FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the *Coroners' Act 2008*

Court reference: 3385/11

Inquest into the Death of EVELYN FAYE SCHERGER

Delivered On:	22 April, 2013
Delivered At:	Mildura
Hearing Dates:	14 and 15 March, 2013
Findings Of:	Coroner Pauline Spencer
Representation:	Assisting the Coroner – S/C Blair
Place of Death/ Suspected Death:	Western General Hospital, Gordon St, Footscray, Melbourne
Victoria Police Investigator:	Det. S/C Dale LONG (CIU, Mildura)

FORM 37

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Section 67 of the *Coroners' Act 2008*

Court reference: 3385/11

In the Coroners' Court of Victoria at Mildura

I, PAULINE SPENCER, Coroner

having investigated the death of:

Details of deceased:

Surname:	SCHERGER
First Name:	EVELYN FAYE
Address:	119 Olive Ave, Mildura

And having held an inquest in relation to this death on 14 and 15 March, 2013 at the Mildura Law Courts, Mildura find that:

the identity of the deceased was EVELYN FAYE SCHERGER

and the death occurred on 8 December 2011

at Western General Hospital, Gordon St, Footscray, Melbourne

from

I (a) HYPOXIC BRAIN INJURY COMPLICATING MIXED DRUG TOXICITY

in the following circumstances:

INTRODUCTION

1. The family and friends of Evelyn Faye Scherger knew her as Faye and requested that she be referred to as Faye during the inquest.

2. Faye was born on 10 December 1948. She was a respected member of the Mildura community and a successful real estate agent. She was married to Anthony Scherger. She was a mother to children Cindy, Emmet and Luke and a grandmother.

3. In late 2010 the 40 year marriage between Faye and Anthony began to slowly deteriorate. Anthony began an extra marital affair around this time. Faye learned of Anthony's extra marital affair in late June 2011, with the revelation shocking the entire family and devastating Faye.

4. Faye did not cope well with the deterioration of the marriage. On one occasion Faye went missing and took steps consistent with a plan to commit suicide. She was found in Sunbury and then stayed with her son Emmet for a period of time.

5. In 27 July 2011 Faye was admitted to the Mildura Base Hospital after overdosing on a combination of about 40-50 different types of tablets (valium, temazepam and alprazolam). After being medically cleared she was admitted into the Northern Mallee Area Mental Health Service (MHS) from 28 to 31 July 2011. During her stay at the MHS she was diagnosed with an Adjustment Disorder. She was discharged with follow up appointments organised and a referral recommendation for relationships counselling.

6. Over this time Anthony continued to come and go from the marriage. Faye's mental health oscillated and her physical state declined.

7. On 3 September 2011 Anthony informed Faye that the marriage was at an end.

8. On the morning of 5 September 2011 Faye took medication while in her parked car outside Anthony's work. She was found and conveyed to the Mildura Base Hospital.

9. Faye remained at the Mildura Base Hospital for the majority of the day in the Emergency Department. Faye was assessed by a Crisis Assessment and Treatment Team (CATT). Faye was discharged later that same day with a follow up appointment with the MHS organised for the following day. Cindy took Faye back to Faye's home where Emmet was staying. Emmet sat with Faye while she went to sleep.

10. The next morning, 6 September 2011 at approximately 6:45am Faye was found unresponsive seated on the edge of the Mildura Wharf located in Hugh King Drive, Mildura, after a suspected polypharmarcy overdose. Faye was revived by ambulance officer and Faye conveyed to the Mildura Base Hospital for treatment. Her condition did not improve.

11. Faye was transferred to the Western Hospital in Footscray, Melbourne arriving at 2:20am on Wednesday the 7th of September 2011. On Thursday the 8th of September 2011 Faye's life support was terminated and at 5:11pm Faye was pronounced dead.

THE INQUEST

12. Evelyn Faye Scherger's death constituted a reportable death and an inquest into her death was held pursuant to the *Coroners' Act 2008*.

13. A comprehensive brief of evidence was prepared by Detective Senior Constable Long. The Inquest held on 14 and 15 March 2013. Senior Constable Blair appeared to assist the Coroner. Family and friends were in attendance. There was no appearance by any other interested party. Evidence was heard from the following witnesses:

Cindy Pascoe	Daughter
Emmet Scherger	Son
Dr Suleiman Halabi	Emergency Ward Registrar (5 Sept)
Dr Mark Wadsworth	Emergency Ward Consultant (5 Sept, AM)
Dr Robin Endersbee	Emergency Ward Consultant (5 Sept, PM)
Dr Mirabel McConchie	CATT, MHS (5 Sept)
Dr Pawan Singla	Consultant Psychiatrist (July & 5 Sept)
Dr Alexander Caratsanis	Clinical Director, MHS (as at the date of death)

THE CORONIAL PROCESS

14. The Coroner investigating a death must find, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred (s.67 *Coroners' Act 2008*). The aim of the Coronial process is not to find blame, guilt or negligence.

15. A Coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice (s.67(3)). A Coroner may report to the Attorney-General on a death and may make recommendations to any Minister, public statutory authority or entity including recommendations relating to public health and safety or the administration of justice (s.72). If a public statutory authority or entity receives recommendations made by a Coroner then that body must provide a written response, not later than 3 months after the date of receipt of the recommendations (s.72).

16. In identifying the circumstances in which the death occurred and in making comments and recommendations it is necessary to examine systems and the actions of individuals within those systems. This can be confronting for those involved in the care of a patient who subsequently dies. In this case this includes those working in the uncertain and stressful environments of the Emergency Medicine Department and the Area Mental Health Service of a regional hospital. It is only through examining individual's actions within systems and the operation of systems as a whole that the we can reflect on what happened with Faye, learn from this, improve individual and system responses and, if possible, find ways to prevent future deaths.

