IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 004283

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Leveasque Peterson
Deceased:	Carol Austin
Date of birth:	23 December 1952
Date of death:	27 August 2018
Cause of death:	1(a) Plastic bag asphyxia
Place of death:	24 Hardisty Street, Wangaratta, Victoria, 3677

INTRODUCTION

1. On 27 August 2018, Carol Austin was 65 years old when she died at her home in Wangaratta.

2. Carol experienced depression for approximately 20 years and was prescribed antidepressants through her general practitioners (**GP**).

3. Carol moved to Australia from New Zealand in 2014 and is survived by her daughter, Victoria and her sister, Patricia.

THE CORONIAL INVESTIGATION

4. Carol'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.

5. 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.

6. 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.

7. Upon receipt of the families concerns into Carol's psychiatric treatment and care in the months prior to her death, I requested the Coroner's Prevention Unit (**CPU**) Mental Health Investigation Team conduct a review of the care provided to Carol. [1]

8. This finding draws on the totality of the coronial investigation into the death of Carol Austin. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to

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

my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

9. In April 2018, Carol spoke with her GP, Dr Justin Donaldson, after she had self-ceased citalopram[3] in the weeks prior and subsequently felt her depression was getting worse. Dr Donaldson prescribed the antidepressant fluoxetine and made regular follow-up appointments. Carol improved as the dose was increased however she refused a mental health treatment plan (**MHTP**) and referral to a private psychologist for longer term cognitive behavioural therapy (**CBT**).

10. In April 2018, Carol advised her GP she was feeling significantly better and self-ceased the fluoxetine and wished to cease all other medications. Then, on 26 June 2018, Carol consulted Dr Gayan Dassanayake. Carol was staying with her sister Patricia at the time as she wasn't coping. She felt depressed and was experiencing suicidal ideation but without plan or intent. She was referred to Older Persons Mental Health Service (**OPMHS**). Patricia contacted the OPMHS and Dr Dassanayake and advised that Carol had made a suicide attempt in the days prior. OPMHS tried unsuccessfully to contact Carol and Patricia on 26, 27, 28, and 29 June 2018.

11. On 2 July 2018 Carol was admitted to Northeast Health Wangaratta Hospital with burns that occurred when she was holding a kettle of boiling water and felt faint. She was taken to the Alfred Hospital with burns to 6% of her body. OPMHS case manager Gail Benton made multiple unsuccessful attempts to contact Carol and Patricia and was notified by Patricia on 6 July 2018 that Carol had been admitted to Alfred Hospital.

12. Whilst at the Alfred Hospital, Carol was assessed by psychiatric consultant, psychiatric registrar and Victorian Adult Burns Unit psychologist Bridgit Pfitzer, with whom she had several sessions with until her discharge on 18 July 2018. Carol reported that her mood had improved. Ms Pfitzer made regular contact with OPMHS, Gateway Health and Patricia

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[2] 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.

[3] Citalopram is a second-generation antidepressant (SSRI) indicated in the treatment of major depression, anxiety disorders, obsessive compulsive disorder, bulimia nervosa and premenstrual dysphoric disorder.

Austin. Carol was provided with the contact details of local private psychologists Ms Pfitzer had contacted. Ms Pfitzer contacted Ms Benton from OPMHS by phone and letter. Local emergency contacts were provided to Patricia and Carol and she was referred to Northeast Health Hospital's home program.

13. On 24 July 2018 Ms Benton assessed Carol at her home and developed a plan to engage her with a psychologist for CBT, to provide support until Carol was engaged with a psychologist. Carol had reportedly not made any attempts to contact the private psychologists she was advised by Ms Pfitzer to contact.

14. Ms Benton attempted to contact two of the psychologists for Carol. On 2 August 2018, Ms Benton gave Carol the details of the costs and waitlist and Carol agreed to organise an appointment for herself. Ms Benton advised that OPMHS would remain involved until Carol was successfully linked with a psychologist.

15. On 6 August 2018, Ms Pfitzer spoke with Ms Benton and discussed Carol's apparent reluctance to engage with a psychologist and OPMHS. Ms Pfitzer also spoke to Gateway Health and to Carol and reiterated the private psychologist details as Carol had not made any appointments.

