IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6380

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Mr BB
Date of birth:	4 September 1962
Date of death:	Between 18 and 20 December 2018
Cause of death:	1(a) Hanging
Place of death:	Sydenham, Victoria

INTRODUCTION

1. Mr BB was a 56-year-old man who lived in Sydenham at the time of his death.

2. Mr BB lived with his wife, Mrs BC, from whom he separated in February 2018. Together, they have a daughter, Ms BD.

3. Mr BB took his own life sometime between 18 and 20 December 2018.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr BB's death was reported to the Coroner as it appeared to be both unexpected and unnatural, and so fell within the definition of a reportable death in the *Coroners Act 2008.*

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

7. I also obtained advice from the Coroners Prevention Unit regarding the mental health care provided to Mr BB and a further statement from the consultant psychiatrist who assessed Mr BB on 17 December 2018.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

IDENTITY

9. On 20 December 2018, Mrs BC visually identified her husband, Mr BB, born 4 September 1962.

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

[1] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

BACKGROUND

11. According to Mrs BC, her husband was diagnosed with bipolar affective disorder[2] by a psychiatrist about 20 years before his death, and was commenced on an antidepressant medication, which he later stopped taking.

12. Medical records indicated possible bipolar affective disorder however this was never formally diagnosed due to the lack of unequivocal evidence of a pathological elevated mood state (though some behavioural abnormalities possibly suggestive of an elevated mood state were noted, and it was considered that these may have been features of a narcissistic personality structure[3]). Mr BB frequently drank alcohol and his family noticed more pronounced symptoms of mental illness during and after he had been drinking.

13. Mrs BC noted her husband had a history of becoming very angry over small things and not talking for a few days, before returning to his usual presentation. This occurred more frequently after he been drinking. He also impulsively quit his job at a warehouse on several occasions after someone said something that he did not like, or he had an argument with someone.

14. Ms BD also recalled periods when her father appeared *"out of control"* and would have to remove himself from the family. There were other times when he was verbally abusive to the family. Ms BD believed these outbursts occurred when Mr BB moved from a manic phase to a depressed phase in his illness, which sometimes culminated in him spending weeks in bed.

15. According to his general practitioner, Dr Michael Hocking, Mr BB had a pattern of becoming non-compliant with medication leading to either a depressive or manic/hypomanic episode (both of which usually included excessive alcohol use). His mental state would settle when medication was recommenced but after a short period of stability, he would again become non-compliant.

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[2] Bipolar affective disorder is a mental illness characterised by episodes of mania and/or depression that last for weeks or months at a time.

[3] Narcissistic personality disorder is characterised by a pervasive pattern of grandiosity, need for admiration and lack of empathy. This may present as a sense of self-importance, exaggeration of achievements and talents, a sense of entitlement, unreasonable expectations of favourable treatment, expecting to be recognised as superior without commensurate achievements, preoccupation with fantasies of success, brilliance, power or beauty, a belief that one is special or unique and can only be understood by (and thus associate with) other special or high status people, exploiting or taking advantage of others for personal gain, envy of others or a belief that others are envious of him or her, arrogant or haughty attitudes and behaviours.

16. Mrs BC noted that her husband's mental health began to deteriorate in early 2018 when he had an altercation with his manager. Although he had had altercations and had resigned on several previous occasions, she said this time was different. Mrs BC stated that he was in a *"bad way"* after this incident and started drinking and crying a lot. This incident appeared to be the starting point of Mr BB's months-long deterioration that Mrs BC stated left him *"a shell of a person"* and led to multiple contacts (including admissions) with public mental health services to mitigate his risk of suicide.

17. Dr Hocking last saw Mr BB on 1 August 2018 at the request of the area mental health service. His family had reported that he was transitioning to a mood-elevated phase as he had just bought a new car. However, Dr Hocking assessed Mr BB to be well – he was neither obviously depressed nor mood-elevated.