THE CIRCUMSTANCES IN WHICH FAYE DIED

Faye's mental ill health

17. Faye was diagnosed as suffering from an adjustment disorder (a temporary reaction to a significant life stressor).[1] A person with an adjustment disorder may experience symptoms of anxiety, depression and agitation. Usually these symptoms will resolve in up to six months. If they do not resolve the person may have developed another mental health disorder such as depression.[2]

18. Treatment for an adjustment disorder may involve problem solving around the stressor. In the case of marital problems a referral for relationship counselling may be appropriate. Individual psychotherapy may also be helpful. Medication may be prescribed but not usually in the first instance[3].

July 2011 suicide attempt

19. On Monday 25 July Anthony left the family home to go to a motel. Cindy arranged to have coffee with her mother the next morning but she could not get hold of her mother at that time. Cindy attended at Faye's home and everything was locked. Cindy saw a letter and jewellery on the bench. Cindy got into the house and found her mother on the bed with empty pill bottles and a couple of bottles of wine.

July 2011 assessment and treatment

20. Faye was conveyed to Mildura Base Hospital on 26 July. She was treated and medically cleared on 27 July and then assessed by the CATT, MHS. The MHS formed the view that Faye required admission to the MHS. It was felt that if she didn't agree to this voluntarily she should be admitted involuntarily. Faye was reluctant but Cindy managed to convince Faye to stay voluntarily.[4]

21. Dr Singla, MHS Consultant Psychiatrist, viewed the July suicide attempt as a serious suicide attempt (her clinical presentation was consistent with the taking of a large amount of medication) and noted it was a planned attempt rather than impulsive. He also noted that her daughter Cindy was very concerned and not comfortable with Faye's safety if she was discharged. He noted that Faye was denying that she was suicidal and had no future plans to self-harm. It was his view that the situation was uncertain and as this was Faye's first contact with the MHS it was decided to err on the side of caution and admit her for observations.[5]

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[1] Letter of Dr A Caracatsanis, Clinical Director, MHS, 5 January, 2012
[2] Evidence of Dr Singla, Consultant Psychiatrist
[3] Evidence of Dr Singla, Consultant Psychiatrist
[4] Evidence of Cindy Pascoe
[5] Evidence of Dr Singla, Consultant Psychiatrist

22. Faye remained under the care of the MHS until 31 July. She had supportive counselling sessions by her contact nurse on the ward and arrangements were made for her to have "day leave" away from the hospital with Cindy to see whether she was able to maintain the gains she had made in hospital. As leave went well arrangements were made for her discharge. Discharge arrangements were made for her to have psychological support from the CATT and to have family counselling sessions from appropriate practitioners outside the hospital[6].

Events and treatment post July 2011 discharge

23. On 2 August 2011 Faye's MHS Case Manager contacted Faye and recommended that Faye engage with relationship counselling and contact her GP or MHS Triage if needed in future.[7]

24. On 6 August 2011 Faye attended Tristar Medical Clinic (not her usual GP Dr Douglas Schneider) stating that she was anxious as her husband had left her. Tristar clinic documents note: *"Poor sleep. Early morning wakening. Panic attacks. Normal mood. Low self esteem. Irrational fear. No suicidal thoughts. No substance abuse."*[8] It appears that Faye did not report her overdose or involvement with MHS to the Tristar doctor. She was prescribed Xanax and filled a prescription for 50 tablets that day at the Chemist Warehouse.[9]

25. On 9 August it appears that a community risk assessment was completed by Faye's MHS case manager where her risk was assessed as low.[10] It appears that Faye did not disclose her recent anxiety symptoms necessitating attendance at the Tristar clinic just days before and she did not disclose that she now had access to 50 Xanax tablets. The recommendation was to discharge Faye from community care. An "interagency case summary" was sent to Dr Schneider, Faye's usual General Practitioner Dr Schneider.[11]

26. Despite being encouraged to do so it does not appear that Faye attended any relationship counselling or received any individual psychological counselling in this period.

27. Faye's family continued to be concerned about Faye's mental health and risk of self-harm between July and September. Her physical state declined. She was not eating and lost a lot of weight. She was a "shadow of her former self" and appeared to have "given up".[12]

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[6] Letter of Dr A Caracatsanis, Clinical Director, MHS, 5 January, 2012
[7] MHS notes, Inquest Brief p.368
[8] Tristar notes, Inquest Brief p.571
[9] Chemist Warehouse Prescription History, Inquest Brief p.574
[10] Community risk assessment, Inquest Brief p.370
[11] Interagency Case Summary, Inquest Brief p.374
[12] Evidence of Cindy Pascoe; Evidence of Emmet Scherger

5 September 2012 suicide attempt

28. On 3 September 2011 Anthony informed Faye that the marriage was at an end.

29. On the morning of 5 September 2011 Faye left her handbag, mobile phone, purse, money and legal documents (all items required for day to day living) in a bag on Cindy's doorstep. Faye then drove her vehicle and parked it opposite Anthony's workplace and again took prescription medication, leaving a note. Faye however was found by passersby while still conscious and was conveyed to the Mildura Base Hospital. The note subsequently went missing but the passerby who assisted has stated that the note said "Call Matt Robinvale Police".[13] Matt is Matt Pascoe, Faye's son-in-law and a police officer.

Assessment and treatment on 5 September 2012

30. Ambulance attended the scene. Faye seemed to be asleep but was easily rousable. Ryan Clifford, Ambulance Officer, was told by Faye that she had taken an intentional overdose of prescription medication.[14] Ambulance Officer Kylie Wilson notes that Faye was a "very poor historian in that that she could not state how many tablets she had ingested. What [patient] had taken, as in the type of tablet (Xanax, Panadeine Forte, Temazepam) did not change but the amount of tablets changed (eg. [patient] stated four Xanax, which she then changed to two Xanax, and then back to four Xanax)." It was also noted that there was a bag of medication in the car.[15]

31. Faye was conveyed to the Mildura Base Hospital. Ambulance officers gave a verbal handover to medical staff. It is not clear what information was passed on in this handover.

