



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 2609

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Ingrid Giles
Deceased:	Ms YPM ¹
Date of birth:	[REDACTED] 1992
Date of death:	17 May 2020
Cause of death:	1a) Hanging
Place of death:	[REDACTED] Caulfield South, Victoria, 3162
Keywords:	Suicide, suicide attempts, psychiatric care, borderline personality traits, depression, anxiety, eating disorder, risk assessment, communication between treating team, family involvement in care

¹ This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased, and replace or redact the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

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INTRODUCTION

1. Ms YPM (a pseudonym) was 27 years old when she died at her home in Caulfield South on 17 May 2020. Ms YPM lived with her parents Ms MXL (a pseudonym) and Mr DXL (a pseudonym), along with her younger brother. She had a loving family and was very close to her younger brother, who she relied upon for friendship, support, and advice.
2. According to her mother, Ms YPM was a very social, friendly, and loving person. She was renowned for her gentleness, inclusivity, wit, and clever sense of humour. She had many close friends. Ms YPM was extremely creative, talented, and theatrical. She loved painting, drawing and her true passion was photography and videography.
3. Ms YPM had a strong study and work ethic. She studied a Bachelor of Laws and Journalism at [REDACTED] University and completed her degree in January 2020. At the time of her death, Ms YPM had been employed by [REDACTED] and seconded to [REDACTED] [REDACTED] as a lawyer. She also maintained her own business as a videographer.
4. Ms YPM had a long history of mental ill health dating back to her teenage years when she had been diagnosed with anorexia nervosa following an admission to the adolescent unit at the Monash Medical Centre. Ms YPM had also been diagnosed with borderline personality traits, major depressive disorder, and anxiety. She had multiple presentations to the Alfred Hospital, as well as to The Melbourne Clinic. Many of these presentations related to overdoses of prescription medication.
5. The medical records report her parents and brother were seen by Ms YPM as protective factors. Ms YPM's mother described that Ms YPM's health was always their family's top priority.

THE CORONIAL INVESTIGATION

6. The death of Ms YPM was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
7. 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.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
9. Then-Deputy State Coroner Jacqui Hawkins held carriage of the investigation until it came under my purview in October 2023 for the purposes of conducting additional investigations, analysing expert evidence, obtaining further material, and making findings.
10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Ms YPM's death. The Coroner's Investigator conducted inquiries on the Court's behalf and submitted a coronial brief.
11. Due to the complexities associated with Ms YPM's medical history, this case was referred to the Coroners Prevention Unit (CPU) to conduct a review of the circumstances of Ms YPM's death. The CPU conducted an investigation which included reviewing the medical records, engaging an expert, and obtaining statements from some of the relevant clinicians.
12. This finding draws on the totality of the coronial investigation into the death of Ms YPM. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.²
13. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards

² 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.

of their profession and, in so doing, caused or contributed to the death under investigation.

14. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.³ Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.⁴

IDENTITY OF THE DECEASED

15. On 17 May 2020, Ms YPM, born on [REDACTED], was visually identified by her cousin.
16. Identity is not in dispute and requires no further investigation.

CIRCUMSTANCES SURROUNDING THE DEATH

17. This is a summary of the circumstances leading to Ms YPM's death.
18. In early 2020, Ms YPM lost her job due to an extended period of leave following rhinoplasty surgery that she required due to a deviated septum. She moved back into the family home and found employment with [REDACTED] in March 2020, and was seconded to [REDACTED].
19. After a period of stability, Ms YPM experienced an increase in anxiety, emotional dysregulation, body image issues and weight loss. Medical records of her treating team including her psychiatrist Dr Chia Huang (**Dr Huang**), her psychologist Janet Lowndes (**Ms Lowndes**) and her General Practitioner (**GP**) Dr Alexander Shannon (**Dr Shannon**) suggest that change in mood may have been due to work stressors, and some difficult interpersonal relationships.

³ *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

⁴ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

20. In February 2020, Ms YPM was referred by Ms Lowndes to dietician Thomas Scully (**Mr Scully**), due to a recent loss of weight after surgery in the context of her longstanding eating disorder.
21. On 25 February 2020 Ms YPM consulted with dermatologist, Dr Ashling McNally (**Dr McNally**) who commenced her on isotretinoin (brand name Roaccutane). Dr McNally explained the risks and side effects as required. Ms YPM was reviewed in April 2020 by dermatologist Dr Friyana Bhahba (**Dr Bhahba**) and was reported to be tolerating the drug well, and reported a stable mood. Her dose was increased in April 2020, and a review was planned for four months' time.
22. A few weeks after commencing her new role, COVID-19-related restrictions and lockdowns required Ms YPM to work from home. Her hours were subsequently reduced due to the lockdowns. Ms YPM's mother described that Ms YPM was frustrated by the COVID-19 related restrictions which resulted in additional stresses, changes to work hours, isolation from friends and her new colleagues, and pressures on her relationship.
23. On 24 April 2020 (a Friday), Ms YPM saw her GP Dr Shannon and advised her that she had taken an overdose of tapentadol, Mersyndol Forte, agomelatine and fluoxetine two days prior, and did not seek immediate treatment. She reported that her boyfriend had cheated on her and that she had consumed alcohol for three days and moved between friends' houses. Ms YPM said she had been stressed about work and was tired. She explained that she had not intended to kill herself, but she did not care if she died. Dr Shannon sent a letter to Dr Huang to advise him of the overdose and of the ongoing treatment plan, which included, amongst other things, blood tests, an ECG, contacting Dr Huang and a follow-up appointment the following week.
24. On 28 April 2020, Ms YPM had a telehealth session with her psychologist, Ms Lowndes. She reported that she had deteriorated after she had ceased her medications without discussing this with her doctors. She acknowledged the dangers associated with this but felt she was improving and planned to recommence her medications. She was advised to see Dr Huang for psychiatric review. Ms Lowndes sent a letter to Dr Shannon, CCing Dr Huang, advising that Ms YPM had then attended for ten sessions of psychological therapy, and had been advised of the requirement for a medical review to approve a further course of treatment.

25. On 1 May 2020, Ms YPM saw Dr Huang and told him she had ceased the antidepressants fluoxetine and agomelatine some three weeks prior and did not want to recommence fluoxetine. She agreed to blood tests to check her liver function prior to restarting agomelatine.
26. On 4 May 2020, Ms YPM saw Dr Shannon who prescribed Valium (diazepam) and noted that she had been *‘[i]n to discuss results. All ok for now. Needs all back before restarting medication. Seeing Dr Huang this Friday for next review’*.
27. On 6 May 2020, Ms YPM had a telehealth session with Ms Lowndes and reported she had completed the blood tests as requested by Dr Huang, which were a precondition to her being prescribed a new antidepressant. She also said that her relationship with her partner was back to normal and she was seeing him most days. She reported that she experienced a lack of trust, felt stuck due to lockdown, and expressed less hope for the future of the relationship. She was considering moving out of the family home, was eating more than she wanted and was stressed by work in the context of reduced working hours and money.
28. On 8 May 2020, Ms YPM saw Dr Huang. Dr Huang states that Ms YPM told him she had recommenced taking agomelatine after review with Dr Shannon. Dr Huang noted Ms YPM was depressed, self-destructive, non-motivated, was suicidal but did not know how to die, and had not told her mother. She refused a private admission to The Melbourne Clinic but agreed for a review in three days. Ms YPM refused her consent for her mother to be contacted by Dr Huang.
29. At 11.45pm, Ms YPM told her family she was staying with a friend at his place.

Attendance at the Alfred Hospital

30. On 9 May 2020 at 2am, Ms YPM attended Alfred Hospital Emergency Department (ED) with her friend. She disclosed that she had taken prescription medications of diazepam and agomelatine with a significant amount of alcohol. She was sedated and intoxicated and was medically observed.
31. At 11.25am, when she was appropriately alert, Ms YPM was assessed by the Emergency Psychiatry Service (EPS). She denied her polypharmacy overdose represented a suicide

attempt and indicated that said she had wanted to shut off from a challenging day and that she had been in conflict with her partner. She acknowledged several stressors in the preceding weeks which included a toxic relationship, adjusting to new employment, and a desire to move out of home. She reported she had ceased her antidepressants three weeks prior due to feeling dull and admitted to experiencing dark thoughts over the previous week. She mentioned she had seen Dr Huang the day before at which time she had not been suicidal.

32. The EPS clinician concluded that Ms YPM was presenting with low mood on a background of borderline personality vulnerabilities. She expressed chronic thoughts of suicide but denied that she had attempted to end her life on this occasion. She denied any intention to do so in the immediate future. Ms YPM highlighted that her relationships with her parents and brother were protective factors.
33. Ms YPM was assessed under the *Mental Health Act 2014* (Vic) and deemed not to meet the criteria for compulsory treatment. An admission to The Melbourne Clinic was suggested, however she declined this, stating she would discuss this with Dr Huang when she saw him on 11 May 2020. Ms YPM was also offered intensive community follow up by Alfred Crisis and Assessment Treatment Team (CATT) and TriagePlus, but refused both. She was assessed as being at her baseline risk, was provided with contact details for 24-hour crisis services, and was advised to return if she needed. Ms YPM was discharged around lunchtime on 9 May 2020 after declining any Alfred Health follow up.
34. At 4.28pm, Ms YPM's mother, Ms MXL, messaged the friend Ms YPM said she was with because she was unable to contact her. The friend said he thought Ms YPM was asleep and that he had spoken to her a few hours earlier.
35. At 5pm, Ms YPM arrived home, said she was tired and went to bed. At 9pm Ms MXL spoke to her daughter and noticed a sticker on her chest, however Ms YPM did not offer an explanation and asked her mother to leave.
36. On 10 May 2020, Ms YPM went shopping with friends and returned at about 5.30pm with a Mother's Day gift for Ms MXL. Ms YPM's mother reported that she noticed that Ms YPM seemed 'very weak' this day, although she was unaware at this time of Ms YPM's overdose or her attendance at the Alfred Hospital. Ms YPM then went out for

dinner with her former boyfriend and later rang to inform her mother she would stay overnight and that her friend would take her to the organised appointment tomorrow with Dr Huang.

37. On 11 May 2020, Ms YPM had an appointment with Dr Shannon and discussed the overdose, and noted that she had tried to cut her legs. Dr Shannon noted she was acutely suicidal, that her ex-boyfriend was driving her to The Melbourne Clinic. Dr Shannon walked her to their car.
38. Shortly afterwards, Ms YPM saw Dr Huang who arranged for admission to The Melbourne Clinic with a deterioration in mental state, increased anxiety, and depression. The admission was for crisis containment and medication review. During the admission, Dr Huang added mirtazapine and olanzapine to Ms YPM's medication regime.

Admission to The Melbourne Clinic

39. At 12.26pm on 11 May 2020, Ms YPM was admitted to The Melbourne Clinic and was assessed as having a moderate level of risk. She rated her distress and feelings of hopelessness as 10/10 but denied any suicidal thinking or intent. At the admission assessment at 1.30pm, she reported some suicidal thinking but no plan. She said her family was unaware of the admission and she was isolated from her friendship circle. She expressed concern her employer would terminate her employment if they were made aware of her admission. At 2pm, she told the nurse that her toxic relationship had broken down, that the cutting she reported five days earlier was self-harm, and that that she did not have any suicidal thinking. She did not identify any goals for the admission.
40. At 3pm, Ms YPM was found in the bathroom with a scarf tied in a knot/noose, having opened an overhead ceiling vent. She was unable to explain what she was doing but told staff she was '*trying to find a way out*'. Staff took the scarf away from her as it presented a risk. Ms YPM was then assessed by psychiatric registrar Dr Georgina Tuck (**Dr Tuck**) who noted her to be distracted and unengaged. She stated she felt the same as when she took the recent overdose and did not want to be in hospital. She was transferred to the ICU for containment because of the risk of leaving, and to receive a higher level of support and monitoring. She was prescribed olanzapine as needed.

