IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002530

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Boe Luke Memery
Date of birth:	6 December 1994
Date of death:	19 May 2019
Cause of death:	1(a) Neck compression in the circumstances of hanging
Place of death:	3128 San Mateo Avenue, Mildura, Victoria, 3500
Keywords:	MILDURA; ABORIGINAL; SUICIDE; ACCESS TO MENTAL HEALTH SERVICES; ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM; MALLEE DISTRICT ABORIGINAL SERVICES

INTRODUCTION

1. Boe Luke Memery was 24 years old when he was found deceased at his ex-partner's home on 19 May 2019. Boe was of Aboriginal descent. He had recently separated from Ms Boronagh Williams which had caused him significant stress and anxiety. Boe also had a son from a previous relationship.

2. Boe had a history of mental health issues, depression, and self-harm. He had attempted suicide in the past and received support and treatment for his mental health in Mildura.

THE CORONIAL INVESTIGATION

3. Boe's passing 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.

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

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

6. Victoria Police assigned Senior Constable Brenton Farmer to be the Coroner's Investigator for the investigation of Boe's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. Upon receipt of the coronial brief and concerns regarding a heightened number of suicides among the Aboriginal population in Mildura, the Coroner's Prevention Unit (**CPU**) conducted an investigation.[1] The CPU reviewed the coronial briefs of evidence for seven passings to

[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.

establish commonalities between the deaths, and whether availability (or lack of) services at all contributed to the passings.

8. There was consensus among all parties and organisations consulted in the investigation that persons living in Mildura are significantly affected by several stressors including: high rates of crime, unemployment, family violence, low socioeconomic status, geographic isolation (which can impede access to health and other services), lack of available housing and accommodation support, and lack of access to availability of mental health services. Significantly, all parties and organisations identified substance misuse as the most prevalent stressor in the Mildura area, indicating that this is compounded by there being no drug and alcohol rehabilitation or detoxification facilities in Mildura.

9. The findings of the CPU, and how they relate to Boe's passing are discussed in more detail below.

10. This finding draws on the totality of the coronial investigation into the passing of Boe 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

IDENTITY OF THE DECEASED

11. On 19 May 2019, Boe Luke Memery, born 6 December 1994, was visually identified by his ex-partner, Boronagh Williams, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

13. On 21 May 2019, Dr Victoria Francis, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Francis considered the Victoria Police Report of Death Form 83 and the post-mortem computed tomography (**CT**) scan and provided a written report of her findings.

The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[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.

14. The post-mortem examination showed an adult male with a ligature mark in keeping with the submitted ligature. The post-mortem CT scan showed no obvious laryngeal injuries.

15. Routine toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol), venlafaxine,[3] delta-9-tetrahydrocannabinol,[4] and promethazine.[5]

16. Dr Francis provided an opinion that the medical cause of death was 1 (a) neck compression in the circumstances of hanging. I accept Dr Francis's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. On 18 May 2019, Boe was staying at Ms William's home in breach of a Family Violence Intervention Order. Ms Williams ended the relationship in April due to reported verbal and physical violence perpetrated by Boe. Ms Williams allowed Boe to stay at her home from 16 May 2019 as he said he had nowhere else to stay.

18. Ms Williams advised they were drinking alcohol and discussing their relationship on the night of 18 May 2019. Boe stated he wanted to continue the relationship, but Ms Williams told him it was over. Boe apparently told Ms Williams he felt had no one, as he had lost his son and his family, and he felt he had nothing left.

19. Ms Williams went to bed at about midnight. She woke up at about 3:00am and found Boe hanging from the patio. Emergency services attended and began to administer CPR, however eventually confirmed Boe had passed.