32. Dr Suleiman Halabi was an intern working at the Emergency Department, Mildura Base Hospital. Dr Halabi interviewed Faye who said that she had taken one benzodiazepine 'to get through the day', drove to her daughter's house to drop something off, drove to her husband's workplace and then taken another sleeping pill. Faye specifically denied suicidal ideation and only admitted to taking two pills. She denied the note had been a suicide note.[16] Dr Halabi was not convinced about Faye's reports to him as to her intent and what medication she had taken noting:

> [Patient] easily rousable but providing poor [history] regaring intention and medication.[17]

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[13] Statement of Michael Pongraz, Inquest Brief p.175
[14] Statement of Ryan Clifford, Inquest Brief p.177
[15] Statement of Kylie Wilson, Inquest Brief p.185
[16] Statement of Dr Halabi, Inquest Brief p.195
[17] Emergency Department Medical Notes, Inquest Brief p.658

and further in the column marked "Medication" Dr Halabi has noted:

> Xanax, Panadeine Forte, ? Temazepam, ? another sedative[18]

33. Despite Faye's denials regarding suicidal intent, Dr Halabi became even more suspicious after speaking with Cindy who told him that Faye had dropped off her personal effects at her house that morning. Dr Halabi recorded in the medical notes:

> On further quesitoning, it is known pt dropped off pesonal effects @ daughters house...in addition to the note, it appears highly suspcious.[19]

34. The Supervising Consultant in the Emergency Department on the morning of 5 September was Dr Wadsworth. Dr Wadsworth was also suspicious of Faye's intentions depsite her denials and ordered a psychiatric review by CATT, MHS. Dr Wadsworth stated:

> Of most concern to me was the unusual behaviour surrounding her presentation. In particular she described having driven to her daughter's house in the early hours of the morning ...in order to drop off her personal belongings 'in case something happened to her'. Again from memory these belongings included her purse and other items that would generally be required for day to day living. When asked directly what made her think something was going to happen to her, she was evasive. She was also unable to explain why she no longer needed her personal items and why she felt compelled to drop them off to her daughter at such an early hour. These aspects made me highly suspicious of strong intent for self harm/suicide and as such we made an early referral to the Mental Health Unit for further assessment.[20]

35. In Dr Wadsworth's opinion, in light of the observable facts and the suspicous answers given by Faye, any denial of suicidal plans should have been taken with a "grain of salt".[21]

36. This is certainly the common sense view of Faye's son Emmet who gave evidence that Faye was making a "very bad attempt" at making out that her actions that morning were not a suicide attempt. He gave evidence that the way his mother was talking at the hospital that morning was "bullshit" and that "any joker could have seen that". Emmet was understandably upset with

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[18] Emergency Department Medical Notes, Inquest Brief p.658
[19] Emergency Department Medical Notes, Inquest Brief p.660
[20] Statement of Dr Wadsworth, Inquest Brief p.192
[21] Evidence of Dr Wadsworth

this situation and was asked to leave the hospital. He didn't have a chance to talk with any doctors.[22]

37. That morning at the hospital Faye had told Cindy that she would "never ever ever go back to Ward 5".[23] Cindy was of the view that because of this Faye had a story for everything. For example in respect of the purse she said she didn't want to drive with money or her personal papers so she left them in her bag on Cindy's front step. In Cindy's view these stories were "just stupid".[24]

38. Dr Wadsworth gave evidence that in his view Faye was at moderate to high risk of self-harm or suicide. Given the level of his concern he was of the view that if Faye had not agreed to remain for the CATT he would have taken steps to admit her as involuntary patient under the *Mental Health Act* so that she would have had to be evaluated by a psychiatrist.[25] He did not consider this necessary as he understood as at the time of going off his shift Dr Wadsworth noted from the Emergency Department Medical Note made by Dr McConchie at 11.20am that it was anticipated that 'admission to ward 5 or other would be required due to the high level of suicide.'[26] It was therefore his expectation that Faye would be admitted to the MHS and he was surprised to hear at a later time that she had not been admitted.[27]

39. Dr Halabi and Dr Wadsworth gave evidence that the referral to the MHS as at 5 September 2011 was made via phone call from the Emergency Department to the Triage of MHS at Mildura Base Hospital. Neither doctor could recall actually making the call. The Screening Register Detail document generated by MHS triage records:

> 9.45 – PC from Dr in ED stating that Evelyn is medically clear and requires [risk assessment]. It was reported that she actually consumed on 2 x Temazepam 10mg, however that she had intent to consume all medication due to note written to family and fact that clt had left all her possessions with her daughter.[28]

40. Faye was assessed at length by CATT clinician, Dr Mirabel McConchie. Dr McConchie is a clinical psychologist with many years experience with CATT.

41. Dr McConchie first attended Faye at 11.20am however Faye was too drowsy to properly engage in an assessment. Dr McConchie spoke to Cindy at this time who told her what had happened previously regarding her father's affair, the July suicide attempt, the text sent by her father on the Saturday just passed ending the relationship, the bag with personal papers that had been left at her front door that morning and the note found in the car. Cindy said that she

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[22] Evidence of Emmet Scherger
[23] Transcript of video interview Cindy Pascoe, Inquest Brief p.102
[24] Evidence of Cindy Pascoe
[25] Evidence of Dr Wadsworth
[26] Statement of Dr Wadsworth, Inquest Brief p.193
[27] Evidence of Dr Wadsworth
[28] Screening Register Detail, Inquest Brief p.362

spoke to Dr McConchie for about ten minutes and "I told her as much as I knew".[29] Dr McConchie does not recall Cindy saying that she wanted her mum to be kept in overnight for safety. It may have been said but she does not recall it being said.

