IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 2883

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**JY**
Hearing Dates:	**10 – 13 DECEMBER 2018**
Coroner's Assistant:	**ACTING SERGEANT ROSS TREVERTON**
Representation:	**MS MICHELLE WILSON FOR DEPARTMENT OF HEALTH AND HUMAN SEERVICES** **MS DEBORAH FOY FOR EASTERN HEALTH** **MR BENJAMIN MASON FOR THE PUBLIC ADVOCATE**

HIS HONOUR:

I, JOHN OLLE, Coroner, having investigated the death of JY

AND having held an inquest in relation to this death on 10 – 13 December 2018

at the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was JY

born on [redacted]

and the death occurred on 1 July 2013

at Alfred Hospital, Prahran 3181

from:

1(a) INJURIES SUSTAINED IN DESCENT FROM HEIGHT

in the following circumstances:

BACKGROUND

1. JY was aged 24 years at the time of her death. She lived alone in a 6th floor apartment at 603/95 Tram Road, Doncaster ('the apartment').

2. At 7.15pm on 1 July 2013, a pedestrian observed JY sitting on the balcony railing of the apartment. Emergency services were called and attending police officers knocked on JY's door. Whilst attempting to engage her and gain access, JY tragically fell from the railing to the ground below.

3. Paramedics arrived at the scene at 7.45pm. JY was documented as unconscious with moderate respiratory distress and copious blood. She was stabilized and transported to The Alfred Hospital due to major internal trauma. A computed tomography (CT) scan indicated an unsurvivable brain injury, following which the decision was made to cease further resuscitation efforts and palliate. JY died at 10.45pm.

PURPOSES OF A CORONIAL INVESTIGATION

4. Reportable death[1] requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdiction nexus with the state of Victoria, the definition of a reportable death includes all deaths that appear "to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury." The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the

[1] Section 4 of the Act

identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death, and to limit the investigation to circumstances sufficiently proximate and causally relevant to the death.

5. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and a power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice[3] regarding reports, recommendations and comments respectively.

6. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and, by ascertaining the circumstances of a death, a coroner can identify opportunities to help reduce the likelihood of similar occurrences in future.

UNCONTENTIOUS MATTERS

7. At the completion of the police investigation, and prior to the commencement of the inquest, it was apparent several facts about JY's death were known and uncontentious. These include JY's identity, the medical cause of her death and aspects of the circumstances, including the place and date of her death.

8. Given this, I formally find that the deceased was JY, late of Doncaster; that she died on 1 July 2013 at The Alfred Hospital, Prahran; and the medical cause of her death is injuries sustained in descent from height.

INTRODUCTION

9. The coronial brief prepared by coroner's investigator Sergeant Timothy Price is comprehensive.

10. All interested parties fully cooperated with my investigation. Department of Health and Human Services (DHHS) former and current case managers, Victoria Police members, Eastern Health (EH) medical and allied health professionals comprised the witnesses who gave oral evidence throughout the 4-day inquest. Without exception, all witnesses provided

[2] Section 67 of the Act
[3] Section 72(1), 72(2) & 67(3) of the Act

frank and forthright evidence. Where appropriate, individual and systemic shortcomings were acknowledged. Certainly, lessons have been learnt.

11. I refer to EH who publicly acknowledged an inadvertent information transfer shortcoming in respect to JY's management whilst a patient. It is important to note, however, there were no identified shortcomings in the management of JY whilst she was a patient at EH. I consider the above acknowledgement clearly illustrates the determination of EH to review and continually improve its service delivery.

12. I do not purport to summarise all of the material or evidence in this finding but will refer to it only in such detail as is warranted by forensic significance and where otherwise appropriate. The absence of reference to an aspect of the evidence, either obtained through a witness or tendered in evidence, as well as submissions and replies, does not infer that it has not been considered.

13. I take this opportunity to thank my assistant, together with the legal representatives of all interested parties, and note that the submissions and replies have greatly assisted my role. I also particularly thank Sergeant Price for his unstinting support throughout my investigation.

14. In addition, I note the dignity which JY's parents, TY and HY, displayed throughout the inquest. In her application for inquest, TY stated she did not seek to blame any organisation or individual for JY's death, however, she hoped that lessons could be learnt to avoid similar tragedies. I consider lessons have been learnt. I commend TY and HY and offer their family my sincere condolences.