41. Ms YPM spoke briefly to her mother and asked her to contact her work and let them know she would not be in.
42. Upon admission to ICU, Ms YPM was assessed as high risk of suicide, vulnerable and at risk of leaving. She was reviewed at 4.30pm by Drs Huang and Tuck. At that stage she was more settled but upset that the scarf had been removed because it gave her comfort. She told her treating clinicians that she wanted to discharge and die. It was explained that she was too unwell and in crisis. Dr Huang explained he would have to make her subject to an Assessment Order under the *Mental Health Act 2014* (Vic) and transfer her to Alfred Health if she insisted on leaving. Ms YPM agreed to remain as it was explained she would not have to stay in the ICU for an extended period, with a plan to review the following morning. She was prescribed temazepam and isotretinoin and slept until the following morning.
43. The next day, Ms YPM had breakfast and returned to the general ward. She was assessed to be flat, with a restricted affect and a low mood. At 2.45pm she was again reviewed by Dr Huang and Dr Tuck and informed them that she had calmed down, was feeling better and had only needed a rest, and that she wanted to go home. According to Dr Huang, he wanted her to continue the admission. However, Ms YPM said she would be better off at home with the support of her family.
44. At this time, Ms YPM was assessed as low risk and Dr Huang agreed to discharge her, with a limited supply of her medication prescribed by him, being mirtazapine, olanzapine and agomelatine. Ms YPM said her mother would come and collect her. Dr Huang stated that when he specifically requested Ms YPM's consent to contact her family, she refused. Ms YPM contacted her mother and requested to be picked up.
45. At 3.45pm, Ms YPM was given her medication, and the plan was that she would see Ms Lowndes on 15 May 2020 and Dr Shannon within the week, as well as Dr Huang again. Contacts for crisis services were provided and Ms YPM left the ward unaccompanied due to COVID-19 restrictions.
46. When Ms MXL arrived at the clinic, she described that the entrance was taped off and there were approximately 20 people standing outside the hospital. No one was allowed in, and she had to collect Ms YPM in a car park at the front of the clinic. Ms YPM reported to her mother that due to COVID-19 restrictions the hospital was chaotic.

Programs were cancelled and patients were confined to their rooms, with no access to the internet.

Days following discharge from The Melbourne Clinic

47. The next day, Ms MXL asked Ms YPM why she had only been admitted to The Melbourne Clinic for one night. Ms YPMa said she couldn't really explain it, but it had to do with her medications. In her mother's presence, Ms YPM called and left a message for Dr Huang to call Ms MXL to discuss Ms YPM's medication. According to Dr Huang, he tried to return Ms YPM's call the following day, and left a voicemail, but did not hear from her (which was reportedly not out of character and therefore did not raise concerns for him).
48. On 13 May 2020, Alfred Health EPS were unsuccessful in making direct contact with Dr Huang to hand over Ms YPM's care, but spoke with his reception and were advised that Ms YPM had attended the scheduled appointment on 11 May 2020. The EPS documentation was then faxed to Dr Huang.
49. On this same day, a discharge summary from The Melbourne Clinic was sent to Dr Shannon, which included the reason for her transfer to ICU, the changes to her medications and limited supply at discharge.
50. Ms YPM caught up with friends on the evening of 13 May 2020. She returned home and seemed relaxed and well.
51. Over the next few days Ms YPM spent time with her family, walked her dogs, and cleaned her room.
52. On 15 May 2020, Ms YPM had a telehealth session with Ms Lowndes. She described the overdose on 8 May 2020 including that her friend had come to the house after thinking she sounded groggy during a phone conversation. She reported that she had only become distressed in The Melbourne Clinic ICU, and had not been suicidal, but reported she had been because she wanted to be moved from the general ward. Ms YPM stated she had a week off work, that her family were aware of her admission but not of the details, and Ms Lowndes recommended she speak openly with her family.

53. According to Ms Lowndes, Ms YPM identified her supports as family and friends, and that these were part of the safety planning discussed regularly in sessions, however at times she refused friends' and family involvement.
54. Ms YPM said she was relieved her relationship was over, was not suicidal and she presented as settled. Ms Lowndes did not consider she was at imminent risk or increased risk. She was advised to avoid alcohol for a week as general safety advice because of its effects on impulse control, to take her medications only as prescribed and another appointment was made for Monday 18 May 2020 to specifically discuss and plan for her return to work which she had expressed concerns about, including that her boss was friends with her mother.
55. On the evening of Saturday 16 May 2020, COVID-19 restrictions had been lifted and Ms YPM went out with her friends.
56. Between 1.48am and 3am on 17 May 2020, Ms YPM had a text message exchange with her former boyfriend. She returned home at approximately 3.15am and had a brief conversation with her mother, who was reading a book on the couch, and stated she was tired and going to bed. Her former boyfriend was concerned about Ms YPM's state of mind and the nature of the messages, which had included '*I don't know how to do it anymore.... I try... to be good*'.
57. Ms YPM's ex-boyfriend then sent a text to Ms YPM's brother and asked him to check on her. Ms YPM sent a final text to her ex-boyfriend, '*I love you and thank you. Bye.*'
58. At approximately 9am on 17 May 2020, Ms YPM's brother awoke and saw he had received a message earlier that morning regarding his sister's welfare. He ran to his parents' bedroom and Mr DXL forced open the bathroom next to Ms YPM's bedroom, which was locked, and found her hanging from the shower frame by a piece of tied cloth. Her parents got her onto the floor and commenced cardiopulmonary resuscitation (**CPR**), and called emergency services and the Hatzolah Ambulance (a local community emergency response service) (**Hatzolah**).
59. The Hatzolah and Victoria Police arrived shortly after and continued CPR. Ambulance Victoria Paramedics arrived shortly after that. Despite all best efforts, Ms YPM was unable to be resuscitated, and she was pronounced deceased.

60. A coronial investigation was commenced. Members of Victoria Police spoke with family and took photographs of the scene. A number of prescription medications were located in the bathroom. Police did not identify any suspicious circumstances.

MEDICAL CAUSE OF DEATH

61. On 18 May 2020, Dr Paul Bedford, Forensic Pathologist, from the Victorian Institute of Forensic Medicine conducted an external examination on Ms YPM's body. He also reviewed the Victoria Police Report of Death, and post mortem CT scan.
62. The findings at external examination of the body showed a ligature abrasion around the neck and were consistent with the history.
63. Postmortem toxicological analysis detected the presence of alcohol, methylamphetamine, cocaine, diazepam, olanzapine, mirtazapine, fluoxetine, and loratadine. Agomelatine was not detected.
64. Dr Bedford provided an opinion that the medical cause of death was *1a) Hanging*.
65. I note that hanging is a form of asphyxia due to compression of the neck structures by a ligature tightened by the weight of the body. Death may be due to reflex cardiac arrest, occlusion of the blood vessels of the neck or airway obstruction. In cases of hanging, unconsciousness can occur very rapidly, and death follows shortly after.
66. While the more contemporary formulation of a cause of death in such circumstances is *1a) neck compression; and 1 b) hanging*, I accept Dr Bedford's opinion and formulation as to cause of death.⁵

⁵ I was advised that the cause of death, and its replication on Ms YPM's death certificate, caused significant (and understandable) distress to Ms YPM's family, including due to privacy concerns. In this connection, I note that Births, Deaths and Marriages Victoria (**BDM**) offers [two death certificates](#), one *with* and one *without* the cause of death listed. This process is intended to assist families to protect sensitive information such as the cause of death when dealing with organisations who do not need the cause of death, for example to close a bank account. While this does not address the full spectrum of concerns held by Ms YPM's family on this issue, I consider it to be an initiative that appropriately addresses the privacy issue entailed by multiple entities being apprised of a cause of death when it is unnecessary in the exercise of their functions.

FAMILY CONCERNS

67. On 18 October 2021, Ms YPM's family wrote to the Court and provided detailed submissions expressing extensive concerns regarding the care provided in the lead-up to Ms YPM's death. Ms YPM's parents had several concerns about the medical, psychiatric and psychological treatment, communication, discharge planning and follow up care provided to Ms YPM. They had particular concerns about Ms YPM's admission and discharge to/from the Alfred Hospital and The Melbourne Clinic in the days before her death, which they submitted occurred without any safety plan in place and without appropriate communication with family members.
68. Having met with certain of Ms YPM's clinicians and having assembled a lengthy set of materials relating to Ms YPM's care and treatment, the family provided further material to the Court on 31 March 2022 which included a chronology of Ms YPM's medical history, records from Airlie Women's Clinic, the Alfred Health, Caulfield Dermatology, The Melbourne Clinic, Dr Huang, and Ms Lowndes. All medical records have been compiled as part of the coronial brief in this matter.
69. The Family also made submissions, via counsel and otherwise, after receipt of various expert reports, which will be referred to further below.

CPU INVESTIGATION

70. In the interests of a comprehensive coronial investigation, and to assist the Court in investigating the extensive family concerns received, this case was referred to the Coroners Prevention Unit (**CPU**) to review the circumstances of Ms YPM's death and the adequacy of her treatment, medical care and management.
71. The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.
72. The CPU provided a detailed Mental Health Advice Memo on 11 April 2023. This document was provided to Ms YPM's family and Interested Parties. In the course of

providing its advice, the CPU considered a number of materials, including the coronial brief and medical records, and assisted in obtaining further statements in addition to those in the originally-compiled coronial brief, including from:

- Ms Gaylyn Cairns, The Melbourne Clinic, dated 7 September 2022;
- Ms Lowndes of *‘Mind, Body, Well’*, dated 7 September 2022;
- Dr Huang, dated 18 November 2022; and
- Dr Evan Symons, Alfred Health, dated 6 October 2022 and 15 November 2022.

73. Details of two internal reviews were obtained by the CPU to assist in the consideration of the care and treatment provided to Ms YPM. These included: (i) the Alfred Health Internal Review; and (ii) The Melbourne Clinic critical systems review. I will briefly summarise the outcome of these reviews prior to providing a summary of the CPU advice.

Alfred Health Internal Review

74. According to Dr Evan Symons, Unit Head, Consultation-Liaison and Emergency Psychiatry (**Dr Symons**), Alfred Health was not aware of Ms YPM’s death until contacted by the Court on 4 August 2022. The required case review was then undertaken with no recommendations made at that time. However, Alfred Health sought and were provided with a summary of the family’s concerns from the Court which resulted in a Leadership Review of the initial case review on 21 October 2022.
75. The review panel (**Panel**) noted two improvement opportunities associated with Ms YPM’s episode of care on 9 May 2020. Firstly, it noted the absence of any documentation about involvement of a carer or support person with Ms YPM, and that Ms YPM’s living arrangements were not clearly documented in the medical records.
76. The Emergency Psychiatry Service (**EPS**) clinician involved with Ms YPM, who was consulted as part of the review, advised that, consistent with their usual practice, there would have been a reason for not contacting Ms YPM’s family (for example, lack of consent, or that Ms YPM did not live with her parents). However, it was acknowledged that this was not documented in the electronic medical records (**EMR**).

77. The second issue identified by the Panel was that the handover of care from Alfred Health to Dr Huang should have ideally occurred on Monday 11 May 2020 as a priority, noting that this was part of the intended plan by the EPS team. An attempt was made by the EPS to conduct this handover on 12 May 2020, with a voice message left with Dr Huang. The handover then occurred via fax on 13 May 2020 after a discussion with The Melbourne Clinic, staff from whom had confirmed that Ms YPM had attended her appointment with Dr Huang on 11 May 2020.
78. Notwithstanding the two issues identified, the Panel found the care provided by Alfred Health was clinically appropriate and that it was reasonable to discharge Ms YPM at that time, noting that she did not meet the criteria under the *Mental Health Act 2014* for involuntary treatment, that a clear rationale for discharge was documented in the EMR, that supports were offered to Ms YPM in the community, and the possibility of a private admission to The Melbourne Clinic discussed with Ms YPM. The Panel concluded it was not below the reasonable standard of care that Ms YPM's family was not contacted upon discharge in the circumstances.
79. As a result of the Internal Review, the following two recommendations were made, which were reported as having been completed in 2022:
- a) Recruitment for a new EPS leader position, based in the ED, that will be responsible to oversee and lead the completion of clinical reviews and handover processes; and
 - b) For Ms YPM's case to be presented to relevant staff and to the EPS team, with key learnings to be disseminated.