20. Handwritten notes from Boe were found expressing his anger at Ms Williams.

CPU INVESTIGATION INTO SUICIDES IN MILDURA

21. In July 2019, Murray Primary Health Network (**Murray PHN**) contacted the Coroners Court of Victoria to convey concern about a perceived increased frequency of suicides that had occurred in the Mildura Local Government Area between May and June 2019. Following this, the CPU were requested to identify suspected suicides which had occurred in Mildura and determine whether this purported elevated frequency of suicides had occurred.

[3] An antidepressant.
[4] Cannabis or marijuana.
[5] An antihistamine.

Analysis of suspected suicides

22. The CPU used the Victorian Suicide Register (**VSR**) to conduct a retrospective case series examination of suspected suicides where the location of the fatal incident or the location of the deceased's usual residence was in Mildura. The CPU identified seven suspected suicides that had occurred in Mildura between May and June 2019, being the highest frequency of suspected suicides to occur in a two-month period in Mildura over the 10-year period examined.

23. This retrospective examination showed that between May and June 2019, Mildura experienced an elevated frequency of suspected suicides. This met the Centre for Disease Control and Prevention's definition of a suicide cluster.[6]

24. This review did not uncover any known personal links between the people who suicided, however, there was evidence of several stressors that recurred across multiple deaths. These stressors included: substance misuse, diagnoses and suspected mental ill health, experience of abuse as both victim and perpetrator, and in some cases, consequent involvement with the criminal justice system, and recent or threatened separation from and/or conflict with a partner. Further analysis of the VSR also showed that, compared to other regional Victorian local government areas, Mildura had the highest average annual suicide rate per 100,000 residents across the period 2010-2019, with a rate of 35.5 suicides per 100,000 Mildura residents.

Meetings and submissions

25. Given this elevated frequency of suicides, staff from the CPU and Koori Engagement Unit at the Court were invited to meet with several organisations and community members from the Mildura area. The aim of these meetings was to obtain informed input regarding the vulnerabilities of Mildura residents, with the aim of assisting to make prevention focused recommendations in these matters.

26. Court representatives visited Mildura on 22 and 23 August 2019 and met with representatives from the Aboriginal Health Unit at the Mildura Base Hospital, Mallee District Aboriginal Services, Mildura Justice Services Centre, Mildura Magistrates Court and Murray PHN as well as community members in attendance at the Sunraysia Mallee Prevention Awareness and

[6] *"A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

Support Network Community Proposal Meeting run by Murray PHN. All participants were invited to openly discuss vulnerabilities faced by the Mildura community, including barriers to accessing health and other services in the region. I would like to acknowledge and thank all the parties and organisations who engaged with the Court as part of this investigation.

27. Additionally, I received a submission from Murray PHN detailing their response to this elevated suicide frequency. On behalf of the Victorian Government, Murray PHN leads implementation of the Mildura Place Based Suicide Prevention Trial (2017-2022). The Mildura trial takes a systems approach to community suicide prevention and incorporates postvention and community response planning within its remit.

28. Immediately after Murray PHN identified that suicides in their region had occurred, the suicide postvention response for the region was activated. Additionally, Murray PHN engaged with Orygen to review the Northern Mallee Suicide Postvention Protocols and conducted a thematic review of the suicides that occurred in Mildura in 2019 to inform ongoing strategic activities for the Mildura Place Based Suicide Prevention Trial and Murray PHN. I would like to further acknowledge and thank Murray PHN for providing a submission to me as part of this investigation.

CPU REVIEW OF THE CIRCUMSTANCES OF BOE MEMERY'S PASSING

29. Specifically in relation to Boe's passing, I requested the CPU investigate the availability (or lack of) services in the Mildura area, with a particular focus on Aboriginal specific mental health care in Mildura.

Boe's mental health background

30. Boe had a history of suicidal behaviours following a previous relationship breakdown. In 2016, following the end of a seven-year relationship with the mother of his son, Boe had two presentations to hospital with suicidal behaviours. He was diagnosed with Adjustment Disorder in the setting of a relationship breakdown and cannabis dependence.