42. Following this consultation Dr McConchie planned as follows:

> CATT to return later this afternoon to complete [risk assessment] (when Ct not so drowsy)
>
> Probable admission to MBH (wd 5 or other if no bed available) due to high level of suicide risk.[30]

43. Dr McConchie gave evidence that at this point an admission was probable and that this opinion was formed mainly after discussing the situation with Faye's daughter Cindy. On the basis of the provisional information at the time she formed the view that Faye was high risk.

44. Dr McConchie then re-attended later in the afternoon and conducted a thorough assessment with Faye over about one and a half hours. Cindy was not present through this interview as she had to collect her children.

45. Dr McConchie noted the following during the assessment: the recent final breakdown of the marriage, the leaving of the handbag with financial affairs at Cindy's home, the leaving of the note and the taking two pills and the finding of a bag of various medication in the car with her. Faye "adamantly denied" to Dr McConchie that her actions that morning had been a suicide attempt. She was noted as "clear, logical, coherent and voiced numerous future plans." She reported "feeling very tired and that she wanted a break from work." She "denied feeling depressed or low, rather reported increasing anxiety" but also "acknowledging feeling low and overwhelmed by her current circumstances.' A risk assessment was completed. Dr McConchie noted that Faye agreed to engage in the treatment process and accepted an appointment to see the Mental Health Services Consultant Psychiatrist the next day.[31]

46. It appears that Dr McConchie formed the view that Faye had only taken two pills and this appears contributed to her conclusion that this was not a serious suicide attempt. It is unclear where this conclusion, that there were only two pills taken, comes from. It appears to have come from Faye's self reporting. While Faye's clinicial presentation was consistent with her not having taken a significant number of pills it is not clear how many she took. She was found with a bag of medication out of their specific packaging so that the number of pills could not be accounted for, she varied in her reports to ambulance officers regarding what types of medication she had taken and how much, Dr Halabi had question marks over what was taken and testing for the range of possible drugs was not undertaken as it was not considered to be necessary for

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[29] Evidence of Cindy Pascoe
[30] Emergency Department Medical Notes, Inquest Brief p.661
[31] Statement of Dr McConchie, Inquest Brief p.197

her medical management. While it is clear that Faye did not take a significant quantity of pills it could not be concluded with confidence that she had only taken two.

47. It appears that Faye indicated to Dr McConchie that she did not have access to prescription medication and that Dr McConchie accepted this.[32] This statement would have to be seriously questioned given the bag of medication that had been found with her on that day, the fact that the medication found was out of its specific packaging and could not all be accounted for, the fact that Faye had had access to significant amounts of medication when she attempted suicide in July and had reported to staff upon admission in July that she had been saving up medication over the last six months.[33]

48. Dr McConchie gave evidence that she did not consider the note found with Faye that day as being a conclusive suicide note. In her statement she provided "...The note simply requested anyone who found her to contact her son in law (a police officer). There was no mention of suicide or intent to suicide or die."[34] It is clear that anyone writing such a note is expecting to be found in an unresponsive state. It is also clear that the person writing this note is aiming that a police officer is contacted rather than another next of kin. When considered in the context of the past suicide attempt and the other features of the morning (such as the dropping off of personal effects) this note should have been considered to be very concerning.

49. Dr McConchie's formulation in relation to this case was written upon her returning to the MHS (probably around 5-5.30pm that day). This contemporaneous note provides:

> 62 yo female [brought in by ambulance] post ingestion of 2-3 x 0.5mg Xanax. **[Client] was possibly in process of suicide attempt but reconsidered this and went to sleep.** She denies any suicidal ideation, event when challenged with **significant** evidence that points toward a planned attempt. She has recently taken a very significant overdose that required hospitalisation, however denies that today was a planned attempt. [Client] has been under increased stress and pressure due to a marriage breakdown. Her husband had left her for another female. The family is a very tight knit group which is both protective for [client] in terms of support, yet it highlights the change in circumstances due to her husband's absence. [Client] has three adult children who are extremely supportive and protective. She works full time as a real estate agent and is highly motivated to achieve this capacity. There is nil family history, not any substance abuse. [emphasis added]

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[32] Statement of Dr McConchie, Inquest Brief p.197
[33] Assessment Details, Inquest Brief p.284
[34] Statement of Dr McConchie, Inquest Brief p.198

50. It is noted that in the statement provided to police assisting signed by Dr McConchie on 23 February 2012 the formulation is reproduced more or less verbatim with two key differences (noted in bold in the above extract). The first bolded sentence – where the possible suicide attempt that was reconsidered is noted – has been deleted from the statement. Secondly the word "significant" has been changed to the word "some" so in her statement to this Inquest that sentence reads "**some** evidence that points toward a planned attempt." When questioned about this during the inquest Dr McConchie did not see this change in word from "significant" to "some" as having any real consequence. I do not find this response to be satisfactory. It is clear that at the time of making the assessment Dr McConchie was of the view that Faye's actions that morning were possibly a suicide attempt that was reconsidered and that there was significant evidence that pointed toward a planned attempt. Dr McConchie's contemporaneous notes are the more accurate assessment.