The Melbourne Clinic Internal Review

80. Ms Gaylyn Cairns, General Manager of The Melbourne Clinic (**Ms Cairns**) provided a statement to the Court dated 7 September 2022 and, *inter alia*, advised that a Critical Systems Review (**CSR**) in relation to the care provided to Ms YPM on 11-12 May 2020 was completed on 16 June 2020. The focus of the review appears to have been in relation to the incident on the day of her admission with the scarf and open vent.

81. The CSR found that there had been thorough communication between the multi-disciplinary team and that the incident with the scarf had been escalated appropriately, noting that one-on-one supervision was subsequently arranged while Ms YPM was transferred to the ICU for close monitoring and containment.⁶
82. With respect to environmental factors, it was determined that the so-called ‘manhole’ in the bathroom should have been locked to prohibit patients from accessing this. The ‘manhole’ was inspected on 12 May 2020 and a lock was fitted. The remaining ‘manholes’ on the ward were fitted with similar locks on 22 May 2020.
83. Ms Cairns noted that the CSR did not identify any other issues with the care Ms YPM received.

CPU DISCUSSION

84. The CPU also considered the family concerns and provided a detailed discussion on:
 - a) Borderline personality disorder;
 - b) Risk assessments;
 - c) Lack of communication between the treating teams;
 - d) Prescription of isotretinoin (Roaccutane);
 - e) Treatment of depression in lead-up to death;
 - f) Alcohol and substances; and
 - g) Clinical communication and discharge information.
85. At the conclusion of its advice, the CPU also suggested two potential coronial recommendations, which have received support from Ms YPM’s family and Dr Huang.

⁶ I note that The Melbourne Clinic CSR states: ‘Mother was updated on [Ms YPM]’s presentation... [Ms YPM] agreed to discharge to care of mother’. However, following receipt of submission from Ms YPM’s family on this issue, on 14 January 2025, Healthscope on behalf of The Melbourne Clinic advised the Coroners Court that this aspect of the review was inaccurate, and that ‘[Ms YPM]’s family was not updated about her admission to the Clinic in May 2020, given that [Ms YPM] did not consent to same. We apologise for any inconvenience or confusion caused by this error’. I find this error in the review to be concerning. However, I note that amendments to the *Health Services Act 1988* made since Ms YPM’s death provide for new and rigorous review processes following serious adverse patient safety events, including on the part of private health providers, to meet the requirements for statutory duty of candour. In light of the changes made since Ms YPM’s death, I have not made comment or recommendations flowing from the breadth or content of the CRC conducted by The Melbourne Clinic.

86. The CPU provided some background information about certain psychological diagnoses and their potential impact on mental ill health and suicidality. Ms YPM's history supports she was vulnerable to impulsive decision-making, which was usually the result of emotional dysregulation, however she was high functioning and was engaged with her work and social life for most of the time.
87. The CPU noted that, in order to understand the context of Ms YPM's suicide and mental ill health it is important to understand some of her challenges.

Borderline Personality Disorder⁷

88. Borderline Personality Disorder (**BPD**) is a debilitating disorder characterised by rapid and extreme mood changes including depressive, aggressive and anxious states; intense fears of abandonment and rejection; a pattern of unstable and intense interpersonal relationships; impulsivity; a persistent unstable sense of self; chronic feelings of emptiness and a tendency toward self-harming and suicidal behaviours.
89. BPD behaviour often disrupts family and work-life, long-term planning, and interpersonal relationships.⁸ The literature on BPD supports the notion that many people with the diagnosis suffer from chronic suicidal ideation in response to recurring

⁷ In submissions provided to the Court on 5 September 2025, Ms YPM's mother disputed that Ms YPM had been diagnosed with borderline personality disorder (**BPD**) but took no issue with her being described as having '*traits of BPD*'. In particular, Ms YPM's mother noted that '*had I been made aware of such a diagnosis, I would have sought further clarification and engaged in discussions with her treating clinicians and [Ms YPM] to understand more clearly her diagnosis*'. It is certainly the case that the material before the Court is equivocal on this front. Dr Huang, Ms YPM's treating psychiatrist, refers in his statement of 18 November 2022 as Ms YPM having a diagnosis of '*borderline personality traits*'. The Alfred Health medical records from Ms YPM's most recent admission of 9 May 2020 refer to an impression of '*Cluster B personality structure - prominent BPD features with low mood*' but also a patient history of '*depression, BPD and anorexia*' (emphasis added). I have referred in this finding to the diagnosis of her longtime-treating psychiatrist, Dr Huang, as Ms YPM having a diagnosis of '*borderline personality traits*'. However, I remain of the view that comments on BPD at the conclusion of this finding remain apposite. In this regard (and without making any comment as to any diagnosis of BPD versus BPD traits), I have reviewed the expert material before me, including the opinion of Professor Hopwood of 2 June 2023 that '*[I]t is my overall opinion that [Ms YPM] presented with a combination of difficult to treat eating disorder, best characterised at the time of her death as bulimia nervosa, and a set of unstable mood and anxiety symptoms with impulsive self-harm and a pattern of unstable interpersonal relationships that is consistent with the presence of a Borderline Personality Disorder or Borderline Personality Traits. I note this diagnosis has been made several times by clinicians who met [Ms YPM] both at The Melbourne Clinic and the Alfred Hospital. I do recognize the limits of making personality disorder diagnoses retrospectively on file review alone but the clinical pattern here is strongly suggestive*'.

⁸ Beatson, J., Rao, S., & Watson, C. (2010). Borderline personality disorder: Towards effective treatment. Victoria: Australian Postgraduate Medicine, p.173.

interpersonal stress. Chronic suicidal ideation and threats can be present in up to 86% of people diagnosed with BPD.⁹

90. Of note, death is not the primary objective from these threats and any resultant actions. Instead, it is more a means for communicating their internal distress.¹⁰ However, resultant behaviours can still be of high lethality. Often these behaviours are reflective of having a means of control over the lives of those with BPD in choosing whether to live or die.
91. The CPU discussed that there is limited evidence to suggest that hospitalisation decreases the risk of completed suicide.¹¹ Instead, in the absence of severe psychosis or imminent risk behaviours, community intervention is deemed the most appropriate treatment response.¹²
92. The CPU explained that intense and highly changeable emotions experienced, and impulsivity exhibited by those with BPD, make risk assessment difficult. Emotional dysregulation is a complex collection of processes that may include:
 - a lack of awareness, understanding, and acceptance of emotions;
 - a lack of adaptive strategies for regulating the intensity and duration of emotions;
 - an unwillingness to experience emotional distress whilst pursuing desired goals; and
 - an inability to engage in goal-directed behaviour when experiencing distress.¹³
93. Further, the CPU reported that a risk assessment completed at any given time is unlikely to remain accurate after the person experiences a triggering event or stressor, and it can

⁹ Gunderson, J., Ridolfi, M. (2001). Borderline personality disorder: Suicidality and self-mutilation. *Annals of the New York Academy of Sciences*, 932, pp.61-77; Paris, J. (2001). Half in love with easeful death: The meaning of chronic suicidality in borderline personality disorder. *Harvard Review of Psychiatry*, 12, pp.42-48; Paris, J., & Zweig-Frank, H. (2001). A 27-year follow-up of patients with borderline personality disorder. *Comprehensive Psychiatry*, 42, pp. 482-487.

¹⁰ Beatson, J., Rao, S., & Watson, C. (2010). *Borderline personality disorder: Towards effective treatment*. Victoria: Australian Postgraduate Medicine, p.174.

¹¹ Paris, J. (2004). Is hospitalisation useful for suicidal patients with borderline personality disorder? *Journal of Personality Disorders*, 18, pp. 240-247.

¹² Beatson, J., Rao, S., & Watson, C. (2010). *Borderline personality disorder: Towards effective treatment*. Victoria: Australian Postgraduate Medicine, p.179.

¹³ Gratz, K. L., & Roemer, L. 2004. Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioural Assessment*, 26(1), 41–54.

often be difficult to predict when triggering events may occur and what responses the person may have.

94. Ms YPM had a long-standing safety plan which included cognitive behavioural therapy (CBT). She had identified her family and friends as her protective factors, and the use of crisis contacts when she was feeling unsafe and/or suicidal, and her history, supports she was able to enact her safety plan. Ms YPM was aware of crisis services over many years and was aware of how to access them, and what they offered.

Involving family

95. The CPU also discussed clinicians' involvement of Ms YPM's family in her treatment and care. According to the medical records, Ms YPM's family was supportive of her engagement with mental health treatments, however, in the lead-up to her passing, she appeared to have utilised close friends for her support. Some of the medical records demonstrate that Ms YPM indicated that she sometimes found having her parents closely involved was stressful.
96. The medical records support that Ms MXL had been often involved in meeting with and speaking to her daughter's treating team, however it appears Ms YPM did not agree to this in the last few months of her life, despite the encouragement of Dr Huang and Ms Lowndes to be open with her family, and/or offers to speak directly with Ms MXL.
97. Ms MXL states the family was not aware Ms YPM was being treated for depression or that she was prescribed isotretinoin, believing the antidepressant was prescribed for anxiety. It appears it was Ms YPM's decision to not inform her family of this information as she had been clear she did not give her consent to her treating team to speak to her mother.
98. Ms MXL notes that after her daughter agreed to Dr Huang speaking to her about her medication on 13 May 2020, she did not receive a call from Dr Huang. Dr Huang left a voicemail with Ms YPM but did not get a response. It is not clear if Ms YPM's decision to allow Dr Huang to speak with her mother was communicated to the reception staff and/or Dr Huang, or if this was to be given once Ms YPM spoke with Dr Huang.

99. Ms MXL stated they relied on practitioners to advise the family regarding supporting Ms YPM with her care as she was so unwell as to be unable to care for herself. The CPU noted that it is possible for practitioners to speak with family, especially if they are required to directly monitor medications, or maintain direct supervision, and to do so without providing details of diagnosis and treatments, but it remains that without consent, clinicians are restricted by the Health Privacy Principles.
100. The CPU noted that Principle 2.2 (Use and Disclosure) per the [*Health Records Act 2001 \(Vic\)*](#) states:

An organisation must not use or disclose health information about an individual for a purpose other than the primary purpose for which the information was collected unless at least one of the following paragraphs applies: [...]

(h) the organisation reasonably believes that the use of disclosure is necessary to lessen or prevent:

(i) a serious and imminent threat to an individual's life, health, safety or welfare; or

(ii) a serious and threat to public health, public safety or public welfare – and the information is used or disclosed in accordance with guidelines, if any, issued or approved by the Health Complaints Commissioner.

101. In this connection, the CPU noted that Ms YPM was not assessed as at a serious or imminent risk at the time of her discharge from Alfred Health on 9 May 2020, or The Melbourne Clinic on 12 May 2020, or at her appointment with Ms Lowndes on 15 May 2020. This is addressed further below.

Risk Assessments

102. The CPU noted that there are no reliable tools or methods for predicting suicide. While there are some factors known to increase suicide risk, most people with these risk factors do not suicide. It is difficult to assess which people with identified suicide risk factors may suicide, and if they might suicide in the short term.

103. Predicting suicide is even more difficult in people who experience suicidal ideation in response to external stressors, as it can be difficult to predict when a stressor may occur and whether the person will experience suicidal ideation in response. Suicide attempts in such people tend to be impulsive and unpredictable.
104. The CPU reported that a risk assessment is a clinical opinion formed by a trained clinician and is relevant only at the time of assessment and its completion. After discharge, clinicians have no control over the actions of a person that may change the severity or nature of that person's risks and of the ongoing validity of protective factors that have been used to inform the clinical opinion of current overall risk.