18. Mr BB also regularly saw a private psychologist, Crescenzio (Chris) Santalucia, throughout 2018 and a private psychiatrist, Dr Peter Smith, in 2018 at the request of his employer.

19. On 15 December 2018, Mr BB ended his relationship with his girlfriend. He thereafter became intoxicated and began saying he intended to take his own life.

20. Mr BB continued drinking heavily the next morning, 16 December 2018. Later that day, he went to a shopping centre where he purchased a one-way airline ticket to Bali. When he returned home, his low mood continued despite his friends visiting. Mrs BC stated that he *"kept ranting and raving"* until the family contacted NorthWestern Mental Health Psychiatric Triage Service with concerns that Mr BB was becoming increasingly suicidal. The family reported that he had planned to purchase a one-way ticket to Bali with a plan to overdose on illicit substances and die. Mr BB declined all assistance from family and friends and actively avoided telephone calls from the Psychiatric Triage Service. His family advised that he would likely leave if he knew that mental health services planned to visit. The Psychiatric Triage Service therefore referred Mr BB for follow up by the Mid-West Area Mental Health Service Rostered Function team.

21. At approximately 3.15pm that day, two clinicians from the Rostered Function team conducted a home visit to assess Mr BB in the presence of his wife and a friend. Mr BB reported experiencing several stressors, including the break-up of his relationship with his girlfriend, the dissolution of shared assets with Mrs BC, and selling the house. He reported increasing suicidal ideation over the previous two days, that his mood had never been so

low, and recent increased alcohol intake. When asked about his plan to travel to Bali, he initially stated it was for a holiday, but later indicated that his intention was to suicide.

22. The clinicians made Mr BB subject to an Inpatient Assessment Order[4] under the *Mental Health Act 2014* (Vic). He refused to be transported to hospital and police and ambulance paramedics were called to assist. Mr BB asked police to handcuff and shoot him and asked paramedics to sedate him. He was handcuffed by police and restrained in the ambulance for transport to the Sunshine Hospital emergency department, though was not physically aggressive nor combative during transport.

23. Mr BB remained settled in the emergency department and slept intermittently overnight. He was given 5mg diazepam and 5mg olanzapine on arrival, and nicotine replacement overnight. He was provided diazepam and olanzapine again the next morning.

24. At 10.50am on 17 December 2018, Dr Naveen Thomas, consultant psychiatrist, reviewed Mr BB. In his statement, Dr Thomas described Mr BB as cooperative, euthymic, and cheerful. Mr BB denied current suicidal ideation and there were no evident symptoms suggestive of a depressive syndrome or psychosis. Mr BB acknowledged some distress and attributed this to his relationship issues.

25. Dr Thomas considered that Mr BB had experienced a situational crisis,[5] alcohol abuse/ harmful use of alcohol, and that he was not at significant risk of harm to himself at the time of review. As such, Dr Thomas considered that Mr BB did not satisfy the criteria for a further compulsory treatment order and he was made a voluntary patient. Mr BB was offered a voluntary admission, which he declined, and he agreed to receive treatment in the community from the Rostered Function team.

26. Dr Thomas attempted to contact Mrs BC, however, was unsuccessful. Ms BD stated that she left her contact details with the hospital along with a request to call her to obtain her father's history, but she did not receive a call.

27. Mrs BC stated that she arrived at the hospital at approximately 11.00am with some clothes for Mr BB in the expectation he would be admitted. When told he was going to be

[4] An Inpatient Assessment Order enables a person to be compulsorily taken to, and detained in, a designated mental health service and examined by an authorised psychiatrist to determine whether the treatment criteria apply to the person.

[5] A situational crisis is not a mental health diagnosis, but a term used when a person's coping mechanisms are affected due to a particular stressor or circumstance in the absence of a mental illness. Situational crises are often associated with acute distress and sometimes increased risk of self-harm and suicide, however typically resolve quickly especially when the stressor is addressed or the person is removed from the situation.

discharged, she felt angry and confused as nobody from the hospital had sought information from the family. She was also concerned that Mr BB had been assessed while heavily sedated.

