IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 877

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of TAMARA ANN BURT

Delivered On:	11 November 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street SOUTHBANK VIC 3006
Hearing Dates:	18-19 August 2014
Findings of:	CORONER JACQUI HAWKINS
Representation:	Ms D Foy of counsel for Eastern Health Mr F Scully of counsel for ARAFEMI / MIND Australia
Police Coronial Support Unit	Leading Senior Constable K Ramsey appeared to assist the Coroner.

I, Jacqui Hawkins, Coroner, having conducted an inquest into the death of TAMARA ANN BURT

on 18 and 19 August 2014

at Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006

find that the identity of the deceased was TAMARA ANN BURT

born on 3 September 1978

and the death occurred on 7 March 2011

at 11a Woodhouse Grove, Box Hill North, Victoria, 3129

from:

1 (a) ALCOHOLIC KETOACIDOSIS

in the following circumstances:

1. Tamara Burt was 32 years old at the time of her death. She was born in South Africa and moved to Australia when she was 4 years old with her parents Chris and Kathy and brother Tim.
2. Tamara went to MacRobertson Girls School as a teenager and later attended Melbourne University where she completed a Bachelor of Arts degree in English and History with Honours.
3. Tamara was considered by many as friendly, articulate, well-educated, assertive, intelligent and someone who had a passion for justice.
4. Tamara began suffering from alcohol related issues in her teens which continued into her university years and the early stages of her career. After university, she obtained employment with a series of jobs however they all seemed to end due to behaviour associated with her overuse of alcohol. She attended and received counselling from numerous different agencies and counsellors over the years, however her pattern of behaviour when not coping with life's stressors seemed to regularly repeat.
5. Tamara eventually consulted a psychiatrist who diagnosed her as having bipolar affective disorder and alcohol abuse.
6. Tamara had a history of accommodation instability, interpersonal difficulties and erratic compliance with medications which was predominantly contributed to by her alcohol abuse.
7. Since 1998 Tamara had multiple presentations to the Box Hill Hospital Emergency Department. These presentations usually occurred in the context of having self-inflicted injuries or deliberate self-harm ideation, overdoses of prescription medication and alcohol intoxication.

8. In 2008 she attended Windana Drug and Alcohol Recovery Program where she stayed for three months and was reportedly improving until she was asked to leave following an incident[1].

9. On 18 March 2009, Tamara was admitted to a psychiatric unit, Upton House after an attempt to take her own life while intoxicated. Tamara was discharged on a Community Treatment Order (CTO) under the *Mental Health Act* 1986 (Vic) (Mental Health Act)[2].

10. In 2009 Tamara had seven admissions to Upton House and one to Maroondah Hospital. She was eventually admitted to the Canterbury Road Continuing Care Unit (CCU)[3] and entered into a rehabilitation program in October of that year.

11. Whilst at the CCU Tamara functioned well and seemed to respond effectively to the structured rehabilitation environment. With adequate support and prompting, she appeared to take her medication and made functional gains. In particular, her relationship with her family improved and her parents would often see her on weekends.

12. However, CCUs are not intended as a permanent placement and Tamara eventually had to transition into independent living. When it came time for her discharge, Tamara was offered several accommodation options and ultimately accepted a place in a supported share house managed by the Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI). ARAFEMI provide low level home based outreach support to people living with psychiatric illness. The ARAFEMI house was located at 11A Woodhouse Grove, Box Hill North (Woodhouse Grove).

13. Tamara shared this house with two other residents, Fiona Hopper and Tina Moorthy. According to Ms Hopper, initially Tamara seemed intelligent, friendly and sophisticated and they were happy to have her as a co-resident however after a short time she began to isolate herself in her room.

14. On 28 October 2010, Tamara experienced a mental health crisis and requested her co-residents to call the Crisis Assessment and Treatment Team (CAT team) however Ms Moorthy instead drove her to Box Hill Hospital Emergency Department where Tamara was re-admitted to Upton House.

15. On 8 November 2010, Tamara returned to Woodhouse Grove with a transition plan which involved attending CCU two nights a week and other structured support, including receiving a call from CCU every night to prompt her to take her medication.

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[1] The nature of this incident was not examined as part of this Inquest

[2] I note that as of the date of this Finding the Mental Health Act 1986 (Vic) has been repealed. A reference to the Mental Health Act in this Finding is a reference to the Act in place at the time of Tamara's death.

[3] Community care units provide medium to long-term accommodation, clinical care and rehabilitation services for people with serious mental illness and psycho-social disability. Located in residential areas, they provide a 'home like' environment where people can learn or re-learn everyday skills necessary for successful community living. While it is envisaged that people will move through these units to other community residential options, some consumers required this level of support for a number of years.

16. On 16 November 2010, Tamara's co-residents complained of a malodorous smell emanating from her room which was associated with Tamara's dual incontinence. She was once again admitted to Upton House and returned to CCU.

17. Tamara was referred to the Box Hill Mobile Support Treatment Service (MSTS) in December 2010 from the CCU. She was formally discharged on 23 December 2010 with case management and support provided by: Daniel Nicholson, MSTS Nurse; Danielle Hose, ARAFEMI outreach worker; and Daryl Ribaux, Eastern Drug and Alcohol Service (EDAS) worker. Tamara was also required to see Psychiatrist Dr Jaideep Thoduguli who was employed by the Eastern Health Adult Mental Health Program at Box Hill MSTS.

18. Over the December holiday period Tamara went to New Zealand with her parents and, according to them, controlled her alcohol intake and appeared well. She then returned to Woodhouse Grove.

19. Throughout January and February 2011 Tamara's behaviour worsened and had a negative impact on Ms Hopper and Ms Moorthy.

20. On 20 January 2011, Mr Nicholson completed a risk review which highlighted an escalation in behaviour due to increased stressors, alcohol use and a risk of unintentional harm to herself. He arranged a medical appointment for the following day.

21. On 21 January 2011, Tamara did not attend her medical appointment and a decision was made by Mr Nicholson not to assertively chase her regarding follow up of her non-attendance because it would set an inappropriate and unsustainable precedent.

22. On 24 January 2011, Mr Maxwell replaced Ms Hose as the new ARAFEMI worker and had a meeting with the co-residents who advised they were very unhappy living with Tamara. A meeting was held at Woodhouse Grove three days later with the tenants and Tamara. The co-tenants outlined their concerns and the impact Tamara was having on their everyday lives. Consequently, Tamara requested a two week probationary period.

23. On 9 February 2011, Ms Hopper and Ms Moorthy again expressed concerns to Mr Maxwell about Tamara. Mr Maxwell served a breach notice under the *Residential Tenancies Act* 1997 (Vic) (Residential Tenancies Act) on Tamara later that day, as a first warning that she had breached the Act by misuse of the premises, including not keeping the premises clean and affecting the amenity of her co-tenants. Mr Maxwell believed that Tamara clearly wanted to stay in the house.