Legislation and capacity

105. The *Mental Health Act 2014 (Vic)* (**MHA**), as applied during Ms YPM's episodes of care,¹⁴ provides for persons with mental illness to be treated compulsorily, where certain criteria are met. Treating a person against their wishes necessarily raises human rights issues. In recognition of the gravity of this infringement, the MHA 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 persons mental/physical health or serious harm to the person or to another person, and there must be no less restrictive means reasonably to enable the person to receive that immediate treatment. The MHA assumes capacity.
106. The CPU noted that, at the time of discharge on 12 May 2020, Dr Huang did not consider Ms YPM met the requirements for involuntary admission to a public mental health ward under the MHA. He commented that this is a difficult and considered decision for a clinician to make and requires balancing the interests of the patient to consent to treatment whilst ensuring that a patient is not at risk of serious harm. Ms YPM was prepared to continue outpatient treatment with her longstanding treating team. She agreed to take her antidepressant medications and had identified other supports that she was willing to call upon.
107. Overall, Dr Huang considered that her discharge (with the plan for community treatment) was the less restrictive means of providing treatment to Ms YPM. In addition, Ms YPM's

¹⁴ I note that new legislation commenced on 1 September 2023 – the [*Mental Health and Wellbeing Act 2022*](#).

presentation on 12 May 2020 was more settled than the day prior. She did not express any suicidal ideation. She expressed plans for the future and showed a willingness to comply with her treatment plan. He found no reason to believe she was an imminent risk of serious harm. Ms YPM was willing to engage in community-based care and had done so for many years and with an established treating team.

108. The CPU noted that, throughout her statement and submissions, Ms MXL stated that Ms YPM did not have capacity to care for herself. The CPU noted that Ms YPM was 27 years old, high-functioning and was not subject to any legislation (including administration, guardianship, or medical treatment) that would suggest she was unable to make her own informed decisions or that she did not have capacity. During her presentations at Alfred Health and The Melbourne Clinic, the care provided was appropriate, keeping her safe in crisis, and providing care and supervision until she was medically cleared as no longer sedated or intoxicated, or in an agitated and emotionally dysregulated state, at which time assessments were undertaken and shared decision making with Ms YPM completed.
109. The CPU noted that the expectation that Ms YPM be subjected to the MHA (initially by way of Assessment Order) would not have guaranteed family involvement with treatment or an admission to a public mental health unit. The Assessment Order is to ensure an assessment by an appropriate mental health practitioner and the decision to subject Ms YPM to a treatment order would have been their decision. Ms YPM would have needed to have met all of the criteria and her history suggests that, once settled, this was unlikely. The CPU opined that experiencing suicidal thinking or suicidal gestures/acts do not by themselves meet the criteria for compulsory treatment.
110. Finally, the CPU noted that the Informed Financial Consent form provided by the family, which noted a stay of 21 days is required before an admission to a hospital, did not necessarily mean Ms YPM would be admitted for that duration, which was a concern raised by Ms YPM's family. All patients are fully informed of potential costs and provide their informed financial consent before admission to reduce the risk of loss of income due to patients not paying their expenses. It is an administrative form and is not an indication of clinical decision making or length of stay.

Lack of communication between members of the treating team

111. According to Ms MXL, Dr Shannon was not aware of Ms YPM's discharge from The Melbourne Clinic on 12 May 2020 and believed she was still an inpatient at the time of her death. The discharge summary from The Melbourne Clinic (13 May 2020) and from Alfred Health (9 May 2020) were both sent to the Airlie Women's Clinic, which means they were available to Dr Shannon. It is unclear if Dr Shannon having read these summaries would have impacted Ms YPM's care. A review of records does not suggest there was proactive contact with Ms YPM unless she failed to attend a scheduled appointment. Ms YPM had not made an appointment with Dr Shannon as advised by The Melbourne Clinic.
112. In relation to his lack of communication to the family, Dr Huang stated that Ms YPM did not give consent for him to speak with her family and as she was an adult he was unable to compel her to do so. He said that whilst Ms YPM found her parents supportive, in the period before her death, she had described that involving them was at times stressful and preferred to utilise close friends for support. He considered it appropriate to respect her wishes.
113. This was consistent with what Ms YPM had discussed with Ms Lowndes. Ms Lowndes reported that Ms YPM was reluctant to involve her family in her therapy would not have permitted any communication from her to her friends.
114. A review of the records reveals there was regular communication between Drs Huang, Shannon and Ms Lowndes, with the most recent being The Melbourne Clinic discharge summary provided to Dr Shannon, a progress report by Ms Lowndes to Dr Shannon and copied to Dr Huang on 28 April 2020, and a letter of Dr Shannon to Ms Lowndes and Dr Huang on 24 April 2020. This level of communication is appropriate.

Isotretinoin

115. The CPU noted that Ms MXL opined that the isotretinoin prescribed for her acne impacted her daughter's mental state. Ms YPM was last reviewed by the prescribing

dermatologist in April 2020, when she reported she was tolerating it well. It was at this appointment the dose was increased to 20mg, which is within the clinical guidelines.¹⁵

116. According to the Therapeutic Guidelines:

*The link between oral isotretinoin and depression or suicide has not been proven. A recent review suggests an association of the use of isotretinoin in patients with acne with significantly improved depression symptoms; however, more randomised controlled studies are required. Studies have found that when a patient is taking oral isotretinoin, their mood and wellbeing usually improve as the acne improves. A history of depression is not a contraindication to the use of oral isotretinoin, and patients can be treated for depression and acne at the same time.*¹⁶

117. The Monthly Index of Medical Specialties (MIMS) from 2020 stated:

*Psychiatric disorders. Depression, depression aggravated, psychotic symptoms, anxiety, aggressive tendencies, mood alterations, psychosis and, rarely suicide, suicidal ideation and suicide attempts have been reported with isotretinoin. Particular care needs to be taken in patients with a history of depression and all patients should be monitored for signs of depression and referred for appropriate treatment if necessary. Although no mechanism of action for these events has been established, discontinuation of therapy may be insufficient to alleviate symptoms and therefore further psychiatric or psychological evaluation may be necessary.*¹⁷

118. As noted by Ms MXL, the family was unaware Ms YPM was prescribed isotretinoin. However, she was referred to the dermatologists with the knowledge of both her psychiatrist and psychologist, according to the medical records. Ms MXL also stated that Dr Huang was not aware of the isotretinoin. The CPU opined that the medical records do not support this, noting the prescribing of isotretinoin while in The Melbourne Clinic on 9 May 2020.

119. The CPU notes that Ms YPM was consulting regularly with a psychiatrist, private psychologist and her GP, which is a reasonable standard of monitoring, and she was engaged in treatment for depression. The monitoring of her mental state and how this was undertaken would not have changed because she was taking isotretinoin.

120. The medical records support Ms YPM's symptoms of depression and the prescribing of antidepressants at therapeutic amounts was long-standing and may have contributed to

¹⁵ Isotretinoin - Therapeutic Guidelines, published August 2022

¹⁶ Isotretinoin - Therapeutic Guidelines, published August 2022. Li C, Chen J, Wang W, Ai M, Zhang Q, Kuang L. Use of isotretinoin and risk of depression in patients with acne: a systematic review and meta-analysis. BMJ Open 2019; 9(1).

¹⁷ Isotretinoin – MIMS revised October 2020.

her sustained period of wellness in 2019. The presence of treated depression is not a contraindication in relation to prescribing isotretinoin. It cannot be established that the isotretinoin was a contributing factor to Ms YPM's death, or whether her choice to cease the antidepressants without consultation impacted this.

Treatment of depression

121. The CPU noted that it can take up to four weeks for both mirtazapine and agomelatine to have a full therapeutic effect, which Ms YPM was aware of and is reflected in the SMSs to her friends included in the family submissions.
122. Mirtazapine is a first line treatment for major depression in adults and young people (as was the previous antidepressant fluoxetine) and agomelatine is a second line treatment.¹⁸ The CPU advised that, at the time of her death, Ms YPM's medications were unlikely to have been therapeutic in treating the diagnosed major depressive disorder.

Alcohol and substances

123. According to Ms MXL, Ms YPM did not have an addiction to alcohol and did not use illicit substances. However, the CPU noted that the presence of alcohol with the prescribed medication overdoses was documented in medical records for some but not all instances of overdose after May 2015.
124. During her final session with Ms Lowndes, Ms YPM was advised not to consume alcohol given the potential impact alcohol could have on impulse control. She had in the past exhibited highly impulsive behaviour, so the recommendation was made as a safety precaution.
125. The CPU opined that Ms YPM was not *naïve* to the implications of taking large amounts of prescribed medications and of mixing them, or to the disinhibiting effects of alcohol alone or in combination with medication. There is also some reference to her use of illicit substances, with self-reported cannabis use some two weeks prior to the Alfred Health presentation on 9 May 2020 (though nothing to support that there was long-term use).

¹⁸ Treatment of depression in adults and young people - Therapeutic Guidelines updated March 2021.

126. Post mortem toxicology shows the presence of cocaine, ketamine, and methylenedioxymethamphetamine (**MDMA** or ecstasy) which are illicit substances and which Ms YPM had at some stage accessed and chosen to use. It is unknown whether this was a new behaviour, and it is therefore unknown what impact any or all of these substances would likely have on Ms YPM's mental state.

Clinical communication and discharge information

127. The CPU noted that Ms Lowndes was the only clinician who saw Ms YPM between her discharge from The Melbourne Clinic and her death. She was also pivotal to the discharge planning for community follow-up for both Alfred Health and The Melbourne Clinic, yet she did not receive a discharge summary or any information about the admissions.
128. Ms YPM appears to have minimised and misrepresented to Ms Lowndes her actions in The Melbourne Clinic that resulted in her transfer to ICU, saying she was moved from the general ward which she did not like and that she only became distressed and suicidal in ICU, which is not the timeline supported by the medical records.
129. The CPU reported that it is unclear if Ms Lowndes would have come to any different conclusions during her session with Ms YPM on 15 May 2020, if she had been made aware of the correct version of events in The Melbourne Clinic, but it would have provided her the opportunity to explore what Ms YPM was reporting to her and may have contributed to assessment of current risks.
130. When a psychologist is part of a long-standing community-based treating team, especially in circumstances of chronic mental illness and associated high risk behaviours, it is reasonable that the treating psychologist who is included as the practitioner nominated in the discharge summary to provide the follow up care after discharge (and who is essentially delegated ongoing responsibility to enact the discharge plan) should receive a copy of the discharge summary. The Melbourne Clinic and Dr Huang were both aware of Ms Lowndes' role in the treating team. Medical practitioners (and other treating services such as community mental health teams etc) are provided with copies of discharge summaries, but not necessarily psychologists.
131. The CPU noted that it is increasingly the experience of the Coroners Court that when a patient is already engaged with a private community-based psychologist, the discharge

planning frequently suggests the patient consult with them, and that they will often do so prior to seeing the involved medical practitioners. Accordingly, the CPU has proposed I make two recommendations to address this gap, which are detailed below.

CPU Conclusions

132. The CPU noted that Ms YPM had become less emotionally dysregulated, had reduced symptoms of the eating disorder, a reduction in the frequency and lethality of prescription medication overdoses, required no hospital admissions from April 2019 and had a sustained improvement in her mental state and psychosocial function during 2019, including her studies. She had been proactive in her engagement with the treatment plan and with her longstanding treating team including private psychiatrist Dr Huang, Dr Shannon (GP) and Ms Lowndes (psychologist).
133. The family have no control over the variables that might impact on a loved one's mental state including them deciding to stop prescribed medications, using alcohol and illicit substances and the impact of this is entirely distressing.
134. The CPU commented that the risk of suicide is inherent in people with a diagnosed Major Depressive Disorder and the medication treatment regime at the time of her death would not have been therapeutic. In the context of the blood alcohol level detected at death,¹⁹ the associated disinhibition and impulse control and the unknown effects of the multiple illicit substances including impaired judgement, Ms YPM was vulnerable to experiencing emotional dysregulation and an increase in suicidal thinking and acting on them.
135. As described by Ms MXL, her daughter had a quiet week after her discharge from The Melbourne Clinic, she was off work and engaged in painting, shopping, cooking and being with her family firstly, and catching up with friends. Ms MXL did not provide any evidence that Ms YPM was agitated, distressed, in crisis or appeared to be at imminent risk during that time. She described her as excited to be going out with her friends on the evening of 16 May 2020 after the lockdown restrictions had been lifted.

