IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 002276

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 SUZANNE BERG
without holding an inquest:
find that the identity of the deceased was SUZANNE BERG
born on 4 August 1950
and that the death occurred on a date between 31 January and 25 May 2013
at 41/81-97 Mitcham Road, Donvale, Victoria 3111
from:

I (a) UNASCERTAINED

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

Background and Personal Circumstances

1. Ms Berg was a 62-year old mother of three children; two from a relationship with Peter Lawrance, and her youngest, David Berg, from an unnamed father. Ms Berg's relationship with Mr Lawrance has been characterised as 'violent'[1], and she told friends that he was 'controlling and manipulative'.[2] In 1974, Ms Berg left the relationship after a violent argument, taking the two children with her. In 1976, Ms Berg apparently placed her two older children up for adoption, an action she later attributed to being 'tortured, hypnotised and threatened … by "evil agents"'.[3] Her youngest child, born in 1988, recounted a transient lifestyle during his childhood, with frequent relocations and not being allowed to attend school, due to his mother's paranoid fear that 'something bad was going to happen'.[4]

2. Information from family and friends suggests that Ms Berg exhibited paranoid beliefs and bizarre behaviour from the early 1970s onwards. Reportedly, Ms Berg was guarded in her communications

[1] Coronial Brief of Evidence (Statement of Peter Lawrance).

[2] Coronial Brief of Evidence (Statement of Robert Fensham).

[3] Coronial Brief of Evidence (Statement of Peter Lawrance).

[4] Coronial Brief of Evidence (Statement of David Berg).

with others, was paranoid about her youngest son being taken from her, and had an established pattern of disappearing for days or months at a time if worried or fearful.[5] Despite this, it was not until approximately 1996 that she engaged with mental health services. In August 1998, Ms Berg was involuntarily admitted to Maroondah Hospital due to her significantly impaired mental state. She was diagnosed with paranoid schizophrenia and commenced treatment. Ms Berg's youngest son was removed from her care and for a two-year period was placed in the temporary care of friends. Ms Berg's mental health improved when she was compliant with prescribed medication and her son returned to live with her. However, child protection services remained involved due to concerns about Ms Berg's care of her son.[6]

3. Around 2007, Ms Berg and Mr Berg moved to a unit in Mitcham Road in Donvale. It appears that Mr Berg assumed a carer's role, encouraging his mother to attend medical appointments and comply with medications. Mr Berg described his mother as lethargic, isolative, fearful and noncompliant with treatment. Indeed, by 2010 it appears that Ms Berg's engagement with treatment had declined significantly and her behaviour had become erratic, difficult and violent. Due to her refusal to engage in treatment and challenging behaviour, Mr Berg moved out of the house in October 2010. Although Mr Berg did not disclose his new address to Ms Berg for fear she may harass him there, he continued to visit her twice each week, bringing her groceries and toiletries until her behaviour discouraged him from doing so.[7]

4. Mr Berg last saw his mother in January 2012, when he perceived that she was experiencing a paranoid episode; screaming at him and physically forcing him out of the unit. It does not appear that Mr Berg sought the assistance of any mental health or crisis services at this time, and the two did not communicate for several months thereafter. Late in 2012, Ms Berg reportedly began calling her son repeatedly, sometimes in the 'middle of the night', and when the frequency of her calls increased, Mr Berg asked her to stop. Ms Berg then began sending her son letters via his grandmother.[8]

5. From December 2012, Mr Berg attempted to reconnect with his mother, without success. Her telephone was disconnected and there were no lights on, or response to knocking at the door, when he attended the unit. By April 2013, Ms Berg's mail remained uncollected and the home appeared abandoned and so Mr Berg believed that his mother may have moved. On 25 May 2013, after another visit to Ms Berg's home, Mr Berg reported his mother as a missing person to police.[9]

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[5] Coronial Brief of Evidence (Statements of David Berg, Heather and Alan Holt, Robert and Elizabeth Fensham).

[6] Coronial Brief of Evidence (Statement of Heather Holt).

[7] Coronial Brief of Evidence (Statement of David Berg).

[8] Ibid.

[9] Ibid.

