean that police members could see ESTA communications outside of the vehicles (where their MDT is located). This project was due to commence in October 2018 and be completed by 2019.[197]

152. In February 2022, the Chief Commissioner provided an update regarding the implementation of the BlueConnect program.[198] The BlueConnect program has since rolled out 12,000 Mobile

---

[193] CB 104-105.
[194] CB 104, 420.
[195] CB 105. According to the Interim Report, a Sunbury unit (NSB311) was available and could have been dispatched: CB 119.
[196] CB 105, 421-422.
[197] CB 403.
[198] Correspondence from Russell Kennedy Lawyers, dated 8 February 2022.

Technology (**MT**) devices to frontline members (uniformed members whose primary role is frontline duties). The MT device takes the form of an iPad mini or iPhone, which allows members to carry the device on their person and to see and receive notifications that relate to assigned and localised jobs, including updates for incidents. I accept the Chief Commissioner's advice that these technological improvements will facilitate the exchange of information and improve connectivity of police out in the field.

AMBULANCE VICTORIA RESPONSE ON 30 NOVERMBER 2015

153. According to Ambulance Victoria, an ambulance was dispatched to a psychiatric patient on a Code 2 Priority (non-lights and sirens) at 11.27pm. Just as the ambulance drove into the street, it was diverted to a more urgent case (a patient with chest pain). The paramedics stopped to talk to Ms Sako and one of her sisters (presumably Lara Sako) and advised that they were being diverted but another ambulance (and police) would be along shortly. Ms Sako's sister explained the call was made in relation to Ms Sako's ongoing issue with threatening suicide and she had been found with a knife earlier that evening. Ms Sako or her sister advised that they would wait for another ambulance and that family members would stay with Ms Sako until further authorities arrived.[199] [200]

154. In his statement, Paul Viti, Advanced Life Support Paramedic, stated that during the brief conversation, Ms Sako had said *"apparently I'm the crazy one"*, however she appeared calm and non-emotional. She was not angry or displaying any threatening behaviour toward herself nor the paramedics. He stated, *"there was nothing to indicate the patient was in any immediate threat to herself or that she required any intervention from us"*. Ms Sako's sister reassured the paramedics that the family would keep an eye on her until police arrived.[201]

EMERGENCY SERVICES TELECOMMUNICATIONS AUTHORITY RESPONSE ON 30 NOVEMBER 2015

155. ESTA receives emergency calls from the public and dispatches emergency services (ambulance, police, fire, and the State Emergency Service).[202]

---

[199] CB 332, 342-343, 345-346.

[200] I note that in their submissions, ESTA also noted that the paramedics who attended the Sako family home before being called away should have provided an update that Ms Sako was no longer in possession of a knife to ESTA so that the emergency response could be reassessed: CB 395-396, 403.

[201] CB 346.

[202] CB 348.

Relevant procedures and practices

156. Standard Operating Procedures are in place for emergency call taking and dispatch of emergency police calls.[203]

157. When police or another emergency service attendance is required, the ESTA call-taker must either create a new event or duplicate an event in accordance with the requirements of the procedure. Each event is assigned a priority for dispatch category – this category does not necessarily reflect the priority a police unit will assign to their attendance at the incident.[204]

Whether ESTA complied with procedures and practices in responding to emergency calls regarding Ms Sako

First call – 10.33pm on 30 November 2015

158. In a call to emergency services, Lara Sako advised that her sister was threatening suicide, intoxicated, mentally unstable, and there was blood from an unknown source on her bed.[205]

159. Lara Sako's call was answered by Police Call-Taker 1, who created and accepted an event in the Computer Aided Dispatch (**CAD**) system. This would have notified Police Dispatcher 1 to the event.[206]

160. The event was coded as *"597-EME-THR ATTEMPT, OR THREAT, SUICIDE"* and was given a Priority 2 category for police dispatch only. Police Call-Taker 1 entered the following comments into the CAD event:[207]

> *... THREAT OF SUICIDE ... I'M GOING TO KEEP DRINKING AND KILL MYSELF ... COMP STATES THERE IS BLOOD ON F'S BED – NK FROM WHERE – NIL INJ NOTICED ON FEMALE THOUGH ... F IS INTOXICATED ...*

161. The Sunbury patrol sergeant then directed this event be placed on hold for the nightshift commencing at 11.00pm. Police Dispatcher 1 then placed the event on hold.[208]

162. At 10.51pm, and at the direction of the Sunbury patrol sergeant, Police Dispatcher 1 assigned the event to the Broadmeadows nightshift unit (NBS311), which made the event available on

[203] CB 349.
[204] CB 349.
[205] Transcript of call is located at CB 98-101, 359-365.
[206] CB 350.
[207] CB 350.
[208] CB 350.

their MDT, along with eight other events. The Police Dispatcher also spoke directly with the unit at this time to dispatch the event.[209]

163. At 11.02pm, the police unit became available and proceeded to another Priority 2 event.[210]

164. Timothy Madigan, Executive Manager of Operations for Word Trade Centre and Police/SES services, reviewed the events and concluded that the Police Call-Taker had appropriately coded and prioritised this event with the applicable Standard Operating Procedures.[211]

165. Mr Madigan re-reviewed the first call after Ms Sako's family identified that the transcript of the call at page 361 of the coronial brief was missing the words, *"but she's trying to attack me"*, spoken by Lara Sako. He confirmed that the first call was correctly coded and prioritised on the basis that the call-taker asked further questions during the call, which elicited answers from Lara Sako that her sister did not have any weapons and had not committed any physical violence to Lara or others. Therefore, the information provided during the day did not disclose any real or imminent threat to the personal safety of the caller or other persons at the time of the call.[212]

Second call – 11.18pm on 30 November 2015

166. Before police attended the Sako family home, another call was made, which was answered by Police Call-Taker 2. Lara Sako advised that her sister was threatening suicide, this was her second call, and that Ms Sako was now holding a knife.[213]

167. Police Call-Taker 2 created a multi-agency event coded as *"594-AP EME-THR PSYCHIATRIC PATIENT"* and assigned a Priority 2 category. The call-taker updated the event comments to reflect that Ms Sako was now holding a knife and accepted the event into the CAD system for ambulance and police dispatch, which would have alerted the Ambulance Dispatcher and the Police Dispatcher.[214]

---

[209] CB 350.
[210] CB 350.
[211] CB 356. I note that the Sako family also commissioned a review of ESTA's response and a finding was made that the first call should have been coded as a Priority 1 because the caller stated the patient was bleeding from an unknown location and there was blood about the house: CB 665-669.
[212] CB 681-682.
[213] CB 350-351. Transcript of call is located at CB 366-370.
[214] CB 352.