24. On 10 February 2011, Tamara was taken by ambulance to Box Hill Hospital and re-admitted to Upton House in an alcohol affected condition.

25. On 14 February 2011, Tamara was given a letter which detailed the difficulties with the other co-residents and that ARAFEMI considered that the house was becoming unworkable. Tamara was requested to leave the house, with ARAFEMI offering full support and assistance to find suitable accommodation.

26. On 23 February 2011 Mr Nicholson sent an email to all appropriate services reinforcing the plan regarding communication and roles and responsibilities of each service.

27. On 24 February 2011 Mr Nicholson spoke to Tamara on the phone. She reported being well and having no major concerns. Further he said she reported attending all appointments and being compliant with medications. He also completed a final draft of Tamara's management plan, following further discussions with Dr Thoduguli.

28. On 28 February 2011 Ms Hopper called Mr Maxwell and informed him that Tamara had been isolating herself in her room and that there was a smell of urine coming from inside. Mr Maxwell visited and noticed she was alcohol affected and suggested she should stop drinking and 'sleep it off'.

29. On 1 March 2011, Mr Maxwell met with Tamara at Box Hill Central. He stated she presented very well and on this occasion was positive about the future.

30. On the same day, Tamara attended her scheduled case management meeting with Mr Nicholson. He said she reported poor sleep cycles in the last few days, admitted she had not been using her prescribed sleeping tablets, however insisted she was compliant with her other medication. She initially denied alcohol use but then admitted she had been drinking that morning. She reported that she had been discussing crisis issues with Mr Maxwell and Mr Nicholson confirmed she should be having those discussions with him. He confirmed their sessions would focus on reducing stress by allowing Tamara time to vent her anxieties and identify crisis issues, early warning signs and appropriate responses to these. Mr Nicholson assessed her as being slightly dishevelled and smelling strongly of urine and noted that she had some rapid speech. The meeting concluded with her agreeing to a further case management meeting on 3 March and a medical review for 16 March was scheduled. This was Mr Nicholson's last contact with Tamara.

31. On 2 March 2011, Mr Maxwell contacted Mr Nicholson and stated that Tamara had alluded to being in crisis. According to Mr Nicholson, Mr Maxwell did not seem too concerned about this. Mr Nicholson unsuccessfully attempted to call her on her mobile and landline. He spoke to the psychiatric registrar and agreed to place her on triage alert if he had not heard from Tamara by the afternoon; a situation which ultimately eventuated.

32. On 3 March 2011 Tamara did not attend her meeting with MSTS and Mr Nicholson made attempts to contact her, which were to no avail. Mr Maxwell also reported not being able to contact her by phone. Due to other work commitments, Mr Nicholson said he was unable to do a home visit that day but asked Mr Maxwell to contact MSTS if he had any concerns.

33. That same day, Ms Moorthy called Mr Maxwell and said the relationships in the house were becoming increasingly strained. Once again, the co-residents were concerned that Tamara was isolating herself in her room and they did not know what might happen if she needed

help. MSTS strongly advised Ms Hopper and Ms Moorthy, as had ARAFEMI that they were not responsible for Tamara.

34. Mr Maxwell made several calls to Tamara which went unanswered. Mr Maxwell checked with Mr Nicholson as to whether Tamara had kept an appointment with him and was advised she had not. Mr Maxwell then attended the house and knocked on Tamara's bedroom door and she said she did not want to talk. He asked if she was okay and there was no response, so he asked if she would meet the next day and Tamara agreed.

35. On Friday 4 March 2011, Mr Maxwell was with another client until early afternoon, after which he attempted to call Tamara but there was no answer.

36. Ms Hopper called Mr Maxwell on Sunday 6 March 2011 and left a message advising that she was very stressed, that the smell of urine was going through the house and that she could not stand living with Tamara much more. Mr Maxwell's phone was out of range for most of the day and he did not get the call until later that evening.

37. Ms Hopper returned home about 8 or 9pm and heard Tamara call out for some yoghurt and water. In response, Ms Hopper told her she was not going to assist her and that she had to come and get it herself. Ms Hopper offered to call someone for her and then left. Ms Hopper considered that she sounded very drunk and was slurring her words.

38. On 7 March 2011, Mr Maxwell called Ms Hopper around 9am and she advised that Tamara had called out on the previous evening from her room and Ms Hopper had not assisted her as advised.

39. Mr Maxwell attended the house at around 10.30am and when there was no answer he called a female colleague, Louise Neumann to attend at the residence. Mr Maxwell entered the room and located Tamara kneeling next to her bed with her head resting on it.

40. An ambulance was called and on arrival confirmed that Tamara was deceased.

41. Victoria Police attended and commenced a coronial investigation. They located three empty Vodka bottles and ten wine cask bladders strewn throughout the bedroom. Also located were the following prescription medications: Seroquel, Sodium-Volproate and Lamotrigine.

JURISDICTION

42. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] Section 67 of the Coroners Act 2008 (Vic) (Coroners Act) provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred, which are sufficiently proximate and causally relevant to the death.[5]

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4 Section 89(4) of the Coroners Act.

5 This is the effect of the authorities, see for example *Harmsworth v The State Coroner* (1989) VR 989; *Clancy v West* (unreported, 17/8/1994, Supreme Court of Victoria, Harper J).

43. It is not the role of the coroner to lay or apportion blame, but to establish facts.[6]

44. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

45. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[7]

CORONIAL INVESTIGATION[8] AND INQUEST

Request for Inquest

46. Ms Hopper wrote to the Court on 30 June 2011 and requested an inquest be held due to concerns she had in relation to Tamara's death.

47. Based on the circumstances of Tamara's death and in light of Ms Hopper's request, a decision was made to conduct an inquest, which was held on 18 and 19 August 2014.

Evidence at the Inquest

48. The following witnesses gave evidence at the Inquest:
    - Mr Chris Burt, Tamara's father;
    - Mr Fiona Hopper, ARAFEMI co-resident;
    - Mr David Maxwell, Outreach Community Support Worker, ARAFEMI;
    - Mr Daniel Nicholson, Registered Psychiatric Nurse, Box Hill MSTS; and
    - Mr Darryl Ribaux, Counsellor, EDAS.

49. Counsel for Eastern Health and MIND Australia provided oral submissions at the conclusion of the Inquest. Mr Burt provided written submissions a few weeks later and Interested parties were given an opportunity to respond. In writing this Finding, I have considered all of the evidence including the oral and written submissions.[9]

Issues investigated

50. Section 67 of the Coroners Act requires me to find:
    a) the identity of the deceased
    b) the cause of death, and
    c) the circumstances in which the death occurred.

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6 *Keown v Kahn* (1999) 1 VR 69.