31. Boe accessed treatment through Mildura Base Hospital Mental Health Services and engaged with a private psychiatrist. He later engaged with a psychologist in 2018 but was inconsistent in his attendance. Boe was prescribed antidepressants and apparently experienced an improvement in his mood. In early 2018 he was recorded to have a stable mental state and no suicidal ideation.

32. Proximate to his passing, Boe experienced a decline in his mental health in response to psychosocial stressors: a relationship breakdown, court matters, and a lack of stable accommodation. Boe sought treatment through Mallee District Aboriginal Services (**MDAS**).

33. Ms Williams advised that they had an argument on 17 April 2019. Boe threatened to hurt himself and Ms Williams tried to take him to hospital. Boe jumped out of the car on the way and the police were contacted. Following this incident, Victoria Police took out a Family Violence Intervention Order (**FVIO**) on behalf of Ms Williams. Ms Williams ended the relationship after this incident and Boe was no longer able to reside with her.

34. Boe made contact with Ms Williams in breach of the FVIO and Ms Williams reported these incidents to police. Prior to his passing, Boe attended court in relation to breaches of the order. Boe was due to attend court on 22 May 2019. His ex-partner advised the Court that he was petrified of going to jail.

35. On 25 April 2019, Boe called his half-sister and said he was having thoughts of suicide. They spoke on the phone and Boe eventually confirmed he would be alright. Boe again expressed suicidal thoughts on 6 May 2019 and showed evidence of self-harm. At the end of the conversation Boe stated he was no longer having thoughts of suicide.

Review of treatment provided by Mallee District Aboriginal Services

36. In April 2019, Boe was referred to MDAS in Mildura. According to a statement provided, Boe was offered support at court on 16 April 2019. He was then accompanied to MDAS to see Men's Behaviour Change Program Support Worker, Mr Nathan Kelly.

37. Mr Kelly coordinated emergency accommodation for Boe and introduced him to the Social and Emotional Wellbeing Team. No mental health practitioners were available on that day however Martin Williams, Dual Diagnosis Worker conducted an initial intake assessment exploring Boe's substance use. Boe declined a comprehensive assessment.

38. Boe advised he had relapsed into substance use after being abstinent for two years. He stated he had used cannabis but denied drinking alcohol or using any other substance. Boe requested support for stress and anxiety. On a structured screening measure of general psychological distress, Boe reported experiencing a very high level of psychological distress in the last four weeks. Boe denied suicidal ideation during the intake assessment.

39. On 1 May 2019, Boe called Mr Williams and stated he was having a breakdown. Mr Williams transferred Boe to a mental health officer who scheduled an appointment with the mental health team for 2 May 2019, however Boe missed this appointment.

40. The next day, Mr Peter Matsumoto, Aboriginal Mental Health Practitioner, attempted to call Boe and left a message. Boe then attended MDAS that same day requesting support for anxiety, depression, and grief and loss issues. Mr Matsumoto developed a plan with Boe to provide support with financial counselling, Centrelink and accommodation. Appointments were scheduled for Cognitive Behavioural Therapy and Grief and Loss Therapy. There is no documented mental state or risk assessment.

41. Boe was contacted on 8 May 2019 by the Bringing Them Home Program[7] to organise an assessment. Boe reportedly presented with severe anxiety, night terrors, and reported self-harm in the form of superficial cutting when feeling overwhelmed. It was noted that a thorough assessment needed to be completed. An appointment with a general practitioner (**GP**) was scheduled for 10 May 2019.

42. At the GP appointment, Boe reported a history of mental health issues since the age of 12 and a recent deterioration in his mental health after his relationship breakdown. Boe reported anxiety, sleep issues, and flashbacks to childhood trauma. Boe advised he had recently self-harmed but denied any current thoughts of self-harm. He was considered to have good insight and to be help-seeking. The treatment plan was to commence a low dose of antidepressant desvenlafaxine and a referral was made to Mildura Base Psychiatric Ward. A follow up appointment with the GP was scheduled for the next month. However it appears Boe did not attend an appointment with Mildura Base Psychiatric Ward prior to his passing.

