IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 003855

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of KATE TAMMA MILLER
without holding an inquest:
find that the identity of the deceased was KATE TAMMA MILLER
born on 16 August 1972, aged 39
and that the death occurred on 11 October 2011
at The Melbourne Clinic, 130 Church Street, Richmond Victoria 3121
from:

1 (a) HANGING.

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Miller was a 39-year-old single woman who was a patient at The Melbourne Clinic (TMC) at the above address. From late 2010 until her death, Ms Miller was under an arrangement of shared care with the Alfred Hospital providing her with elective admission when she was in crisis, and TMC providing her with treatment in the community.

2. Ms Miller had a diagnosis of borderline personality disorder considered severe, and depression with multiple high lethality and impulsive suicide attempts, constant urges to suicide, deliberate self-harm and cutting. She had a five-year history of psychiatric service use and treatment. From 2008 to 2011, she spent extended periods in psychiatric inpatient settings, including numerous inpatient treatments at TMC, with little significant improvement in her mental state over that time.

3. Ms Miller had been in a relationship with Ms Sue Torenbeek from late 1998 to March 2006, and had been in other same sex relationships in the past. She struggled with her family's

refusal to accept her sexuality, and went to great lengths to conceal her relationships from her family. Despite the end of their relationship, Ms Torenbeek continued to support Ms Miller when she discovered the extent of Ms Miller's depression and that she was self-harming.

4. In March 2009, Ms Miller called Ms Torenbeek whilst she was on the Westgate Bridge and told her that she intended to commit suicide. Ms Torenbeek spoke to her over a period of three hours and, with assistance from Ms Miller's psychologist and attending police, she was convinced to leave the bridge, was taken into police custody and conveyed to The Alfred Hospital where she was admitted.

5. After this serious suicide attempt, Ms Miller sought voluntary treatment from TMC, and would admit herself on a regular basis or see her psychiatrist, Dr Rowan McIntosh, if required. By late 2010, the increased frequency of episodes of deliberate self-harming resulted in her being considered no longer manageable at a private psychiatric facility, and she was referred from TMC to public mental health services.

6. In late 2010 a conference with clinicians from Alfred Psychiatry, Spectrum[1] and TMC took place where it was agreed that:
   - crisis intervention had not worked and that the treatment goal for Ms Miller should be crisis prevention;
   - Alfred Psychiatry would offer Ms Miller elective admission to prevent a crisis, and
   - Ms Miller would still receive psychological interventions from TMC in the form of Dialectic Behavioural Therapy (DBT) program and individual therapy.

7. The clinicians met and communicated regularly after this conference to discuss Ms Miller's progress and review her management plan. Dr McIntosh stated that Ms Miller began to have an increasing number of crisis presentations and inpatient treatment periods at the Alfred Hospital, and that there was a coordinated treatment response that involved Dr McIntosh, TMC and the Hospital throughout 2010 and 2011.

8. In August 2011, Ms Miller consumed an overdose of antidepressants and sleeping tablets and cut her wrists, before calling the Crisis Assessment and Treatment (CAT) Team. Ms Miller was located unresponsive in her apartment, was resuscitated and transferred to Intensive Care.

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[1] Spectrum is a statewide service in Victoria that supports and works with local Area Mental Health Services to provide treatment for people with personality disorder.

After this significant overdose, Ms Miller consented to having her brother and parents kept informed of the seriousness of her condition.

9. Ms Miller again presented to the Alfred Hospital Emergency Department on 4 October 2011, after threatening to jump off a bridge. After assessment by the Psychiatric Registrar and Consultant Psychiatrist Dr Jianyi Zhang, Ms Miller was deemed not at immediate risk and was encouraged to return home. Ms Miller attended TMC on the same day, and was admitted following review by Dr McIntosh. She was seen by Dr McIntosh for a routine review on the afternoon of 11 October 2011.

10. On Tuesday 11 October 2011 at approximately 9.00pm, nurse Zena McMahon was performing a room check when she found Ms Miller hanging by a belt tied to a light fitting affixed to a wall. Ms McMahon immediately pressed the emergency alarm and supported Ms Miller's weight until assistance arrived. Nursing staff released the ligature, commenced CPR and called 000. Paramedics arrived and continued CPR, but Ms Miller could not be resuscitated and was pronounced deceased. A suicide note was found by police on Ms Miller's bed.