THE FOCUS OF THE INVESTIGATION

15. The issues to be considered in the inquest were set out at the commencement of the proceeding and comprise;

    (a) The appropriateness of JY's accommodation, in the context of a person who had threatened suicide on the 8 March 2013 whilst standing on the balcony railing of her 6th floor apartment; and

    (b) The appropriateness of JY's mental health care at Upton House, post 9 March 2013 admission, including the reasons for the discharge on 15 March 2013 and supports offered upon discharge.

SUMMARY OF CIRCUMSTANCES

16. JY was the youngest of three children to TY and HY. TY reported noticing that there was something different about JY from an early age, as she failed to meet normal developmental milestones. A standardised cognitive assessment of JY conducted at the age of 7, indicated that JY was functioning in the mildly intellectually disabled range. Consequently, JY completed her education through special needs schools, finishing in 2007.

17. From a young age, JY demonstrated self-harming behaviours and was referred to treatment for mental health issues. At the age of 18, a deterioration was observed in JY's mood and behaviour. There were concerns about suicidal ideation, self-harming and violent behaviours directed towards her family. In 2011, JY's psychiatrist, Dr Pokharel, formed an opinion that JY had a comorbid diagnosis of Borderline Personality Disorder (BPD) in addition to her intellectual disability. The diagnosis of BPD was due to JY's sensitivity to rejection, unstable relationships, self-harming and impulsivity. Dr Pokarel noted that when JY "does not take her medication, she becomes more irritable and unstable".

ALLOCATION OF DISABILITY CASE MANAGER FROM DHHS

18. JY was allocated a disability case manager through DHHS, Box Hill. Case manager Thallini Weliwatte reported observing a volatile relationship between JY and her mother and believed that living in the family home was not sustainable. JY was not willing to move to a Supported Residential Services (SRS) home as she did not believe she had a disability and did not want to live with other people. Following exploration of alternative solutions, JY obtained a public housing unit in August 2011. The move was gradually undertaken, with JY able to stay at her parents' house and new home on a flexible basis. Ms Welliwate stated the aim was to "allow JY to adjust at her own pace, reducing the stress and anxiety placed on her by the move." At times, JY would refuse to leave her parents' home, becoming argumentative and physically aggressive.

19. In September 2011, due to JY's aggressive and violent behavior, TY applied for an Intervention Order (IVO) under the *Family Violence Protection Act 2008*. Under the conditions of the IVO, JY was not permitted to go within 200 metres of her parents' house unless she had her mother's permission to attend the home. In December 2012, the IVO was amended to allow JY to visit her parents' home between 2 and 9pm on Tuesdays and Thursdays. It is apparent JY did not understand or respect the intention of the IVO. For example, over a series of days in September 2012, JY presented to her parents' house outside

permissible hours. She would beep her car horn or bang on the door yelling verbal abuse at TY and demanding various items from the house, such as CDs, medication or food. Ms Welliwatte explained:

> "Unfortunately, with the order, the only end result was police involvement, and given JY's fascination with police this would always act as an incentive rather than a deterrent."

Throughout 2012, JY was arrested 8 times for breaching the conditions of the IVO.

20. In January 2013, TY applied to the Victorian Civil and Administrative Tribunal (VCAT) for a guardian for JY. An investigator from the Office of the Public Advocate (OPA) made an assessment that JY's circumstances appeared satisfactory and did not recommend guardianship. However, VCAT determined that JY needed a guardian "to make decisions concerning accommodation" and on 30 January 2013 ordered an OPA guardian be appointed. On 9 April 2013, Suzanne Bull was appointed JY's guardian.

21. At 7.30pm on 8 March 2013, JY contacted Lifeline to advise of her intentions to jump off the balcony of the apartment. Lifeline contacted emergency services. Police entered the building and spoke to JY through the front door of the apartment, asking her to open the door. JY was observed to fall backwards onto the balcony, which police interpreted as accidental. JY agreed to accompany police to Box Hill Hospital under Section 10 of the *Mental Health Act 1986*. At assessment in hospital, JY reported suicidal ideation stating that the trigger was her parents stealing money from her bank account. JY was assessed as a high suicide risk and was accordingly voluntarily admitted to Upton House. JY was initially placed on 15-minute observations and remained an inpatient from 9–15 March 2013. At discharge, though not referred for mental health case management, the discharge treatment plan was for JY to take her medications and engage with a psychologist or psychiatrist through general practitioner (GP) referral.