¹⁹ I note that CPU stated this to be 0.2g/100mL though this may be a typographical error, given that it was in fact 0.12g/100mL, which I note still represents over twice the legal limit for driving and would, depending on the tolerance of the individual, result in some degree of inhibition. I do not consider this to materially impact the CPU advice, noting also that there was also MDMA and cocaine detected on post-mortem toxicological testing.

136. The CPU concluded that it is unclear why Ms YPM did not ask for help from her family, as she had spoken to her mother when she arrived home in the early hours on 17 May 2020. The health records suggest Ms YPM contacted friends when she had overdosed or planned to. In more recent times, she had relied heavily on friends to arrange for her to go to an emergency department and told them not to tell her family. Ms YPM did not have access to prescribed medication that would have met her usual amounts taken in overdose. Ms YPM had sent a message to her ex-partner saying ‘*goodbye*’ and it is not known if she expected him to intervene as had previously occurred. Ms YPM was not *naïve* to the potential outcomes of her high risk behaviours, but in the context of her intoxication evidenced upon post mortem toxicology, her judgment was likely impaired.
137. Taking into account all available information, as noted above, the CPU suggested two recommendations to promote better information-sharing with private psychologists, which I intend to make, and which are contained at the conclusion of my findings.

EXPERT OPINIONS, SUBMISSIONS AND FURTHER EVIDENCE

138. As noted above, in October 2023, I assumed carriage of the investigation into Ms YPM’s death. In addition to the CPU advice, a number of expert opinions, submissions and further statements have come before me for consideration since that time. A brief summary of this procedural history following receipt of the CPU advice is noted below.
139. Counsel engaged by the family provided the Court with an expert report they had obtained from Dr Michael Giuffrida (**Dr Giuffrida**), Forensic Psychiatrist practising in New South Wales, dated 24 August 2022. This report was provided to the Court in May 2023.
140. On 28 August 2023, legal representatives for Dr Huang provided the Court with the expert opinion of Professor Malcolm Hopwood (**Professor Hopwood**) dated 2 June 2023.
141. On 26 August 2024, at my direction, and to assist in weighing the somewhat disparate opinions of Dr Giuffrida and Professor Hopwood, the Court obtained an expert opinion from Dr Jacqueline Rakov (**Dr Rakov**).

142. On 26 November 2024, following receipt of the report of Dr Rakov, legal representatives for Dr Huang filed a supplementary expert report from Professor Hopwood dated 18 November 2024.
143. On 15 November 2024, following receipt of the report of Dr Rakov, Alfred Health filed a statement on behalf of Associate Professor Simon Stafrace (**A/Prof Stafrace**), Consultant Psychiatrist and Program Director of Alfred Mental and Addiction Health dated 15 November 2024.
144. On 9 January 2024, The Melbourne Clinic filed two expert reports by Professor Matthew Large (**Professor Large**) dated 8 August 2023 and 14 October 2023 respectively, with apologies that these reports had not previously been provided to the Court.
145. It is noted that all Interested Parties, as well as Ms YPM's family, have been provided with a copy of all submissions and reports and afforded an opportunity to respond, either via Counsel or directly to the Court.
146. In addition to those Interested Parties who filed expert reports and submissions, it is noted that brief submissions were also received by legal representatives on behalf of psychologist, Ms Lowndes. All have been considered by me in my consideration of the relevant issues.

A NOTE ABOUT THE EXPERT OPINIONS

147. For completeness, I note that not all expert opinions appear to have been obtained specifically for the coronial proceedings into Ms YPM's death (certainly, however, this *was* the case for Dr Rakov, who was engaged by the Court with the assistance of the CPU).
148. However, on the basis that all reports are: (i) authored by qualified psychiatrists; and (ii) bear basic indicia of reliability (including that all experts explicitly agreed to be bound by an Expert Witness Code of Conduct), I have seen no reason to exclude consideration of any reports that appear to have been obtained for collateral proceedings and tendered

in the coronial proceedings. These reports are relevant and address, for the most part, the very same issues within the scope of my own investigation.²⁰

149. However, I have paid particular attention to the documents used to instruct each expert in delivering their opinion, which are unfortunately not uniform, and have considered any resultant impact on the opinion proffered (even where I have not explicitly stated this vis-à-vis a particular opinion).
150. I note further that, in coronial proceedings, save for limited exceptions, the rules of evidence do not apply. When I refer in this finding to preferring one expert opinion over another, I have done so having assessed the reason or basis upon which the opinion was expressed, and have given limited weight to opinions that fail to state any basis beyond a mere assertion, for example, an opinion of what ‘*clearly*’ should have occurred in Ms YPM’s care (without stating the basis for the opinion, or standards upon which it is based, where other experts have drawn a different conclusion and have provided an evidentiary basis for the same).
151. Ultimately, while the expert reports express a range of opinions, which I have been required to reconcile, I have not found it necessary to make findings on each issue upon which an opinion has been provided.
152. In evaluating the expert evidence, I have also considered the advice of the CPU on the basis that, while this is not accorded the status of independent expert advice, it has been disclosed to Interested Parties, is relevant to my investigation, was authored by a suitably qualified clinician, and has usefully addressed some broader prevention issues.

CONSIDERATION OF ISSUES

153. I have carefully considered the history of Ms YPM’s care and treatment over the years prior to her death, however I have focused the scope of my inquiry on the events that are sufficiently proximate and causally related to the death. This included consideration of the treatment and care provided to Ms YPM in May 2020 by Drs Huang and Shannon,

²⁰ In this connection, I note the requirements in *Priest v West* (2012) 40 VR 521 (enshrining the well-established principle that, in investigating a death, the coroner must pursue all reasonable lines of enquiry, be an active investigator and discover all they can about the circumstances surrounding the death (at [521], [525] and [560])), coupled with the flexibility in the coronial jurisdiction that a coroner may inform themselves as they see fit, which I consider extends to consideration of all expert reports that have been submitted for my consideration in the present proceedings.

Ms Lowndes (in the context of their longstanding treatment of Ms YPM), and clinicians at Alfred Health, as well as the communication between these practitioners and with Ms YPM's family.

154. In undertaking this task, I have considered: (a) the contents of the coronial brief, medical records and supplementary statements; (b) advice provided to the Court by the Coroners Prevention Unit; (c) the four experts' opinions provided on the adequacy of care provided to Ms YPM in the lead-up to her death; (d) all sets of family concerns; and (e) submissions made on behalf of family and Interested Parties on the various issues, opinions and prevention opportunities.
155. These documents run into thousands upon thousands of pages. As noted above, I will refer only to that which is relevant to the findings I am required to make under section 67(1) of the Act, though I have read and considered the extensive materials before me.
156. For completeness, I note that Ms MXL initially filed a request for inquest in this matter which was subsequently withdrawn. Despite the complexity of preparing a 'Chambers finding' in this case (i.e. not convening any Court hearings), I have been guided by the family preference for this investigation to be dealt with '*on the papers*' for reasons of maintaining the privacy of Ms YPM's family, which I understand to have guided their desire to proceed without inquest. While not determinative, it has also guided my decision to make findings without convening any hearings, noting the requirements of section 8 of the Act to minimise distress for families, and given I have been able to provide for a natural justice process through invitation of written submissions.
157. Having canvassed these preliminary issues, I will now proceed to assess the adequacy of the care and treatment provided to Ms YPM in the immediate lead-up to her death, focusing on her consultation with Dr Huang on 8 May 2020, her admission to the Alfred Hospital on 9 May 2020, and her admission to The Melbourne Clinic from 11-12 May 2020.

Consultation with Dr Huang on 8 May 2020

158. As noted above, Ms YPM attended upon Dr Huang on 8 May 2020, following a previous consultation on 1 May 2020 at which she had divulged that she had ceased taking her prescribed medications. Dr Huang states that Ms YPM told him on 8 May 2020 that she

had recommenced taking agomelatine after review with Dr Shannon. On 8 May 2020, Dr Huang noted she was depressed, self-destructive, non-motivated, was suicidal but did not know how to die, and had not told her mother. Ms YPM refused her consent for her mother to be contacted by Dr Huang, which he acceded to.

159. Dr Huang noted that, at this consultation, Ms YPM ‘*would not agree to my suggestion of an inpatient admission but agreed to another appointment on 11 May*’, which was some three days later.
160. In his expert report dated 24 August 2022 submitted on behalf of Ms YPM’s family, Dr Giuffrida stated that Dr Huang ought to have in the first instance arranged for Ms YPM’s admission to The Melbourne Clinic or the Alfred Hospital immediately at the consultation on 8 May 2020. However, in the instance that he did not organise for an admission, Dr Huang ought to have alerted Ms YPM’s family that she was feeling suicidal and explained to Ms YPM’s family what type and level of supervision they should provide for Ms YPM’s safety. Dr Giuffrida considered that Dr Huang’s failure to take either of these steps amounted to ‘*critical failures in Dr Huang’s care and treatment of Ms YPM*’.
161. In her expert report dated 26 August 2024, Dr Rakov stated that she considered that hospitalisation could have provided a safer environment for Ms YPM as of 8 May 2020, by allowing for immediate intervention, ongoing assessment of risk, and exploration of her underlying mental state.
162. However, Dr Rakov highlighted that in circumstances where Ms YPM had declined a voluntary admission to The Melbourne Clinic, any decision to subject her to compulsory treatment under the MHA would need to comply with the criteria for compulsory treatment, which required evaluating whether inpatient care was the least restrictive option necessary to prevent serious harm. Dr Rakov considered that it was difficult to assess this issue in the absence of a ‘*comprehensive clinical assessment*,’ noting that Dr Huang had mentioned the recommencement of agomelatine but did not provide specific details of her overall mental state. She considered that a detailed clinical assessment would have better clarified the severity of Ms YPM’s risk and guided the decision-making process regarding the appropriateness, or otherwise, of compulsory treatment.

163. In the absence of a comprehensive clinical assessment, Dr Rakov considered that it was not possible to determine conclusively whether or not Ms YPM met the criteria for an Assessment Order at the time of her consultation with Dr Huang on 8 May 2020. Dr Rakov noted that on the evidence available – namely, that Ms YPM presented as *‘depressed, self-destructive, non-motivated, and suicidal but did not know how to die, and had not told her mother of this’* and had declined a voluntary admission to The Melbourne Clinic – she *‘leaned more strongly’* toward a view that Ms YPM may have required hospitalisation as the least restrictive option necessary to prevent serious harm.
164. However, Dr Rakov considered it was also possible that Ms YPM may have been managed safely in the community, so long as there was a robust plan to mitigate any immediate risks and her outpatient care team was equipped to provide the necessary level of supervision and support. Dr Rakov noted that in these circumstances, Ms YPM would not have met the criteria for compulsory treatment as the least restrictive option.
165. Regarding communicating with Ms YPM’s parents, Dr Rakov considered that Dr Huang ought to have made clear to Ms YPM that *‘involving her family was not a discretionary part of her care but essential to managing the immediate crisis and ensuring a comprehensive support system’*. Dr Rakov did not comment explicitly on the appropriate steps to be taken by Dr Huang, should Ms YPM have continued to refuse consent to speak with her parents. However, she later refers in the context of Ms YPM’s discharge from the Alfred Hospital to a *‘duty to warn’* which she states *‘arises from the need to ensure those caring for her are fully aware of her risks and prepared to respond appropriately to any signs of further deterioration’*.
166. In response to Dr Rakov’s report, Counsel for Dr Huang maintained that it was reasonable at the time for Dr Huang not to make an Assessment Order in relation to Ms YPM. In their submission, Dr Huang did conduct an assessment and determined that Ms YPM’s presentation did not warrant the making of an Assessment Order, on the basis that she had recommenced taking agomelatine and agreed to an appointment on 11 May 2020 with him. Counsel for Dr Huang highlighted, in this respect, that a similar conclusion was reached by clinicians at the Alfred Hospital the following day, on 9 May 2020, where Ms YPM had presented following an overdose.²¹

²¹ Dr Huang Counsel submissions dated 26 November 2024, p. 2.