28. Mrs BC took Mr BB home and left him alone in the hope that he would settle down. She thereafter stayed with her daughter.

29. Sometime that day, Mr BB's sister, Ms MT, called the Rostered Function team to express her concerns that the family's perspectives were not being considered in treatment decisions. Ms MT was concerned that Mr BB was discharged from hospital, and was worried about his ongoing erratic behaviour, overspending, recent loss of two jobs, grandiose behaviour, overvaluing his relationship with his ex-partner, and ongoing suicidality. A clinician explained the relevant provisions of the *Mental Health Act 2014* and outlined the Rostered Function's treatment plan, which included a telephone call that evening, and a home visit the next day.

30. That evening, the Rostered Function team left a voicemail for Mr BB with an appointment time the next day.

31. On the morning of 18 December 2018, Mrs BC spoke to Mr BB and asked him how he was feeling. She stated that he sounded *"ok"*. He had been to the real estate agent and signed the contract to sell the house. However, during the call his mood changed, and he became agitated and asked why mental health services kept calling him. Mrs BC reminded him that this was part of the discharge plan. This appeared to trigger *"a rage"* and Mrs BC thereafter ended the call.

32. The Rostered Function team left another voicemail for Mr BB and a text message was sent. Ms MT advised the Rostered Function team that she had attempted to contact Mr BB, but he did not answer her calls. The Rostered Function team attempted to contact Mrs BC, but she did not answer, and a voicemail was left.

33. Ms BD contacted the team and advised that Mr BB was currently avoiding everybody, including herself, was very angry, and hated everything including his life. She reported that the telephone calls were making him upset and he did not want anyone visiting him. She also advised that police should be present if a home visit was conducted that day as he was uncooperative and could be aggressive. Ms BD was unable to advise whether Mr BB was suicidal or feeling safe at home.

34. Mr BB did not attend the scheduled appointment on 18 December 2018 and there was no answer when clinicians conducted an unscheduled home visit or telephoned while at his house. The Rostered Function team contacted Ms BD and she noted that he was probably inside and choosing to ignore the clinicians. They left a contact card on the door.

35. Mrs BC stated that Ms MT and Ms BD continued to contact mental health services over the following days requesting that they conduct another home visit.

36. Another voicemail message was left on 19 December 2018 with an appointment time for 21 December 2018 and a text message was also sent with the details. Ms BD was advised that the Rostered Function team was again unsuccessful in contacting her father and she reported that she would ask Mrs BC to check on him.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

37. On 20 December 2018, the Rostered Function requested that police conduct a welfare check on Mr BB.

38. When police members arrived at the house at approximately 7.45pm, no one answered the door, but police noted Mr BB's car was present and the television was switched on. A card left by the Rostered Function Team on 18 December 2018 was still in the door.

39. Police called Mrs BC to request the keys and upon entering the house about 30 minutes later, they found Mr BB deceased.

CAUSE OF DEATH

40. On 21 December 2018, Dr Heinrich Bouwer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 21 December 2018. In that report, Dr Bouwer concluded that a reasonable cause of death was '*Hanging*'.

41. Toxicological analysis identified the presence of ethanol,[6] olanzapine,[7] and oxazepam.[8]

42. I accept Dr Bouwer's opinion as to cause of death.

[6] Alcohol.
[7] Olanzapine is used in the treatment of schizophrenia and related psychoses. It can also be used for mood stabilisation and as an anti-manic drug.
[8] Oxazepam is a sedative/hypnotic drug of the benzodiazepine class.

REVIEW OF MENTAL HEALTH TREATMENT

43. Mr BB's family wrote to the Court on a number of occasions expressing their disappointment with the mental health treatment Mr BB received during the months preceding his death. They noted that his mental health significantly deteriorated during this time and he voiced clear suicidal intentions. They reported that they had reached out to mental health services on a number of occasions for help and believe that Mr BB did not receive adequate assessment, treatment, support, and follow-up.