51. On 5 September Dr McConchie formed the view that an admission to the MHS was not warranted. At 4.30pm she noted:

    a. [Client] denies she was suicidal
    b. Challenged on planned behaviour today and leaving belonging at daughters
    c. [Client] possibly had suicidal ideation however changed her mind
    d. [Client] guarantees safety – will stay [with] daughter Cindy
    e. Discussed [with] on-call psychiatrist Dr Singla
    f. [Appointment] made [with] psychiatrist for 6.9.11 @ 15.30 – [client] agreeable to attend. For CATT follow up at home.[35]

52. When Dr McConchie was asked what had changed between her assessment of the level of risk between 11.20am and 4.30pm she indicated that her assessment of Faye had shifted her view. In particular Faye had very strong plans for the future, she was tired and anxious but knew very well what she was and was not agreeing to.

53. Dr McConchie gave evidence that she formed the view that Faye was not of high risk because of the following key features:
    - she denied ongoing suicidal ideation
    - she was denying what she had done that morning was a suicide attempt
    - she had no plans for further harm.

54. When it was posed to Dr McConchie whether Faye's responses could be considered credible in the face of other doctors suspicions and the known facts, Dr McConchie indicated that she had challenged Faye on these issues and that Faye was cogent and oriented, she was showing insight and judgement and therefore was in her view Faye was competent. While it may have been that Faye was competent this does not mean that her answers were credible for the purposes of relying on them to reduce her risk status.

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[35] Emergency Department Medical Notes, Inquest Brief p.661

55. If Faye's answers regarding ongoing suicidal ideation, denial that the morning's actions was a suicide attempt and the self-reports of having no plans for further harm could not be considered credible then Faye's risk would, on balance, be considered as high rather than moderate.

56. Dr McConchie spoke with the Dr Singla, Consultant Psychiatrist, via telephone following her assessment of Faye. Dr Singla was off-site when this call was made. He did not have any access to any medical notes, CATT risk assessments or notes. He relied upon what was conveyed to him by Dr McConchie over the phone. There are no notes of this conversation made by either Dr McConchie or Dr Singla. Dr McConchie gave evidence that she would have told Dr Singla all the relevant facts.[36] Dr Singla's recollection of what information he was provided by Dr McConchie is not clear. He seems to recall that it was indicated that Faye had only taken only a small amount of medication and that at this stage she was denying suicide, she does not need admission, daughter happy to support her. He was not clear whether he knew about Faye dropping off her personal belongings to her daughters, the note or that she had been found with a much bigger bag of medication with her in the car. He had not been told of Dr Wadsworth's opinion. Dr Singla said that this would have been helpful as he is a well respected doctor. Dr Singla said tha this information could have made a difference to his assessment. Dr Singla noted the MBH Clinician Guide that "great weight" to be given to the views of family. He said he did not recall being told of the views of the family in this instance. He noted that in respect of the first admission in July the daughter's view helped him to make a decision that Faye be admitted. While it is not clear what information Dr Singla had it is clear that he formed the view that this incident was not as serious as the first time and categorised Faye's actions on this occasion as a "cry for help". He concurred with Dr McConchie's recommendation that Faye be discharged with the proposed treatment plan in place.

57. Dr McConchie acknowledged that Faye's passing was a tragic outcome however even with the benefit of hindsight she feels she would not have changed her assessment.

58. Dr McConchie telephoned Cindy. Dr McConchie is of the view that she discussed her assessment with Cindy at this time.[37] Cindy is not so clear about this and feels that he decision was presented to her as something that had already been decided and that she needed to come to the hospital to pick up her mother.[38] Dr McConchie told Cindy that Faye needed to be seen by "Robin". Dr Robin Endersbee was the Emergency Medicine Specialist on duty at that time having taken over from Dr Wadsworth. Dr Wadsworth gave evidence that he would have done a verbal handover to Dr Endersbee as is the usual practice at the end of a shift. Neither Dr Wadsworth or Dr Endersbee specifically recall what information was passed on during this verbal handover. In particular it is not clear whether Dr Wadsworth passed on his

[36] Evidence of Dr McConchie
[37] Evidence of Dr McConchie
[38] Evidence of Cindy Pascoe

strong suspicions about Faye's stated answers to Dr Endersbee. As noted above Dr Halabi's suspicions were certainly noted in the Emergency Department Medical Notes that would have been available for Dr Endersbee.

59. In any event Dr Endersbee also identified Faye's evasiveness:

> She had been observed in the Emergency Department and seen and assessed as safe for discharge by the CATT. I then attend Evelyn Scherger in the presence of her daughter. I found her [ES] alert and able to give a reasonable account of herself. She was a little withdrawn and evasive or tangential when pressed on specifics in the history but was not demonstrating current suicidal intent or preparedness, nor certifiable psychiatric illness.[39]

60. Dr Endersbee expressed his concerns to Faye's daughter Cindy. Cindy recalls that upon returning to the hospital Dr Endersbee took her aside and said:

> ...you know, how she's putting up a wall of words, you know ...how people who sometimes talk about killing themselves, but have no intentions of doing it, whereas she was putting up a wall of words and saying that she's not, which was a bit concerning.[40]

61. At some point during the day Cindy had a conversation with Dr Endersbee that he would have to admit Faye involuntarily as she would not stay voluntarily.[41]

62. Dr Endersbee gave evidence that in his view Faye presented as a case of someone who may complete a suicide.[42] When asked what could have been done about this Dr Endersbee discussed at length his own research into this question following the suicide death of a close member of his own family. He indicated that in his view there is a "socially negotiated system" to try to deal with suicide risk which may include hospitalisation, psychotherapy etc but the outcomes are questionable. He concluded that there does not seem to be something that "turns the risk off". This view is consistent with Dr Endersbee's conversation with Cindy to the effect that "...ultimately, if someone's going to do it, they're going to do it...".[43]

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[39] Statement of Dr Endersbee, Inquest Brief p.194
[40] Transcript of interview, Cindy Pascoe, Inquest Brief p.105
[41] Evidence of Cindy Pascoe
[42] Evidence of Dr Endersbee
[43] Transcript of interview, Cindy Pascoe, Inquest Brief p.105/6

63. When Dr Wadsworth's view (that Faye should be admitted) was put to Dr Endersbee he could see why Dr Wadsworth would form this view. He could see how she would be regarded as a risk of suicide. Dr Endersbee notes on the Emergency Department Medical Notes support his concerns. Under "Discharge Diagnosis" he noted:

> Overdose benzo suicidal ideation[44]

And further:

> Substantial stress unresolved. Suicidal ideation. Seen by CATT, home [with] family, [psychiatric] review...[45]

64. In evidence before this Inquest Dr Endersbee confirmed that at the time he was worried for Faye and that is why he spent some time with her. He concluded that in hindsight and within the system that currently is in operation Faye probably should not have gone home.[46]

65. Despite all this Dr Endersbee did not seek to override the recommendation to discharge Faye as made by the CATT clinician, Dr McConchie.