167. Legal representatives for Dr Huang did not make any specific comments as to whether Dr Huang should have communicated with Ms YPM's family on 8 May 2020. However, in relation to similar issues raised on 12 May 2020, they noted that Dr Huang did not notify Ms YPM's family on the basis that she was an adult who gave clear instructions that she did not consent to him speaking to her family, and also reported that she found it stressful to include her family in her care.²²
168. Professor Hopwood did not make any specific comment on the adequacy of care provided by Dr Huang on 8 May 2020, although noted that during the last week of Ms YPM's life, Dr Huang '*appeared to very clearly recognize the level of risk and appropriately emphasized inpatient care and safety wherever possible.*' Professor Large did not make any specific comment on the adequacy of care provided by Dr Huang on 8 May 2020.

Conclusion as to adequacy of care provided by Dr Huang on 8 May 2020

169. Overall, I consider that there is insufficient evidence before me to suggest that Ms YPM met the criteria for compulsory assessment under the MHA at the time she presented to Dr Huang on 8 May 2020.
170. Dr Huang recognised that Ms YPM's mental health had deteriorated and offered her an inpatient admission, but she was not accepting of this proposed course of action. On the basis that Ms YPM reported to Dr Huang that she had recommenced agomelatine, and agreed to an appointment with him on 11 May 2020, it was not unreasonable to conclude that she could be appropriately managed via '*less restrictive means*' in the community and thus did not meet the MHA requirements. While it is possible, as suggested by Dr Rakov, that a more comprehensive assessment may have revealed a higher risk level, this suggestion is speculative (as acknowledged by Dr Rakov) and does not raise any basis on which to make an adverse finding.
171. Similarly, in circumstances where Ms YPM was refusing consent for Dr Huang to speak with her family, I consider there was no clear basis for Dr Huang to breach doctor-patient confidentiality by speaking with her parents without her consent. In this regard, I note that Ms YPM was an adult assessed as capable of engaging in treatment on a voluntary basis in the community, and that there was no evidence that she posed a serious and

²² Correspondence from Avant Lawyers dated 26 November 2024.

imminent threat to herself at that time so as to justify such notification (the legal bases for which are explored further below).

172. I note that Dr Giuffrida (based in NSW), in opining that Dr Huang ‘*clearly*’ ought to have in the first instance arranged for Ms YPM’s in-patient admission on this date, or at least to have informed Ms YPM’s family of her suicidality, does not explicitly address the Victorian MHA criteria, including the requirement to treat patients by the least restrictive means, nor the Health Privacy Principles regarding patient confidentiality. Accordingly, given Dr Giuffrida does not address the applicable legislative landscape, I have not been persuaded by his opinion on these issues.
173. In drawing my conclusion, I do not dispute the view of Ms YPM’s family, and of Dr Giuffrida, that she may have benefited from inpatient treatment or further involvement from her family at this time. I note in particular that Ms YPM’s mother, who provided further submissions to the Court on 5 September 2025, submitted that Ms YPM’s lack of consent to involve her family in her treatment represented a change after years of her parents communicating with the treatment team, including Dr Huang, and that ‘*[they] were not informed on 8 May – or at any time – that [they] no longer part of Ms YPM’s long-established support team or being excluded from important information*’.
174. In this respect, I consider that it would have been appropriate for Dr Huang to take all available steps to advise Ms YPM of the benefits of involving her family, and the possible risks of not doing so, in an effort to gain her consent to action a more proactive approach. However, while this may have optimised Ms YPM’s care, I consider that Dr Huang’s treatment plan on this date to have been adequate.

Presentation to Alfred Hospital on 9 May 2020

175. As noted above, on 9 May 2020 at approximately 2am, Ms YPM attended Alfred Hospital Emergency Department (**ED**) with her friend following a polypharmacy overdose. It was reported that she had taken prescription medications including diazepam and agomelatine, after consuming a significant amount of alcohol (half a bottle of tequila). As she presented as sedated and intoxicated, it was determined that she required medical observation until both resolved and then would require a thorough mental health assessment. She indicated upon presentation to the ED that she ‘*desired a lethal injection from the psychiatrist*’.

176. At 11.25am, Ms YPM was considered to be sufficiently alert for a mental health assessment by the Emergency Psychiatry Service (EPS). Ms YPM denied her polypharmacy overdose represented a suicide attempt and said she had been in conflict with her partner and wanted to shut off from a challenging day. She acknowledged several stressors in the preceding weeks which included a toxic relationship, adjusting to new employment, and a desire to move out of home. She reported she had ceased her antidepressants three weeks prior due to feeling dull and admitted to experiencing dark thoughts over the previous week. She mentioned she had seen Dr Huang the day before.
177. The treating EPS clinician suggested Ms YPM consider a voluntary admission at The Melbourne Clinic under the care of Dr Huang but she declined and indicated that she would follow up with Dr Huang on 11 May 2020. She was also offered and declined intensive community follow up by Alfred CATT. The EPS clinician did not consider that Ms YPM met the criteria for compulsory treatment under the MHA. According to the statement of Dr Evan Symons, in circumstances where Ms YPM did not meet criteria for compulsory treatment, assertive public mental health follow up could not be enforced against Ms YPM's will.
178. In the Alfred Hospital's internal review, the panel felt it was clinically appropriate that Ms YPM was discharged home from the Alfred at that time. Dr Symons noted that there was a clear rationale documented in the EMR by the EPS clinician for this discharge and that multiple mental health community supports were offered but declined. Overall, the panel felt that the care provided to Ms YPM, including the assessment and discharge planning was clinically appropriate. The panel considered it was not below a reasonable standard of care that Ms YPM's family was not contacted at the time of her assessment.
179. In his expert report submitted by Ms YPM's family, Dr Giuffrida stated that Ms YPM's risk was assessed as 'risk +++', although the source of this statement is unclear noting this does not appear in the medical records.²³ Dr Giuffrida opined that, on his understanding of Ms YPM's risk rating, he considered it was '*extremely difficult to*

²³ In submissions received on 5 September 2025 on behalf of Alfred Health, it was submitted that, while Dr Giuffrida's report notes that the risk was assessed as 'risk +++', this is not reflected in Ms YPM's clinical records for her presentation on 9 May 2020. With reference to the assessment by the Emergency Psychiatry Service clinician, it was noted '*denies current suicidal planning or intent*', her risk of suicide and deliberate self-harm was assessed as not being high and she was assessed as being at her baseline risk. I have reviewed the medical records and I accept Alfred Health's submissions in this regard. My consideration of Ms YPM's risk level is below.

understand’ why Ms YPM was discharged the same day and believed she should have been considered, and made subject, to an order for compulsory assessment or treatment. Dr Giuffrida stated, ‘[I]t is incomprehensible as to why given that Alfred Health/Hospital must have known that Ms YPM represented a very high to extreme risk of suicide – didn’t provide an ongoing admission and immediately contact Ms YPM’s treating doctors is equally incomprehensible.’

180. Counsel for the family stated in submissions dated May 2023 that on a proper construction of section 29 of the MHA, Ms YPM’s presentation met the criteria for an Assessment Order given that:

- a) Ms YPM appeared to have a mental illness (she had taken an overdose and was experiencing dark thoughts);
- b) Her apparent mental illness needed immediate treatment (or assessment) to prevent serious harm to herself (she had taken a potentially fatal overdose and was at risk of further such action);
- c) Ms YPM was able to be assessed if an order was made (she was at the Alfred Hospital with access to an appropriate assessment by an authorised psychiatrist); and
- d) There was no less restrictive means reasonably available to have her assessed (she was unwilling to accept voluntary admission to The Melbourne Clinic).

181. It was submitted that given Ms YPM’s rejection of the admission to The Melbourne Clinic, voluntary admission to the Alfred Hospital should have been offered and if that was rejected, that an Assessment Order should have been made.

182. In an expert report obtained by the Court, Dr Rakov agreed that Ms YPM appeared to meet the criteria to be placed on an Assessment Order on 9 May 2020.²⁴

183. In considering the adequacy of the assessment conducted by the treating EPS clinician, Dr Rakov opined that while the assessment was thorough in documenting Ms YPM’s

²⁴ While Dr Rakov considered that Ms YPM appeared to meet the criteria under the MHA, she acknowledged that it was also reasonable to argue that Ms YPM could potentially have been managed at home, in circumstances where clinicians ensured appropriate collateral information, an appropriate discharge plan and adequate support.

presentation, she had ‘*significant concerns*’ regarding the conclusions drawn. In particular, Dr Rakov considered that the assertion that Ms YPM had ‘*intact*’ judgment lacked specificity and may not have fully captured her mental state. In contrast, Dr Rakov considered that Ms YPM’s judgment was ‘*in a likelihood compromised,*’ noting in particular that a large overdose in the context of withdrawing herself from prescribed medication can impair cognitive function and decision-making capacity.

184. In this context, Dr Rakov considered that Ms YPM required a comprehensive assessment by a psychiatrist on the basis of her new risk factors – such as withdrawing from her prescribed medications, a breakdown in perceived supportive relationships due to family and romantic tensions, and changes in her work circumstances – to determine whether compulsory treatment was necessary, or if not, to ensure a robust discharge plan with adequate follow-up and communication.
185. While noting the potential for less restrictive options, Dr Rakov considered that Ms YPM’s medication withdrawal suggested that community-based care was ‘*not really sufficient to manage her risk effectively at that time*’.
186. In addition, Dr Rakov opined that the discharge plan in these circumstances was inadequate. Dr Rakov noted that the 2018 RANZCP clinical practice guideline provides that for patients who frequently present with deliberate self-harm, primary and specialist care providers should be identified and should collaborate with hospital staff to develop a management plan. In this instance, Dr Rakov noted there was no evidence of any management plan in existence. Given Ms YPM’s history of repeated ED presentations and admissions following impulsive overdoses, Dr Rakov considered that her case should have been ‘*flagged*’ as requiring a more structured approach.
187. Dr Rakov considered that the plan prepared at the time of Ms YPM’s discharge reflected some appropriate elements, such as respecting Ms YPM’s preference to engage with her established psychiatric care team, and recognising her family as protective factors. Dr Rakov considered, however, that the discharge plan lacked a comprehensive risk management strategy, and did not sufficiently address her elevated risk of self-harm noting:
 - a) Her recent withdrawal from medications;

- b) A recent overdose; and
- c) Strained support networks.

188. In particular, Dr Rakov noted that the discharge plan relied heavily on Ms YPM's self-report and assurances. Dr Rakov considered that in circumstances where she had seen her psychiatrist the previous night, taken a significant overdose, and committed to attending another appointment on Monday, Alfred Health should have '*sought further confirmation of the suitability of this plan, including contacting relevant parties (i.e. her parents) to ensure that her suggestion to return home was appropriate.*' Issues related to the adequacy of communication upon discharge with Ms YPM's treating clinicians and family are discussed further below.
189. Dr Rakov also noted that '*no assertive follow-up measures were implemented.*' While acknowledging that Ms YPM declined support from CATT and TriagePlus, there may have been a possibility for enhanced strategies to encourage patients like Ms YPM, who are high risk but ambivalent about receiving care, to access further care.
190. Overall, Dr Rakov considered that the decision to discharge Ms YPM to her home on 9 May 2020 without appropriate safeguards – including a coordinated follow up plan, sufficient communication with her support network, or confirmation that outpatient care arrangements were effectively in place – fell below a reasonable standard of care. Dr Rakov considered that a '*more structured and coordinated approach*' to discharge including both closer monitoring and better communication would have been more suitable.
191. In response to Dr Rakov's report, a further statement was submitted by Associate Professor Simon Stafrace (**A/Prof Stafrace**), Consultant Psychiatrist and Program Director of Alfred Mental and Addiction Health.²⁵ A/Prof Stafrace stated that he '*respectfully disagree[d]*' with the opinion of Dr Rakov and considered that it was entirely appropriate to manage Ms YPM on 9 May 2020 using a less restrictive approach, with planned follow-up with her private psychiatrist on 11 May 2020, and that this approach aligned with legislative requirements in place at that time.

