IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 1574

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	BL
Date of birth:	7 March 1991
Date of death:	29 March 2019
Cause of death:	1(a) neck compression consequent upon hanging
Place of death:	The wider Mildura region
Keywords:	Suicide, public mental health services, post-discharge follow up

INTRODUCTION

1. On 29 March 2019, BL[1] was 28 years old when he was found deceased at his home.

2. At the time of his death, BL lived on a large rural property in the Mildura region with his partner, WM. BL's parents also resided on the property in a different house.

THE CORONIAL INVESTIGATION

3. BL'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.

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 First Constable Peter Kent to be the Coroner's Investigator for the investigation of BL's death. 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. This finding draws on the totality of the coronial investigation into the death of BL 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]

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[1] This is a pseudonym.

[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.

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

Circumstances in which the death occurred

BL's personal and medical background

8. On 7 March 1991, BL was born to parents PL and SL, and was welcomed into the family as brother to OL and NL. The family lived in the wider Mildura region. BL attended high school until the end of year nine when he left school due to bullying. Around this time, BL started seeing a psychologist.

9. When BL was about 15, he was involved in a couple of motorcycle accidents. After one accident, he spent several weeks in hospital and thereafter was quite afraid of hospitals.

10. At age 17, BL began working for PL and SL who ran a nursery and a transport company. At age 18, BL went to work with NL at the mines in Western Australia. He was working in a fly-in-fly-out capacity, which was of concern to his parents. During this period of his life, BL began heavily drinking alcohol.

11. In 2013, BL lost his job due to his drinking habit. He remained in Perth looking for work. A flat mate called PL and advised her that BL had been using illicit substances. PL immediately flew to Perth and brought BL back to Mildura with her.

12. In March 2014, BL was diagnosed with severe personality disorder with possible underlying attention deficit hyperactivity disorder.

13. Between 2014 and 2015, BL's overall wellness continued to decline. PL described that BL continued using illicit substances. Around this time, BL was charged with some criminal offences.

14. BL attended a rehabilitation facility in Queensland for approximately three months. Upon his return, there was a noticeable improvement to his health.

15. Throughout 2018, although BL still had some difficulties, he was managing well. He studied a horticultural course at this time.

16. On 6 July 2018, BL asked his General Practitioner (**GP**) Dr Prashanthi Godakumbura to prescribe him Seroquel.[3] He had been taking Seroquel for some time by then. Dr Godakumbura refused to prescribe Seroquel as there were no letters from a psychiatrist endorsing this prescription.

17. Around October 2018, BL's relationship broke down.

18. At the end of 2018, BL and WM began a relationship. WM moved in with BL shortly thereafter.

19. On 25 February 2019, BL called PL, threatening to suicide, following an argument with WM. PL immediately went home to check on him. She found a note that read, "I love you, save me." PL called emergency services who arrived shortly thereafter and took BL to hospital.

20. BL was admitted to the Mental Health Ward of Mildura Base Hospital (**MBH**) that evening. BL advised Emergency Health Clinician, Redgina Balchin, that earlier that day he had attempted suicide twice by trying to hang himself with a necktie on a wall hook, however the hook had broken. He had also attempted to suffocate himself. BL also told Clinician Balchin that he had attempted to hang himself two days prior, and that he had attempted suicide several times in the years prior. Clinician Balchin noted that BL was a "*high risk of suicide by misadventure*". BL initially accepted a voluntary psychiatric admission, but then declined. He was placed on an Inpatient Assessment Order, pursuant to the *Mental Health Act 2014* (Victoria). He was prescribed medications sodium valproate (500 mg in the morning and 1000 mg at night), and quetiapine (50-100mg).

21. On 26 February 2019, BL was reviewed by senior psychiatric registrar, Dr Slobodan Curcic. BL reported that he often felt empty, acted impulsively, experienced sudden mood changes, had a fear of abandonment and, when consuming alcohol, was highly unpredictable. BL disclosed to Dr Curcic that he had consumed cannabis and methamphetamine prior to admission but denied any thoughts of suicide. Dr Curcic assessed him as being a low risk of suicide and self-harm, and a moderate risk of harm to others due to his unpredictable behaviours.