7 Sections 72(1) and (2) of the Coroners Act.

8 I am grateful for the assistance of the Coroners Prevention Unit (CPU) which strengthened my prevention role throughout the investigation

9 The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not imply that it has not been considered.

51. I now consider the evidence in relation to each of these points in turn.

IDENTITY OF THE DECEASED

52. I find that the identity of Tamara Ann Burt was without dispute and required no additional investigation.[10]

CAUSE OF DEATH

53. On 10 March 2011, Dr Sameera Gunawardena, Medical Practitioner practising in Forensic Medicine and Pathology at the Victorian Institute of Forensic Medicine conducted a post mortem examination. Dr Gunawardena attributed Tamara's death to 1a) ALCOHOLIC KETOACIDOSIS.

54. Ketoacidosis means acidosis accompanied by an accumulation of ketones in the body, resulting from an extensive breakdown of fats because of faulty carbohydrate metabolism. It occurs primarily as a complication of diabetes mellitus and is characterised by a fruity odour of acetone on the breath, mental confusion, dyspnoea, nausea, vomiting, dehydration, weight loss, and, if untreated, coma. Emergency treatment includes the administration of insulin and IV fluids and the evaluation and correction of electrolyte imbalance.[11]

55. Alcoholic Ketoacidosis means the fall in blood PH (acidosis) sometimes seen in alcoholics and is associated with a rise in the levels of serum ketone bodies.[12] Dr Gunawardena commented that Tamara had no previous history of diabetes and no glucose was found in any post-mortem vitreous analysis, therefore a diabetic ketoacidotic state was unlikely. Further, she stated that

> According to forensic literature a high level of beta hydroxybutrate in serum can be an indicator for alcoholic ketoacidosis and this is a known cause for sudden death in individuals with chronic alcohol abuse and fatty liver.[13,14]

56. Toxicological analysis revealed a blood alcohol concentration of 0.13mg/100mL, which is almost three times the legal limit. Any reading at this level can cause depression of the central nervous system.

57. Dr Gunawardena also commented that at autopsy Tamara was found to have recent injuries indicative of superficial blunt trauma to her upper limbs and hip, however, her opinion was that these injuries were not significant enough to have caused or contributed to death.[15]

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10 Statement of Identity completed by David Maxwell dated 7 March 2011.

11 Mosby's Dictionary of Medicine, Nursing and Health Professionals, Elsevier Science, 9th edn, 2013

12 Mosby's Dictionary of Medicine, Nursing and Health Professionals, Elsevier Science, 9th edn, 2013

13 Autopsy Report, p11

14 Hockenhull, J, Dhilio W, Andrews R, & Paterson, S, 2012 "Investigation of markers to indicate and distinguish death dye to alcoholic ketoacidosis, diabetic ketoacidosis and hyperosmolar hyperglycaemic state using post-mortem samples." *Forensic Science International (Online)*, 214(1), 142-147. doi:http://dx.doi.org/10.1016/j.forsciint.2011.07.040

15 Autopsy Report, p10

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

58. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

Issues investigated as part of the Inquest

59. There were a number of complex and interrelated issues surrounding Tamara's death, however for the purpose of this Finding I have considered the following issues:
    - Appropriateness of Tamara's accommodation;
    - Appropriateness of Tamara's mental health care and management;
    - Management of Tamara's alcohol abuse; and
    - Whether there should have been a more coordinated response between the services.

Appropriateness of Tamara's accommodation

60. Due to her alcohol abuse, Tamara had suffered accommodation instability over a number of years, which often caused her emotional stress and in turn caused her to drink.

61. At the time of her death, Tamara was living in supported accommodation with ARAFEMI. Prior to this, she had been living voluntarily in supported accommodation with CCU.

Stability in CCU Accommodation

62. In October 2009, Tamara was offered a place in the CCU which offers high-level care and support for those with mental illness. The aim of her admission was to improve her compliance with psychotropic medications, assist with abstinence from alcohol and support her in improving her problem solving skills, particularly in relation to her future vocational and housing options.[16]

63. Tamara lived at CCU for 13 months prior to her transition to the ARAFEMI accommodation at Woodhouse Grove. The average length of stay at CCU is usually between 6 and 15 months.[17] Evidence was given that there are only 20 beds in the CCU clinic and it is quite a stretched resource.[18] Tamara was also aware there is a maximum stay of two years at CCU.

64. Due to this period of stabilisation and her length of stay it was agreed by the CCU and Tamara that she was ready to live independently in the community. Therefore, in October 2010 Tamara transitioned from CCU to the ARAFEMI accommodation. She was formally discharged from CCU to Woodhouse Grove in December 2010.

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16 Inquest brief, p47,50

17 Transcript of evidence, p14

18 Transcript of evidence, p115

ARAFEMI Accommodation

65. Woodhouse Grove was managed by ARAFEMI which was provided funding to support residents by the Department of Human Services. The Inquest heard that since December 2013, ARAFEMI has been owned and operated by MIND Australia.

66. Tamara's ARAFEMI case manager was originally Danielle Hose, however she left and Mr Maxwell took over her case management. Mr Maxwell described his role as psychosocial rehabilitation. He commented that ARAFEMI did not provide clinical treatment but offered a wide range of support in dealing with the social consequences of mental illness that can range from poor self-esteem, lack of confidence, everyday living skills, daily activities, help with legal issues, referral to other services and support with alcohol and drug issues. The support is usually based on the needs of the individual in the service.[19] ARAFEMI was funded to offer approximately three hours of assistance a week per person.[20]

67. Mr Nicholson was not involved in her placement but based on discussions that he had with CCU considered independent living was appropriate at the time.[21]

Responsibility of Woodhouse Grove residents

68. Woodhouse Grove had two other residents, Ms Hopper and Ms Moorthy, when Tamara moved in.

69. A Draft Management Plan was prepared by Mr Nicholson and emailed to services involved in Tamara's care. Part of the plan discussed what should occur in the event of a crisis. The plan stated:

> Tamara's housemates are not to be made accountable for Tamara's wellbeing and safety. Tamara often abdicates her responsibilities to them when she is intoxicated or stress levels are increased and they are overwhelmed by this. They are NOT to engage with her in any way if they feel uncomfortable with her presentation. If they are concerned re her safety they should call an ambulance.[22]

70. This information was conveyed to the residents however, in practical terms, it is evident they still felt responsible for Tamara.[23] Ms Hopper believed she and Ms Moorthy had been left responsible for Tamara's welfare, and they felt this was completely inappropriate given that they themselves suffered from mental illness and had no duty of care to Tamara other than being her co-tenants.[24] Ms Hopper stated that "simply being told that it wasn't our responsibility didn't actually remove the responsibility from us at all".[25] According to Ms

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19 Transcript of evidence, p43

20 Transcript of evidence, p43

21 Transcript of evidence, p91

22 Transcript of evidence, p28 and Exhibit 5, p3

23 Transcript of evidence, p29

24 Letter from Ms Hopper to the Coroners Court dated 30 June 2011

25 Transcript of evidence, p35, Exhibit 3, Statement of Fiona Hopper dated 25 May 2011 p, 1

Hopper she "didn't want to have the responsibility of deciding whether or not [Tamara] needed an ambulance".[26]

71. According to Mr Maxwell, it was made clear to him and the co-residents that the mental health team was responsible for Tamara when she was in crisis[27] but this meant that they had to recognise when this was the case and no one had informed them of what a "crisis" might look like for Tamara.