16. Carol consulted with GP Dr Malay Shah and reported she felt isolated, had not found employment, had financial stressors, poor appetite, lack of enjoyment, trouble sleeping, and was experiencing suicidal ideation without a plan or intent. Dr Shah increased Carol's antidepressant mirtazapine and contacted Ms Benton who discussed Carol's inconsistent engagement.

17. On 9 August 2018, Patricia contacted Ms Benton as she was concerned for Carol's safety. Patricia was going away for four days and wanted Carol to be admitted to hospital. Ms Benton contacted Carol who advised she had specific suicidal plans. Carol was reviewed at OPMHS by Senior Medical Officer Dr Alexander and she was admitted as a voluntary patient. She advised she had made a suicide attempt and regretted that she had not been successful.

18. Carol was diagnosed with major depression and treated with a combination of venlafaxine with mirtazapine, in the absence of improvement on the previous two antidepressants.[4] During her admission Carol had individual psychology sessions with Kerford Unit psychologist

[4] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Mood Disorders; Australian and New Zealand Journal of Psychiatry 2015; 49 (12): 1087-1206, page 29 – combined antidepressant therapy.

Naomi Craker and access to daily unit-based programs facilitated by occupational therapists. Carol refused to attend all but one of these sessions. Carol had repeat mental state examinations, risk assessments, physical health investigations, several sessions with the unit discharge coordinator and was reviewed by consultant psychiatrist Dr Michael Cowen and mental health senior medical practitioner Dr Alexander. Carol advised throughout her admission that she wanted to go home, that she felt better and was no longer having suicidal thoughts.

19. On 21 August 2018, Carol was discharged to Patricia's home with follow-up to be provided by OPMHS. Crisis contacts were given to Carol and Patricia. Ms Craker referred Carol to the Wangaratta Community Health Service psychology team for treatment post-discharge and she was listed for an intake assessment.

20. On 23 August 2018, Ms Benson contacted Carol who advised she was out shopping with Patricia. Carol stated she was feeling much improved and did not have any suicidal thoughts. Carol was reminded that Ms Benson was going on leave and an interim case manager, Alex Penfold, was to follow up with Carol on 28 August 2018 to arrange a face-to-face visit. Carol told Ms Benson that she had not received any contact from a private psychologist or the community heath psychology service.

21. On 24 August 2018, Carol left Patricia's home in the afternoon, stating she wanted to be at her own home for a couple of days while Patricia was busy. On 26 August 2018, Patricia attempted to contact Carol in the evening and left her a message.

22. On 27 August 2018, Patricia and her husband went to Carol's home to have coffee with her. They located Carol in bed with a plastic bag over her head, loosely sealed at the base with a dressing gown cord. Feeding into the bag was a plastic pipe connected to a gas bottle. A suicide note was found in the home.

23. Patricia contacted emergency services who attended and pronounced Carol deceased at the scene.

24. On 28 and 29 August 2018, Alex Penfold tried unsuccessfully to contact Carol and Patricia. Patricia returned a call to OPMHS and informed them that Carol had passed away.

Identity of the deceased

25. On 27 August 2018, Carol Austin, born 23 December 1952, was visually identified by her sister, Patricia Austin.

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

Medical cause of death

27. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 28 August 2018. Dr Glengarry also considered the Police Form 83, Carol's suicide note, and the post-mortem computed tomography (**CT**) scan and provided a written report of her findings dated 30 August 2018.

28. Examination of the post-mortem CT scan showed no skull fracture or intracranial haemorrhage. There was a small right pleural effusion, subpleural air and mediastinal air.

29. The external examination did not identify any injuries.

30. Toxicological analysis identified Mirtazapine, venlafaxine and desmethylvenlafaxine. These were not considered to be at excessive levels. Carol's blood alcohol level was 0.09g/100mL.

31. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) plastic bag asphyxia.

32. I accept Dr Glengarry's opinion.

FAMILY CONCERNS

33. The family communicated several concerns to the court. I note that some of these concerns fall outside my jurisdiction, however I requested the Coroner's Prevention Unit to review the concerns which related to the long wait Carol had to see the OPMHS psychiatrist, the delay in being referred to a psychologist by OPMHS, the lack of access to inpatient counselling and activities and the lack of notification of Carol's death amongst the treating practitioners.