66. Dr McConchie gave evidence that she called Cindy and gave her a summary of the assessment and a summary of the plan and she was of the view that Cindy was agreeable to Faye staying with her overnight.[47] On the other hand Cindy felt that the decision to discharge Faye on 5 September was presented to her as the way it was going to be without further consultation. She was surprised that she was released only 12 or so hours after she had been admitted particularly given she had been admitted in July. Both she and Emmet were of the view, and remain of the view, that Faye should have been admitted to the MHS on 5 September.[48]

Discharge arrangements and events post discharge on 5/6 September

67. Cindy gave evidence that she did not at any time indicate to Dr McConchie or anyone else that Faye would be staying with her upon her discharge from hospital on the night of 5 September. Cindy and Dr McConchie had had an earlier discussion that maybe in the longer term Faye could come and live with Cindy's family. In the shorter term however there was simply no room at Cindy's house for Faye to stay.

68. Cindy gave evidence that there was no discussion with Dr McConchie or Dr Endersbee about over night planning. There was no instruction, no advice and definitely no instruction that Faye should not be left alone. Also Cindy did not

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[44] Emergency Department Medical Notes, Inquest Brief p.658
[45] Emergency Department Medical Notes, Inquest Brief p.660
[46] Evidence of Dr Endersbee
[47] Evidence of Dr McConchie
[48] Evidence of Cindy Pascoe and Emmett Scherger

have any information about the appointment that had been arranged for the next day. Dr McConchie seems to recall that she gave a contact card to Cindy but Cindy strongly maintains that she did not get given any contact card by the Dr McConchie or anyone else.

69. Cindy took Faye back to Faye's home where Emmet was staying. Emmet later observed Faye later as being "wasted" and "swaying". He took her to her bed, covered her up and sat with her for some time. He checked her again about 2-3 hours later. She was still sleeping and she looked like she had not moved. Emmet then went out to visit a friend. He did see Faye leave the house.

70. Emmet gave evidence that Faye had been left in his care without any instructions, advice or preparation. It is clear that the family were put in a position of responsibility that they were not adequately prepared for or equipped to deal with. Understandably Emmet continues to be very distressed about this situation.

The events of 6 to 8 September, 2011

71. On 6 September 2011 at approximately 6:45am Faye was found unresponsive seated on the edge of the Mildura Wharf located in Hugh King Drive, Mildura, after a suspected polypharmarcy overdose. Faye was revived by ambulance officer and Faye conveyed to the Mildura Base Hospital for treatment. Her condition did not improve.

72. As a result Faye's worsening condition, she was transferred to the Western Hospital in Footscray, Melbourne arriving at 2:20am on Wednesday the 7th of September 2011. Faye's condition further deteriorated. On Thursday the 8th of September 2011, Faye's life support was terminated and at 5:11pm Faye was pronounced dead.

CONCLUSION

73. In conclusion I find that, Evelyn Faye Scherger, intentionally took her own life by medication overdose on 6 September 2011. This was following discharge from the Mildura Base Hospital on 5 September, 2011 after being assessed as a moderate risk of suicide in circumstances where her risk was, on balance, higher. That upon readmission to Mildura Base Hospital her condition deteriorated and she was transferred to Western General Hospital, Footscray, Melbourne where she was pronounced dead on 8 December 2011. Evelyn Faye Scherger's cause of death was hypoxic brain injury complicating mixed drug toxicity.

COMMENTS

The decision not to admit Faye to the MHS on 5 September 2011

74. Determination of suicide risk and management of such risk is challenging. As Dr McConchie stated in evidence this process is not a precise science. Doctors and clinicians are required to consider a range of factors and to apply their professional judgement. Dr Caracatsanis, then Clinical Director of the MHS, gave evidence that such factors may be static (such past suicide attempt history) and dynamic (such as stated suicidal ideation or plans for the future). Some factors can be identified from independent sources of evidence (such as a documented history of past suicide attempts) whereas other factors rely upon self-reporting (such as future suicidal plans). Risk Assessment forms provide a structure for decision making around risk.

75. In Faye's case there were a range of factors to consider. Some factors pointed to high risk and others ameliorated that risk. The difficulty I have with the assessments made in respect of Faye is that the factors that shifted her from high risk to moderate risk were all factors that relied upon Faye's self-reporting.

76. The people who knew Faye best, her children Cindy and Emmet, were concerned that Faye's answers did not add up. This suspicion was shared by Dr Halabi, Dr Wadsworth and Dr Endersbee. Dr Wadsworth gave evidence that in light of the objective facts he would have treated Faye's answers denying suicide with a "grain of salt". Dr Endersbee said to Cindy that Faye was putting up a "wall of words".