72. Ms Hopper stated that Mr Nicholson refused to speak to her and told her that Tamara herself had to call for help.[28] Ms Hopper confirmed that they had a few meetings with Mr Nicholson, ARAFEMI staff and the co-residents and that Mr Nicholson advised them that Tamara was choosing her behaviour and was responsible for the consequences of it. Further, he advised her and Ms Moorthy not to do anything to help her unless they were really worried about her safety and to call an ambulance if they were.[29] She said Mr Nicholson could not do anything for her until she wanted help.[30]

73. Ms Hopper believed that Mr Nicholson had a 'tough love' approach which is something he denied at Inquest.[31]

74. Despite being told they were not responsible for Tamara's welfare, Ms Hopper said "the situation took over our lives".[32]

Extent of knowledge of alcohol abuse

75. Mr Maxwell and the co-residents confirmed they had not been aware of the extent of Tamara's alcohol abuse.[33] Mr Maxwell was aware that it had been under control at CCU. [34] Due to issues of privacy, the co-residents were not aware of her mental health diagnoses nor were they aware the extent of her alcohol abuse. The reality of the situation was that is was distressing for the co-residents to see Tamara so unwell.

76. Ms Moorthy insightfully summed up Tamara's behaviour when she said "the pattern seemed to be that when she returned to Woodhouse Grove after three days of being well she would then just camp out in her room and start drinking alcohol and not come out to go to the toilet or get a drink or [anything]".[35] Prophetically, Ms Hopper commented "it was a fear of ours that she would die in her room".[36]

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26 Transcript of evidence, p29
27 Transcript of evidence, p45
28 Exhibit 3, Statement of Fiona Hopper dated 25 May 2011 p, 1
29 Exhibit 3, Statement of Fiona Hopper dated 25 May 2011 p, 1
30 Exhibit 3, Statement of Fiona Hopper dated 25 May 2011 p, 1
31 Transcript of evidence, p110
32 Transcript of evidence, p33
33 Transcript of evidence, p45
34 Transcript of evidence, p45
35 Inquest brief, p32
36 Exhibit 3, Statement of Fiona Hopper dated 25 May 2011 p, 1

Threat of eviction

77. Tamara's behaviour caused Mr Maxwell to serve a breach notice on her on 9 February 2011.[37] Mr Nicholson made Mr Maxwell aware there was a technicality with the breach notice and ARAFEMI could not force Tamara to leave because she was a tenant under a Residential Tenancies Agreement.[38]

78. Mr Maxwell said the house situation was unworkable, Tamara would be asked to leave and all assistance would be given to her in that process.[39] It was agreed that a formal process of eviction could not be commenced, however ARAFEMI and MSTS would assist Tamara to find alternative accommodation.[40] The evidence is that the uncertainty of her living arrangements was a cause of great unease for Tamara.

Could Tamara have returned to CCU?

79. Ms Hopper said Tamara wanted to stay at CCU[41] however Tamara had indicated that she was told not to contact the CCU which caused her to be very upset.[42] Mr Maxwell's understanding also was that Tamara could not return to CCU, even though Mr Maxwell believed a return to CCU would have been appropriate.

80. In evidence, Mr Nicholson confirmed that there was no plan for Tamara to return to CCU.[43] The reality is that CCU was only ever a transitional arrangement and never a permanent living situation for Tamara.

Alternative accommodation options

81. As the accommodation at Woodhouse Grove was not working and it appeared that returning to CCU was not an option, a discussion occurred at Inquest regarding what other accommodation options were available.

82. Mr Maxwell testified that options were limited but Tamara could have moved into a self-contained unit and lived alone. However, with the benefit of hindsight Mr Maxwell agreed living on her own would not have been appropriate given her personal circumstances and ill health.[44] He said he encouraged Tamara to look at other options but unfortunately, it did not happen. Mr Maxwell stated that he really regretted not assisting her more to find appropriate accommodation. In particular, at the completion of his evidence Mr Maxwell expressed regret for not doing something more on the Friday before her death.

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37 Transcript of evidence, p68
38 Transcript of evidence, p80
39 Transcript of evidence, p72
40 Transcript of evidence, p72
41 Transcript of evidence, p23
42 Transcript of evidence, p23
43 Transcript of evidence, p100
44 Transcript of evidence, p54

83. During the Inquest, counsel representing MIND Australia provided information that they have intermediate residential rehabilitation accommodation which is staffed 24 hours a day and offers a high level of support and monitoring. It is an intermediate housing arrangement somewhere between the structured environment of CCU and more independent living such as Woodhouse Grove. The information provided by MIND Australia is that these places are available now but are limited to 78. Unfortunately, this was not an available option to Tamara at the time.

84. Long-term residential rehabilitation accommodation for alcohol abuse was also considered at Inquest however this would have required Tamara to be willing to do this and the evidence suggests that she would not have been.

85. Another potential option was placement in a Secure Extended Care Unit (SECU) which would have required Tamara to be detained involuntarily.[45] The SECU is intended for individuals detained involuntarily pursuant to the Mental Health Act due to the nature of their illness; typically someone who would have a severe and enduring mental illness such as schizophrenia or extreme variances of bipolar disorder and who required an assertive level of monitoring.[46]

86. This option presented some difficulties for Tamara, not the least of which being that she would have to meet the criteria to be placed on an Involuntary Treatment Order (ITO) and SECU is a limited resource comprising only approximately 5 available places at the Austin Hospital.

Conclusions as to the appropriateness of accommodation for Tamara

87. Initially Tamara was assessed as being ready for independent living. According to Mr Maxwell at times she was settled and functioning well. However, once she started to decompensate and her behaviours started to escalate, it became apparent that Woodhouse Grove was not an appropriate place for her to reside.

88. The house became unworkable and it was clear that the house dynamics with the two other residents was not working. It is also clear that the co-residents unfairly felt a responsibility to look after Tamara and ultimately their actions were guided by the directions of Mr Nicholson, who confirmed that they were not responsible for Tamara's health.

89. Given Tamara's propensity to lock herself in her room and drink alone, living alone was not an appropriate option. It also appears that returning to CCU or being placed in SECU were not viable options either, leaving Tamara feeling insecure and unstable in relation to her future accommodation, which would certainly have added to her stress and anxiety.

90. The intermediate accommodation described by MIND Australia would have greatly benefitted Tamara and would have been a suitable option in terms of assisting her health and her

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45 Transcript of evidence, p115

46 Transcript of evidence, p115

proclivity to abuse alcohol however was not available at the time. Tamara was in dire need of safe and secure accommodation, similar to CCU which offered a higher level of support and structure. Ultimately, the plan for Tamara to live in independent accommodation proved unsuccessful and the uncertainty about her accommodation caused her enormous stress and exacerbated her condition.