CPU REVIEW OF CARE

34. I requested the CPU Mental Health Investigation Team conduct a review of the care provided to Carol.

Older Persons Mental Health Service (OPMHS) psychiatrist

35. On 26 June 2018, GP Dr Dassanayake referred Carol to the OPMHS who made unsuccessful attempts to contact Carol on 26, 27, 28, 29 June 2018 and 2 and 3 July 2018. They were not aware of Carol's transfer to Alfred Health until 6 July 2018. Carol was assessed by the psychiatric registrar in the Alfred Health on 10 and 17 July 2018.

36. Following contact and review by case manager, Ms Benton, on 9 August 2018, Carol was reviewed by mental health senior medical practitioner Dr Alexander and was admitted to the Kerford Unit. Carol was assessed by consultant psychiatrist Dr Cowen 48 hours after admission and by Dr Alexander on two further occasions during the admission.

37. After being discharged, Carol was contacted by OPMHS on 23 August 2018. It would not be the usual process for a consultant psychiatrist to review a client, who is not in crisis, immediately after discharge and before being reviewed by the case manager. The case manager schedules a review based on the person's needs and availability and the goals of engagement, which was to assess Carol's mental state and support her in the community until she was engaged with a private psychologist for CBT.

38. The level of specialist psychiatric medical practitioner input was considered by the CPU to be appropriate.

Delayed referral to a psychologist

39. OPMHS tried unsuccessfully to contact Carol and Patricia on 26, 27, 28 and 29 June 2018 and was informed of her admission to Alfred Health on 6 July 2018, which put a hold on any referrals at that time. Carol had not had a mental health assessment and making a referral in the absence of a comprehensive assessment would have been clinically unsound.

40. Alfred Health psychologist Ms Pfitzer provided Carol with the contact details of private psychologists while still an inpatient in Alfred Health. Ms Pfitzer also contacted the psychologists, who had offered to see Carol as soon as possible once she had made contact to arrange an appointment. Carol left a message for one of the psychologists, Ms Macpherson.

41. Ms Benton completed a comprehensive assessment with Carol on 24 July 2018 and made referrals to Dr Monks and Ms Macpherson and to a public psychology service at Wangaratta Community Health. Ms Benton attempted to follow up with the psychology services the following day. Ms Benton spoke to Ms Macpherson on 2 August 2018 and provided Carol with the details, costs and waitlist details. Carol was to arrange an appointment at a time that

suited her. During her admission to the Kerford Unit, psychologist Ms Craker also referred Carol to Wangaratta Community Health psychology and she was added to the waitlist.

42. Engagement times with private psychologists range from days to months with the usual timeframe of 2-3 weeks. There is no reference to gap payments for private psychology, and this may have been a contributor to Carol's reluctance to engage due to financial stress. The referral to the community psychology service would most likely have been free, however it is likely that the waitlist would have been extensive and based on priority.

43. OPMHS made timely referrals to psychology services and has no control over private or public service intake and assessment timeframes, waitlist management, response time or availability of resources. Ms Benton and Ms Pfitzer made multiple attempts to engage Carol with a psychologist and advocated and negotiated for her prioritised access. However, it was ultimately Carol's responsibility to arrange an appointment with a private provider that suited her.

44. Even with the Better Access initiative GP Mental Health Treatment Plan, out of pocket or gap payments are routinely charged by private psychologists. This may have contributed to Carol's reluctance to arrange an appointment as she had financial stressors, was struggling to find employment and had only recently applied for Centrelink payments. In addition, the information indicates access to psychology services were limited in Wangaratta across both public and private providers and even with more proactive contact by Carol, it would not have guaranteed a timely appointment.

45. CPU considered it unreasonable to suggest that, had Carol been engaged with a psychologist then her death would have been prevented and I agree with this assessment. Nonetheless, early access and engagement would have provided her with support that she did not have at the time of her discharge from the Kerford Unit. The medical records suggest OPMHS routinely contacted private psychologists as part of the discharge. The attempts to engage Carol expeditiously after her return from Alfred Health were unsuccessful because of long waiting lists across both private psychology and primary care programs and this had not changed at the time of Carol's discharge from the Kerford Unit.

46. Further, there was limited access to private psychologists in Wangaratta. This is evident in the experiences of Ms Benson and Ms Pfitzer who made repeated direct contacts and advocated for Carol to be prioritised. It is also apparent that the private psychologists had extensive

waitlists and heightened demands, with one psychologist not accepting any new referrals until the following year.