²⁵ I note for completeness that this is a statement from a clinician employed by an Interested Party (albeit a very senior one) and not an independent expert report, and it has been considered in accordance with this 'status'.

192. In A/Prof Stafrace's view, Ms YPM was well engaged by the clinician in the EPS at Alfred Health who *'listened empathically, built trust and having determined that [Tanar] retained capacity, allowed choice and control'*. The availability of a less restrictive means was demonstrated by the fact that Ms YPM followed through with the discharge plan by attending the planned appointment with her private psychiatrist on 11 May 2020. A/Prof Stafrace provided that Dr Rakov's opinion was *'unhelpful in perpetuating an often misunderstood and paternalistic view of mental health treatment under the MHA, is not in line with best practice and in [his] view, is inconsistent with the principles of the MHA.'*
193. A/Prof Stafrace further considered that the option of making an Assessment Order was *'not in line with the high threshold appropriately set for compulsory treatment'* and may have been *'construed as undermining the principles of the MHA, in restricting [Ms YPM's] autonomy and her human rights.'* A/Prof Stafrace explained that in his view, that clinicians are required to consider that restrictions of autonomy and movement can *'cause trauma, undermine trust and create long-term risks as patients may in future refuse to seek treatment for fear of being compelled or restricted.'*
194. He noted that such considerations were particularly pertinent for clinicians at the relevant time, as the Royal Commission into Victoria's Mental Health System (**Royal Commission**) was underway and emphasised the need to shift toward a more human rights based, person centred approach, whereby overriding a patient's autonomy should only be considered as a last resort. In this respect, A/Prof Stafrace noted that the view expressed by Dr Rakov would be in conflict with the updated framework provided under the *Mental Health and Wellbeing Act 2022*, which emphasises principles including autonomy, dignity of risk, and less restrictive treatment.
195. Professor Hopwood opined very briefly that Ms YPM had been treated at the Alfred following an overdose *'in an appropriate fashion'*. Professor Large did not provide an opinion on the adequacy of Alfred Health's treatment of Ms YPM on 9 May 2020.

Conclusion as to adequacy of care provided to Ms YPM by the Alfred Hospital

196. I consider that, while overall reasonable, the treatment and care provided to Ms YPM on 9 May 2020 could have been optimised in a number of respects. Firstly, I note that both experts who opined in any detail on the care provided to Ms YPM by The Alfred, namely

Drs Rakov and Giuffrida, were both of the view that, following the overdose, she ought to have been admitted to The Alfred and her treating clinicians and family contacted. Dr Rakov opines further that Ms YPM appeared to meet the criteria for an Assessment Order under the MHA, a proposition with which the family concurs.

197. I note the significant difficulties in retrospectively assessing in such circumstances whether a patient would have met the criteria under section 29 MHA (as then applied) so as to warrant their involuntary assessment at a particular point in time. In Ms YPM's case, she was denying that the overdose represented a suicide attempt (which, in this context, places some doubt on the application of certain section 29 criteria, including s29(b)).
198. In circumstances where all criteria under section 29 are required to be met in order to place a person on an Assessment Order, I consider the assertion that Ms YPM did not meet the criteria under the MHA at that time to be a defensible one.
199. I note further that Ms YPM was known to The Alfred. Information available to her treating clinicians was that she had had numerous previous admissions to The Alfred following overdoses, following which she re-engaged with her treating team in the community. Moreover, I note the emphatic submissions of A/Prof Stafrace that she ought to be treated in the least restrictive means available, consistent with the MHA requirements, as a matter of law and as a matter of her own autonomy and human rights. I agree.
200. What is unclear to me, then, is why a voluntary admission to The Alfred did not appear to be considered or offered to Ms YPM at this point, given that it was a weekend, Ms YPM would not likely be in a position to easily follow up with any existing supports (i.e. Dr Huang) at that time, and that a voluntary admission to The Alfred would be consistent with the requirement to treat her in the least restrictive manner possible. It would have afforded Ms YPM with additional time to recover from the effects of the substances she had ingested, which is a factor noted as critical by Dr Rakov in terms of Ms YPM's judgment, cognition and decision making-capacity, the importance of which is further underscored by her self-reported cessation of psychiatric medications three weeks prior.
201. A voluntary admission would also have allowed for more comprehensive discharge planning, including for contact to be made with the supports in the community, such as

her psychiatrist, psychologist, GP and (if then considered appropriate), family. This would have enabled Ms YPM to receive more coordinated care at a time of great vulnerability.

202. Whether Ms YPM would have accepted such admission, if offered, is speculative; however, it remains that where she was already physically present at The Alfred, and that an admission to The Melbourne Clinic would require planning, consultation and financial commitment, and in circumstances in which her assessing clinician at The Alfred noted her to be ‘*engaged*’ in the assessment process, this ought in my view to have been offered.
203. In circumstances where I cannot find that the section 29 MHA requirements were satisfied, I have no basis to make an adverse finding that the care provided by Alfred Health to Ms YPM fell short insofar as clinicians did not subject her to compulsory assessment under the MHA, noting in particular the assessment of her risk was not considered ‘high’ at that juncture. However, I do consider that there was a missed opportunity in Ms YPM’s care, namely to offer a voluntary admission that would have allowed Alfred Health clinicians to develop a comprehensive risk management strategy upon her release (which Dr Rakov underscored the importance of, given her fluctuating risk) at a time when Ms YPM remained vulnerable, and during a weekend period that would have rendered access to her usual supports more difficult.

Communication following discharge from The Alfred Hospital

204. In submissions dated May 2023, Counsel for Ms YPM’s family also raised concerns about the absence of any communication with Ms YPM’s treating clinicians following her discharge from the Alfred Hospital, in particular with:
- a) Ms YPM’s family – particularly given she had indicated to clinicians that her family were protective factors in her life;
 - b) Dr Huang; and
 - c) Dr Shannon.

Communication Ms YPM’s family

205. Following the Alfred Health internal review, the review panel reflected that there was no documentation in the Electronic Medical Record regarding the involvement of a support

person or carer. The EPS clinician who assessed Ms YPM advised the review panel that they *‘strongly felt that, consistent with their usual practice, there would have been a reason that they did not speak to [Ms YPM’s] family (such as [Ms YPM] may not have provided her consent for contact to occur or she may have reported that she was not living with her parents).’* However, no such reason was recorded in the medical records.

206. In submissions on behalf of Ms YPM’s family, it was contended that, *‘in circumstances where [Ms YPM] had presented following a significant episode of self-harm, was not transitioning to inpatient care, and was not able to access her treating psychiatrist for a period of two days, it was critical to Ms YPM’s safety that the people living with her be armed with the knowledge of her circumstances and what they should be aware of that might indicate a further deterioration in her condition.’* Similarly, Dr Giuffrida considered that Alfred Health acted below a reasonable standard of care in not notifying Ms YPM’s family of the need for supervision prior to her discharge.
207. Dr Rakov agreed that involving family in discharge planning is *‘essential’* in circumstances where family are a *‘key component of the patient’s support network, and a discharge plan is predicated on their support.’* Specifically, Dr Rakov considered that the involvement of Ms YPM’s family would have assisted clinicians in determining the suitability of the proposed plan for Ms YPM to be discharged home and provided an opportunity to warn her caregivers about the risks that she continued to present, since they were to be directly involved in her post-discharge care.
208. In this respect, Dr Rakov considered that Alfred Health clinicians should have emphasised to Ms YPM the necessity of family involvement for effective management of her high risk behaviours and safety. Dr Rakov stated, *‘It is not simply a matter of respecting her refusal to communicate with them; there is also a duty to warn, given that her family would be responsible for her care, and she continued to present a risk of suicide ... This duty arises from the need to ensure those caring for her are fully aware of her risks and prepared to respond appropriately to any signs of further deterioration.’*
209. Dr Rakov concluded that in failing to inform Ms YPM’s family of her overdose, the treatment provided by clinicians at the Alfred fell below a reasonable standard of care, as it did not provide her family with the necessary information to ensure her safety and wellbeing at home.

210. A/Prof Stafrace disagreed with the opinion of Dr Rakov in this regard. He emphasised that Ms YPM was an adult with capacity, was not being treated as a compulsory patient under the MHA, and did not provide her consent to share confidential information with family. In these circumstances, while noting that it is ideal to communicate with family supports in a mental health crisis, he considered that clinicians were not permitted under the MHA to disclose information in absence of consent and a legislated carer relationship, even to co-habiting family members.

Communication with Dr Huang

211. The Alfred review panel found that a handover of care to Ms YPM's private psychiatrist should ideally have occurred as a priority on 11 May 2020, as was the intended plan. It noted that an attempt was made to handover the case to Dr Huang on 12 May 2020, whereby the clinician left a voice message. The next day after speaking with the clinic, the clinician confirmed that Ms YPM had attended Dr Huang's rooms and sent the EPS assessment documentation to his rooms by fax.
212. In submissions dated May 2023, Counsel for the family stated that, *'the failure to provide a handover to Dr Huang was deficient in its reliance on Ms YPM, a distressed and vulnerable individual, to objectively relay the various details of the admission'* at her scheduled appointment with Dr Huang two days later. Similarly, as noted above, Dr Giuffrida considered that it was *'incomprehensible'* that clinicians had not effected handover prior to discharge.
213. In contrast, Dr Rakov considered that some degree of delay in handing over to private practitioners was acceptable noting they do not operate within a 24/7 framework. However, in the context of such limitations, Dr Rakov considered that it would have been advisable for Alfred Health to establish conditional follow-up arrangements that required interim support until her providers could realistically be contacted, likely on Monday morning. This may have involved CATT/Triage Plus.
214. In this instance, Dr Rakov considered that handover to Dr Huang should have been attempted on the day of discharge or the next working day, to ensure continuity of care and informed treatment planning. She noted that it was unclear why the planned handover phone call from Dr Huang on Monday morning, 11 May 2020, did not take place, suggesting a possible process issue within the EPS team. Further, Dr Rakov considered

that a phone call would have been more appropriate than relying solely on a written summary, in order to ensure that Dr Huang had the immediate information that he needed to manage her care appropriately.

215. Noting Ms YPM's acute presentation on 9 May 2020, and her scheduled appointment with Dr Huang on 11 May 2020, Dr Rakov considered that the handover from Alfred Health to Dr Huang on 13 May 2020 was '*unreasonably delayed*', undermined the effectiveness of her care, and reflected a lack of urgency. Although noting this was not causal, Dr Rakov considered that this delay in notifying Dr Huang fell below a reasonable standard of care, given the high-risk and acute nature of Ms YPM's presentation.
216. As acknowledged by Dr Rakov, A/Prof Stafrace emphasised that there is no evidence that the failure to handover to Dr Huang impacted adversely on Ms YPM's care, given that she attended the psychiatric review as planned.

Communication with Dr Shannon

217. There was some contention as to whether or not Alfred Health provided a discharge summary to Dr Shannon, Ms YPM's GP.²⁶ In the event that it did not occur, it would have meant that Dr Shannon did not become aware of Ms YPM's hospital admission until Ms YPM self-presented on 11 May 2020 and disclosed the events of her admission. However, I note that in the medical records of the Airlie Women's Clinic, there is an Alfred Health discharge summary for 9 May 2020 on p.287 thereof. The provenance of this discharge summary is unclear (i.e. it is not attached to a facsimile, email or similar). However, it is evident that Dr Shannon, at some point, received a discharge summary from The Alfred regarding the admission on 9 May 2020.
218. In this respect, I note that the Alfred internal review acknowledged that handover was planned to occur with Dr Huang, but not with her GP, as it had been discussed with Ms YPM that she was actively engaged with her private psychiatrist.