91. There was no evidence before me that anyone from ARAFEMI or MSTS made the proposed enquiries for Tamara to move into more appropriate accommodation. I acknowledge that ARAFEMI was responsible for the day-to-day management of the house and accept they had no clinical responsibility for Tamara's health, however I find once it was apparent that the house was not working and Tamara's health was in decline, ARAFEMI should have done more to ensure MSTS assisted Tamara to find more appropriate accommodation.

92. I further find that by mid-February it was apparent that Tamara's transition into independent living was not working and that MSTS should have done more to assist Tamara find appropriate accommodation.

Appropriateness of Tamara's mental health care and management

93. Tamara had been in the care of Eastern Health for a number of years in various modes before she became involved in MSTS. Since January 1998 Tamara had multiple presentations to Box Hill Emergency Department for issues including self inflicted injuries or deliberate self-harm ideation, overdose or prescription medications and alcohol intoxication.[47]

Referral to the Box Hill Mobile Support and Treatment Service

94. As part of her transition from CCU to independent living a referral form was provided to MSTS. The form set out the reasons for the referral including the following summary:

> Tamara has responded well to the structured environment, strengthened her family relationships (whom live in Box Hill) and is increasing her sustainable community contacts in the form of CAE courses, volunteer work and has just been offered a paid monthly advocacy role. She is currently well linked in with her EDAS worker and has a Connect 2 worker, whose support will be independent on how much support she will be offered through ARAFEMI.[48]

95. The referral form also stated:

> Due to Tamara's extensive history of poor coping skills, poor maintenance of relationships with flatmates and friends, relatively new community contacts and weekly routines, decreased support and limitations as set by CCU policies (ie no drinking on site, 24 hour staff contact), she will be at an increased risk of relapse and excessive alcohol use.[49]

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47 Inquest brief, p46

48 Inquest brief, p161

49 Inquest brief, p162

96. Once Tamara was discharged from CCU, the MSTS was responsible for her mental health including crisis presentations and management. The MSTS is governed by a consultant psychiatrist, registrar, team leader, manager, psychiatric nurses, occupational therapists and social workers who all have responsibility for her treatment. Therefore, all major clinical decisions relating to Tamara were made as a team.[50]

97. Mr Daniel Nicholson was Tamara's case manager. His role was to coordinate the support, care and treatment for her clinical needs whilst Tamara transitioned to community living, including medical reviews and day-to-day management.[51]

98. According to Mr Nicholson, Mr Burt provided him with some appropriate strategies to utilise in his interactions with Tamara to facilitate rapport building, such as avoiding 'assertive' approaches and using a 'firm but supportive' approach while reminding her of the consequences of her actions. Mr Burt described Tamara as 'extremely manipulative' and pointed out that he believed it would be 'very difficult' for her drinking habits to be changed. Mr Nicholson reported that Tamara has a history of self-ceasing medications 'for manipulative reasons' and supported his suggestion that MSTS should not supervise her medications to promote independence and self-responsibility.[52]

99. Mr Nicholson's evidence is that he had many conversations over the phone and in person with Tamara. He stated that she was highly intelligent and difficult to manage because she would often not accept what he told her.

Psychiatric condition/ dual diagnosis

100. Tamara had a dual diagnosis of Bipolar Affective Disorder[53] and Alcohol Abuse/Dependence Disorder[54]. Mr Nicholson believed Tamara was exhibiting traits of Borderline Personality Disorder[55] but was awaiting a formal diagnosis of such. In fact, Mr Nicholson had referred the

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50 Transcript of evidence, p94

51 Transcript of evidence, p90

52 Exhibit 8 - Statement of Daniel Nicholson dated 23 March 2011, Inquest brief, p16

53 A disorder characterized by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). International Classification of Disease and Related Health Problems 10th revision, World Health Organisation, 2010, http://apps.who.int/classifications/icd10/browse/2010/en#, retrieved 30 October 2014.

54 A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances. International Classification of Disease and Related Health Problems 10th revision, World Health Organisation, 2010, http://apps.who.int/classifications/icd10/browse/2010/en#, retrieved 30 October 2014.

55 Personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability to outbursts of emotion and an incapacity to control the behavioural explosions. There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored. Two types may be distinguished: the

question of Tamara's behaviour to SPECTRUM[56], a state-wide personality disorder service on 21 January 2011. According to SPECTRUM. "Bipolar disorder is both a co-occurring and overlapping condition with Borderline Personality Disorder. These two conditions share some important features. Both conditions show female preponderance, mood lability, impulsivity, unstable relationship patterns and suicidality."[57] At the meeting on 7 March 2011, SPECTRUM clinician Rada Semec prompted Mr Nicholson to change the language in the draft management plan "given the lack of clear diagnostic picture".[58]

101. The significance of a diagnosis of Borderline Personality Disorder is that the management is very different to Bipolar Affective Disorder. Bipolar Affective Disorder can be treated with medication however, Borderline Personality Disorder requires treatment with behaviour management strategies.[59] Mr Nicholson believed Tamara had a Borderline Personality Disorder and the submissions of Eastern Health suggest "much of the focus of support was directed towards improving [Tamara's] capacity to make autonomous decisions for herself and taking responsibility for her own decisions".[60]

Draft management plan

102. Mr Nicholson was not required to draft a management plan however due to the complexities of Tamara's situation he thought it appropriate.[61] He said management plans are usually drafted on an individual basis taking into the consideration the needs and circumstances of the client. The plan developed for Tamara was not designed to manage day-to-day activities but to manage her transition from more intensive mental health services and to offer support in responding to crisis. [62]

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impulsive type, characterized predominantly by emotional instability and lack of impulse control, and the borderline type, characterized in addition by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts. International Classification of Disease and Related Health Problems 10th revision, World Health Organisation, 2010, http://apps.who.int/classifications/icd10/browse/2010/en#, retrieved 30 October 2014.

56 SPECTRUM is the state-wide personality disorder service for Victoria is a publicly funded specialist mental health service established by Department of Human Services in late 1998. SPECTRUM provides consultation, training, treatment and research in relation to people with severe and borderline personality disorder who are at risk of serious self-harm or suicide. SPECTRUM works closely with area mental health services and clinicians to support their work and develop their skills in providing a more effective response.

57 Beatson, Rao & Watson; *Borderline Personality Disorder: Towards Effective Treatment*, SPECTRUM and Australian Post Graduate Medicine, 2010, p56

58 Exhibit 8 - Statement of Daniel Nicholson dated 23 March 2011, Inquest brief, p25

59 Transcript of evidence, p137-138

60 Eastern Health Submissions dated 31 October 2014, p2

61 Exhibit 5 - Draft Management Plan.

62 Transcript of evidence, p143

103. Mr Nicholson stated that the purpose of the plan was:

> to provide a clear and consistent approach to Tamara's follow-up and support in the community and minimise the risk of Tamara using crisis services inappropriately,.... therefore allowing Tamara to learn the consequences of poor choices and to take responsibility for her behaviours.[63]

104. It was designed to aid many of the services involved in supporting and treating Tamara including triage services, the hospital emergency department, the CAT teams, ambulance and police.[64] Everything in the plan was discussed with her treating clinician.