43. Boe attended a third counselling session with MDAS on 14 May 2019. Boe advised he had commenced an antidepressant, but his relationship remained a major stressor. He advised he was consuming 10 cans of beer a day. Boe was counselled and provided with some coping strategies. There is no documented mental state or risk assessment. No further contact occurred with Boe prior to his passing on 19 May 2019.

[7] This program provides counselling and support to people who are part of, or affected by the Stolen Generation, or by more recent removal of children.

44. In a statement provided to the Court MDAS advised they provided holistic and culturally safe support to Boe. Support was continually provided regardless of missed appointments, and Boe was regularly followed up when he was unable to be contacted.

45. Based on the evidence provided, CPU were of the view that availability of services did not appear to be an issue proximate to Boe's passing. MDAS offered a range of services and supports to Boe, all suitable to his needs. Boe was offered community based mental health, medical, and substance use treatment. Additionally, he was offered support with transport, emergency accommodation, Centrelink, and financial counselling. MDAS was proactive and flexible in engaging with Boe.

46. Suicide risk assessments were not documented at each contact with Boe and it is unclear if this was discussed during counselling sessions with Mr Matsumoto. The last reference to self-harm was on 10 May 2019, when Boe acknowledged recent acts of self-harm but denied any current thoughts. It appears that during this review Boe did not disclose the suicidal thoughts he reported to his half-sister on 6 May 2019.

47. Although there is evidence that Boe's alcohol and substance use increased prior to his passing, it was appropriate for MDAS to initially focus on his mental health as he identified this as his presenting issue. Boe declined to conduct a comprehensive AOD assessment with the dual diagnosis worker in April 2019, limiting the ability of MDAS to provide an appropriate intervention.

48. Alcohol and cannabis were identified on the post-mortem toxicology and Ms Williams described Boe as *"pretty drunk"* at around midnight prior to his passing.

49. The presence of alcohol and illicit substances appears to be prevalent in suicides in Mildura. According to the Victorian Suicide Register, 63.8% of suicides in Mildura had alcohol and/or illicit substances detected in post-mortem toxicology. Compared to other regional local government areas, Mildura has the highest prevalence of alcohol in post-mortem toxicology.

Royal Commission into Victoria's Mental Health System

50. Since the passing of Boe in 2019, the Royal Commission into Victoria's Mental Health System (**the Commission**) has released its interim report in November 2019 and final report in February 2021, as well as recommendations.

51. The Commission heard evidence on the high rates of psychological distress and mental health disorders in Aboriginal people. The data obtained suggested the prevalence of depression and anxiety was greater among Aboriginal people compared with non-Aboriginal Victorians. The Commission also identified a heightened risk of suicide in Aboriginal people, particularly Aboriginal youth.

52. In developing recommendations suitable to the needs of Aboriginal communities, the Commission considered aspects such as the right to Aboriginal self-determination, the centrality of family and kinship groups, recognition of trauma and the impacts of racism and social disadvantage, strengths-based care and culturally valid understandings of mental health.

53. The Commission made the following recommendation regarding Aboriginal social and emotional wellbeing:[8]

> *The Royal Commission recommends the Victorian Government, through the Mental Health Implementation Office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:*
>
> - *Dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations, with statewide coverage within five years*
> - *Scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five yeas*
> - *Recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host, and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:*
>   - *Clinical, organisational, and cultural governance planning and development;*

[8] Royal Commission into Victoria's Mental Health System - Recommendations (rcvmhs.vic.gov.au)

- *Workforce development – including by enabling the recommended scholarships;*
- *Guidance, tools, and practical supports for building clinical effectiveness in assessment, diagnosis and treatment; and*
- *Developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice.*

54. The Commission also identified a need to focus on youth mental health and wellbeing and made further recommendations supporting Aboriginal social and emotional wellbeing in youth in their final report.[9]

55. The Victorian Government has committed to implementing all recommendations of the Royal Commission into Victoria's Mental Health System as part of a 10-year reform plan.