11. An external examination of Ms Miller's body was performed by Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (VIFM) who reviewed the circumstances as reported by the police to the coroner and post mortem CT scanning of Ms Miller's body, and provided a written report of his findings. In the absence of performing a full autopsy, Dr Lynch attributed death to *hanging*, and noted evidence of a ligature mark around the neck and that post mortem CT scanning was unremarkable.

12. Toxicological analysis revealed the presence of diazepam at ~0.1mg/L and its metabolite nordiazepam at ~0.1mg/L, sertraline at ~0.1mg/L and quetiapine at ~0.01mg/L in blood, consistent with therapeutic administration, and no ethanol (alcohol) or other commonly encountered drugs or poisons.

13. I find that Ms Miller intentionally took her own life, and that the cause of her death is hanging.

COMMENTS

Pursuant to Section 67(3) of the ***Coroners Act 2008***, I make the following comment(s) connected with the death:

1. In light of the circumstances in which she died, I asked a Mental Health Investigator (MHI) from the Coroners Prevention Unit (CPU) to assess the clinical management and care provided to Ms Miller in the period immediately preceding her death. The MHI conducted the review on the basis of the medical records provided by TMC and Alfred Health and the brief of evidence compiled by the police.

2. The MHI advised that due to her mental ill health, Ms Miller was chronically at high risk of self-harm. She was however participating in DBT at TMC and spoke to nursing staff when she was overwhelmed by strong urges to self-harm. On several occasions since her admission on 4 October 2011, Ms Miller had settled and slept after working through her suicidal thoughts by talking with the nursing staff. It would have been difficult for staff to predict that Ms Miller would have hanged herself on 11 October, rather than contacting nursing staff, which had been her practice in the recent past.

3. The MHI also advised that the shared care arrangement arrived at in late 2010 provided overall good clinical management of Ms Miller's serious and difficult circumstances.

4. With respect to the issue of ligature points in mental health inpatient facilities, I recognise that it is necessary to strike a balance between creating a safe environment for patients and avoiding the creation of a prison-like environment.

5. However, I note that in 2012 there were two other hanging deaths at TMC, which suggests that such ligature safety assessments as were conducted at TMC had failed to identify a number of hazards. While the removal of ligature points is unlikely to prevent inpatient deaths altogether, it can reduce the ability of patients to self-harm impulsively, as appears to have occurred in Ms Miller's case.

6. TMC advised that they undertake regular six-monthly ligature audits of inpatient mental health facilities using the Psychiatric Environment Risk Tool (PERT). One such audit was undertaken immediately following Ms Miller's death on 12 October 2011, and all of the light fittings that were the same as the one used by Ms Miller had already been removed.

7. TMC submits that its ligature audit process has developed considerably since the audit undertaken before Ms Miller's death in August 2011, including incorporating a recognition of

the fact that hanging deaths also occur using ligature points below head height, and do not necessarily require full suspension, and that this has added a parameter to its ligature audits.

8. It was suggested to TMC that a best practice audit tool such as the Worcestershire Mental Health Partnership NHS Trust Policy be used for assessing ligature risk. The Clinic submitted that the Worcestershire Policy is not preferable to the PERT, as the PERT is an audit of the many risks within a patient environment including a ligature audit, and that there are aspects of the Worcestershire Policy that may not be suitable for TMC facilities. However, TMC indicated that it could incorporate aspects of the Worcestershire Policy into its audits, for example the ligature point rating that recognises height of the ligature in its risk rating.

RECOMMENDATIONS

Pursuant to Section 72(2) of the ***Coroners Act 2008***, I make the following recommendation(s) connected with the death:

1. That TMC undertake a ligature audit of the wards in which any psychiatric patient is admitted using the PERT amended to incorporate the Ligature Point Rating from the Worcestershire Mental Health Partnership NHS Trust Policy for assessing, addressing and managing ligature risks in inpatient areas, 24-hour off site nursed units and other clinical treatment areas.

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

The family of Ms Miller

Dr Rowan McIntosh, The Melbourne Clinic

Mr Andrew McKenzie, General Manager, The Melbourne Clinic

Dr Jianyi Zhang, Alfred Health

Constable Sachine Jayawickrame, Fitzroy Police Station

Office of the Chief Psychiatrist

Signature:

PARESA ANTONIADIS SPANOS

PARESA ANTONIADIS SPANOS
CORONER
Date: **23 January 2014**

cc: Manager, Coroners Prevention Unit.