44. In light of these concerns, Mr BB's case was reviewed by an experienced mental health practitioner in the Coroners Prevention Unit (**CPU**).

45. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

46. As noted above, my jurisdiction is limited to determining a number of issues, which includes the circumstances in which the death occurred. This has been determined to mean 'surrounding circumstances', which are limited to events that are sufficiently *proximate* and causally related to the death. While Mr BB had a long history of mental ill health, the CPU only reviewed his most recent contact with mental health services to determine whether there was a missed opportunity for intervention.

47. The CPU reviewed the family's concerns as follows:

Wait for mental health assessment

48. Mr BB was made subject to an Assessment Order at 4.20pm on 16 December 2018, triaged at the Sunshine Hospital emergency department at 5.39pm and given 5mg diazepam and 5mg olanzapine at 6.00pm. He was reviewed regularly by emergency department nursing staff overnight and reviewed by Dr Thomas at 10.50am the next morning.

49. As Mr BB was subject to an Inpatient Assessment Order, he required a review by an authorised psychiatrist within 24 hours.[9] Consultant psychiatrists are usually on-site during

[9] Section 34 of the *Mental Health Act 2014* states that an Assessment Order comes into force when the order is made and remains in force, unless the assessment order is extended in accordance with this section or revoked in accordance with section 37, in the case of an Inpatient Assessment Order for a period (whichever is the shorter)— (i) ending

business hours and on-call outside of business hours. Mental health clinicians who are typically on-site 24 hours a day can review the patient to assist with immediate management if required but cannot complete the assessment as required by the *Mental Health Act 2014.* Given Mr BB arrived in the emergency department outside of business hours, an authorised psychiatrist was not immediately available to review him. As required by the *Mental Health Act*, he was appropriately reviewed by an authorised psychiatrist as soon as practicable and before the Assessment Order expired.

Sedation during mental health assessment

50. According to the medical records, Mr BB was given 5mg diazepam and 5mg olanzapine at 6.00pm on 16 December 2018 and the same the next morning. No other medications (other than nicotine replacement) were documented as being administered.

51. The CPU advised that the administration of psychiatric medication does not preclude a mental health assessment or discharge if adverse effects are not evident. In many cases, the administration of psychiatric medication can improve the patient's ability to engage in a mental health assessment and thus contribute to a more robust assessment.

52. The doses provided to Mr BB were not excessive and they were approximately 15 hours apart, which was reasonable. While the doses had the potential to cause sedation, there was no evidence that Mr BB was sedated during the mental health assessment, and Dr Thomas described him as *"cooperative, euthymic and cheerful"* and *"he did not present as being substance intoxicated or experiencing withdrawal"*. Nursing notes documented that Mr BB was alert and oriented at 7.35am and eating breakfast at 8.00am.

53. It was likely Mr BB was settled and calmed by the medications, especially as they were given an hour prior to assessment and therefore had sufficient time to take effect. It is common to give medications to settle or calm a patient prior to an assessment to lessen their distress (as some questions asked during a psychiatric assessment can be very upsetting for patients) and to allow the patient to engage better in the assessment process (thereby obtaining more information and making the assessment process more robust).

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24 hours after the person who is subject to the order is received at a designated mental health service in accordance with the order; or (ii) of 72 hours, if the person who is subject to the order is not received at a designated mental health service. Section 36 of states that an authorised psychiatrist must examine a person who is subject to an Assessment Order as soon as practicable after the person is received at a designated mental health service, in the case of an Inpatient Assessment Order.