[3] Seroquel is indicated for bipolar disorder, and for the prevention of relapse/recurrence of manic, depressive or mixed episodes.

22. On 27 February 2019, Dr Curcic reviewed BL. BL denied thoughts of suicide, had reconciled with WM and was requesting to be discharged. BL was advised to attend his GP and organise a Mental Health Care Plan. BL was referred to the Acute Community Intervention Service (**ACIS**) for follow-up via phone call and provided with discharge medications that he had been prescribed during his hospital. The discharge summary states that BL was assessed as being a low risk of suicide, though the risk was considered changeable.

23. On 1 March 2019, ACIS contacted BL, who reported feeling much better. BL advised he wanted to see a psychiatrist, and he was again told to attend his GP and obtain a referral to psychiatrist Dr Santhusa Wijekoon. BL reported that he had not been taking his medications. He requested additional phone support from ACIS and was informed that, due to the improvements in his mood, he would be discharged from ACIS. BL was told to contact psychiatric triage if he required additional support. He was provided with the contact details. At the conclusion of this phone call, he was rated as being low risk.

24. On 5 March 2019, BL attended his GP, Dr Godakumbura, who gave him a referral to Dr Wijekoon. Dr Godakumbura advised him to book another appointment with her if his mental health deteriorated whilst he waited for an appointment to see Dr Wijekoon.

25. On 9 March 2019, BL and WM had an argument. BL again contacted PL threatening to take his life. PL called emergency services again, who attended and took BL to MBH. BL was reviewed by Clinician Balchin in the Emergency Department (**ED**). BL reported that he did not want to suicide that night. PL reported that BL had been hitting himself in the head with an item. BL reported poor sleep, and both BL and PL identified poor sleep as negatively affecting his mental state. Dr Curcic indicated that PL did not provide any evidence suggestive that BL had any suicidal intent.

26. It was believed that BL was complying with his medication, and he did not present as intoxicated. It appeared that BL was experiencing a situational crisis in the background of sleep deprivation. Medical records report that BL was provided with a taxi voucher, a script for the sleep aid, zopiclone, and was discharged. Medical records do not contain references to BL's mental state, nor an assessment of his risk.

27. Evidence from WM suggests that BL did not use the taxi voucher, but rather called her to take him home. WM reports that, on their drive home, BL exited the vehicle and ran off. Another friend dropped BL home later.

28. That evening, police attended the BL's property, as BL had returned home from hospital in an agitated state which had escalated into an argument between BL and SL. BL ran into the vineyard behind the property saying that he was going to kill himself. While police were at the property talking to WM, BL calmly reappeared, advising police he wanted to go to sleep. Police contacted psychiatric triage who cleared BL to remain at the address.

29. On 26 March 2019, BL attended an appointment with Dr Godakumbura. BL reported being distressed due to poor sleep. BL advised that he had been provided medication from MBH to help him sleep, however he could not recall the name of the medication and Dr Godakumbura told him to call back when he found the box of medication at home. BL did not action this request. Dr Godakumbura referred BL for an urgent telehealth appointment with a psychiatrist at the Royal Flying Doctors Service (**RFDS**). Another appointment with Dr Goakumbura was scheduled for 29 March 2019 to review BL's sleep and to provide her with an update following his appointment with RFDS.

Events proximate to BL's death

30. On 28 March 2019, BL had borrowed his father's ute to pick up WM's daughter, KM, from school. After returning home from picking up KM, BL had approximately three alcoholic drinks.

31. PL called BL to advise him that NL would be collecting the ute keys. BL was upset by this as he believed that his parents did not trust him with the car. BL hid in a cupboard for an hour.

32. NL arrived to collect the car keys and BL met him outside, where an argument ensued. WM attempted to calm BL down, however she was unsuccessful. BL again hid in a cupboard, this time taking more alcoholic drinks with him.

33. WM and BL ate dinner together later that evening at approximately 8.30 pm. BL washed the dishes as WM and KM left the house.

34. When WM returned to the house, BL advised her that he had had another fight with his brother, who had accused BL of stealing from their parents. BL stripped down to his underwear, which WM reports he often did when he was having manic episode.