105. The plan was about promoting independence and control of her decision making and to make her more autonomous.[65] It provides excellent insight into Tamara's personality traits, coping skills and tendency to deflect responsibility and react negatively to life's stressors. Regular planned engagement with services were described, including a weekly meeting with her case manager and monthly medical appointments. It also provided a proposed strategy for when she was in crisis, noting:

> Tamara is to take responsibility for contacting services independently if she feels she is coming into crisis and cannot cope with her emotions. She is not to defer this responsibility to others by asking them to contact services or by being avoidant of others' attempts to engage her in times of crisis/increased stress.[66]

106. The plan was about encouraging Tamara to accept responsibility for seeking support when she felt she needed it. According to Mr Nicholson Tamara was happy with the plan.[67] Mr Nicholson said she was actively encouraged to contact MSTS when there was an escalation in crisis or if she just wanted to have a chat about how she was travelling.

107. Mr Nicholson emailed the plan to various people involved in her care on 19 January 2011 and requested any feedback, comments and recommendations so that it could be further discussed.[68] Mr Maxwell confirmed he received the email and read the plan but did not provide any formal feedback. Mr Ribaux also had no problem with the draft plan.

108. The plan was never formally activated by the services involved in her care and it had not had formal sign off from the consultant psychiatrist; there were outstanding issues that needed to be addressed before sign off including a conversation with Tamara and a review by SPECTRUM and the Dual Diagnosis Service.[69]

109. Due to ongoing and persistent concerns by her co-residents and others involved in supporting Tamara, Mr Nicholson considered that the plan was not working, needed to change and suggested a new strategy was required. He emailed all those involved with her support and treatment on 23 February 2012 with a proposed course of action.[70] He also explained that due

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63 Transcript of evidence, p133 and Exhibit 5 – Draft Management Plan
64 Transcript of evidence, p134
65 Transcript of evidence, p138
66 Exhibit 5 - Draft Management Plan, p3
67 Transcript of evidence, p151
68 Transcript of evidence, p60 and 133
69 Transcript of evidence, p132
70 Exhibit 6 – Email to various people from D Nicholson dated 23 February 2011

to her continued cycle between crisis and her usual pattern of drinking to excess, Tamara had escalated into 'complex care status'. Mr Nicholson also suggested a case conference with all those involved in her care to discuss roles and responsibilities.[71] However, Mr Maxwell thought that a case conference might have been too confrontational for Tamara.[72]

110. Tragically on the day Tamara died, Mr Nicholson was escalating her plan to senior clinicians within the whole of the adult mental health service and SPECTRUM for assessment of a diagnosis of a Borderline Personality Disorder.

Tamara was a complex case

111. Words like "complex" and "challenging" were used by her mental health care worker to describe Tamara. Mr Nicholson stated Tamara's case was probably more complex than many other cases he had due to the different services involved.[73] Mr Nicholson confirmed she "could be difficult to engage at times because she was quite … an assertive personality and if there was maybe a difference of opinions between herself and someone speaking with her, she could be assertive in how she expressed herself".[74]

Evidence of non-compliance with medication

112. The evidence is that Tamara's compliance with medication was inconsistent and often fluctuated.

113. When Tamara was transitioning from CCU, someone from CCU would ring her daily to confirm that she had taken her medication. Once Mr Nicholson became involved with her care, he said Tamara indicated that she felt she could manage her medications independently and she had identified strategies for doing so, one of which was putting reminders in her mobile phone and he believed she was able to do that.[75] According to Mr Nicholson she insisted that she was taking her medication[76] however, Mr Nicholson felt it was difficult to know if she was.

114. On 16 February 2011, Mr Nicholson was advised by Woodhouse Grove Pharmacy that Tamara had not collected her medications since 31 January 2011. However, Mr Nicholson said that he was not worried because she had just been released from Upton House with further medication.[77]

115. Her medical history shows that when she was taking her medications to stabilise her moods, it assisted her to control her anxiety which also helped to control her alcohol abuse. Conversely, when she did not take her medication her mood and subsequent behaviours declined.

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71 Transcript of evidence, p96
72 Transcript of evidence, p66
73 Transcript of evidence, p107
74 Transcript of evidence, p108
75 Transcript of evidence, p92
76 Transcript of evidence, p131
77 Exhibit 8 - Statement of Daniel Nicholson dated 23 March 2011, Inquest brief, p21

Should Tamara have been placed on an Involuntary Treatment Order?

116. Whether Tamara should have been placed on an Involuntary Treatment Order (ITO) formed part of the issues discussed and considered at Inquest. The evidence is that a decision was made by her treating psychiatrist that it was not required.[78]

117. Section 8(1) of the Mental Health Act set out the following five criteria for involuntary treatment:

    a. The person appears to be mentally unwell; and

    b. The person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an ITO; and

    c. Because of the person's mental illness, involuntary treatment of the person is necessary for his or her 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.

118. An answer in the negative to any of the five criteria meant the person could not be detained and treated involuntarily. Mr Nicholson agreed that Tamara met the criteria outlined in sub-sections 8(1)(a)-(c) but not sub-sections (d) and (e) because she was able to consent to treatment and because her treating team felt she was able to receive treatment in a less restrictive manner.[79] Further, section 8(2) of the Mental Health Act offered exclusions from the criteria set out in section 8(1) wherein a person was not to be considered mentally ill by reason only that they consumed drugs or alcohol[80].

119. Based on the criteria set out above Mr Nicholson said it was the opinion of the treating team that they did not feel Tamara could be treated involuntarily.[81]

Impact of an involuntary treatment order on Tamara

120. Mr Nicholson said that Tamara would not have appreciated being treated involuntarily. He said she was assertive, passionate and very clear what her views were on her treatment and what she wanted. Further, he said it would have negatively impacted their working relationship had she been subject to an ITO. He noted "when you remove someone's right to choose and when you remove someone's autonomy, it does put a barrier in terms of effective

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78 Transcript of evidence, p91 and p108
79 Transcript of evidence, p122-125
80 Section 8(2)(k) Mental Health Act
81 Transcript of evidence, p126

communication and working relationship and it can impact on ... your ability to offer that service to the person or their ability to accept it".[82]

121. Mr Nicholson commented that Tamara was a voluntary patient in CCU. He said she was clear she wished to dictate her own activities and did not want to have the routine and structure of CCU. There was a strong desire for Tamara to be in control of her own circumstances.