Lack of access to Kerford Unit counselling and activities

47. Carol had access to daily unit-based programs facilitated by occupational therapists and refused to attend all but one of these sessions during her admission. Carol did however, have one-on-one psychology sessions with Kerford Unit psychologist Naomi Craker, several sessions with the discharge coordinator and she was reviewed by consultant psychiatrist Dr Michael Cowen and mental health senior medical practitioner Dr Alexander. This level of access to programs and practitioners was appropriate, and it appears Carol's reports to Patricia were not reflective of what was available to her during the admission.

Lack of notification of Carol's death amongst the treating practitioners

48. According to the medical records, OPMHS were not notified of Carol's death until 29 August 2018 after failed attempts to make contact over two days.

49. Whilst I acknowledge Patricia's concerns in this regard, it relates to activities and events which occurred after Carol's death and as such I will not make comment on it.

CPU Findings

50. Carol's care by the Gateway Health GPs and OPMHS prior to her admission to the Kerford Unit was appropriate, as was the response by Northeast Health and Alfred Health to the treatment of her burns and investigation of any causes of her fainting spell. The communication and information provided was appropriate and it appears that there were proactive and timely responses to contact made by Carol and Patricia.

51. The care provided during Carol's admission in the Kerford Unit was also appropriate and included discharge planning. The frequency of contact made was negotiated with Carol and Patricia. They were advised to contact the service if Carol's situation changed, which it did not prior to Ms Benson's planned contact two days later. During that contact call, Carol was out shopping, she advised she was feeling better and was not experiencing suicidal thoughts.

52. Staff enquired frequently about Carol's suicidal thinking and explored these thoughts for plans and intent and completed risk assessments. From 16 August 2018, Carol denied any suicidal thoughts through to her discharge on 21 August 2018. Carol's reporting of no further suicidal thoughts rather than a subsidence of such thinking overtime suggests she may have been

providing unreliable information. However, clinicians have very few tools at their disposal in circumstances such as these (once a person is post- discharge), to inform an assessment of current risk. It also must be noted that any assessment of mental state and associated risks is only reflective of the point in time the assessment is completed and is not predictive. There are a number of variables in this context which cannot be controlled.

53. Ms Benton's planned leave likely did not impact Carol's decision, as there was no established therapeutic relationship and Carol had previously stated she did not like Ms Benson's approach. Ms Benson and the interim case manager Alex Penfold followed the discharge plan with scheduled telephone contacts in the week following discharge. Although failed attempts to contact Carol were not escalated for two days, this would not have prevented Carol's death as she had already passed away prior to the planned contact. The planned face-to-face assessment on 28 August 2018 met the mandated 7-day follow up post discharge timeframe. Carol was contacted on 23 August 2018 and stated she felt better and was not experiencing suicidal thoughts.

54. The discharge plan was informed by the understanding that Carol was staying at Patricia's home and was being observed and was not alone. However, she returned to her own home on 24 August 2018 which likely increased her risk of acting on suicidal ideation during that time. There is no information available to suggest OPMHS was informed of this change in plan.

<u>Albury Wodonga Health Internal Review</u>

55. A letter dated 5 December 21 from consultant psychiatrist Dr Jennifer Ellix, the then Acting Clinical Director of North East Border Mental Health Service, Albury Wodonga Health to Deputy Chief Psychiatrist Dr Lakra stated:

> *Discussed at the North East Border Mental Health Service Morbidity and Mortality Meeting on 4 December 2018. It was determined the Service would:*
>
> *a) Undertake a review of the Departmental Guidelines of the discharge of a suicidal patient*
>
> *b) Undertake a review of how the Service provides Case Management to ensure continuity of service across changes of episodes of care*

56. In July 2019, Albury Wodonga Health was asked about the progress of these recommendations. Clinical Director of North East Border Mental Health Service, Albury

Wodonga Health Dr Elizabeth McArdle stated the recommendations above were made prior to the in-depth review and as part of a general Morbidity and Mortality Review. Albury Wodonga Health considered those recommendations were based on inadequate information from other stakeholders. Dr McArdle provided a complete copy of the in-depth review which supports this position.