35. About 45 minutes later, WM went looking for BL and located him in a shed on the property. BL was still in only his underwear. BL had opened all of the doors to the shed and was tinkering with the cars.

36. WM stayed in the shed with BL, attempting to calm him down. They both continued drinking in the shed. At approximately 3.00 am, WM realised that they had started a second bottle of scotch. She hid the remainder of the bottle upon realising they had both drank enough.

37. WM drove the ute back to the house, but BL wanted to walk. When WM got back to the house, she got into bed and fell asleep.

38. On 29 March 2019, WM woke up at midday. BL was not in bed when WM woke up, and she did not remember him coming to bed throughout the night. WM began searching for BL. She searched PL and SL's house, the office, and the shed.

39. Near the shed was a small greenhouse made of plastic. WM observed BL inside the greenhouse. She immediately went to him. BL was sitting upright on the bench inside the greenhouse. He was leaning up against a metal pole. There was a large spool of plastic from the greenhouse wrapped around his neck, the other half of which was tied to the top of the pole that BL leaned against.

40. WM attempted to revive BL. She then ran back to the house and instructed KM to call emergency services.

41. Emergency services arrived shortly thereafter. Paramedics on scene confirmed that BL was deceased.

Identity of the deceased

42. On 29 March 2019, BL, born 7 March 1991, was visually identified by his partner, WM.

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

Medical cause of death

44. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 1 April 2019 and provided a written report of her

findings dated 3 April 2019. Dr Glengarry also reviewed the Police Report of Death for the Coroner (**Form 83**) and the post-mortem computed tomography (**CT**) scan.

45. The post-mortem examination and CT scan showed features consistent with hanging.

46. Toxicological analysis of post-mortem samples identified the presence of ethanol (~0.05 g/100mL), oxycodone (~0.1 mg/L),[4] methylamphetamine (~0.3 mg/L), amphetamine (~0.1 mg/L),[5] tramadol (~0.1 mg/L),[6] oxazepam (~0.8 mg/L),[7] delta-9-tetrahydrocannabional (~7 mg/L),[8] chlorpheniramine (~0.01 mg/L)[9] and paracetamol (< 5.0 mg/L).

47. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) neck compression consequent upon hanging.

48. I accept and adopt Dr Glengarry's opinion.

REVIEW OF CARE

49. BL's matter was referred to the Coroners Prevention Unit (**CPU**).[10] In correspondence dated 13 April 2019, BL's mother, PL, wrote to the Court expressing her concerns with the care provided to BL by MBH. The CPU carefully considered PL's concerns.

50. Dr Katherine James, former Clinical Director of Mental Health Services at MBH provided a response to PL's concerns. Dr James stated that a postvention service was not in place at the time BL was receiving treatment from MBH.

51. Dr Thomas Callaly, Clinical Director and Consultant Psychiatrist at MBH, further explained that the postvention service is a suicide prevention program which encompasses the Hospital

[4] Oxycodone is a semi-synthetic narcotic analgesic related to morphine, used clinically to treat moderate to severe pain.
[5] Amphetamines is a collective work to describe central nervous system stimulants structurally related to Dexamphetamine. Of these, methamphetamine is often known as 'speed' or 'ice'. Methamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.
[6] Tramadol is a narcotic analgesic used for the treatment of moderate to severe pain.
[7] Oxazepam a sedative/hypnotic drug of the benzodiazepine class.
[8] Delta-9-tetrahydrocannabional is the active form of cannabis.
[9] Chlorpheniramine is a selective histamine receptor antagonist at central and peripheral sites, preventing histamine-induced mediator release. In Australia, the drug is present in numerus cold and flu preparations indicated for the relief from runny nose, nasal congestion, headache, body ache, fever and sneezing.
[10] 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.

Outreach Post-Suicide Engagement (**HOPE**) program and The Way Back Support Service (**TWBSS**).

52. HOPE provides assertive follow-up to individuals following a serious suicide attempt, or who have displayed serious suicidal ideation and engaged in significant self-harm. HOPE offers support for patients and families, for up to 12 weeks, to identify and build protective factors to help reduce the risk of suicide. TWBSS provides psychosocial support to individuals following a suicide attempt and is staffed by individuals with a lived experience background. The Postvention Program has been operational since May 2021.