77. When presented with the objective facts and Cindy's concerns in the morning Dr McConchie formed the view that suicide risk was high and flagged "probably admission" to the MHS. By the afternoon however Faye appeared to Dr McConchie as cogent and lucid and after a long assessment in which Dr McConchie challenged Faye's answers, Dr McConchie formed the view that Faye's risk was moderate and that discharge with follow up the next day was appropriate. There is certainly the risk that Faye, a smart and articulate woman who was determined to "never ever ever" be admitted to the MHS, was telling Dr McConchie what was necessary to avoid admission. Dr McConchie does not accept this as she feels she challenged Faye at length. When this scenario was presented to Dr Caracatsanis he opined that the clinician may have placed too much emphasis on the dynamic factors over the known static factors. I am of the view that in the light of objective facts Faye's self-reporting should have been given less weight. If that had been the case it is likely that Faye's suicide risk would have been continued to be considered high and an admission to the MHS would have been warranted.

78. This is consistent with the views of the family, Cindy and Emmet, who felt that Faye was discharged too soon. It is also consistent with the opinion of Dr Wadsworth who gave evidence that if he did not anticipate that Faye was going to be admitted he would have taken steps himself. Dr Singla conceded

that maybe with all the information known it would have been prudent to keep her in emergency until her psychiatric appointment the next day.

79. Given that Faye was unlikely to volunteer admission, Dr McConchie was required to consider whether grounds existed for involuntary admission under the *Mental Health Act*. Dr McConchie remains of the view that the circumstances were such that involuntary admission would not be justifiable. Section 8 of the *Mental Health Act* provides:

> (1) The criteria for the involuntary treatment of a person under this Act are that—
>
> (a) the person appears to be mentally ill; and
>
> (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
>
> (c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
>
> (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
>
> (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

80. It is undisputed that Faye appeared to be mentally ill. It is also uncontroversial that her mental illness (adjustment disorder) required treatment and that that could have been obtained through involuntary treatment. Whether immediate treatment through involuntary admission was necessary may depend on the assessment of risk. The higher the risk the more likely the criteria would be met. If risk is assessed as moderate then the necessary treatment may not involve admission. In such circumstances follow up the next day may be the necessary treatment. The stated willingness of Faye to attend an appointment the next day may have meant that the treatment could have been considered to be able to be delivered in this least restrictive manner. If, however, her suicide risk was high then it is certainly more arguable that admission would be necessary to keep her safe. In these circumstances if Faye refused admission then involuntary admission may be warranted.

81. In the face of Faye's stated willingness to attend an appointment the next day Dr McConchie was faced with a difficult decision. Given her assessment of the suicide risk as moderate it appears that the rigors of the involuntary admission process in the *Mental Health Act* may have led Dr McConchie to

feel that the least restrictive manner of treatment – discharge with a follow up treatment the next day – was appropriate. If the suicide risk assessment had remained that of high risk then the decision may have been easier. The criteria presents a high bar and is required to be applied in circumstances where the patient may not have stabilised and all information may not be known.

82. Suicide risk is difficult to manage. As Cindy Pascoe rightly observed it was not possible to watch her mother "24/7". It is not possible to say whether admission to the MHS on 5 September would have prevented Faye from suiciding in the medium or longer term. It would have however been the safest place for her to be at this critical time, allowed for a full assessment of her situation including further and more detailed meetings with family members, allowed for practical steps to be taken such as a comprehensive search for hoarded medication and the commencement of the psychological intervention she required for her diagnosed mental ill health, adjustment disorder.

Involvement of the Faye's family in the decision to discharge

83. Mental health care at Mildura Base Hospital is guided by the *Clinician's Reference Guide to Mental Health Treatment & Care.*[49]

84. The Guide provides:

> That ***great weight*** is given to information and opinion gained from those who know the consumer well, whether they are family/carers, health professionals, friends or staff.[50]

85. Dr McConchie confirmed that it is her practice to place great weight on the views of family.[51] When Dr McConchie first attended upon Faye in the morning the objective facts coupled with Cindy's concerns led Dr McConchie to the preliminary assessment of high risk and "probable admission".

86. When Dr McConchie met with Faye in the afternoon and when she was considering her recommendation in consultation with Dr Singla, Cindy was not present. Dr McConchie's assessment changed. While Dr McConchie says that she explained her assessment to Cindy over the phone, Cindy felt that the decision to discharge had been made and that she was required to come and collect her mother.

87. In all the circumstances it would have been prudent for Dr McConchie to meet again with Cindy prior to finalising her decision to admit or discharge. Cindy would then have been in a position to reiterate her concerns. She would have

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[49] Version 4 of this document was endorsed on 15 September 2011. Dr Caracatsanis indicated that a version of this document was in operation as at the time of Faye's involvement with the hospital

[50] Clinician's Reference Guide to Mental Health Treatment & Care, p.13

[51] Evidence of Dr McConchie

had an opportunity to explore with Dr McConchie her mother's stated view that she "never ever ever" wanted to be admitted to the MHS and that she may have been saying whatever Dr McConchie needed to hear to avoid this outcome.

Discharge care planning for Faye's family

88. There appears to be a misunderstanding on the part of Dr Endersbee and Dr McConchie that Faye would be staying with Cindy upon discharge. This was clearly never going to be the case due to a lack of room at Cindy and Matt Pascoe's home. Upon the decision being made to discharge Faye there should have been a meeting with all family who would be involved in Faye's care to clarify the care arrangements. Emmet who would be with Faye overnight should have been involved in this process. It appears that Faye may have taken medication after she was returned home (as Emmet reported that she was "wasted"). Emmet could have been clear about what Faye was and was not prescribed and the effects so that he could monitor and report any change. He may also have been warned not to leave Faye alone in the home overnight.