122. A hospital admission was counter-therapeutic to Tamara, according to Mr Nicholson.[83] He said that it is recognised that when people have emotional dysregulation disorders, it is actually more beneficial for them to be managed in the community than in hospital settings where it can almost reinforce certain negative elements of the condition and associated behaviours and responses. Further, he said it is not practical to work with someone in an inpatient setting when you are trying to build rapport with them.[84]

123. Mr Ribaux also confirmed that in his opinion it was important for Tamara to have voluntary mental health treatment.[85] Mr Ribaux said he knew Tamara did not want involuntary treatment and this was motivation for her to take her medication.[86]

Conclusions as to appropriateness of mental health care and management

124. Eastern Health submitted that no criticism should be directed at Mr Nicholson, Tamara's treating team or Eastern Health, as their care and management was reasonable and appropriate in the circumstances.

125. As Tamara's case manager, Mr Nicholson had regular and weekly contact with her. I also acknowledge Mr Nicholson expressed his condolences to Tamara's family at Inquest and that this may have given them some relief.

126. Mr Nicholson prepared a draft management plan that was thorough, thoughtful and consistent with Tamara's issues. He shared it with her other services and sought feedback. Unfortunately, the plan was only ever in draft form and was awaiting feedback and had not yet been approved or implemented. The plan also had yet to be acknowledged and understood by Tamara.

127. I do acknowledge that when Mr Nicholson recognised the plan was not working, he elevated her management to more senior practitioners, albeit it too late to make any difference.

128. Mr Nicholson believed Tamara had Borderline Personality Disorder, which influenced the plan in accordance with management of that condition, namely that Tamara needed to be treated with behaviour management strategies, however I note that there had never been a formal diagnosis of Borderline Personality Disorder and I query whether her treatment and management should have been designed around a suspicion of a diagnosis that had never been

82 Transcript of evidence, p128-129
83 Transcript of evidence, p137
84 Transcript of evidence, p156
85 Transcript of evidence, p198
86 Transcript of evidence, p198

confirmed. It would appear that medication for her Bipolar Affective Disorder should have been at the forefront of her treatment.

129. It is disappointing and somewhat concerning that Mr Nicholson identified MSTS as the service responsible for responding to all 'crisis' issues in relation to Tamara, yet at Inquest could not identify what constituted a 'crisis' for Tamara, stating that 'it would depend on the circumstances'[87]. The evidence demonstrates that there were patterns of behaviour that could constitute a crisis for Tamara including incontinence, slurred speech, locking herself in her bedroom and not talking to co-residents, however there was not clear guidance around this issue. There was also an expectation that Tamara should recognise when she was in crisis and seek appropriate assistance however this seems an impossible task for someone who has a mental illness and who regularly abuses alcohol.

130. I accept that the treating clinicians considered that Tamara did not meet the criteria for involuntary treatment according to the Mental Health Act and acknowledge that involuntary treatment would probably have been counter-therapeutic to Tamara, as her express wish was to have some control and autonomy over her life and that voluntary treatment was in accordance with her wishes.

131. I also accept that Tamara presented as a challenging and complex client due to her psychiatric ill health, dual diagnosis and alcohol abuse.

132. I find it unfortunate that the escalation in Tamara's behaviour was not actioned sooner. This action may have included bringing more structure or supervision to her medication regime and assistance finding alternative and more supported accommodation. However, I acknowledge that when Tamara presented to Mr Nicholson on the last occasions she indicated that she was taking her medication and was well.

133. It is an unfortunate set of circumstances that Mr Nicholson was not able to follow up the concerns raised by Mr Maxwell on Thursday 3 March 2011 due to being unavailable on Friday 4 March 2011 to attend Tamara's house. However I acknowledge that Mr Nicholson did attend a meeting to escalate her management, on the day she died.

Management of Tamara's alcohol abuse

134. Tamara had been seeing Mr Ribaux, Alcohol and Drug Counsellor for EDAS since June 2009 and had developed an excellent rapport with her. The EDAS treatment model is based upon collaborative client-centred counselling with a focus upon ceasing or reducing harms associated with alcohol and other drug use. [88]

87 Transcript of evidence, p102
88 Exhibit 11 - Statement of Daryl Ribaux dated 3 July 2011, p1

135. Appointments were either weekly or fortnightly depending on Tamara's needs. Her last appointment with Mr Ribaux was 24 February 2011 and her next scheduled appointment was for 8 March 2011, the day after she died.[89]

Tamara's Alcohol abuse

136. Tamara's main abuse of alcohol was through chronic binge drinking. Mr Ribaux testified it was not always a daily problem.[90] He said according to Tamara's self-reporting to him, she used to manage emotional distress by drinking.

137. The evidence shows that Tamara used alcohol to manage her fluctuating mood states, anxiety and stress. When stressed, Mr Ribaux said she would have lots of racing thoughts that would go around and around and when this occurred she always tried to problem solve because she did not like uncertainty.[91]

138. According to Dr Jennifer Babb, Consultant Psychiatrist from the CCU Tamara tended to minimise her impulsivity particularly in respect of her alcohol use. Dr Babb said:

> She appeared to be able to manage her alcohol within a controlled environment and acknowledged the need for structure and routine to assist her in being abstinent from alcohol on discharge from the .. CCU.[92]

139. According to Mr Nicholson, Tamara did often minimise the impact of her drinking and its use and she often claimed that she had not been drinking at times which she later recanted.[93]

140. Mr Nicholson said Tamara tended not to discuss alcohol issues with him but he considered one of the triggers for her alcohol use was when she was not coping with her emotional distress. However, he acknowledged that he would not often know what caused that emotional distress.[94] He also confirmed that MSTS responded to mental health issues, not alcohol intoxication.

Treatment

141. The focus of Mr Ribaux's treatment of Tamara was: the development of strategies to reduce binge drinking and associated harms; management of cravings for alcohol; strategies to manage stress anxiety and low mood associated with alcohol use; encouraging adherence to her psychiatric medication; and developing positive engagement with other treatment providers. [95]

142. Mr Ribaux states that he conducted regular risk assessments and regularly liaised and worked collaboratively with her other services.

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89 Exhibit 11 - Statement of Daryl Ribaux dated 3 July 2011, p1
90 Transcript of evidence, p177
91 Transcript of evidence, p188
92 Inquest brief, p47
93 Transcript of evidence, p147
94 Transcript of evidence, p150
95 Inquest brief, p45

143. Harm minimisation was said to be key to her treatment. Although abstinence is one form of harm minimisation, it is not something they focused on in counselling. Mr Ribaux said as a counsellor you do not have the ability to enforce alcohol related decisions, you are more focused on having conversations with people moving them towards solutions other than alcohol and towards change.[96] Mr Ribaux said that given alcohol was one of her coping mechanisms with life's stressors it was a big thing to ask her to abstain. The goal was to try and encourage her to limit her intake to a safe level.