53. Dr James stated that patients no longer requiring inpatient care were generally referred to ACIS for short-term support, or to the Adult Continuing Care Team (**CCT**) for ongoing case management. ACIS provides assessment and support during a crisis and CCT provides care for patients with a mental illness who are not in crisis or requiring assertive care.

54. BL was followed up by ACIS on 1 March 2019 where he expressed an interest in seeing a private psychiatrist and was advised to see his GP for a referral. Dr James stated that given BL's condition was no longer acute and he was compliant with his medication, he was discharged from ACIS.

55. Dr James stated that BL would not have been considered appropriate for ongoing case management with CCT as he wanted to see a private psychiatrist. Dr James stated that BL's desire to obtain private assistance would have been preferable because there were, and remain, limited mental health resource across the region. Dr James added that "*BL's indication that he would obtain private treatment would have been considered the best option for him at the time*."

56. Dr James further stated that it is unlikely that BL would have met criteria for CCT as she described that CCT is more for people with complex, chronic long-term mental health issues and more appropriate for someone who is on injectable medication and/or compulsory treatment orders.

57. Dr Callaly stated that the clinical rationale for discharging BL from MBH was because he was working, was no longer suicidal and was being supported by family. He further stated that ACIS is a service providing support during a crisis, and given BL reported he was no longer suicidal, that was likely the basis for discharging him from ACIS.

58. MBH Continuing Care Team Assessment and Allocation policy lists the intake criteria for CCT as:

a) Prospective client aged between 18 and 65;
b) Clients having established mental health diagnosis or symptomology identified by triage as indicative of a mental health diagnosis;
c) There is an absence of acute risk of suicide or high level deliberate self-harming behaviours requiring acute follow up;
d) Prospective clients are voluntary and wishing to engage in treatment or clients that have been transferred to Mildura Mental Health Service on a Treatment Order from another mental health service;
e) If triage presentation indicates the client has a stable mental state and is wanting to engage with structured therapy and case coordination is provided;
f) Clients previously managed by CCT within the past six months will be given the opportunity to re-engage with their previous case manager if possible;
g) Clients currently being case-managed by another mental health service that have moved to the Mildura catchment area.

59. The policy further states that once referral has been received, the CCT clinician will:

a) Conduct a comprehensive mental state assessment

b) Utilise this comprehensive assessment to collaboratively determine the best treatment pathway for client, with input from client, carers and relevant stakeholders to either:

i. Commence CCT therapy and care coordination as an outcome of the assessment, or

ii. Refer to external agencies for treatment and continued support client whilst this linkage is made.

60. Following CPU review, it appears a referral to CCT would have been appropriate to enable BL to receive treatment and support whilst awaiting linkage with the private psychiatrist.

61. Dr Godakumbura was aware of BL's admission to MBH in February 2019, after BL disclosed this. In her statement dated 14 February 2022, Dr Godakumbura advised that she did not receive a discharge summary from MBH and therefore was unaware of medications that had been prescribed to BL, or of any follow-up support arranged. Dr Godakumbura

stated that community mental health support is arranged by the hospital as part of the follow-up care following discharge.

62. By contrast, Dr Callaly identified that community supports are limited, and that Mallee Family Care can provide case management to individuals with a mental illness, however it is the responsibility of the GP to implement referral to community supports when developing a mental health care plan.

63. Following CPU review, it does not appear that consideration was given to arranging interim supports for BL until he was able to be connected to a local private psychiatrist. Given that this was BL's first contact and admission to MBH, with a recent history of suicidal ideation, recent significant suicide attempts and was help-seeking, it would have been appropriate for additional clinical supports to be implemented, such as referral to CCT or extending the duration of ACIS support.

64. Furthermore, it appears that MBH assumed that follow-up arrangements would occur via BL's GP, however there was no communication with Dr Godakumbura regarding this. As Dr Godakumbura did not receive a discharge summary, she was limited in her ability to follow up with prescribing medications and appropriate treatment. Dr Godakumbura was under the impression that ongoing mental health follow up would be arranged by MBH. It does not appear that Dr Godakumbura contacted MBH to obtain the discharge summary, list of discharge medications, or any information regarding follow-up arrangements.