168. Mr Madigan noted that the preferred event type in fact would have been a *"597-P EMR-THR-ATTEMPTED OR THREATENDED SUICIDE"* with a Priority 1 as the caller had reported Ms Sako now had a knife.[215]

Ambulance dispatch

169. The Ambulance Dispatcher was unable to locate a suitable ambulance to dispatch and referred the event to the Ambulance Victoria Duty Manager. An Ambulance Victoria Clinic Support Paramedic Team Leader acknowledged that no units were available to attend.[216]

170. At 11.22pm, the Clinic Support Paramedic Team Leader directed ambulance unit HD473 attend following their meal break. The Ambulance Dispatcher therefore held the event for 20 minutes.[217] However, shortly thereafter ambulance unit SA422 became available and was dispatched to the event, but was cancelled shortly thereafter to attend a priority 1 event. The event was held for ambulance unit HD473 again before a closer unit (BK276) was dispatched at midnight, still on a priority 2 basis.[218]

171. Mr Madigan concluded that the Ambulance Dispatcher had acted in accordance with the applicable Standard Operating Procedures despite the preferred priority being Priority 1 – an ambulance had attended the Sako home before Ms Sako set herself alight and were able to speak to her family who advised she no longer had a knife. This information was communicated the Ambulance Victoria Duty Manager and Clinic Support Paramedic Team Leader who made dispatch decisions based on that information.[219]

Police dispatch

172. At 11.22pm Police Dispatcher 1 duplicated the event into the first event, which is standard practice with events where multiple events have been created. The event comments were made available to the police unit via their MDT but there was no communication update via radio about the new event.[220]

---

[215] CB 352, 356, 394.
[216] CB 352.
[217] CB 352.
[218] CB 353.
[219] CB 353, 356.
[220] CB 352, 356.

173. Mr Madigan noted that comments regarding Ms Sako having a knife were missed and opportunities to increase the priority to Priority 1 and to communicate the new detail to the supervising sergeant were missed.[221]

174. In an Observation Report Response to Victoria Police, ESTA acknowledged that the incorrect prioritisation of the event may have resulted in a delayed Victoria Police response. ESTA noted that the staff members involved had been provided feedback in relation to the correct usage of the *"597-P EMR-THR-ATTEMPTED OR THREATENDED SUICIDE"* code. The need to ensure that new and subsequent material information is broadcast to police units (rather than just updating the event comments) has also been reinforced with the Police Dispatcher.[222]

Whether these missed opportunities led to a missed opportunity to prevent Ms Sako's death

175. In submissions dated 30 July 2018,[223] ESTA noted that the conceded missed opportunities would not have necessarily prevented Ms Sako's death because it is unclear whether, if the updated information regarding Ms Sako possessing a knife had been notified over the radio, a police unit would have indeed been immediately dispatched and arrived before Ms Sako self-immolated. Rather, the missed opportunity was limited to the opportunity for police to conduct a risk assessment, which may have led to a unit being sent earlier. It was further submitted that there was no way to know how much time would have elapsed between a notification of the updated information, a unit being dispatched, and its arrival at the scene.[224] It could only be said that had the preferred coding been used, police may have arrived at the Sako family home earlier – the evidence could not take the point any further.[225]

176. It was submitted that the errors made in this instance did not bespeak of broader systemic issues nor deficiencies in ESTA's training.[226] The staff involved have been provided feedback and guidance as noted above and have since been subject to regular audits.[227]

[221] CB 356, 394. I note that the Sako family also commissioned a review of ESTA's response and similar findings were made regarding the second call: CB 665-669.
[222] CB 283, 356-357.
[223] CB 394-401.
[224] CB 396.
[225] CB 400.
[226] CB 399, 401, 404.
[227] CB 400-401, 405.

Screening by the Inspector General for Emergency Management

177. I note ESTA's submission that the Inspector General for Emergency Management (**IGEM**) had conducted a review of ESTA's actions, and no criticism was advanced. ESTA noted that the IGEM had concluded that ESTA would be less likely to have the same performance issues if the circumstances reoccurred and that ESTA had taken action to mitigate the likelihood of the issues reoccurring.[228]

178. The IGEM has provided advice to the Court that a review was not conducted as that term has a specific meaning. In fact, a 'screening' was conducted, which is a type of assurance activity IGEM undertakes as part of its monitoring of ESTA, which includes consideration of ESTA's investigation report.[229] The screening was closed in the terms noted above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

179. Ms Sako was clearly a loved and cherished member of her family. It appears the trigger for the alcohol abuse that overshadowed the last months of her life was the breakdown of her marriage. Although apparently abusive, Ms Sako struggled to deal with this loss and her alcohol consumption escalated. Her family pleaded with her to seek and accept help, which Ms Sako consistently declined or refused. This in turn affected Ms Sako's relationship with her family and it appears toward the end of her life the Sako family suffered a degree of carer fatigue. It is clear they feel let down by the public health system and struggled to get Ms Sako the help she clearly needed.

180. Sadly, suicide in the context of alcohol abuse is not uncommon. There is a well-established relationship between alcohol and other drug abuse and suicide with alcohol consumption being associated with suicide attempts that are both planned and impulsive.[230] Additionally, alcohol may play an important role in events leading to suicide amongst individuals with no previous psychiatric history.

181. The Australian Government's *Alcohol and Other Drugs Handbook for Health Professionals* states post-mortem studies find alcohol or other drugs at measurable levels in 30 to 50 percent

---

[228] CB 879.

[229] Letter from Tony Pearce, Inspector-General for Emergency Management, dated 6 September 2021, attaching a copy of the screening report and the IGEM's recent assessments of ESTA's progress against recommendations related to the risks associated with its management of this event.