22. In May 2013, Judy Broberg assumed the role of case manager of JY "due to a change of boundaries with DHS". Ms Broberg continued to provide case management at the time of JY's death.

RELEVANT PROXIMATE FACTS

23. On 16 June 2013, JY attended her parents' house in breach of the conditions of the IVO. An argument ensued between JY and TY, necessitating a call for police assistance. JY was

required to attend court and was held in custody until 26 June 2013 at Melbourne Custody Centre, Dame Phyllis Frost Centre and Marrmak Unit (Forensicare).

24. On 26 June 2013, JY attended court in respect to the IVO breach allegations. She was granted bail; however, the conditions of her IVO were made more restrictive. A meeting was held on 27 June 2013 between TY, JY and DHHS staff, in which limitations were set on the contact between JY and TY. On 28 June 2013, JY attended work and spent time with her brother and sister. On 29 June 2013, JY spent the day with her parents and extended family. Her behavior was variable throughout the day; at times she was described as happy, and, at other times, physically violent.

25. On 30 June 2013, JY's family attended her apartment and discovered she had damaged the oven and security door and smashed her mobile phone and clock. JY was yelling at her family and physically assaulted her brother. TY reported being scared, describing JY as "out of control" and "the worst I have ever seen her". TY and her son attended Doncaster Police Station requesting police check on JY. TY also called the EH Crisis Assessment and Treatment Team (CATT).

26. At 2.15 pm, police attended the apartment to conduct a welfare check. JY was initially reluctant to open the door, telling police she was fine and to go away. Upon subsequently allowing police entry, explained the property damage was accidental and declined their offer of medical treatment for a cut on her hand. Police assisted JY to clean up the broken glass in the apartment. An officer described JY as "her normal self" and left the apartment with no concerns for her safety or welfare.

FATAL INCIDENT

27. On the morning of 1 July 2013, JY did not answer her door to her workplace transport and did not attend work that day. TY called Ms Broberg informing her of JY's violent and destructive behaviour the previous day. TY considered JY required more support with household duties as she was unable to look after herself. Ms Broberg spoke to police who advised a welfare check was conducted and that "police had assisted JY sweep up broken glass and there was no further action taken". Ms Broberg attempted to telephone JY, without success.

28. At 3.30pm, Leading Senior Constable Giles saw JY at Westfield Shopping Centre. At 4.30pm, Ms Broberg visited JY at the apartment and observed the flat to be dirty and noted the broken oven and security door. JY acknowledged causing the damage. She agreed with Ms Broberg's suggestion to clean the apartment together and to develop a shopping list for the

following day. Further, Ms Broberg reminded JY of her appointments the following day with her GP to discuss medications, Centrelink and her corrections officer. JY handed Ms Broberg a letter from VicRoads regarding demerit points.

29. Ms Broberg was informed by JY she had not opened the door to her transport or attended work that day because she had felt uncomfortable on Friday when she had no lunch. Ms Broberg reported that she "had no immediate concerns for her welfare" and left the apartment around 5.15pm.

30. At 7.15pm a passing pedestrian observed JY sitting on the balcony railing of the apartment. As detailed in paragraph 2 herein, despite police attending and attempting to talk JY into allowing them access she tragically fell from the balcony railing to the concrete steps below.

31. JY was transported to The Alfred Hospital, unconscious with moderate respiratory distress. Following confirmation of an unsurvivable brain injury on the CT scan, the decision was made to cease further resuscitation and commence palliation. JY was pronounced deceased at 10.45pm on 1 July 2013.

ANALYSIS AND CONCLUSIONS

The appropriateness of JY's accommodation, in the context of a person who had threatened suicide on 8 March 2013 while standing on the balcony railing of her 6th floor apartment

32. I am satisfied DHHS undertook a number of assessments and reports obtaining input from Dr Radler, Dr Pokharel, Dr Graham, Dr Davis, and members from EH Child & Youth Mental Health Service (CYMHS) unit, including social worker Ms De Kam. I accept that at no time was there a recommendation that JY be removed from the apartment or that she should not live independently.

33. JY received case management from DHHS, Disability Services, on a voluntary basis. She had received this service for several years prior to her tragic death.