65. Dr Callaly further stated that BL self-reported he was compliant with medications during his phone call with ACIS and that he was compliant with medication during his brief inpatient admission. It does not appear that collateral information was obtained to support this, nor were any tests undertaken to determine BL's level of compliance with the medication.

FOLLOWING CPU REVIEW

66. BL's first admission to mental health services occurred via admission to MBH on 25 February 2019 until he was discharged on 27 February 2019. This admission was in the context of suicidal threats and a recent history of high lethality suicide attempts. On 1 March 2019, BL received a phone call from ACIS, as per the discharge plan from MBH, and was then discharged from ACIS after he was advised to attend his GP for a referral to private psychiatrist, Dr Wijekoon.

67. Given that this was BL's first admission to mental health services, his recent history of significant suicide attempts and that he was actively seeking help to manage his mental health, it would have been appropriate and reasonable for BL to be offered assertive mental health follow-up following his discharge from MBH, until such time when he was able to be seen by Dr Wijekoon.

68. At the time of BL's involvement with MBH, there were no postvention services in place. The HOPE and TWBSS would have been appropriate if they existed at the time of BL's treatment at MBH. Alternatively, according to the CCT Assessment and Allocation policy, CPU concluded that BL would have met the intake criteria for CCT. Furthermore, CCT would have been able to provide treatment and support to BL until links were established with a private psychiatrist. It is further noted that this policy was not in place at the time of BL's death. Had the policy been in place at the time of BL's admission to MBH, he may have qualified for CCT, however I cannot speculate with any certainty. The lack of ongoing follow-up support by MBH appears to be a missed opportunity.

69. There appears to be a lack of communication between MBH and Dr Godakumbura. Dr Godakumbura did not receive a copy of the discharge summary (despite MBH records stating that there was a plan to forward a copy to BL's GP) and was unaware of the medication that had been prescribed to BL which created difficulty in ensuring continuity of care and medication prescription.

70. MBH's discharge plan was for BL's GP to make a referral to a private psychiatrist, however this was never communicated to Dr Godakumbura. Dr Godakumbura was aware of BL's admission only after BL had disclosed this to her, and she was under the impression that mental health follow-up was to be arranged by MBH as part of the discharge process. MBH's failure to forward the discharge summary to Dr Godakumbura may also be considered a missed opportunity.

71. BL was brought to MBH ED on 9 March 2019 by police pursuant to the *Mental Health Act 2014* (Vic). BL was reviewed in ED and discharged following this review. The entry in the MBH record does not provide an adequate description of BL's mental state, nor an assessment of his risk. There was further phone contact with BL and psychiatric triage later that night after police attended the family property. There is no documentation in the MBH medical record relating to this phone call.

72. Given the lack of documentation, it is not possible to gain an understanding of BL's mental state and risk at that time, although it is possible that, given the increased frequency of his contact with mental health services and police in one day, there was an escalation in BL's behaviour and/or a deterioration in his mental state. He may have benefited from further mental health supports at this point, such as ACIS or an inpatient admission. This may represent another missed opportunity.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was BL, born 7 March 1991;

    b) the death occurred on 29 March 2019 in the wider Mildura region, from neck compression consequent upon hanging; and

    c) the death occurred in the circumstances described above.

74. I am satisfied that BL intentionally took his own life, having regard to the manner chosen and BL's recent interactions with the mental health system.

RECOMMENDATIONS

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

(i) For clients that are being discharged from inpatient/acute settings, MBH implement a formal process to ensure communication with general practitioners regarding admission details, medication and follow up arrangements.

(ii) MBH implement a formalised process to ensure that discharge summaries are completed and provided to relevant stakeholders within a timely fashion.

(iii) MBH ensure staff are aware of the requirements to document all clinical contacts relating to clients, with documentation to include adequate mental state examinations and descriptions of risk.

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

Pursuant to section 73(1B) 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:

PL and SL, Senior Next of Kin

Mildura Base Hospital, care of Jessica Jones, HWL Ebsworth

First Constable Peter Kent, Coroner's Investigator

Signature:

John Olle
Coroner

Date : 31 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.