[230] Conner, K, Beautrais, A & Conwell, Y, 2003, 'Risk Factors for Suicide and Medically Serious Suicide Attempts Among Alcoholics: Analyses of Canterbury Suicide Project Data', Journal of Studies on Alcohol, vol. 64, pp. 551–554.

of suicides. Specifically, alcohol use has been associated with increased rates of suicide ideation, attempts, and completions in cross-sectional studies. People dependent on alcohol have a 4.6 times greater risk of suicidal thinking and 6.5 times greater risk for suicide attempts than for people who are not dependent on alcohol.[231]

182. This data is similarly reproduced by the Victorian Suicide Register (**VSR**) data, which shows that alcohol is consistently detected during post-mortem examination in between 25 and 35 percent of Victorian suicides each year. Substance misuse generally predisposes an individual to suicide by disinhibiting or providing 'courage' to overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders. However, it should be noted that the nature of the association between alcohol consumption and self-harm/suicide is not entirely clear. Consumption of alcohol might influence self-harm/suicide due to the depressant influence of the substance itself; likewise, acute alcohol intoxication might contribute to disinhibited or impulsive behaviours.

The adequacy of Ms Sako's medical assessment on 29 November 2015

183. Ms Sako's family was critical that a BAL test had not been undertaken during her last hospital presentation despite undergoing such a test at her previous presentations.

184. I accept Professor Kelly's opinion that knowledge of Ms Sako's specific BAL would not have altered the medical treatment she received. While a BAL may be useful in some respects, it is not a clear indicator as to a person's capacity to make decisions or care for themselves. Professor Kelly noted and I accept the following:[232]

> *... The specific level of blood alcohol would not have altered clinical management. Different levels of blood alcohol have different effects on people, related mainly to how habituated they are to alcohol. For one person a level of 0.1 might result in very obvious clinical intoxication including drowsiness and severe unsteadiness on walking. For another person with chronic alcohol consumption there may be no evidence of clinical intoxication. Thus, clinical decisions, especially about fitness of discharge, are made on clinical features, not on the basis of a blood test result.*

[231] Australian Government Department of Health and Ageing, 2004, Alcohol and Other Drugs: A Handbook for Health Professionals. This statistic is also captured in: American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, fifth edition, 2013, p. 493.
[232] CB 464.

185. This accords with Dr Peter Jordan's statement that persons who regularly drink alcohol heavily become tolerant and may appear cognitively intact despite very high levels of alcohol.[233]

186. I note the only direct evidence regarding Ms Sako's presentation and apparent level of intoxication is from the psychiatric nurse, who noted that Ms Sako did not appear intoxicated during this presentation and was able to engage her in conversation, noting she appeared *"bright"*. Notes from the medical assessment did not refer to any appearance of intoxication.[234]

187. While Dr Giuffrida made reference to indications that Ms Sako may have had liver disease and was possibly suffering seizures, I also accept Professor Kelly's opinion that there was no acute medical need for Ms Sako to remain in hospital. Ms Sako had previously been referred for outpatient follow-up in regard to the seizures and abnormal liver function, which were appropriate, however ultimately not taken up by Ms Sako.[235]

188. Ms Sako's family was also concerned that she had not been offered a stay in the hospital's Short Stay Unit while she sobered. While I note that such offers had been previously made to and taken up by Ms Sako, I accept Professor Kelly's opinion that there was no clear indication for admission in this instance.[236] Referring to one of Ms Sako's earlier presentations, Professor Kelly explained, which I accept, that emergency departments are not in a position to admit patients "*simply because they are drunk or exhibit chronic alcohol or drug misuse"*.[237] Further, Ms Sako did not raise any concerns about returning home and did not request to stay in hospital.

189. I am satisfied that the medical assessment was reasonable and there was no basis upon which Ms Sako required admission to the Short Stay Unit.

The adequacy of Ms Sako's mental health assessment on 29 November 2015

Relevant provisions of the Mental Health Act 2014

190. In 2014, mental health legislation underwent major reform in Victoria. The new *Mental Health Act 2014* sought to reflect the community's expectations that persons with mental illness

---

[233] Director of Emergency Medicine at Northern Health: CB 28.
[234] CB 723, 725.
[235] CB 461,
[236] CB 464.
[237] CB 462.

should be involved in their own treatment and recovery decisions and that compulsory treatment should only be provided in limited circumstances and for limited periods.

191. These overarching principles are enshrined in section 11(1) of the *Mental Health Act 2014*, and relevantly include the following:

(a) persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred;

(b) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected;

(c) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;

(d) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted; and

(e) persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.

192. I also note the principles recognise the role of carers as follows:

(a) carers for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible; and

(b) carers for persons receiving mental health services should have their role recognised, respected and supported.

193. *'Mental illness'* is defined in section 4(1) of the *Mental Health Act 2014* as follows:

> *... mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.*

194. Sub-section 4(2) qualifies this definition, relevantly as follows:

> *A person is not to be considered to have mental illness by reason only of any one or more of the following—*
>
> *(j) that the person engages in antisocial behaviour;*

> *(l)* *that the person uses drugs or consumes alcohol;*
>
> *(n)* *that the person is or has previously been involved in family conflict;*
>
> *(o)* *that the person has previously been treated for mental illness.*

195. Further qualified by sub-section 4(3):

> *Subsection (2)(l) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has mental illness.*

196. The first step in the treatment of a patient pursuant to the compulsory treatment process under the *Mental Health Act 2014* is the making of an Assessment Order. Section 29 provides the criteria for the making of such an order as follows:[238]

> *(a)* *the person* ***appears*** *to have 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.*

197. Importantly, *all* of these criteria must be met before an Assessment Order can be made.

198. The making of an Assessment Order by a registered medical practitioner or mental health practitioner triggers an assessment by an authorised psychiatrist within a defined period. I note that section 37 requires an authorised psychiatrist to immediately revoke an Assessment Order if, after assessing the person subject to the order, the authorised psychiatrist is satisfied that the treatment criteria do not apply to the person.

[238] My emphasis.

Comprehensiveness of Ms Sako's mental state examination

Whether the mental state examination was sufficiently comprehensive

199. The opinions of three of the four psychiatric experts in this matter were relatively consistent in their criticism regarding the comprehensiveness of the assessment conducted on the evening of 29 November 2015. Themes of criticism included:

(a) while the psychiatric nurse noted that he had regard to an *In Depth Assessment* completed on 4 November 2015 when Ms Sako presented in similar circumstances, there was criticism that a more comprehensive review of Ms Sako's recent history was seemingly not conducted, which had associated implications;[239]

(b) a further exploration regarding Ms Sako's disclosure of recent depression was needed;[240] and

(c) that collateral information should have been obtained from Ms Sako's family in terms of her history, the events leading up to her presentation, and the appropriateness of her discharge back to the family home.[241]

200. Ms Sako had a number of hospital presentations in the months preceding her death. At least one expert described this period as a 'pattern of escalation'. While I am not necessarily satisfied there was an escalation, there was indeed a pattern of Ms Sako presenting in the context of intoxication and psychosocial stressors with threatened or actual self-harm which she later denied. Dr Rakov noted that an adequate assessment would have included an appreciation of the salient points of these presentations – something that is not clear from the evidence. Professor Newton appeared to agree, noting the repeated presentations warranted a more explorative assessment of Ms Sako's recent history, which may have led to an appreciation that she was downplaying her suicidality, and which may have led to the implementation of a treatment plan.[242]

201. I accept Professor Newton's reasons for concluding the assessment was deficient which I have extensively extracted above. There is no need for me to repeat his reasons here.