Statement from Mallee District Aboriginal Services

56. MDAS were asked to provide a statement to the Court outlining any challenges experienced providing mental health treatment in Mildura, and whether the recommendations made by the Commission cover the areas of need in Mildura.

Service Model

57. MDAS advised that the Commission's recommendations cover the areas of need for MDAS to support the people of Mildura. They advised that MDAS has commenced work on their business service model in line with the recommendations. MDAS advised they intend to expand with a wellness centre to run wellbeing and therapeutic programs for the community.

Access to Qualified Clinicians

58. MDAS experience challenges in attracting and retaining qualified clinicians. They advised that four of the seven clinicians who had contact with Boe no longer work for MDAS. This appears to result in a loss of skills and impacts the support and treatment programs provided. MDAS previously provided suicide prevention training but lost this resource due to staff movements and turnover. MDAS advised the service would like to assist staff to become qualified clinicians.

[9] Recommendation 33, Royal Commission into Victoria's Mental Health System - Recommendations (rcvmhs.vic.gov.au)

59. The shortage of Aboriginal mental health professionals was also identified by the Commission, with data from 2014 indicating that 0.3% of all Victorian psychologists are Aboriginal. This issue is addressed in Recommendation 4 of the report, through a proposed scholarship scheme.

60. In addition to the under-representation of Aboriginal people in the health workforce, the Commission identified a more general need to attract mental health workers to rural and regional services and made recommendations regarding providing additional resources, trialling a new digital service delivery model, and developing strategies to attract and retain mental health workers in rural and regional areas.[10]

CPU Findings

61. The CPU considered that Boe was not presenting with significant symptoms of depression proximate to his passing. He self-identified his presenting issues as high levels of anxiety, flashbacks to childhood trauma and difficulty coping with his relationship breakdown. He also reported a recent relapse into alcohol and substance use. MDAS was working with Boe to address his psychosocial and mental health treatment needs proximate to his passing and had offered a range of supports and referrals. Boe's mental state and suicidal thoughts appeared to fluctuate in response to psychosocial stressors. The CPU considered it was appropriate for MDAS to support Boe at court and with accommodation and finances.

62. The evidence suggests that Boe sought support through his family rather than treatment providers when experiencing suicidal thoughts. His half-sister advised he had expressed suicidal thoughts to her on 25 April and 6 May 2019 and said he had self-harmed. On 6 May 2019, Boe reportedly changed his mind after speaking with her. She had no further contact with him prior to his passing. Boe reported self-harm to his treatment providers on 8 and 10 May 2019, but there are no documented discussions regarding suicidal thoughts or plan.

63. Availability of services does not appear to have been a contributing factor in Boe's passing, however I consider that a prevention opportunity may exist in improved documentation and record keeping at MDAS. For example, it is unclear if suicide risk assessments were conducted or not documented by the clinicians providing support to Boe proximate to his

[10] Recommendations 39 and 40, Royal Commission into Victoria's Mental Health System - Recommendations (rcvmhs.vic.gov.au)

passing. A further prevention opportunity may exist in providing training to MDAS staff in suicide risk assessments and management plans.

64. Proximate to Boe's passing, a need for a psychiatric review was identified on 10 May 2019, however it appears no psychiatric review occurred. The available information suggests that Boe was unable to directly access a psychiatrist through MDAS at that time and required a referral to another service. The statement provided by MDAS does not specify if access to an onsite psychiatrist will be part of the new model of care, however having a psychiatrist available at MDAS would potentially enhance access and engagement and thereby improve mental health outcomes.