Collateral information

54. According to Dr Thomas, prior to assessing Mr BB, he had been informed that Mr BB had self-ceased his medication, had separated from his wife and recently broken up with his girlfriend, was in conflict with his daughter, had a plan to suicide in Bali, had previous suicide attempts, abused alcohol, and was verbally aggressive and intimidating. Dr Thomas reviewed the previous discharge summaries, emergency department assessments, and the assessment provided by the Rostered Function team.

55. Dr Thomas stated that Mr BB did not meet the treatment criteria for compulsory treatment as there was no current evidence of a diagnosable mental illness or need for immediate treatment, and less restrictive options for treatment were available.[10] Dr Thomas's clinical impression was that Mr BB had experienced a situational crisis, alcohol abuse/ harmful use of alcohol, and that he was no significant risk of harm to himself at the time of the review.

56. Dr Thomas stated that he attempted to call Mrs BC but was unsuccessful.

57. The CPU advised that while Dr Thomas's assessment that Mr BB did not satisfy criteria for compulsory treatment appeared correct based on the information in his statement, collateral information would have contributed to a more robust assessment and higher confidence that he did not satisfy the criteria. The Assessment Order allowed Sunshine Hospital to detain Mr BB for 24 hours after he was received at the hospital. Dr Thomas therefore had several hours after he saw Mr BB to seek collateral information as a part of his mental health assessment before the Assessment Order expired. Alternatively, Dr Thomas could have asked emergency department staff to contact him when Mrs BC collected her husband that morning, which would have allowed him to seek collateral information from her.

58. Based on the CPU's advice, I obtained a further statement from Dr Thomas regarding why collateral information about Mr BB's history was not sought before he was discharged. Dr Thomas provided the following information:

    (a) Sunshine Hospital and NorthWestern Mental Health Service do not have a specific policy regarding the significance of obtaining collateral information in the

[10] Section 5 of the *Mental Health Act 2014* requires that <u>all</u> of the following treatment criteria are met for a person to be subject to a Temporary Treatment Order or Treatment Order: (a) the person has mental illness, (b) because the person has mental illness, the person needs immediate treatment to prevent (i) serious deterioration in the person's mental or physical health or (ii) serious harm to the person or another person and (c) the immediate treatment will be provided to the person if the person is subject to a temporary treatment order or treatment order and (d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

assessment of a patient. However, NorthWestern Mental Health Service issued a Clinical Risk Bulletin in April 2009, which provides that collateral information should be obtained before deciding on a management plan wherever possible;

(b) Dr Thomas stated he considered the collateral information available to him at the time of the assessment, which included a handover from the emergency mental health clinicians who had reviewed Mr BB and he reviewed Mr BB's file, which included collateral information provided by his family and information about his previous admissions. He was therefore aware of the information provided by Mr BB's family regarding his increasing suicidality and considered he was informed of the family's concerns and aware of Mr BB's mental health history;

(c) Dr Thomas telephoned Mrs BC with the intention of advising her that Mr BB was being discharged and to inform her of the management plan post-discharge. Unfortunately, she did not answer his call and he thus provided a handover to the emergency department psychiatric team about the plan should she telephone back;

(d) Dr Thomas did not attempt to seek any collateral information from any other family members as he believed he had sufficient information; and

(e) Dr Thomas believed he had enough information to determine that Mr BB did not meet the treatment criteria to enable the continuation of compulsory detention under the *Mental Health Act 2014.* He could not therefore keep Mr BB in the emergency department.

59. I note that NorthWestern Mental Health Service conducted an In-depth Case Review after Mr BB's death. One of the issues identified by the review was that information from Mr BB's family was not available when determining whether to revoke his Assessment Order. The review made two recommendations regarding this issue:

(a) family consultation and/ or collateral information should, as far as practicable, routinely be incorporated and may influence decision-making processes; and

(b) cross-sectional assessments should take into consideration all available longitudinal mental health history or information.

60. Accepting that obtaining collateral information and communicating with family members is always preferable and to be encouraged, I note the recommendations from the In-depth Case Review emphasise the importance of family consultation and collateral information.