[239] See Dr Giuffrida's report at CB 437-438, 487; Professor Newton's reports at CB 663, 882; Report from Dr Jaqueline Rakov, dated 25 May 2020, pp 12-13.
[240] See Dr Giuffrida's report at CB 487; Professor Newton's report at CB 882; Report from Dr Jaqueline Rakov, dated 25 May 2020, p 13.
[241] See Dr Giuffrida's report at CB 437-438 and 488-489; Professor Newton's report at CB 663, 882-883; Report from Dr Jaqueline Rakov, dated 25 May 2020, pp 12-14.
[242] CB 663, 883.

202. I am not satisfied that a more comprehensive assessment would have prevented Ms Sako's death or even led to compulsory treatment under the *Mental Health Act 2014*. However, an assessment in the terms as outlined by Professor Newton would have recognised a clear pattern in Ms Sako's behaviour and triggered some sort of management plan, such as further assessment by community mental health services (whether or not she would have participated).

203. A more inquisitive assessment would have also explored what Ms Sako meant when she disclosed that she had been depressed for the past two weeks but recently felt *"good"*. Dr Giuffrida felt Ms Sako suffered from a mood disorder. Professor Newton noted that the possibility Ms Sako was experiencing a depressive illness was not adequately reviewed. Ms Sako's response that she felt good did not negate the need for a further exploration of her history.[243] I accept Professor Newton's conclusion on this point – this issue may have been explored further had the pattern been recognised.

204. I discuss the lack of collateral information from Ms Sako's family below.

Whether collateral information should have been obtained from Ms Sako's family

205. A particular theme that emerged from the expert evidence was that collateral information should have been obtained from Ms Sako's family in order to provide a fuller picture of her mental state and their view regarding the appropriateness of her discharge.

206. While there was evidence of family contact[244] and also of Ms Sako's refusal for family to be contacted during her previous presentations,[245] the record of assessment on 29 November 2015 did not reveal whether permission had been sought to contact her family nor whether Ms Sako had refused family contact. I note that Lara Sako had left her contact details with the front desk but there is no evidence as to whether those details were passed on to the clinicians.

[243] CB 882.

[244] For example, on 3 November 2015 clinicians had spoken to Ms Sako's mother at which time she reported Ms Sako's previous threats of self-harm and that she could no longer cope with her daughter's behaviour. While she was accepting her daughter's return, she did not want to collect Ms Sako from hospital and refused to have other family members collect her or pay for a taxi: CB 731.

[245] For example, on 29 September 2015 Ms Sako refused to have clinicians contact her family to obtain collateral information: CB 752.

207. The experts opined that an appropriately comprehensive assessment would have also included contacting Ms Sako's family to obtain collateral information, such as:

(a) the circumstances leading to Ms Sako's presentation, including threats of and actual self-harm especially in the context of her denials;[246] and

(b) whether Ms Sako's family were willing to have her return and/or capable of dealing with her in the context of ongoing family disharmony.[247]

208. The *Mental Disorder Transfer* form completed by police nominated the following reason for transporting Ms Sako to hospital pursuant to section 351 of the Mental *Health Act 2014*:[248]

> *Female under influence of alcohol, has threatened family. Picked up kitchen knife & held to her own stomach. Family has wrestled knife from female. Female has then grabbed a lighter and was trying to light her clothing on fire, family members held her on the ground.*

209. To my mind, this evidence raises two issues. Firstly, in the face of Ms Sako's denials that she had threatened harm to herself or had tried to set fire herself, I am satisfied that further information should have been obtained from Ms Sako's family about the circumstances of these threats. As Professor Newton opined, there did not appear to be a recognition that Ms Sako was understating the concerns that had brought her to the hospital even though there was history of her denying such risks.

210. Follow-up with her family may have also elicited information that Ms Sako was seeing demons on her walls on the evening of 29 November 2015 – information that would have been relevant in determining whether she had mental illness.

211. Secondly, and most concerningly, there is clearly a reference to Ms Sako threatening her family and that she has been held on the ground. This raises the possibility that she was a perpetrator of family violence and/or (but less likely) a victim of family violence. This is a point highlighted by both Professor Newton and Dr Rakov.[249] Professor Newton goes further – he notes that they should have been contacted *without* Ms Sako's permission given there

---

[246] See Dr Giuffrida's report at CB 438-439, 488-489; Professor Newton's report at CB 663, 882-883; Report from Dr Jaqueline Rakov, dated 25 May 2020, p 13.
[247] See Dr Giuffrida's report at CB 439; Professor Newton's report at CB 663, 882-883; Report from Dr Jaqueline Rakov, dated 25 May 2020, p 14.
[248] CB 727.
[249] CB 663, 882; Report from Dr Jaqueline Rakov, dated 25 May 2020, p 14.

was a known threat to Ms Sako's family and a history of family disharmony, and the discharge plan included her returning to the family home.

212. I note the view of NorthWestern Mental Health that in the context of ongoing family disharmony, it could not be determined whether family contact may have been advisable – it would be speculative to consider whether it would have been beneficial or the reverse.[250] And Ms Sako had advised the clinician that she would go home and apologise to her family and had a plan for moving out.

213. However, this submission minimises the seriousness of the events of 29 November 2015, the history of family disharmony, and the potential that Ms Sako would have made further threats to her family. Although apparently unknown to clinicians, police had collected Ms Sako from what they later described as a hostile environment. The family were resentful at Ms Sako being at the house and wanted her removed, they were sick of her behaviour, they did not want her to return, and they requested an intervention order.

214. In the context of Ms Sako's threats to her family, which were clearly known at the time of her assessment (even without the subsequent elaboration from police), I am of the view that it was essential to obtain the family's view as to whether they were accepting to have Ms Sako return home. The tense family environment later described by police may have been elicited with this follow-up.