Circumstances Proximate to Death

6. At 4pm on 25 May 2013, police attended Ms Berg's unit to conduct a welfare check. When there was no response to their knocking, police attempted to gain entry by climbing a ladder to the balcony but, upon seeing a leg from the window, contacted the Country Fire Authority for assistance to gain entry. Once inside, police observed that the window and front door were barricaded with furniture.[10] Ms Berg was found lying on a couch and it was clear from the decomposition of her body that she had been deceased for quite some time.[11]

7. It is unclear when Ms Berg's death occurred. Ms Berg's neighbours reported not seeing her for 'several months' and Mr Berg had been unable to contact his mother since December 2012. Police found an opened utility invoice in the unit dated 31 January 2013. A letter addressed to Mr Berg, indicating that Ms Berg was missing her son, was located and while it was dated '24 February' the year was not specified.[12]

8. Senior Forensic Pathologist, Dr Michael Bourke, of the Victorian Institute of Forensic Medicine reviewed the circumstances of Ms Berg's death as reported by police to the Coroner, post-mortem computerised tomography [CT] scans of the whole body and performed an autopsy. Dr Bourke observed that his post-mortem examination was rendered difficult due to decomposition, however, he did not find any evidence of recent injury or natural disease that would have led to death. Toxicological analysis detected sub-therapeutic levels of zuclopenthixol (an antipsychotic), but no other drugs, poisons or alcohol and as such was not contributory to death. Dr Bourke concluded that the cause of Ms Berg's death was unascertained.[13]

Medical and Mental Health Engagement Prior to Death

9. Medicare records and a Pharmaceutical Benefit Scheme [PBS] Patient Summary were obtained for the period 25 May 2009 to 25 May 2013. Both records indicate that Ms Berg did not access any medical treatment through Medicare, or purchase medication through the PBS, after 22 August 2011. It is possible, though unlikely, that Ms Berg accessed treatment privately.

10. Medicare records indicate that Ms Berg attended three general practitioners [GPs], two pathologists and two optometrists in the last five years of her life, but that she did not access specialist mental health providers, such as psychiatrists or psychologists, through Medicare. PBS records indicate that Ms Berg purchased medications for diabetes (glimepiride androsiglitazone maleate/rosiglitazone), thyroid hormone deficiency (thyroxine sodium), medication for tremors (benztropine mesylate) and an antipsychotic medication (zuclopenthixol decanoate) during the same period.

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[10] Coronial Brief of Evidence (Statement of Leading Senior Constable Peter Bennett).

[11] Coronial Brief of Evidence (Statement of First Constable John Logan).

[12] Coronial Brief of Evidence.

[13] Medical Examination Report of Dr Michael Bourke dated 18 June 2013.

11. Ms Berg was not a client of a mental health service at the time of her death but had previously received community case management and crisis care from Eastern Health Mental Health [EHMH]. EHMH briefly, and most recently, provided services to Ms Berg in December 2010 and April 2011, and on both occasions the contact was limited to brief assessments and no ongoing treatment.

12. On 4 December 2010, Ms Berg was assessed by Eastern Health Crisis Assessment and Treatment Team [CATT] having apparently been contacted by Mr Berg.[14] Medical records document an assessment of Ms Berg's mental state which included reference to symptoms of paranoia, guarded responses to questions, poor judgement and no insight into her mental illness. CATT determined that there were no grounds for involuntary treatment because Ms Berg reported compliance with medication and engagement with her GP. She declined a voluntary psychiatric admission and any further CATT involvement. CATT recommended that Ms Berg's antipsychotic dosage be increased and that a further CATT review occur if she refused. This recommendation was communicated to Dr Elaine Coulter, Ms Berg's GP at Mooroolbark Family Health Clinic [MFHC] and MFHC records reflect that Ms Berg reluctantly agreed to a medication increase on 17 December 2010.[15]

13. Ms Berg's next contact with Eastern Health occurred on 6 April 2011, when Dr Coulter contacted the Mental Health Triage Service [Triage] concerned that Ms Berg had cancelled three appointments in a row and had not had antipsychotic medication since 9 February 2011. Dr Coulter's notes indicate that Ms Berg's 'case worker' was contacted, suggesting that the GP may have believed that Eastern Health had a greater level of involvement with her patient's ongoing care than it did.[16] Eastern Health's records indicate more information was required for clinicians to evaluate Ms Berg's mental state and level of risk and so the agreed plan was for a practice nurse at MFHC would follow-up with Ms Berg the next day to review her mental state and contact Eastern Health if its further involvement was required. On 7 April 2013, the MFHC nurse contacted Ms Berg and scheduled an appointment on 13 April 2013, emphasising that if she did not attend Ms Berg would be referred to Eastern Health.[17]