34. I accept the submission of counsel for DHHS that the circumstances of the admission to Upton House, namely the incident relating to the balcony railing at the apartment on 8 March 2013, was information in the possession of EH which should have been transferred to all parties, in particular the DHHS case manager and JY's family. The acknowledgement of counsel for EH is appropriate and I accept that the failure to do so was inadvertent. Counsel for DHHS postulates that, possibly due to the multitude of people involved with JY at that

time, it may have been assumed that all parties were aware of the incident that led to the admission:

> "Specifically, in circumstances where the mother had attended, not only the meeting but at an earlier time as well."

35. Nonetheless, the regrettable consequence of the information transfer failure was that JY's family, DHHS and the OPA were unaware of the 8 March balcony incident. In addition, a number of individuals involved in JY's care were equally unaware – including her psychologist, Mr Bill Shorten, the family therapist, Ms Butera-Prinzi, her corrections worker, Katie, her lawyer, who represented her in relation to criminal proceedings, support workers from Independence Australia who were working with her consistently throughout that period, and the magistrate who was sentencing JY in respect of the breach of an IVO, together with members of CATT whom TY had been calling during June 2013. DHHS submits it remains a possibility that JY's GP, Dr Katy Abraham, was also not informed of the balcony incident. I accept the submission of counsel for DHHS:

> "The evidence from Ms Broberg, Ms Bull, Ms Welliwatte, and Ms Auld is that they all agreed that it would not be that nothing would happen. Their evidence was slightly different about what may have occurred. But in my submission all four of them agreed that there would have been further assessments and a review of whether the accommodation was appropriate."

36. I further accept counsel's submission that acknowledging hindsight bias, it cannot be said that JY would have been removed had knowledge of the 8 March 2013 incident been shared. This is particularly so considering JY's history of suicidality. However, all persons involved in JY's care, in particular her family, should have been made aware of the 8 March balcony incident. It is important to note, however, that the failure to communicate the nature of the incident of 8 March to all parties was inadvertent and in no way reflects the excellent care and professional attention JY received throughout her admission at Upton House. Counsel for EH submit that DHHS should have enquired of EH about the nature of the reason for admission. However, I accept that all parties, other than EH, were informed that the catalyst for the deterioration in JY's mental state which precipitated the March 2013 admission, was JY's incorrect belief that her parents were taking money from her account. It follows, there was no reasonable basis for parties to question the decision of EH to admit JY.

37. I consider that information of the 8 March balcony incident been shared between all parties, a risk assessment of the apartment would have been undertaken. However, despite its 6th floor location, with balcony access, without speculation I am unable to find that the risk assessment would have resulted in accommodation transfer. I am satisfied that the opportunity to conduct a risk assessment was lost by the unintentional failure of EH, to appraise all parties of the 8 March balcony incident.

The appropriateness of JY's mental health care at Upton House, post 9 March 2013 admission, including the reasons for the discharge on 15 March 2013 and supports offered upon discharge.

38. I am satisfied that JY received reasonable support upon her discharge, in respect to taking her medication. In particular, JY's psychologist, with the support of TY, encouraged JY to take her medication. I am further satisfied that family therapy took place, as recommended in the second aspect of the discharge plan. I note that TY was also extremely supportive of this aspect of the discharge plan. In addition, JY was compliant with, and received support services which were foreshadowed in the discharge plan. I note the commendable role of Ms Broberg, who had taken over as JY's case manager from the excellent work of Ms Welliwatte, throughout the period of her discharge until the tragic event. Ms Broberg was committed to facilitating JY availing herself of all psychological and support services following her discharge from Upton House.

39. Having heard the evidence of various witnesses and submissions, I have not identified any shortcomings in the professional care JY received at Upton House or upon her discharge on 15 March 2013. Importantly, professional persons involved in JY's care, her therapy in particular, consistently encouraged JY to comply with medication. It appears that after undertaking a Google search, JY unilaterally decided to cease taking her medication. Nevertheless, I do not consider there were reasonable grounds to enforce medication upon her. I note the evidence-based benefit of medication for JY is vexed and unclear, although certainly her behaviour appeared to deteriorate once she had ceased taking her medication.