215. In March 2022, NorthWestern Mental Health provided a copy of its procedure titled *MH02.02.24 Identifying and Responding to Patients Experiencing Family Violence Procedure*.[251] This procedure came into effect on mid-2018 and sets out what steps staff should take if it becomes known a patient is a perpetrator of family violence. If there is an assessment that a patient may 'imminently and seriously harm' someone upon discharge, staff are required to contact the police or the Family Safety Team/ NorthWestern Mental Health Specialist Family Violence Advisors. Where the patient does not pose an imminent and serious threat to others on discharge, the procedure suggests making referrals to the relevant support services. While I am not satisfied that Ms Sako posed an imminent threat to her family, had this policy been in place at the time of her presentation, I am satisfied this procedure would have required a consideration of family violence issues and triggered further actions.

[250] CB 512.
[251] Correspondence from Lander & Rogers, dated 22 March 2022.

Previous finding regarding the importance of collateral information

216. I note Deputy State Coroner English's previous finding into the death of Mr BB,[252] which involved the suicide of a man who had a possible diagnosis of bipolar affective disorder and abused alcohol. He was transported to Sunshine Hospital by police in the context of threats to suicide. During an assessment the next day, he presented as cheerful and denied suicidal ideation. The clinician reviewed Mr BB's previous discharge summaries and ultimately concluded there was no evidence of mental illness and it appeared Mr BB was experiencing a situational crisis in the context of alcohol abuse. He declined a voluntary psychiatric admission. The clinician unsuccessfully attempted to contact Mr BB's wife. When she subsequently arrived at hospital, she was advised that Mr BB was being discharged, which concerned her.

217. During her investigation, her Honour was informed that Sunshine Hospital and NorthWestern Mental Health did not have a specific policy regarding the significance of obtaining collateral information during patient assessment.

218. NorthWestern Mental Health conducted an In-depth Case Review after Ms BB's death, which resulted in two recommendations:

    (a) family consultation and/ or collateral information should, as far as practicable, routinely be incorporated and may influence decision-making processes; and

    (b) cross-sectional assessments should take into consideration all available longitudinal mental health history or information.

219. While Deputy State Coroner English was satisfied that collateral information about Mr BB's suicide risk was on his file, which the clinician considered, her Honour was critical that his discharge plan was not discussed with his wife. Her Honour noted that this was important to discuss the reasons for the plan, the family's concerns with the workability of the plan, and to implement a safety plan. She therefore made a recommendation that NorthWestern Mental Health update relevant guidelines to include a requirement for contact with a family member or carer (where possible) prior to the patient being discharged in situations where a risk has been identified that the patient may be minimising their suicide risk and/or where conflicting information has been provided regarding their suicidality.

[252] Finding into the death of BB without inquest COR 2018 6380, dated 30 March 2021, published.

220. In June 2021, Deputy State Coroner English received a response that NorthWestern Mental Health had drafted an update to the *MH02.02.28 Suicide and Self Harm Risk Assessment and Management Procedure*, which included the following:

> *Wherever possible, collateral history should be obtained from a family member, carer, friend and/or other clinicians before a patient who presented with suicidal thoughts/attempts (or increased risk) of suicide is discharged from [the emergency department] This is particularly important where there is evidence that a patient may be minimising their suicide risk, or where conflicting information has been provided about suicidality. If this history cannot be obtained, good clinical practice is to escalate to more senior staff for discussion.*

221. In March 2022, NorthWestern Mental Health provided an update regarding the implementation of this amendment.[253] The amended version provided to Deputy State Coroner English on 22 June 2021 has not yet been implemented because it was subject to further change to be more explicit regarding the importance of gaining collateral information from the family. This proposed amended version of the procedure has now been submitted to the Royal Melbourne Hospital Comprehensive Care Committee, which is due to sit to review and likely pass the amendments in April 2022. I note the latest version contains the guideline extracted at paragraph 220 above. In the meantime, NorthWestern Health has provided updated suicide risk training to staff.

222. Had this updated procedure been in place at the time of Ms Sako's presentation on the evening of 29 November 2015, it appears that her family would have been contacted to obtain further information. For this reason, I do not propose to make a further recommendation regarding the need for collateral information.

Whether Ms Sako had a mental illness as defined by the Mental Health Act 2014

223. I note Dr Giuffrida was of the clear view that Ms Sako presented with symptoms of mental illness on the evening of 29 November 2015. He was critical that the psychiatric nurse had accepted Ms Sako's denial of self-harm given her previous self-harm attempts and that people who self-harm often deny their intention.[254] His view was that Ms Sako did suffer from a significant disturbance of thought, which was supported by her expressions of self-harm and actual self-harm and her *"generally self-destructive behaviour"* which involved irrational

[253] Correspondence from Lander & Rogers, dated 22 March 2022.
[254] CB 489.

thinking and behaviour.[255] He noted that it was implicit that Ms Sako also suffered from a mood disorder as Ms Sako disclosed feeling depressed at different points. Dr Giuffirda was also critical that the psychiatric nurse failed to take into account the *"escalating pattern of self-destructive behaviour over many months…"* – the assessment of 29 November 2015 should have involved an assessment of her presentation that evening and consideration of this pattern.[256]

224. While Dr Rakov did not refer to an apparent disturbance of mood, she referred to Ms Sako's disclosure that she had experienced a depressed mood for two weeks. This indicated that Ms Sako appeared to be mentally ill and would have satisfied the first criterion for the making of an Assessment Order. She noted that Ms Sako met the remaining criteria in that Ms Sako presented with immediate risk to herself and she was unable to receive treatment by less restrictive means because she was not accepting it voluntarily.[257]

225. Conversely, Professor Burnett was of the opinion that Ms Sako did not present with mental illness. He noted her previous threats of self-harm and noted that these had all occurred during intoxication and psychosocial stressors.[258] He further noted that Ms Sako did not display a significant disturbance of thought as she was able to give clear rational for what had led to her being taken to hospital and there was no evidence of persistent suicidal thoughts. While she had reported previous depression, she appeared generally bright and reactive, which did not indicate a significant disturbance of mood.[259]

226. For reasons explained above, the Court's expert, Professor Newton did not provide an opinion as to whether Ms Sako presented with mental illness.