Follow up by the Rostered Function team

61. The CPU advised that the follow-up provided by the Rostered Function team appeared reasonable. Regular attempts were made to contact Mr BB and when these were unsuccessful, more assertive attempts to visit him were made.

62. The team were in regular contact with Mr BB's wife, daughter, and sister regarding their inability to contact him. There was no evidence that there were immediate concerns for his safety, and the family advised the clinicians that Mr BB was likely avoiding their calls and was probably inside ignoring them when they attempted home visits.

63. After multiple unanswered telephone calls, text messages, voicemails, and unsuccessful home visits over three days, the Rostered Function clinicians requested a welfare check and informed Ms BD of this, which was appropriate.

64. I agree with the CPU's advice.

FINDINGS AND CONCLUSION

65. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Mr BB, born 4 September 1962, died on Between 18 and 20 December 2018 at Sydenham, Victoria, from hanging in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with Mr BB's death:

1. In accordance with procedural fairness, NorthWestern Mental Health and Dr Thomas were both provided with my proposed comments and given an opportunity to respond. The response from Peter Kelly, Director Operations, has been incorporated into my comments below.

2. Mr BB reportedly experienced mental illness for many years prior to his death, however in the 10 months preceding his death he regularly came into contact with public mental health

services in the context of suicide risk. When unwell, Mr BB's alcohol intake increased, which in turn worsened his mental state, reduced his ability to manage stressors, and increased his suicide risk.

3. Mr BB was referred to mental health services by his concerned family four days prior to his death, resulting in a home visit by Rostered Function team clinicians and Mr BB being made subject to an Inpatient Assessment Order. He was assessed by an authorised psychiatrist within the prescribed timeframe. There was no evidence that Mr BB was overly sedated and therefore unable to appropriately engage in the assessment.

Lack of direct collateral information and discussion regarding the discharge plan

4. Based on information available at the time of assessment, it appeared that Mr BB did not satisfy the criteria for a compulsory inpatient admission; he declined a voluntary admission. An unsuccessful attempt was made to obtain collateral information from Mrs BC. Dr Thomas considered he had enough information to be satisfied that Mr BB was not a current significant risk to himself and could be discharged for follow-up treatment in the community. I note that collateral information about suicide risk from Mr BB's family was on his file.

5. Unfortunately, Mrs BC was not taken through the discharge plan. While Dr Thomas noted that he provided a handover to emergency department staff so that they could provide Mrs BC with information about the discharge *"if Mr BB's ex-wife telephoned the [emergency department]"*,[11] it appears that the discharge information was not passed to the family until they contacted the Rostered Function team. It is unclear why Mrs BC was not informed of the discharge plan when she arrived to collect her husband. It was the time to explain the reasons for the plan, to ascertain the family's concerns regarding the workability of the plan, and to advise the family of a safety plan. There was thus a missed communication for Mrs BC to provide feedback as to whether the discharge plan was indeed a workable plan based on their experiences in providing care to Mr BB.

6. I note that in addition to rights of the patient, the objectives of the *Mental Health Act 2014* also promote the involvement of carers in decisions about assessment, treatment, and recovery whenever this is possible.[12]

[11] My emphasis.
[12] See section 11 of the *Mental Health Act 2014* (Vic).

7. Mr Kelly did not agree that the reliability of the assessment could have been improved had Dr Thomas obtained collateral information from the family. Dr Thomas had formed the view that Mr BB had capacity to make decisions on his own behalf and that his judgement was not grossly impaired. Mr BB gave assurances that the crisis had passed, and he was not currently experiencing suicidal ideation. In accordance with the principles of the *Mental Health Act 2014,* Dr Thomas therefore offered treatment in the least restrictive setting, namely a voluntary admission, which Mr BB declined. He did, however, accept follow-up treatment in the community.