40. I consider the most significant issue confronting JY's mental state was the period of incarceration following a breach of an IVO in June 2013. I do not criticise the rationale for the incarceration in light of the history of IVO breaches, nor do I criticise the role of correctional officers. On the contrary, the evidence reveals that the officers who dealt with JY whilst she was incarcerated at the Dame Phyllis Frost Centre were compassionate, caring

individuals who always had her best interests at heart. Clearly though, they were concerned about her mental state and her inability to understand the custodial setting.

41. Following JY's release from prison, despite the committed care of her case manager and family, her aggressive behaviour appeared to manifest. It appeared the distress and confusion following incarceration was directed towards her family, particularly her mother. Despite extensive support provided by her case manager and family, including the provision of flowers and the engagement of services to support her, her distress did not wane. Around this time TY phoned Ms Bull, the OPA guardian, regarding whether JY should move from the apartment. However, the reason for TY's concerns were not about the safety of the apartment but rather its proximity to the family home which would lead to further breaches. TY did not want JY to face further breach proceedings. As set out previously, JY's behaviour resulted in damaging her apartment and directing aggression towards her family, in particular her mother. The Victoria Police and Ms Broberg attended and it appeared to them, following the support they offered JY, that she had settled. Ms Broberg attended JY following a phone call on 1 July from TY, who had reported a bad weekend. As set out earlier in the finding, I am satisfied Ms Broberg attended and provided JY with appropriate, compassionate care and attention and support. Given JY's demeanour and undertaking to be supported in the following days, Ms Broberg had no reasonable basis to consider JY was unsafe in the apartment. I am satisfied the tragic event which led to JY's death was one of misadventure and that JY did not intend to fall.

INTERVENTION ORDERS

42. I am satisfied the role of the OPA in respect to JY was appropriate at all times and does not require further attention in this finding. The OPA were not informed of the 8 March balcony incident. Further, at no stage were safety concerns in respect to the apartment posing a potential falls risk ever canvassed with the OPA.

43. My investigation has revealed that JY did not grasp the conditions and consequences of breaching an IVO. I consider the use of IVOs for persons suffering an intellectual disability is problematic. Magistrates face extraordinary challenges when IVOs are being consistently flouted. Non-custodial options must inevitably be exhausted. It is important to highlight that my investigation in respect to the appropriateness of IVOs in not intended to criticise judicial decisions in any respect way. On the contrary, I consider judicial officers are placed in an impossible situation, when dealing with persons such as JY, who repeatedly breach the conditions of IVOs.

44. JY was a person who delighted in police company. Breaches of her IVO invariably resulted in the attendance of police members, and occasional periods at the police station. Despite the obvious frustration that police resources were diverted to these instances, the evidence has revealed that police consistently treated JY with respect and compassion. I make particular note of Detective Trusler who offered JY support and care over a lengthy period.

45. I set out hereunder the compelling submission of the OPA, in respect to this vexed issue. Mr Mason for the OPA acknowledged the submission was the brain-child of his colleague Ms Claire McNamara. I thank Ms McNamara for her invaluable assistance.

PUBLIC ADVOCATE SUBMISSION IN RESPECT TO IVOs

46. The Public Advocate submits that it is open to the Court, based on the evidence provided during the coronial inquest, to recommend that the *Family Violence Protection Act 2008* (the Act) be amended in order to contribute to the reduction of the number of preventable deaths, the promotion of the public health and safety, and the administration of justice for Victorians, in particular Victorians with cognitive impairments. It is submitted that there are four relevant issues related to JY's subjection to family violence intervention orders (FVIO), which require consideration.

    The four issues include:

    (a) JY, by reason of her cognitive impairment, did not have the ability to understand the nature and effect of the intervention orders nor the ability to comply with the conditions of the intervention orders;

    (b) making interventions orders where the respondent has a cognitive impairment and is unable to understand the nature and effects of an intervention order or comply with conditions of an intervention order is inconsistent with the purpose of the Act;

    (c) provisions similar to those in the *Personal Safety Intervention Orders Act 2010* (PSIO Act) for respondents with a cognitive impairment may help reduce the likelihood of respondents with cognitive impairments being; found in breach of FVIO, subject to criminal proceedings, remanded in custody, or incarcerated; and

    (d) subjecting JY to a FVIO was a breach of JY's basic human rights to dignity and wellbeing as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (*the Charter*).