227. On the evening of 29 November 2015, Ms Sako did not appear to present with clouding of consciousness, she was not experiencing internal stimuli or other indicators of psychosis, appeared to have capacity to consent, was articulate, educated, understood the health system, knew how to seek help, and the medical records documented her constant refusal to see addiction service. Ms Sako denied suicidal ideation and plans and agreed to engagement with her general practitioner.

---

[255] CB 487.
[256] CB 487.
[257] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 13.
[258] CB 559.
[259] CB 559-560.

228. In response to questions posed about attempts to stab herself with a knife and the attempt to set fire to herself, Ms Sako denied threatening herself with a knife or that she was trying to set fire to herself; she explained that she was going to a have a smoke and was checking to see if the lighter was working. It appears the psychiatric nurse accepted these explanations.

229. In response to questions about her previous act of self-harm, Ms Sako explained this occurred in the context of increased alcohol consumption has was as a result of feeling frustrated by her divorce and family support.

230. Ms Sako appeared to be experiencing psychosocial stressors issues, which included her divorce, family conflict, loss of ongoing employment, a long-standing alcohol addiction for which she refused to engage with treatment and emerging indicators of adverse effects on her physical health and possibly her mental health.

231. I note that the only medical evidence of Ms Sako's state of mind on the evening of 29 November 2015 is the psychiatric nurse's record of the mental state examination he completed for Ms Sako[260] and his statement.[261] Based on this evidence, I am satisfied that Ms Sako did not appear to have a mental illness as defined by section 4 of the *Mental Health Act 2014.* However, my finding is largely tempered by my comments above regarding the comprehensiveness of the assessment. The paucity of evidence does not allow me to make any other finding.

232. Given it appears Ms Sako did not satisfy the first criterion for the making of an Assessment Order, she could not receive compulsory mental health treatment. The apparent lack of any indication that Ms Sako had mental illness also meant that she was not offered a voluntary admission.

Whether Ms Sako's blood alcohol level should have been measured for the purposes of mental state examination

233. Dr Giuffrida was critical that a BAL reading was not taken during Ms Sako's presentation on the evening of 29 November 2015 given that alcohol use increased the risks of self-harm and suicide and her previous threats of, and actual self-harm, had occurred in the context of intoxication.[262]

---

[260] Transition/Discharge Summary: CB p 722-724.
[261] CB 24.
[262] CB 489-490.

234. Dr Rakov noted that while a BAL was not necessary to determine the stages of Ms Sako's assessment, it was not reasonable to conduct an assessment while Ms Sako was intoxicated and without having established her BAL as her intoxication may have affected her ability to be a reliable historian.[263]

235. Professors Burnett and Newton did not comment on whether the psychiatric nurse should have waited for Ms Sako to sober before conducting the assessment.

236. I note the psychiatric nurse's description of Ms Sako's was *"she did not appear to be intoxicated"* and had reported drinking five glasses of wine throughout the day. It appeared she was able to fully engage in the assessment.[264]

237. The evidence suggests that although Ms Sako was intoxicated when police transported her to hospital, she no longer appeared so by the time a mental state examination was completed.

238. I note there is no requirement for a person to be tested as free of alcohol or drugs before a mental health assessment is commenced or completed.[265] The Chief Psychiatrist's guideline for the assessment of intoxicated persons states the following:

> *Alcohol and drug intoxication may influence a person's mental state presentation and may imitate or mask symptoms of an underlying mental or physical disorder. The resulting lack of inhibition and the depressant effect on the central nervous system may increase the risk of harm to self and others and exacerbate the risk of suicide.*
>
> …
>
> *The presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated.*
>
> …

[263] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 12-13.
[264] CB 723.
[265] Department of Health, Chief Psychiatrist Guidelines, Assessment of intoxicated persons www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/assessment-of-intoxicated-persons.

> *Breath testing may be used as a clinical tool where this is clinically appropriate. … Breath testing is not appropriately used to assess the value or necessity of clinical assessment.*

239. I am satisfied that Ms Sako, whilst initially appearing intoxicated during her interaction with police, no longer appeared under the influence of alcohol by the time the mental state examination was completed.[266] Conducting a BAL may have been a reasonable enquiry to provide a fuller picture of Ms Sako's presentation. Indeed, the NorthWestern Mental Health *Assessment and care of intoxicated persons by Northern CATT and Acute services* guideline notes that while intoxication should not preclude someone from receiving comprehensive assessment and care, the degree and effects of intoxication will *form a consideration* as to the most appropriate care and care setting. Assessment of a person's intoxication should not be limited to BAL alone.[267] This is appropriate given the evidence that tolerant individuals often present very differently to non-tolerant persons.

240. However, given the Chief Psychiatrist does not mandate a BAL and for the reasons outlined in paragraphs 184 to 186 above, I am satisfied there was no requirement for a BAL to be undertaken for the purposes of conducting a mental state examination.

Whether Ms Sako should have been referred to additional supports

241. Both Dr Giuffrida and Dr Rakov opined that Ms Sako should have been referred to some type of addiction service. Dr Rakov noted that even if it was known Ms Sako had attended such services or her general practitioner, it would not be unreasonable to have referred her to these supports again.[268]

242. I note that Ms Sako had refused previous offers of review or assessment with addiction services. There is nothing to suggest this would have changed on the night 29 November 2015.

243. I therefore make no finding as to whether Ms Sako should have been re-referred to alcohol addiction services during her presentation of 29 November 2015. While such a referral may have been reasonable in the circumstances, given Ms Sako's ongoing refusal to engage with such services it cannot be characterised as a missed opportunity to prevent her death. As Professor Newton acknowledged in his first report, there is need for a person presenting with alcohol and drug abuse to participate in their own treatment if that treatment is to be successful

---

[266] CB 723, 727.

[267] CB 516.

[268] Report from Dr Jaqueline Rakov, dated 25 May 2020, p 14.

– engaging people so that they become active participants in their own treatment is a slow process.

244. As a qualified nurse, it is unlikely Ms Sako was unaware of the risks associated with the continued acute intoxication and the long-term use of alcohol. However, she clearly voiced an intention to continue drinking. In the absence of her acceptance of voluntary treatment, the only way to compel Ms Sako to receive treatment for severe substance use would be pursuant to the *Severe Substance Dependence Treatment Act 2010* (Vic). It is unlikely she would have satisfied the strict criteria in this legislation.