Access to private psychologists

57. In the 2010 *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative,* rural and remote areas had a lower uptake of Commonwealth funded Medicare items compared to metropolitan (rural and remote areas range from 3.1 – 3.8 per 1,000 total population versus metropolitan range of 7.9 – 9.3 per 1,000 total population).[5]

58. The 2019 *Royal Commission into Victoria's Mental Health System Interim Report* states:

> *It is acknowledged that access to services, the quality of those services, and some of the determinants of poor mental health differ between metropolitan and rural and regional Victoria, where one quarter of the state's population lives. It is not just about distance, although this is important when it comes to the proximity of even primary care and the expense involved in getting to it.*
>
> *Whilst there [is] limited data on the number of rural and regional people who use private specialist mental health services, [research] indicates that, in 2017-18, 7,393 people living with severe mental illness received private services compared with 21,577 people who received treatment through public specialist mental health services. It is likely that the remaining people living with severe mental illness (19,818) are not receiving specialist mental health services.*[6]

59. Private services include psychology services who access the 2008 Better Access to Mental Health Care Initiative Medicare items in private practice for a limited number of sessions using a patient specific GP Mental Health Treatment Plan from a GP. However the Commission stated that *"out of pocket costs are increasing across all relevant mental health*

[5] Harris, M., Pirkis, J., Burgess, P., et al. 2010 *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative.* 2010 University of Melbourne Centre for Health Policy, Programs and Economics.

[6] Victorian Government 2019 Royal Commission into Victoria's Mental Health System Interim Report, page 259.

services under the Medicare Benefits Schedule which appears to be a result of an increasing gap between subsidies and the cost of delivering and using services".[7]

60. In addition, it states that the number of employed psychiatrists, mental health nurses, psychologists and GPs per 100,000 people is significantly lower in regional areas, and specific to psychologists, is significantly less.[8]

61. The ability of the commission to make recommendations about access to private practitioners in regional centres who work under the Commonwealth Medicare system is limited, but Recommendation 7 specifically focuses on improving the public mental health workforce.[9] This should increase the capacity of public mental health services to expand and attract more practitioners to regional areas who may also work in private practice, thereby increasing private practitioner resources. There are also other examples of training programs aimed at attracting psychologists to regional centres.[10]

62. In 2019, the Coroners Court of Victoria provided a report to the Royal Commission into Victoria's Mental Health System, based on the Court's Victorian Suicide Register data. The report addressed clinician contact with patients who received treatment for their mental health within 12 months and six weeks of suicide between 2009 and 2015. Across both male and females, the range of deaths who had contact with a psychologist within 12 months of their death ranged from 15% - 21.8% for metropolitan and 10.8% - 15.3% for rural locations. This

[7] Victorian Government 2019 Royal Commission into Victoria's Mental Health System Interim Report, page 267.

[8] In regional areas there are 32.45 psychologists per 100,000 people. In metropolitan areas there are 78.9 psychologists per 100,000 people.

[9] The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, prepares for workforce reform and addresses workforce shortages by developing educational and training pathways and recruitment strategies by providing a) public mental health services in areas of need, including in rural and regional locations, through an expression of interest process that each year offers a minimum of 60 new funded graduate placements for allied health and other professionals, 120 additional funded graduate placements for nurses, b) postgraduate mental health nurse scholarships for 140 additional nurses each year that covers the full costs of study, c) an agreed proportion of junior medical officers to undertake a psychiatry rotation, effective from 2021, with it being mandatory for all junior medical officers by 2023 or earlier, d) overseas recruitment campaigns, including resources to assist mental health services to recruit internationally, new recruitment partnerships between organisations, and mentoring programs for new employees, e) a 'mental health leadership network' with representation across the state and the various disciplines, including lived experience workforces, supported to participate collaboratively in new learning, training and mentorship opportunities, f) the collation and publication of the profile of the mental health workforce across all geographic areas, disciplines, settings and sub-specialties, and g) mechanisms for continuing data collection and analysis of workforce gaps and projections, and the regular mapping of the workforce to meet these gaps. https://rcvmhs.vic.gov.au/interim-report page 22.

[10] 2020 Latrobe University one-year Master of Professional Psychology which allows rural students to complete all training requirements in regional Victoria www.latrobe.edu.au/new/articles/2019/release/attracting-psychologists-to-rural-areas

decreased across both male and females who suicided within six weeks of contact from 8.2% - 12.4 % for metropolitan and ranged from 5.9% - 7.4% for rural locations.[11]

63. The CPU noted there is limited information about the clinical outcomes for people who do see a psychologist (or other registered private provider) within the Better Access Initiative, therefore it is difficult to extrapolate meaning because it could reasonably be reflective of poor quality engagement, ineffective therapies, or that the low rates are reflective of the positive outcome of engaging with a therapist on completed suicide rates. However, in the context of the noted shortages of private mental health practitioners in regional Victoria, limited accessibility is a reasonable consideration.