47. JY’s DHHS case manager Ms Judy Broberg, gave evidence that it was her belief that the intervention order, its seriousness, and the consequences of breaching the order was something that JY did not fully understand. Ms Broberg further gave evidence that she believed there was a difference between the ability of JY to understand a condition of an order and her ability to comply with a condition of an order in the circumstances considering JY’s tendency to be impulsive.

48. Detective Senior Constable Trusler gave evidence that she did not believe it was in JY’s interest to be held on remand due to her intellectual disability and believed she could not grasp the concept of an intervention order. The intervention order dated 22 October 2012 contained the condition that JY was prohibited from visiting her parents’ residential address except for the hours between 5:00pm and 9:00pm on Tuesday and Thursday. Detective Senior Constable Trusler stated that she had previously given evidence in the Magistrate’s Court that JY breached her intervention order on account of her loneliness and her inability to understand the concept of time.

49. JY’s initial DHHS case manager, Thilini Weliwatte, gave evidence that JY was unable to understand the conditions and consequences of breaching an intervention order. Ms Weliwatte further stated that variations to the intervention order, in addition to consequences for breaching the order being inconsistent, would have caused JY to be “very confused”.

50. The level of doubt regarding JY’s cognitive capacity was so significant and widely recognised by support services and health practitioners that a neuropsychological assessment was recommended by a psychiatric registrar to consider JY’s capacity including her ability to abide by intervention orders. It is reported that JY consented to a neuropsychological assessment shortly after she was release from custody, having been held on remand for approximately eight days in June 2013.

Making intervention orders where the respondent has a cognitive impairment and is unable to understand the nature and its effects of intervention order or comply with conditions of an intervention order is inconsistent with the purpose of the Act.

51. The purpose of the Act is set out in section 1:

The purpose of this Act is to—

(a) maximise safety for children and adults who have experienced family violence; and

(b) prevent and reduce family violence to the greatest extent possible; and

(c) promote the accountability of perpetrators of family violence for their actions.

Section 1 (b) – prevent and reduce family violence to the greatest extent possible

52. It is submitted that FVIO do not prevent or reduce family violence where the respondent is unable to understand the nature or comply with conditions of an intervention order. In such cases use of interventions orders provide little to no effective protection to affected family members.

Section 1 (c) – promoted the accountability of perpetrators of family violence for their action*s*

53. If is further submitted that FVIO are equally ineffective in promoting the accountability of perpetrators of family violence for their actions. In JY's case accountability is likely to have been a complex concept to grasp by reason of both her diagnosed intellectual disability as well as the inconsistency of her experience. JY was permitted to breach the FVIO repeatedly, at time with the consent of the affected family member, without consequence or acknowledgment of the breach.

Provisions similar to those in the *Personal Safety Intervention Order Act 2010* for respondents with cognitive impairment may help reduce the likelihood of respondents with cognitive impairments being; found in breach of FVIO, subject to criminal proceedings, remanded in custody, or incarcerated.

54. The Act provides limited and insufficient provisions for affected family members/respondents who have cognitive impairment. The Act is silent on the issue of whether a Magistrate needs to consider the capacity of a respondent to understand the conditions that the Magistrate proposes to include in an order. The Office of the Public Advocate (OPA) works with people with disabilities who may be affected family members as well as people who may be respondents. OPA submits that respondents who are cognitively impaired and who have orders made against them which they do not understand are at risk of criminal charges if it is alleged they breached those orders. In this context, the aim of the intervention order to protect the affected family member may not be achievable and other strategies require consideration.

55. It is submitted that the Act be amended to include provisions similar to those within section 61 and section 35 of the PSIO Act. The particular subsection to be considered within section 61 is underlined below:

Section 61 (2) of the PSIO Act;

(2) Without limiting subsection (1)(c), in deciding whether it is appropriate to make a final order the court may consider—

(a) if the respondent is a child, the respondent's ability to do the following, taking into his or her age and maturity—

(i) understand the nature and effect of a final order; and

(ii) comply with the conditions of the final order;

(b) if the court is satisfied that the respondent has a cognitive impairment, the respondent's ability to do the following, taking into account his or her cognitive impairment—

(i) understand the nature and effect of a final order; and

(ii) comply with the conditions of the final order.