245. I also note Professor Newton's opinion that given Ms Sako's repeated presentations, a referral for follow-up by NorthWest Area Mental Health Services would have been appropriate. This would have provided an opportunity to longitudinally assess Ms Sako outside of a 'coerced' emergency department setting.[269] I accept that this would have been a reasonable course, however, would have similarly required Ms Sako to participate on a voluntary basis, which she had historically been reluctant to do.

Royal Commission into Victoria's Mental Health System

246. In February 2021, the Royal Commission into Victoria's Mental Health System handed down its final report. In its summary of major themes, it refers to large and growing group of people falling into a 'missing middle' category – too 'complex' or too 'severe' and/or too 'enduring' to be supported through primary care alone, but not 'severe' enough to meet the strict criteria for entry into specialist mental health services. This means they receive inadequate treatment, care, and support or none at all. It is safe to say that this captures the experience of Ms Sako and her family.

247. A further identified theme is that families, carers, and supporters are left out. Despite the *Mental Health Act 2014* specifically recognising the role of carers, they feel excluded by the system and are often left out of engagement that would help them in caring for their loved one.

248. The Royal Commission also clearly recognise that there are many complex factors associated with suicide. There is no one service or treatment that will reduce the incidence of suicide – a government-wide approach is needed.

[269] CB 883.

249. I have previously noted that the recommendations of the Royal Commission aim to transform the provision of mental health services in Victoria by establishing a responsive and integrated mental health and wellbeing system. As well as making recommendations regarding suicide prevention, the recommendations also include developing a system-wide involvement of family members and carers, and a new Mental Health and Wellbeing Act to, amongst other things, reset the legislative foundations underpinning the mental health and wellbeing system.[270]

250. Of the 65 recommendations made by the Royal Commission, I note a number are directly relevant to Ms Sako's circumstances and the lived experienced of her family and, if implemented, will go toward preventing deaths in similar circumstances. These include:

(a) Recommendation 30: Developing system wide involvement of family members and carers to appropriately recognise and include the role of family members and carers in their loved one's treatment and recovery, including the sharing of appropriate information;

(b) Recommendation 31: Supporting families, carers, and supporters by providing tailored information and supports for families, carers, and supporters. This would include the establishment of a state-wide peer call-back service for families, carers, and supporters caring for people experiencing suicidal behaviour;

(c) Recommendation 35: Improving outcomes for people living with mental illness and substance use or addiction, which aims to improving outcomes for people living with mental illness and substance use or addiction by providing integrated, care, and support to people living with mental illness and substance use or addiction; and

(d) Recommendation 36: A new state-wide service for people living with mental illness and substance use or addiction to provide appropriate education and consultation services.

251. Finally, I note the Royal Commission's recommendation (recommendation 55) that compulsory treatment continue to be used only in limited circumstances.

[270] Royal Commission into Victoria's Mental Health System, Final Report, Summary and Recommendations, February 2021, pp 8, 11, 16, 62-3, 66, 78.

The manner of Ms Sako's discharge from hospital on the morning of 30 November 2015

252. Ms Sako's return to the family home in the early hours of 30 November 2015 with bleeding feet, without money or her phone, and after apparently walking approximately 14 kilometres home remained a particularly distressing memory for her family. While they acknowledged that the manner of Ms Sako's discharge was not a contributing factor in her ultimate death, they noted she would have been particularly vulnerable at the time and it was nevertheless a traumatic event that would have been detrimental to her mental health.

253. Unfortunately, it is not clear from the evidence as to whether Ms Sako was taken to hospital with shoes and if so, whether she was indeed discharged without shoes.

254. I accept that the manner of Ms Sako's discharge, if she was discharged without appropriate clothing or means to safely return home, did not directly contribute to her death. However, I acknowledge that this part of the narrative leading to Ms Sako's death has been particularly painful to her family and I accept that she was vulnerable at the time of her discharge.

255. I commend Northern Health for recognising that there was a gap in their relevant policies and deciding to implement changes so that patients are discharged from hospital in a manner that will allow them to return home safely.[271] I am satisfied the hospital has adequately addressed this issue.

Emergency Services Telecommunications Authority response on 30 November 2015

256. Ms Sako's family contended that both calls to emergency services were incorrectly coded.

257. They submitted that the first call, at 10.33pm, should have been coded as a priority 1 given Lara Sako stated her sister was bleeding from an unknown location on her body, there was blood on the bed and around the house, and she could not provide an estimate of the amount of blood loss. Lara Sako also advised that her sister was trying to attack her.[272]

258. While I accept Lara Sako relayed this information to the ESTA call-taker, these extracts do not provide a true characterisation of the totality of the information she conveyed. During the phone call, the ESTA call-taker asked further questions to clarify the circumstances of the

[271] CB 415.
[272] CB 718.

situation to assess the presenting risk and associated priority. These included asking whether:[273]

(a) Lara Sako had observed any wounds on her sister. The answer was *"No"* on two occasions;

(b) Ms Sako had any weapons. The answer was *"No"*;

(c) Ms Sako had committed any physical violence toward Lara Sako or to others. The answer was *"No"*; and

(d) Ms Sako was conscious and breathing. The answer was *"That's correct"*.

259. The dominant intention of the call was to summons help for Ms Sako who was threatening suicide by drinking herself to death. The further information elicited did not reveal information that satisfied the criteria for a priority 1 code. That is, there was no evidence of persons who were seriously injured, in danger, or trapped that required an urgent response.[274]

260. I am therefore satisfied the call was appropriately coded as a priority 2, which required a response as soon as possible for a person who was injured but not serious or not in danger.[275]

261. In relation to the second call at 11.18pm, the Sako family contended that if it had been correctly coded police would have attended Ms Sako's home in time to prevent her death.

262. I accept ESTA's concession that this call was incorrectly coded, and that updated information was not appropriately broadcast.

263. However, I do not accept that the family's submission that had the event been properly coded Ms Sako's death could have been prevented. While there is evidence that a police unit was available at Sunbury,[276] I agree with ESTA's submission that there were too many variables to be certain that the police unit would have reached Ms Sako before her death.[277]

264. The family's contention appears to assume that:

---

[273] CB 98-101.
[274] CB 689.
[275] CB 305, 690.
[276] The Sunbury unit did not log onto their MDT until 11.55pm. A Craigieburn unit logged onto their MDT at 11.27pm and thereafter attended a Priority 1 event: CB 421.
[277] CB 395-397.