14. Ms Berg was a patient of MFHC between October 1999 and August 2011, principally under the care of Dr Coulter. Ms Berg's attendance for fortnightly antipsychotic injections administered by the practice nurse was erratic. Throughout 2010, Ms Berg's engagement with her GP was infrequent and she missed multiple appointments. She attended for her antipsychotic injection twice in January, and once in each of May, July and October 2010. In October 2010 Ms Berg told her GP that she was looking for another general practice and that she would call if she needed another appointment. She re-attended once in November 2010, again on 3 December and, after her CATT assessment, on 17 December 2010

[14] Coronial Brief of Evidence (Statement of David Berg).

[15] Medical Records, Mooroolbark Family Health Clinic, assessment by Eastern Health Mental Health dated 4 December 2010.

[16] Statement of Dr Elaine Coulter dated 14 December 2014.

[17] Medical Records, Mooroolbark Family Health Clinic.

and 12 January 2011 for antipsychotic injections. Ms Berg attended a further appointment on 9 February 2011 for a blood test but there is no documentation indicating that her antipsychotic was administered on that date.[18]

15. On 6 April 2011, Ms Berg telephoned MFHC to cancel her third appointment in a row with her GP, prompting contact with Triage. The practice nurse spoke to Ms Berg the next day and an appointment was scheduled for the following week. She attended the 13 April 2011 appointment with Dr Coulter for administration of her antipsychotic medication and a glucose review, reporting that she had been well. Dr Coulter noted no concerns about Ms Berg's mental state and that she was living alone and managing her diet. Similar notes about Ms Berg's wellness were made following her attendances on 18 May and 22 August 2011. On 12 September 2011, Ms Berg telephoned to cancel an appointment and did not attend the rescheduled appointment on 19 September 2011.[19]

16. In letters dated 21 May and 14 December 2014, Dr Coulter stated her belief that Ms Berg had moved to Doncaster (she had not) and that Ms Berg had reported difficulty in continuing to attend MFHC. The GP also indicated that the telephone number MFHC had for Ms Berg was incorrect.[20] It is unclear whether these incorrect contact details were a result of misunderstanding, or if Ms Berg purposely misled Dr Coulter, the latter being a possibility given Ms Berg's history of paranoia and unwillingness to engage in treatment. Dr Coulter acknowledged that it was incumbent upon GPs to follow-up patients where there is concern about the patient's ability to make decisions is impaired or where other clinical concerns exist. This is a clinical judgment, made case-by-case, and one Dr Coulter indicated she would make on the basis of the patient's history and clinical presentation. Dr Coulter had noted no concerns about Ms Berg's mental state or physical health when she last attended MFHC and so, in light of all the circumstances, no follow-up was initiated when Ms Berg failed to attend on 19 September 2011.[21]

17. In documents dated 10 February and 8 September 2014, Ms Berg's former partner, Mr Lawrance, outlined concerns about the clinical management and care provided to Ms Berg by her general practitioner and mental health services prior to her death. In light of these concerns, I asked the Coroners Prevention Unit [CPU][22] to review Ms Berg's medical records, the coronial brief of evidence prepared by Leading Senior Constable Bennet of Doncaster Police, and provide advice about the adequacy of the care Ms Berg received

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[18] Medical Records maintained at Mooroolbark Family Health Clinic.

[19] Ibid.

[20] Correspondence from Dr Elaine Coulter dated 21May 2014 and 14 December 2014.

[21] Ibid. I note that Dr Coulter reported that in 2011 MFHC had no formal procedures to facilitate patient follow up but that by 2014 a procedure has been developed to assist assertive patient follow-up.

[22] The Coroners Prevention Unit was established in 2008 to assist coronial investigations and the formulation of coronial recommendations and comments aimed at prevention. The CPU is staffed by independent, highly skilled and experienced clinical medical, mental health and allied health care professionals.