64. In 2017, Medicare added access to the Better Access Telehealth Services for people in rural and remote areas, so patients and their families who do not have access to private psychologists locally can access the subsidised sessions with a private practitioner outside of their local area without the added burden of travel and/or cost. Wangaratta, however, did not qualify for the 2017 Better Access Telehealth Services for people in rural and remote areas as it was rated MM3[12]. Notably, Wangaratta is also a district of workforce shortage for psychiatry and is a distribution priority area for general practitioners, and the problem is compounded for patients and their families in accessing specialist mental health private providers, which are the providers of longer term, primary care non-crisis therapies including CBT.

FINDINGS AND CONCLUSION

65. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Carol Austin, born 23 December 1952;

    b) the death occurred on 27 August 2018 at 24 Hardisty Street, Wangaratta, Victoria, 3677, from plastic bag asphyxia; and

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[11] Coroners Court of Victoria, Suicide and Mental Ill Health in Metropolitan Melbourne and Regional Victoria. Data summary prepared to assist the Royal Commission into Victoria's Mental Health System, 17 July 2019.

[12] The Australian Government defines a location as city, rural, remote or very remote using the Modified Monash Model (MMM) with rural and remote classifications of MM2 - MM7 with some areas identified as a district of workforce shortage (DWS) for medical specialists and/or distribution priority area (DPA). This classifications helps to distribute the health workforce and associated funding. Wangaratta is an MM3 (2015 and 2019), is a DPA for general practitioners and a DWS for five specialties including psychiatry. General practitioners are essential to accessing a private provider under the initiative by providing the GP Mental Health Treatment Plan. The Better Access Initiative requires access to a general practitioner, psychiatrist or paediatrician, who completes the Mental health Treatment Plan for the patient, who then contacts the private practitioner. However without access to private practitioners, the program is not practical.

c) the death occurred in the circumstances described above.

66. There is no presumption for or against a finding of suicide. Nevertheless, a finding that a person has deliberately taken his or her life can have long lasting ramifications for families and friends of that person. Therefore, it should only be made when there is clear and cogent evidence.

67. In this case, I find there is sufficient evidence which supports a finding that Carol took her own life, taking into account her history of mental illness, suicide attempts and ideation, as well as the suicide note found in her home.

COMMENTS

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

68. The care provided to Carol by Northeast Border Mental Health Service was appropriate and reflected contemporary practice. Whilst I acknowledge the family concerns, these are not borne out in the available information including the position that there were delays in referring Carol to a private psychologist. Carol's referrals were multiple and timely, however the delays in accessing a private psychologist appear to be due to a lack of local private psychologists and extensive waiting times.

69. An opportunity for prevention lies in addressing the lack of access to a private psychologist for CBT. This access would ideally have occurred in a timely way, preferably prior to, but definitely after, her admission to Alfred Health. Although the Better Access Initiative subsidised consultation sessions, the practicality of the program relies on access to an eligible private provider. In regional Victoria, this resource does not always meet the needs of the communities in providing timely specialist mental health care.

70. The restriction of access to the Better Access Telehealth Services for people in rural and remote areas solely based on an MMM rating presents challenges to optimal access for the community. It results in communities who need specialist mental health care having limited alternatives to tertiary public mental health services for crises, thus forcing a waitlisted for appointments with most private providers or travelling to a city to access a provider in a more timely way.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation to Dr Brendan Murphy, Secretary of the Department of Health:

(i) To improve the access of people in a community who require mental health specialist treatment within the Better Access Initiative, I recommend that eligibility for access to the Better Access Telehealth Services for people in rural and remote areas be extended to those areas with combined ratings of MM3, a district of workforce shortage for psychiatry and a distribution priority area for general practitioners.

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

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

Victoria Austin, Senior Next of Kin

Patricia Austin, Carol's sister

Victorian Government Royal Commission into Victoria's Mental Health System

Vanja Obradovic, Afred Health

Neil Coventry, Office of the Chief Psychiatrist

Signature:

Coroner Leveasque Peterson

Date : 03 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.