(a) the Sunbury unit would have been immediately dispatched after the second call at 11.18pm;

(b) the unit would have taken approximately 23 to 30 minutes to travel to the Sako family home; and

(c) the unit would have arrived before the first emergency call was made at 11.54pm after Ms Sako self-immolated (the time of the actual incident remains unknown).

265. I acknowledge this appears to be a plausible sequence of events on the face of the evidence, however the causal link drawn by the Sako family is tainted by hindsight bias. Had the event been correctly coded and the details broadcast, it would have been up to the night shift supervisor to conduct a risk assessment, ascertain the available resources, and allocate a unit. There is no evidence before me as to whether this process would have taken seconds or minutes and/or whether the shift supervisor would have made further enquiries with Lara Sako to determine the exact nature of the risk.

266. I therefore accept ESTA's submission that it can only be said that police *may* have arrived at the Sako home earlier had the correct code been used and the updated information broadcast.

267. I am satisfied that this missed opportunity does not point to systemic issues within ESTA's policies or training and there is no need for me to make a recommendation.

Victoria Police response on 30 November 2015

268. For the reasons submitted by the Chief Commissioner of Police, I am satisfied Victoria Police acted in accordance with relevant policies and procedures.

269. The first call was coded as a Priority 2 event, and there was no evidence of an imminent danger or threat to Ms Sako or her family. I am satisfied the shift supervisor conducted a reasonable risk assessment and based available resources decided to hold over the job until the next nightshift.

270. While there was a query regarding a minor discrepancy in evidence about the content of a handover conducted between Acting Sergeant Colquhoun and Acting Sergeant Cornish, I am satisfied this did not affect Acting Sergeant Cornish's decision-making regarding resource allocation. The information available to Acting Sergeant Cornish was the same as that available to Acting Sergeant Colquhoun.

271. When the nightshift commenced at 11.00pm, the allocated Broadmeadows unit already had nine events outstanding. That unit immediately attended a Priority 2 family violence incident involving a serious assault with a perpetrator remaining at the scene, which appears to be an incident requiring a more urgent response than a female threatening to drink herself to death in the presence of her family.

272. By the time of the second call at 11.18pm, the Broadmeadows unit were still attending that event. Due to this, they were unable to see the updated information on the MDT in regard to the event relating to Ms Sako.

273. As noted above, as the second call was not escalated to a Priority 1 and not broadcast, there was no opportunity for the shift supervisor to re-assess the events and re-allocate resources if required. I am satisfied the police response to the second call was reasonable given the information available at the time.

Requests for welfare checks and delay in police response

274. I note the Chief Commissioner's advice that there are no rules or guidelines that are directed solely toward how police respond to a request for a welfare check nor the priority to be given to welfare checks. Police members are required to use their own judgment and discretion when conducting a welfare check.[278]

275. I acknowledge welfare checks cover a significantly broad category of events and circumstances and a singular policy or guideline regarding response is likely not appropriate. However, there is room for a police guideline to nominate relevant considerations to be taken into account when assessing priority. For example, a welfare check requested for a person who is currently threatening self-harm is not on par with a request to conduct a welfare check for a person who has not contacted their family for 72 hours. There is a scale of urgency that can be informed by a number of considerations and factors.

276. I also note the Chief Commissioner's lament that responses to non-urgent requests for welfare checks can be delayed depending on triage priority, available information, and available resources. While this is understandable, this is something that may not be clear to callers given there is no requirement to advise callers of ESTA of delays in police attendance.[279]

[278] CB 103.
[279] CB 104, 422-423.

277. For example, the first call from Lara Sako was made at 10.33pm. The second call made at 11.18pm effectively remained unknown to police given the priority was not updated nor was it broadcast. Police then did not attend until the flurry of emergency calls after Ms Sako self-immolated – approximately one and a half hours after the first call. There is an open question as to whether Lara Sako or the Sako family would have managed the situation differently if they had known the police response would not be immediate.

278. I am not satisfied that the lack of rules or guidelines regarding the conduct of welfare checks is a missed opportunity or something that directly contributed to Ms Sako's death. Rather, it is a concern that has emerged in the periphery. For this reason, I do not intend to make a recommendation, however I strongly urge the Chief Commissioner of Police consider implementing a guideline regarding the factors to consider when prioritising a response to a request for a welfare check, including whether to advise callers of delays.[280]

Ambulance Victoria response on 30 November 2015

279. I am satisfied Ambulance Victoria's response was reasonable. Despite being diverted to another more urgent case, paramedics were able to stop at the Sako residence and talk to Ms Sako and her sister. At this time, it was established that she was no longer in possession of a knife and she did not appear to be in any immediate danger to herself; she was being supported by family members. This information was communicated back to the Ambulance Victoria Duty Manager and Clinic Support Paramedic Team Leader who were able to make further dispatch decisions based on that information.

Victorian Suicide Register

280. The 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.

281. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 711 deaths in 2020, then 694 deaths in 2021.[281]

---

[280] I note the Chief Commissioner's response to my recommendation in the Finding into Death Without Inquest regarding Ms ZT, 15 May 2021, published, which indicated a review of existing chapters of the Victoria Police Manual had been completed in 2020 in response to a number of coronial recommendations in relation to welfare checks. The Chief Commissioner's response is available at: https://coronerscourt.vic.gov.au/sites/default/files/2021-08/2016%202733%20Respone%20to%20recommendations%20from%20Victoria%20Police_Ms%20ZT.pdf.

[281] Coroners Court Monthly Suicide Data report, March 2022 update. Published 20 April 2022.

282. 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.

283. 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 VSR, 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.

FINDINGS AND CONCLUSION

284. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Marlene Sako, born 12 January 1990;

(b) the death occurred on 1 December 2015 at Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from self-immolation; and

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

285. Having considered all of the evidence, I am satisfied that Ms Sako intentionally took action to end her own life.

I convey my sincere condolences to Ms Sako's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Fahmi Sako, senior next of kin

Tereza Sako, senior next of kin (care of Maurice Blackburn Lawyers)

Melbourne Health (NorthWestern Mental Health) (care of Lander & Rogers Lawyers)

Northern Health (care of Minter Ellison)

Chief Commissioner of Police (care of Russell Kennedy Lawyers)

Emergency Services Telecommunications Authority (care of K & L Gates)

Alfred Hospital (care of Donaldson Whiting & Grindal)

Office of the Chief Psychiatrist

Senior Sergeant Anthony Combridge, Victoria Police, Coroner's Investigator

Signature:

Judge John Cain
STATE CORONER
Date: 4 May 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.