8. I note the 2009 Clinical Bulletin regarding collateral information, was provided to the Court by Dr Thomas. The Bulletin appropriately emphasises the importance of obtaining collateral information, noting that a patient may minimise risk or deny or rationalise behaviours that would otherwise alarm clinicians. Importantly, it notes that *"[m]ental state assessment by itself is not a reliable predictor of suicidal intent, particularly for patients who are not known to the clinician"*. The Bulletin recommends, where possible, that collateral information be obtained before deciding on a management plan and that the management plan should be discussed with family if the patient is not admitted. This was not carried out in Mr BB's case before he was discharged from hospital.

9. I will make a recommendation that NorthWestern Mental Health Service update relevant guidelines so that, where possible, collateral information is gathered especially in situations where an assessment has identified that the patient may be minimising their suicide risk and/ or where there is conflicting information between the medical record and a patient's report regarding their suicidality.

Limitations on treating patients compulsorily

10. It is sometimes difficult to comprehend why a person, who is clearly experiencing mental ill health, does not receive the mental health treatment that they obviously need. The *Mental Health Act 2014* allows for persons with mental illness to be treated compulsorily, which may sometimes be against their wishes. Treating a person against their wishes necessarily infringes their human rights. In recognition of the gravity of this infringement, the *Mental Health Act 2014* necessarily and appropriately sets a high threshold for compulsory treatment. In addition to suffering mental illness, there must be an immediate need to receive treatment to prevent serious deterioration in the person's mental/ physical health or serious

harm to the person or to another person, and there must be no less restrictive means reasonably available to enable the person to receive that immediate treatment.[13]

11. Where there is a possibility of less restrictive treatment, such as treatment from a private psychiatrist or other clinician, and the person is voluntarily accepting of that treatment, the criteria for a compulsory treatment order will often not be met. A person voluntarily accepting treatment from public mental health services is also considered to be a less restrictive means of treatment.

12. Therefore, once a person demonstrably accepts to receive treatment for their mental illness without compulsion, they will likely no longer meet the high threshold to be compulsorily treated for mental illness under the *Mental Health Act 2014*. Sometimes, a person will not follow through with that treatment and their mental health will once again deteriorate. It is often heartbreaking and frustrating for family and friends to see their loved one refuse the treatment that they so desperately need.

13. As Mr Kelly outlined in his response to my proposed comments, in addition to promoting less restrictive treatment, the *Mental Health Act 2014* promotes consumers being actively involved in their assessment, treatment, and recovery. It acknowledges that sometimes consumers may make a decision with which their treating team or family may not agree but some risk should be allowed in order to protect their rights, dignity, and autonomy.[14]

14. Indeed, the complexities of mental health legislation were acknowledged by Dr Thomas in his additional statement. He noted that although Mr BB's family had reasonable concerns about his wellbeing, during assessment Mr BB presented as cooperative, euthymic and cheerful, and he denied any current suicidal ideations or plans. He thus did not meet the high threshold for compulsory treatment. Dr Thomas noted that as a psychiatrist, he has to weigh up the risk of harm to the person and also consider whether there is a less restrictive means reasonably available to enable the person to be immediately treatment. Whilst rejecting a voluntary admission, Mr BB appeared to willingly accept treatment in the community with follow-up from the Rostered Function team.

15. I acknowledge that Mr BB's family still hold concerns about the mental health treatment he received during the months preceding his death. As previously advised, these are best directed to NorthWestern Mental Health or the Mental Health Complaints Commissioner.

[13] See the treatment criteria listed in section 5 of the *Mental Health Act 2014* (Vic).
[14] See sections 10 and 11 of the *Mental Health Act 2014* (Vic).

16. Subject to the communication issue identified above, I am satisfied that the treatment and care provided by NorthWestern Mental Health from 16 to 20 December 2018 was reasonable.

Victorian Suicide Register

17. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present. The VSR was designed, built and piloted by staff in the CPU between 2011 and 2012, and became integrated into the Court's work in 2013.

18. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

19. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

20. There is an increased rate of suicidal behaviour as well as completed suicide among individuals with an alcohol use disorder.[15] VSR data shows that alcohol is consistently detected during post-mortem examination in between 25% and 35% of Victorian suicides each year. Substance misuse generally predisposes an individual to suicide by disinhibiting or providing 'courage' to overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders. However, it should be noted that the nature of the association between alcohol consumption and self-harm/suicide is not entirely clear. Consumption of alcohol might influence self-harm/suicide due to the depressant influence of the substance itself; likewise, acute alcohol intoxication might contribute to disinhibited or impulsive behaviours.

[15] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, 2013, p.493.

21. According to Victorian Suicide Register data held by the Coroners Court of Victoria, the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 537 deaths in 2010 to 726 deaths in 2019.

22. However, this increase in suicides occurred while Victoria's population was also growing, from approximately 5.3 million people in 2010 to 6.7 million people in 2019 according to Australian Bureau of Statistics estimates. For this reason, suicide rates are probably a more meaningful statistic than frequencies to elucidate what has occurred in Victoria.

23. The annual Victorian suicide rate for the period 2010 to 2019 ranged from 9.8 suicides per 100,000 people (2010) to 11.3 suicides per 100,000 people (2018). It is clear, then, that the increase in suicides over time is at least in part explained by the increase in Victoria's population.

24. The proportion of suicides by history of diagnosed or suspected mental ill health between 2009 and 2016 was 55.7 percent (for those diagnosed) and 19.8 percent (for those suspected but not diagnosed).

Findings of the Royal Commission into Victoria's Mental Health System

25. Since concluding my investigation, the Royal Commission into Victoria's Mental Health System has handed down its Final Report in February 2021. In its summary of major themes, it refers to a 'missing middle', which it describes as *'a large and growing group of people have needs that are too 'complex,' too 'severe' and/or too 'enduring' to be supported through primary care alone, but not 'severe' enough to meet the strict criteria for entry into specialist mental health services.*'

26. The summary of major themes also references families, carers and supporters as being left out: '*Families, carers and supporters can feel excluded by the system, and are often left out of engagement that would help them in their caring role. Many families, carers and supporters require but are unable to access dedicated supports in their own right*.'

27. A further major theme notes that suicide is far-reaching: '*There are many complex factors that are associated with suicide and these can often overlap. Current efforts need to move away from a single health response to a community -and government -wide approach*.'

28. These themes directly relate to Mr BB's death and echo the concerns raised by Mr BB's family during this coronial investigation.

29. The recommendations of the Royal Commission aim to transform the provision of mental health services in Victoria by establishing a responsive and integrated mental health and wellbeing system. As well as making recommendations regarding suicide prevention, the recommendations also include developing a system-wide involvement of family members and carers, and a new Mental Health and Wellbeing Act to, amongst other things, *reset the legislative foundations underpinning the mental health and wellbeing system*. [16]

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation connected with Mr BB's death:

1. To improve the safety of patients who are discharged from an emergency department following an assessment for suicide risk, I **recommend** that **NorthWestern Mental Health** update relevant guidelines to include a requirement for contact with a family member or carer (where possible) prior to the patient being discharged in situations where a risk has been identified that the patient may be minimising their suicide risk and/or where conflicting information has been provided regarding their suicidality.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

[16] Royal Commission into Victoria's Mental Health System, Final Report, Summary and Recommendations, February 2021, pp 8, 11, 16, 62-3, 66 & 78.

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

Mrs BC, senior next of kin

Ms BD

Ms MT

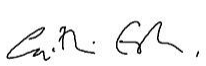
Melbourne Health (NorthWestern Mental Health) (care of DTCH Lawyers)

Dr Naveen Thomas (care of Avant Pty Ltd)

Office of the Chief Psychiatrist

Senior Constable Candice Goullet, Victoria Police, Coroner's Investigator.

Signature:



CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 30 March 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** (the Act), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within six months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.