56. The above PSIO Act provision states that the court "may consider—". This use of "may" is constructed as meaning that the power so conferred may be exercised, or not, at discretion. It is submitted that any similar provisions added to the Act should be strengthen and should be in terms of "must" rather than "may". This strengthening of the provision will ensure better protections under the Act for persons with cognitive impairments and better promote the administration of justice.

Subjecting JY to FVIO was a breach of JY's basic human rights to dignity and wellbeing as espoused in the Charter of Human Rights and Responsibilities Act 2006.

57. Article 8 of the Charter of Human Rights and Responsibilities Act 2006 *(*the Charter), Recognition and equality before the law, states:

(1) Every person has the right to recognition as a person before the law.

(2) Every person has the right to enjoy his or her human rights without discrimination.

(3) Every person is equal before the law and is entitled to the equal protection of the law without discrimination and has the right to equal and effective protection against discrimination.

(4) Measures taken for the purpose of assisting or advancing persons or groups of persons disadvantaged because of discrimination do not constitute as discrimination.

58. By being subject to the requirements and consequences contained within the Act without recognising and accommodating a respondent's cognitive impairment denies persons with a cognitive impairment their right to equality before the law. In its current form the Act did not provide JY's with sufficient safeguards and provisions to ensure she was afforded equal recognition and equality before the law.

59. Under the Act JY and persons with cognitive impairments have unreasonable conditions placed upon them that has the effect of disadvantaging them because of their inability to understand the effects of an intervention order or comply with the conditions imposed by the court.

60. Alternatively, it is submitted that requiring a respondent who, by reason of his or her cognitive impairment, is unable to understand the nature or effects of an order or comply with conditions of an order, is unreasonable and disadvantages respondents because of their cognitive impairment. This amounts to indirect discrimination.

61. The OPA further submits recommendations from paragraph 26:

(a) ensure that Victorians with cognitive impairments are afforded protections of their human rights under the Charter when named as respondents in FVIO applications;

(b) increase public awareness of the need to provide a meaningful and effective system that provides safety to people affected by family violence in circumstances where the perpetrator of violence suffers from a cognitive impairment and are unable to comprehend and comply with the FVIOs;

(c) ensure Victorians with cognitive impairments are not inappropriately subject to criminal proceedings and incarceration due to their inability to comprehend and comply with a civil order;

(d) reduce the overrepresentation of Victorians with cognitive impairments within the criminal justice system

62. I propose to make a recommendation in the terms suggested by the OPA.

INFORMATION SHARING

63. Mr Mason from the OPA made further submission in respect to information sharing as follows:

That the Department of Health and Human Services, in consultation with primary care networks, public hospitals, and disability services, develop a code of practice to be adopted by all Victorian hospitals where a notice system is implemented that notifies appropriate organisations and individuals of presentations or admissions related to self-harm or high-risk behavior in circumstances where –

- the individual has a cognitive impairment;
- the person with a cognitive impairment is known to be a recipient of support services from DHHS or NDIS; and/or
- the person with a cognitive impairment is known to be under guardianship orders and/or has a known carer.

64. At paragraph 26 e of the OPA submission, Mr Mason submitted

> ensure that relevant health information is shared and coordinate in a manner that respects the privacy of Victorians with a cognitive impairment while also ensuring those supporting Victorians with a cognitive impairment are provided with relevant information in a timely manner that ensure the wellbeing and care of the individual is adequately provide for.

65. In response to the OPA submission the DHHS provided the following submission:

> The department has in place comprehensive practice guidelines for working with a suicidal person in an emergency department or mental health service, titled *Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services*. The guidelines include reference to self-harming behavior. They focus on the assessment and management of suicide risk, including discharge planning and follow up. The guidelines stipulate, among other things, that for discharge planning the 'primary care provider, family or significant other have written copies of the treatment plan', and that 'general practitioners, counsellors,

social supports and other community services have been consulted and are in agreement with the discharge plan'. The department is currently updating the guidelines, with a view to making them more user-friendly for front line staff. The update will consider whether specific reference to people with an intellectual disability is required, as is the case with other population groups such s elderly people and indigenous Australians.

The department also has in place the *Transfer of care from acute inpatient services: Guidelines for managing the transfer of care of acute inpatients from Victoria's public health services*, that apply to acute care services. These guidelines state that services need to complete a comprehensive discharge risk assessment considering the patient's physiological, psychological, social and cultural circumstances. These guidelines provide that referrals to appropriate healthcare providers and/or community support services are to be made on completion of a risk assessment and that necessary community support services are to be engaged when a patient is discharged home.