144. Part of the treatment approach for Tamara, according to Mr Ribaux, was taking responsibility for her own treatment and to increase openness of communications with her treatment providers which would give her more control; which was consistent across their therapeutic relationship.[97] He said the best treatment is when someone realises they have to stop drinking and "if a person is not at that point where they are going to do that, treatment is difficult".[98]

Conclusions about alcohol abuse

145. Despite Mr Ribaux's long-term and ongoing treatment of Tamara, she appeared incapable of abstaining from alcohol and indeed had experienced significant difficulty reducing consumption to a level that was safe. Due to uncertain living arrangements and a decline in her mental health Tamara sought relief from these stressors with alcohol. When Tamara was non-compliant with her medication and had time alone, her ability to control her urge for alcohol was limited if not impossible to control.

146. I acknowledge Mr Ribaux had an excellent relationship with Tamara and had developed a certain level of trust over a period of time. I commend his commitment to consistently treating Tamara and being dedicated to assisting her with her alcohol dependence.

Should there have been a more coordinated response between the services?

147. At the time of Tamara's death there were three separate and distinct services involved in supporting her. ARAFEMI was looking after her day-to-day psycho-social and housing arrangements, MSTS were supporting her mental health care and management and EDAS was providing drug and alcohol counselling. The evidence demonstrates that a draft management plan had been developed by Mr Nicholson and he was consulting with the other organisations.

148. It was also clear that Tamara did not like people and services talking about her. In fact, Mr Maxwell said that Tamara did not want him talking to the other services, including Mr Ribaux.[99] Tamara also did not want Mr Nicholson to know about her alcohol abuse.

149. The draft management plan had tried to provide clarity around the roles and responsibilities of each service. Mr Maxwell was of the opinion that the type of compartmentalisation outlined

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96 Transcript of evidence, p178
97 Transcript of evidence, p198
98 Transcript of evidence, p201
99 Transcript of evidence, p44

in the plan might work conceptually but not in practice.[100] This is because the cycle of issues were all interwoven, her alcohol abuse caused unhappiness and resentment with her co-residents who then wanted her to leave, which caused housing instability, which caused stress, which caused her mental heath to decline which caused her to seek relief in the form of alcohol. This set of circumstances provides a complex and challenging proposition for the support and management provided by each individual service involved in Tamara's care.

150. To assist someone from a structured high-level care situation onto the path of recovery requires a collaborative partnership approach. Her physical and mental health requirements needed to be carefully balanced with her right to self-determination and autonomy. I accept this situation is never easy and a solution is not simple.

151. I consider that the three organisations were making good attempts to work together but despite this Tamara's health declined and the outcome was fatal.

FINDINGS

152. I find that Tamara Burt died on 7 March 2011 from 1a) ALCOHOLIC KETOACIDOSIS.

153. I find that Tamara did not intend to die, rather her death was the ultimate outcome of her ongoing struggle to regulate a barrage of stressors including accommodation instability, the recent decline in her mental health and her strong urge to abuse alcohol and drink to excess.

154. I find that her alcohol dependency and her mental illness made it incredibly difficult for her to manage on her own. I also find that when Tamara was in this vulnerable state she was incapable of helping herself.

155. I acknowledge the difficult position in which the co-residents were placed; not only living with someone with a mental illness and a dependency on alcohol but in some ways, as her quasi-carer. I find it unfortunate that despite being told they were not responsible for Tamara's mental health, they were placed in the difficult position of feeling as through they needed to be, in terms of calling an ambulance and effectively making a judgment about her condition, which they were not equipped to do.

156. I find that the co-residents were concerned about Tamara and acted in accordance with their instructions to leave her alone and make her responsible for herself. It is unfortunate but understandable that this meant Tamara did not receive the urgent medical response required to save her life on this occasion.

157. I find based upon all of the available evidence that Tamara functioned well with structure and higher levels of medical, physical and mental health support. The evidence is clear that she was stabilised and functioning well when she transitioned from CCU. Her decline and relapse appears to have been identified as a risk on her discharge from CCU and that risk became a reality.

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[100] Transcript of evidence, p46

158. I find that the ARAFEMI accommodation was initially appropriate for Tamara however by the time her mental health was in decline, it was not, and she required additional supported accommodation. However, I acknowledge this would have been difficult to achieve given the dearth of available and appropriate places. I find that that ARAFEMI in consultation with MSTS should have taken a more proactive approach in assisting Tamara to resolve her evident accommodation difficulties, even if only on an interim basis.

159. Based upon all the available evidence, I find that Mr Nicholson regularly met and consulted with Tamara and prepared a draft management plan outlining the roles and responsibilities of the services. In addition, due to the complexity of Tamara's situation and decline in her mental health, he had appropriately elevated her care and management to a more qualified team. It is unfortunate that this occurred too late to have any positive outcome for Tamara, although I draw no adverse inference from this.

160. Nevertheless, I find that more proactive case management in terms of finding her more suitable accommodation and assistance with her compliance with medication would have been beneficial. I acknowledge the difficulty that MSTS had in terms of balancing Tamara's right to autonomy and choice with more restrictive and protective assistance.

161. I find that there was no one factor that caused Tamara's death rather a cascade of circumstances which in combination resulted in her devastating loss. Tamara's death at such a young age was a tragedy. I acknowledge the heartache and grief her parents and brother have endured as a result of her death and I offer my sincerest condolences.

COMMENTS

Pursuant to section 67(3) I make the following comments connected with the death:

162. When someone is unable to care for themselves despite it being the best treatment model for that person, services need to be flexible and responsive with their support and management to the client's changing conditions to ensure that the client is afforded medical assistance when it is obvious that intervention is required. In this case, the management plan needed to identify when it was appropriate to offer a higher level of support and what that support should have been.

163. As Tamara's mental health, alcohol abuse and accommodation instability were all interlinked, compartmentalising her care was a risk. When multiple services and healthcare professionals are all looking after one person, working together in a partnership is essential. Considering forming a partnership agreement with regular case management meetings between the different services could ensure that each service is aware of their roles and responsibilities, as well as having a holistic approach as to the best possible management of the individual with a mental illness. I acknowledge that this was done to an extent in this case with the development of a management plan, but there was room to improve.

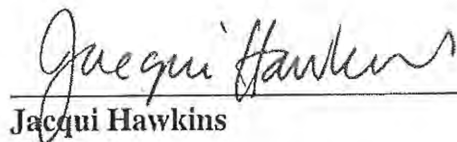
164. The completion of this finding provides a good opportunity for those individuals and services involved in Tamara's care to reflect on the circumstances of her death and ensure their current practices address any identified issues and facilitate continuous improvement.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that finding be published on the internet.

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

- Mr Chris Burt, father of Tamara,
- Ms Fiona Hopper, ARAFEMI resident
- MIND Australia
- Eastern Health
- Mr Darryl Ribaux, Eastern Health
- Mr David Maxwell
- SPECTRUM

Signature:



Jacqui Hawkins
Coroner
Date: 11 November 2014