Information flow between CATT Clinician and Consultant Psychiatrist

89. The affirmation of Dr McConchie's decision by the Consultant Psychiatrist Dr Singla was done via a phone conversation. It is usual practice for the Consultant Psyciatrist to be off-site after hours. Decision making around suicide risk requires as much information as is available. This key oversight mechanism should not rely upon verbal relay of information. The Consultant Psychiatrist should have access to Emergency Department Medical Notes, the MHS Triage Screening Register and the CATT Clinicians Risk Assessment and Risk Assessment Report. These documents should be read by the Consultant Psychiatrist prior to the phone call with the Clinician. It is possible for this to be done conveniently off-site with the use of scanned documents sent by email to mobile/tablet technology.

Access to Medication and Medication management

90. On 6 August 2011 while still under the outpatient care of MHS for the July 2011 overdose of prescription medication Faye attended Tristar Medical Clinic (not her usual GP Dr Douglas Schneider) stating that she was anxious as her husband had left her. It is appears that Faye did not report her overdose or involvement with MHS. She was prescribed Xanax and filled a prescription for 50 tablets that day at the Chemist Warehouse. This is of concern. There needs to be investigation about how information regarding medication use and misuse can be shared between the public hospital system and general practitioners in the community.

91. It is also not clear what happened to the bag of medication that Faye entered the hospital with on 5 September. Cindy gave evidence that she saw a bag of about 30 or so loose pills but she had no idea where Faye got them from. Dr Halibi gave evidence that he recalls there was a bag of medication where the medication was not in their packaging. It would have been placed in her

"cubby hole" but he did not know what happened to her medication. Dr Wadsworth could not recall seeing the bag of medication that came is with Faye. Dr Wadsworth said that medication is usually kept with the medical notes in a patient's 'cubby hole' and when patients are discharged their medication is usually given back depending on what was prescribed. There is no system for tracking what, if anything, was given back to Faye upon her discharge. Dr Endersbee had no recollection of what happened to the medication on discharge. Cindy doesn't believe that Faye had the bag when she was discharged but there is no documentation to ascertain what happened in this regard. This is clearly not a satisfactory situation.

RECOMMENDATIONS

Review of Risk Assessment tools

92. Clinicians use a range of tools for assessing suicide risk. It appears that an automated program that generates a "Risk Assessment Report" is a common tool. This tool lists the common risk factors and allows for a risk assessment score. In this case a professional judgement around the credibility of the self-reporting factors was key to the accurate assessment of risk. It is unclear whether the tool allows for a weighting to be given for credibility of answers.

> **Recommendation 1:**
> That the Office of the Chief Psychiatrist, the Minister for Health and/or the Secretary to the Department of Health consider a review of the Risk Assessment tools to prompt clinicians to consider the credibility of answers provided by a patient and to weight these factors accordingly.

Limited detention provision for assessment and planning

93. In circumstances where the risk is uncertain and further assessments and safety planning is required it may be that the strict criteria of s.8 of the *Mental Health Act* may result in clinicians not recommending involuntary admission in circumstances where it may be unsafe to discharge a patient. In the *Inquest into the Death of Bayden Roy Smith*, State Coroner Judge Jennifer Coate raised the need for some form of limited or temporary custody or detention order that would enable a 24 hour crisis mental health assessment with modified entry criteria.[52] I repeat the recommendation made in that finding.

> **Recommendation 2:**
> That the Minister for Health and/or Secretary to the Department of Health consider providing a statutory capacity in the Mental Health Act to enable a limited 24 hour assessment and safety order to enable a

[52] Inquest into the death of Bayden Roy Smith, 3 March 2010 (Court Ref: 3973/06)

more thorough assessment of a person's level of risk of suicide and planning for safe discharge if considered appropriate.

Adequate consideration of the views of family and friends in decision making around suicide risk

94. The *Clinician's Reference Guide to Mental Health Treatment & Care* applicable to the MHS in this case did acknowledge that great weight be given to information and opinion gain from those who know the consumer well. It is important however to ensure that this goal is achieved in practice in the decision making process.

Recommendation 3:
That the Northern Mallee Area Mental Health Service should review and if necessary modify the Guide to ensure that processes are implemented to ensure that the views of family and friends be given great weight prior to decisions being finalised. Such processes may including meeting with relevant family or friends to discuss the preliminary decision prior to a final decision being made to allow for their further feedback.

Adequate discharge care planning involving family and friends

Recommendation 4:
That the Northern Mallee Area Mental Health Service should review and if necessary modify the Guide to ensure documented care planning with family and friends who will be involved in the consumer's care post discharge.

Information flow between CATT Clinician and Consultant Psychiatrist

Recommendation 5:
That the Northern Mallee Area Mental Health Service consider improving documented information available to off-site Consultant Psychiatrists from the CATT Clinicians including relevant medical notes, MHS Screening Register, CATT Clinician Risk Assessment and Assessment Notes via scanning and tablet technology.

Access to Medication and Medication management

Recommendation 6:
That the Minister for Health and/or Secretary to the Department of Health investigate ways to prevent Mental Health Service patients from being prescribed additional medication from general practitioners without notification to the Mental Health Service.

Recommendation 7:
That the Mildura Base Hospital implements a procedure to record the action taken with regard to patient medication upon discharge.

Pauline Spencer
Coroner
Dated: 22 April 2013

DISTRIBUTION AND PUBLICATION DIRECTIONS

I direct that this finding be distributed to the following:

CEO, Mildura Base Hospital
CEO, Western General Hospital
Director, Northern Mallee Mental Health Service
Attorney General
Minister for Health
Secretary, Department of Health
Office of the Chief Psychiatrist
S/C Blair
Det. S/C Long
Cindy Pascoe
Emmet Scherger
Dr Suleiman Halabi
Dr Mark Wadsworth
Dr Pawan Singla
Dr Robin Endersbee
Dr Mirabel McConchie
Dr Alexander Caracatsanis

I further direct that this finding together with the comments, recommendations and distribution list be published on the Coroners' Court's web-site.