For mental health services, there are also two further guidelines issued by the Chief Psychiatrist; *Working together with families and carers: Chief Psychiatrist's guideline* and *Chief Psychiatrist's guideline: treatment plans*. Under these guidelines, services are expected to engage activity with families, carers, guardians and any other relevant persons/agencies that are in a care relationship with the person. This would include a disability support coordinator.

The Department considers that the existing governance and guidelines around discharge planning for a suicidal person are comprehensive and sufficient, notwithstanding the issues that arose in JY's case.

66. The DHHS letter dated 30 April 2019 attached the following documents:

- Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services (2010)
- Transfer of care from acute inpatient services: Guidelines for managing the transfer of care of acute inpatients from Victoria's public health services (2014)
- Working together with families and carers: Chief Psychiatrist's guideline (August 2018)

- Chief Psychiatrist's guideline: treatment plans (July 2018)

67. I am satisfied that the response of DHHS addresses the issues that arose in respect to information sharing in my investigation which I am satisfied is a genuine and comprehensive endeavor to prevent the recurrent of short comings identified in my investigation.

POTENTIAL MISUNDERSTANDING OF PROVISIONS IN RESPECT TO PATIENT PRIVACY

68. In evidence, I raised a potential issue which I have identified in other investigations relating to clinical staff possibly misconstruing provisions in the *Privacy and Data Protection Act 2014* (Vic). Specifically, in respect of the duty clinical staff have to a patient at risk of suffering serious injury or death if non-compliant with medical advice, including a medication regime. In these circumstances, the primary clinical concern, is the safety of the patient. Appropriate supports on discharge, including communication with family members, case managers and OPA guardians would be fundamental requirements. I repeat my finding that there is no evidence, nor suggestion that any member of clinical staff at EH deliberately withheld information. That was not the case. However, other investigations have highlight apparent confusion in the clinical setting. I note counsel for the respective parties supported this view. Indeed, Ms Foy for EH offered the sensible suggestion that it appears that the *Health Services Act 1988*, which governs all hospitals, provides for disclosure in respect to individuals at risk of death or serious injuries, which facilitate clinicians ensuring appropriate supports are put in place. She submitted:

> "People don't understand the extent of exceptions to their duty."

69. Ms Foy submitted that on the evidence though common sense may dictate that JY be moved from her accommodation in light of the 8 March 2013 incident, to make such a finding would require speculation and I accept her submission. As stated earlier, nonetheless it was important information that all parties should have shared and may have been a missed opportunity to conduct a thorough risk assessment of the appropriateness of JY's accommodation. Ms Foy also submitted with some force Senior Constable Trusler's remark at the conclusion of her evidence, namely:

> "JY was a high-functioning person with an intellectual disability and there are few services available for her."

70. I accept this is a sad reality and why families and professionals entrusted with care are confronted with such significant challenges and complexities. Finally, although I am against Ms Foy's submission that DHHS had a similar obligation to EH to share the information and should have made further enquiries, I find without hesitation that EH would have shared the information had its clinical staff been aware other parties were unaware of the 8 March incident. All parties involved with an individual posing the challenges JY posed should regularly meet. I note the evidence of my Coroner's Investigator Sergeant Price who endorsed the view that Victoria Police should also be involved in these regular management meetings.

RECOMMENDATION PURSUANT TO S. 72(1) CORONERS ACT 2008

I recommend that the Attorney General review the Family Violence Protection Act 2008 and give consideration to include provisions that are similar to those currently contained under sections 61 and 35 of the *Personal Safety Intervention Order Act 2010.*

FINDINGS

Having considered all the evidence, in the circumstances described above:

71. I find that JY died on at The Alfred Hospital, Prahran, from injuries sustained in descent from height.

72. I make no adverse finding against any individual involved in JY's care.

73. I express my condolences to JY's family.

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

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

    (a) JY's family;

    (b) Solicitors on behalf of EH;

    (c) Solicitors on behalf of DHHS;

    (d) Solicitors on behalf of OPA;

    (e) Attorney General - Department of Justice and Regulation

(f) Office of the Chief Psychiatrist; and

(g) Other approved information recipients.

Signature:

MR JOHN OLLE

CORONER

Dated : 6 June 2019