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 Boe Luke Memery, born 6 December 1994;

    b) the death occurred on 19 May 2019 at 3128 San Mateo Avenue, Mildura, Victoria, 3500, from neck compression in the circumstances of hanging; and

    c) the death occurred in the circumstances described above.

66. Having considered all of the circumstances, I am satisfied that Boe intentionally took his own life.

67. I support the findings of the CPU in relation to Boe's access to mental health support in Mildura. I consider that MDAS provided appropriate treatment to Boe prior to his passing.

COMMENTS

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

69. I commend the actions of Murray PHN in promptly responding to the elevated frequency of suicides that occurred in Mildura over the period May to June 2019, and for working collaboratively with other agencies to identify service gaps and subsequent prevention opportunities that would help to strengthen suicide prevention efforts and increase access to services and supports for Mildura residents. Murray PHN is well placed to progress the necessary research and planning required to inform future work, including further inquiries

into the broader issues faced by the Mildura community that do not form part of the coronial jurisdiction.

70. It is clear that further investigation into the suicide deaths of Mildura residents is warranted. Principally, the Victorian Department of Heath ought to liaise with Mildura community groups and appropriate stakeholders to further the knowledge gleaned in this investigation.

71. During this investigation, it has become apparent that no drug or alcohol detoxification facilities exist in the Mildura local government area, despite sustained campaigning by the Northern Mallee Local Drug Action Team for the establishment of such facilities in the region. The establishment of such a facility seems consistent with the evidence gleaned from this suicide cluster and the solutions advocated by the Mildura community and subsequent submissions. At this juncture, it is clear that the Department of Health ought to consider the establishment of drug and alcohol detoxification and rehabilitation services in the Mildura region.

RECOMMENDATIONS

72. Pursuant to section 72(2) of the Act, I make the following recommendations:

To the Professor Euan Wallace, Secretary of the Department of Health:

Recommendation One:

With the aim of promoting public health and safety and preventing like deaths, I recommend that the Secretary of the Department of Health consider the feasibility of establishing drug and alcohol rehabilitation and detoxification facilities in the Mildura local government area that are appropriately resourced and meet demand for such services in the Mildura community.

Recommendation Two:

To ensure continuous, quality, and culturally safe mental health care is available to the Aboriginal community in Mildura, I recommend the Department of Health work with the Victorian Aboriginal Community Controlled Health Organisation and Mallee District Aboriginal Services in Mildura to identify mechanisms to:

a. Attract and retain qualified clinicians;

b. Upskill current staff to become qualified clinicians through scholarships; and

c. Provide access to a psychiatrist at MDAS wellness centre.

To Jacqualyn Turfery, Chief Executive Officer - Mallee District Aboriginal Services:

Recommendation Three:

To improve the quality of care provided and promote consumer safety, I recommend Mallee District Aboriginal Services focus on documentation and record keeping by:

a. Reviewing current file and electronic health record systems to ensure they encourage and facilitate contemporaneous documentation of important clinical information such as suicide risk assessment and management; and

b. Ensuring current staff are aware of and understand their responsibilities in keeping accurate and complete healthcare records in line with the National Safety and Quality Primary and Community Healthcare Standards.

Recommendation Four

I recommend Mallee District Aboriginal Services in Mildura ensure all staff working in mental health programs have training in evidence-based and culturally appropriate suicide risk assessment and management practices.

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

74. 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.

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

Paul Memery, Senior Next of Kin

Jacqualyn Turfrey, Chief Executive Officer - Mallee District Aboriginal Services

Professor Euan Wallace, Secretary, Department of Health and Human Services

Alistair Bonsey, Strategic Projects Lead - Murray Primary Health Network

Dr John Elcok – GV Health

Penelope Main, AHPRA

Senior Constable Brenton Farmer, Coroner's Investigator

Signature:

Jacqui Hawkins, Deputy State Coroner

Date : 30 August 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.