18. The CPU advised:

a. The ease with which Ms Berg disengaged from treatment providers is concerning given that she was chronically unwell, with medication-controlled type 2 diabetes, hypothyroidism and a significant mental health disorder, schizophrenia. Given her minimal insight into her mental illness, in combination with symptoms of paranoia and her social isolation, the chance that Ms Berg would re-engage with treatment providers when she was becoming unwell was significantly reduced. Indeed, it appears that Ms Berg experienced positive symptoms of schizophrenia, barricaded herself in her home and died there, without the awareness of anyone.

b. Eastern Health mental health service involvement with Ms Berg was limited, referring responsibility for ongoing treatment to her GP. The risk assessments conducted by EHMH were appropriate and the decisions made were justifiable. Ms Berg was not willing to voluntarily engage with mental health services, therefore, any treatment would have had to be provided involuntarily under the provisions of the *Mental Health Act* 1986. After each review, Ms Berg would express her willingness to engage with her GP, and temporarily engage with her GP to prevent further mental health service involvement. By voluntarily engaging in some form of treatment, Ms Berg made herself ineligible for involuntary treatment.

c. Unfortunately, due to Ms Berg's social isolation, there was no opportunity for treatment providers to obtain collateral information about her wellbeing: they were reliant on Ms Berg's self-report. Ms Berg was motivated to present herself as well, and as compliant with treatment, because she did not want to engage with mental health services.

d. The treatment provided by Ms Berg's GP was appropriate. Dr Coulter and the practice nurse attempted to engage Ms Berg in treatment, and monitored her mental and physical health when she attended appointments. Dr Coulter demonstrated her willingness to contact mental health services when she had concerns for Ms Berg's attendance in the past, but the result of that contact was for Ms Berg to remain under Dr Coulter's care.

e. Ms Berg's mental state was stable during clinical review in April 2011, and the practice nurse noted that she was well in August 2011. MFHC clinicians were aware of Ms Berg's established pattern of disengaging from treatment and re-engaging several months later, and also, that she had expressed an intention to find another GP. In these circumstances, Dr Coulter's clinical judgement that there were no immediate grounds for concern about Ms Berg's wellbeing was reasonable and clearly informed her decision not to initiate proactive follow-up after Ms Berg disengaged in September 2011.

f. Although the time lapse between Ms Berg's disengagement from any form of treatment in September 2011 and her death in early 2013 makes it difficult to draw any causal

connections, this case does highlight the need for appropriate assertive follow-up of mental health patients who are accessing voluntary treatment and medication management through a general practitioner.

g. Despite "psychological" matters accounting for nearly 10% of all general practice consultations,[23] the Royal Australasian College of General Practitioners [RACGP] 'does not provide any guidelines or policies directly related to patient follow-up in circumstances where a patient is voluntarily engaging in treatment for mental health issues (medication management) and disengages without notice'.[24] RACGP continuity of care guidelines – focusing on risk management, the likelihood and seriousness of harm if follow-up does not occur – exist for other aspects of general practice, like follow-up on tests and results. The frequency with which GPs manage mental health issues suggests that they should have guidance on treatment and follow-up practice specific to this context.

19. I find that Suzanne Berg died on a date between 31 January and 25 May 2013 at 41/81-97 Mitcham Road in Donvale and that the cause of her death is unascertained. The fact that she had barricaded herself in her house suggests that she may have been experiencing symptoms of her mental illness in the period immediately preceding death. The evidence does not support a finding that there was any want of clinical management or car on the part of Dr Coulter or the staff of Eastern Health, that caused or contributed to her death.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act* 2008, I make the following recommendation:

1. That the Royal Australasian College of General Practitioners consider including in its *Standards for General Practices*, a section providing guidance to general practitioners about continuity of care and patient follow-up specific to patients with mental health issues who are prescribed and receiving regular psychoactive medications.

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

David Berg

Peter Lawrance

[23] Data from the Bettering the Evaluation and Care of Health [BEACH] Program for the period April 2010 to March 2011, see http://sydney.edu.au/medicine/fmrc/beach/indes.php

[24] Correspondence from the Royal Australasian College of General Practitioners dated 13 January 2015.

Dr Coulter, Mooroolbark Family Health Clinic

Eastern Health

Royal Australasian College of General Practitioners

Chief Psychiatrist

L/S/C Peter Bennett, Doncaster Police Station

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **31 May 2015**

Cc: Manager, Coroners Prevention Unit