²⁶ In a briefing summary prepared by the Court and provided to Dr Rakov, it was stated that a discharge summary was sent to Dr Shannon. This was also expressed by Counsel for the family in submissions dated May 2023. However, following a comprehensive review of the available evidence, Dr Rakov states that the evidence suggests that EPS did not send any discharge summary to Dr Shannon.

219. Counsel for the family submitted that in the circumstances, immediate and direct communication should have been made to Dr Shannon, and contended that such communication should have been direct rather than via a faxed discharge summary.
220. Dr Rakov, who was of the view that no discharge summary was provided to Dr Shannon, considered that standard acceptable practice would have been for Alfred Health to fax a discharge summary to Dr Shannon on the day of Ms YPM's discharge. This practice would have ensured that Dr Shannon was fully informed of the acute episode, and could coordinate ongoing care accordingly. Instead, Dr Shannon was only able to provide follow up care to Ms YPM following her self-presentation on 11 May 2020, and had to rely on her self-report, rather than having had access to a complete discharge summary. Dr Rakov considered that this lack of timely communication with Dr Shannon represented '*a significant lapse in the coordination of care for a high-risk patient*'.

Communication with Ms Lowndes

221. Dr Rakov considered that communication with Ms Lowndes could have been beneficial and valuable for future therapeutic sessions. However, she recognised that considering resourcing and urgency, it was appropriate that Alfred Health prioritised notifying those clinicians who were responsible for managing Ms YPM's acute mental health needs. In the instance where Ms Lowndes was not directly contacted by Alfred Health, regular updates between Dr Huang, Dr Shannon and Ms Lowndes could still ensure cohesive care, supporting continuity once the acute crisis was managed.

Conclusion as to adequacy of communication of Alfred Health regarding Ms YPM's discharge

222. I agree with the opinion of Dr Rakov (consistent with Dr Giuffrida and noted in the statement of A/Prof Stafrace) that communication with Ms YPM's family upon her discharge from The Alfred would have been valuable in the circumstances, as it would have provided an opportunity to road-test the efficacy of the discharge plan formulated for Ms YPM, noting in particular that the plan involved her returning to the family home and that she had listed her parents as protective factors.
223. However, in circumstances where Ms YPM did not consent to her family being notified, I accept that there was no legal basis for Alfred Health to inform her family of her episode of care or of her discharge. This is because Ms YPM was an adult, with capacity, who

was assessed not to meet the MHA requirements for compulsory assessment or treatment, and who had been assessed not to present a serious and imminent threat to her life, health, safety or welfare at the time of her discharge from hospital. Therefore, there was no legal requirement for Alfred Health to notify her family of her episode of care or of her discharge either under the MHA notification provisions²⁷ or via the carveout in the HPPs.²⁸

224. I consider that, as opined by Dr Rakov, clinicians ought to have taken all reasonable steps to discuss with Ms YPM the benefits of involving family in her care, as a foundational aspect of her discharge plan. Unfortunately, there is a deficiency in the medical records on this issue (given that discussions about family involvement are not recorded in the EMR and Alfred Health's response is based on the presumed usual practice of the EPS clinician). In these circumstances, it is not possible to now assess the appropriateness of discussions clinicians had with Ms YPM about involving loved ones in her care, and whether this factored into appropriate discharge planning. From the standpoint of my present investigation, I consider this to be a concerning gap, rendering the issue incapable of resolution based on the evidence before me. However, as this has been identified and addressed via the Alfred Health internal review, I do not consider it warrants further comment or recommendation.
225. I consider that Ms YPM's care ought to have been handed over to Dr Huang via direct communication from an Alfred Health clinician on the morning of the next business day, namely 11 May 2020, as per the EPS plan. The delay in doing so, and doing so via faxed discharge summary only on 13 May 2020 (*after* Ms YPM's discharge from The Melbourne Clinic), meant that Dr Huang was not fully or independently informed of the circumstances of Ms YPM's recent overdose, which in turn meant that Dr Huang was not as well-positioned to make informed decisions as to Ms YPM's care needs when she

²⁷ The MHA sets out certain circumstances in which treating clinicians must notify nominated persons, who may include family, including following, *inter alia*, the imposition of an Assessment Order.

²⁸ I note that Dr Rakov refers to a 'duty to warn' which she states '*arises from the need to ensure those caring for her are fully aware of her risks and prepared to respond appropriately to any signs of further deterioration.*' However, the basis for a 'duty to warn' was not clearly outlined by Dr Rakov (and I note that it is usually referred to as a duty to warn a patient of the risks attendant upon a particular procedure or proposed clinical course). In these circumstances I preferred the advice of the CPU that, without a patient's consent, clinicians are restricted by the Health Privacy Principles and may only disclose information for a secondary purpose in circumstances where one of the paragraphs in Principle 2.2 applies, including, most relevantly, where the organisation reasonably believes that the use of disclosure is necessary to lessen or prevent '*a serious and imminent threat to an individual's life, health, safety or welfare*'. I note that Ms YPM was not assessed as at a serious or imminent risk at the time of her discharge from Alfred Health on 9 May 2020.

presented in crisis to The Melbourne Clinic on 11 May 2020. I agree with the submissions of Counsel for the family, and the opinions of Drs Giuffrida and Rakov in this regard, that this delay in notifying Dr Huang fell below a reasonable standard of care, given the high-risk and acute nature of Ms YPM's presentation.

226. Given that Alfred Health has itself identified this issue via its internal review and has commendably taken action in response (that is, it has recruited a new EPS leader position, based in the ED, that is responsible to oversee and lead the completion of clinical reviews and handover processes), I consider that the need for a coronial recommendation on this issue is obviated.
227. In relation to Ms YPM's GP, I also consider it to be of critical importance that Alfred Health communicated with Dr Shannon, at the very least, by way of sending a discharge summary upon Ms YPM's discharge from hospital. The existence of a discharge summary in the Airlie Women's Clinic medical records suggests that this did occur at some point, though I cannot determine when. On this basis I do not consider any adverse comment is warranted.
228. However, I emphasise more broadly that it is critical that Alfred Health ensure through its EPS that discharge summaries are consistently faxed or emailed to GPs in a timely way. Having perused all of Ms YPM's medical records in some detail, I note that Dr Shannon had previously raised this as an issue in relation to past episodes of care for Ms YPM at the Alfred, and at which time Dr Shannon had to herself proactively follow up details of Ms YPM's presentation to the Alfred following an overdose as she had not received any information from The Alfred.²⁹
229. In relation to Ms Lowndes, I accept the opinion of Dr Rakov that communication from The Alfred with Ms Lowndes could have been beneficial and valuable for future therapeutic sessions, though it was appropriate that Alfred Health prioritised notifying those clinicians who were responsible for managing Ms YPM's acute mental health

²⁹ See in this regard the letter written by Dr Shannon to Dr Huang on 15 May 2018 contained at p. 175/327 of the Airlie Women's Clinic medical records in which Dr Shannon writes '*I've attached [Ms YPM]'s discharge summary from the Alfred. I called and spoke to the intake at Alfred ED and they confirmed that there had been no attempt to contact you or I when she took an overdose on 30/4/18. The CAT team was not contacted and she had no mental health assessment. I have asked the Alfred ED to look into this breakdown in communication*'.

needs.³⁰ Accordingly, I do not consider that there is sufficient evidence to find any deficiency in care with regard to a failure to communicate directly with Ms YPM's psychologist. Having considered the advice of the CPU, however, a pertinent recommendation will follow.

Admission to The Melbourne Clinic 11-12 May 2020 and treatment therein

230. As noted above, Ms YPM presented to Dr Huang on 11 May 2020 and disclosed her recent admission to the Alfred following a polysubstance overdose. According to Dr Huang's clinical notes, Ms YPM noted, in relation to that overdose, that she '*was depressed, didn't want to be alive, tried to cut [herself] ... looked for a rope and then decided to be out of it so [she] swallowed a lot of Valium.*' Ms YPM agreed to be admitted to The Melbourne Clinic for treatment as an inpatient. She was subsequently admitted at about 12:30pm on the same day.

231. The family submits that at the time of her admission, it was noted in the clinical assessment that:

- a) Ms YPM's family did not know that she had been admitted;
- b) Ms YPM had recently overdosed on diazepam and tequila but had denied suicidal intention;
- c) Ms YPM had been self-harming by experimenting with cutting (8 May);
- d) Ms YPM rated her own risk of harm as 10/10; and
- e) Ms YPM had some suicidal thoughts with plan but was '*unable to do so in hospital*'.

232. The evidence demonstrates that within two to three hours of her admission to The Melbourne Clinic, Ms YPM was found in the bathroom with a '*manhole*' open and what appeared to be a potential ligature (a scarf) in her hand. Ms YPM downplayed the significance of the incident. She was then transferred to the ICU for closer monitoring and supervision. Ms YPM discussed being discharged and Dr Huang advised that he

³⁰ I note that as part of safety planning following a previous episode of care at Alfred Health, both Dr Shannon and Ms Lowndes appear to have been contacted by both phone and fax – see p.6/94 Alfred Health records. It is unclear why this same approach was not taken on 9 May 2020.

would consider making an Assessment Order under the MHA to continue her treatment if she wanted to self-discharge.

233. The family submitted in these circumstances *‘it was wholly inappropriate and unacceptable for Ms YPM to be discharged from The Melbourne Clinic without an Assessment Order being made and transfer to the Alfred Hospital or other public facility for an assessment by an authorised psychiatrist.’*
234. Conversely, Professor Hopwood, the expert engaged by Dr Huang, opined that *‘Dr Huang appeared to very clearly recognise the level of risk and appropriately emphasized inpatient care and safety wherever possible’*.
235. In submissions in relation to Professor Hopwood’s report, Counsel for Ms YPM’s family submitted:
- a) Despite Ms YPM saying she would be better off at home with her family, Dr Huang did not communicate with any of Ms YPM’s family members about her recent multiple attempts of self-harm during her admission;
 - b) Despite Dr Huang’s reasoning that Ms YPM had provided assurance that she would see her psychologist, Ms Lowndes on 15 May, he made no communication with Ms Lowndes in relation to the Ms YPM’s admission or discharge.
236. In the expert report commissioned by the Court, Dr Rakov opined that there were a number of inadequacies in the treatment provided during Ms YPM’s admission to The Melbourne Clinic, including that:
- a) The short length of the admission was *‘insufficient for any hope of thorough stabilisation and assessment compared to her prior inpatient experiences’* which ranged from 5 to 18 days;
 - b) At admission, no collateral information was sought from the Alfred regarding her presentation following an overdose of diazepam and alcohol. Further, the assessment underemphasised the severity of the overdose as a potential indicator of suicidal intent, particularly in circumstances where this mental state had persisted long enough to concern her GP sufficiently so as to arrange the admission;

- c) The initial risk assessments, whereby Ms YPM was labelled as low risk for suicide, self harm and absconding were inappropriate, as Ms YPM's behaviours were *'suggestive of a more substantial risk'*;
- d) The risk assessment, 24 hours later, whereby Ms YPM was noted to have dropped from a 'moderate to high risk' to 'low risk' of suicidality and self-harm was inappropriate, given there had not been sufficient time during the short admission for Ms YPM's risk to be contained and her mental state stabilised;
- e) There was a lack of thorough exploration into recent changes in her circumstances that could have impacted her mental state, such that the care team lacked a complete picture of the stressors contributing to her presentation (e.g. her cessation of psychotropic medications, increased isotretinoin dosage, relationship conflicts, or family tensions); and
- f) There was a lack of detailed documentation, reflecting incomplete care and limiting the ability of future clinicians to understand the full scope of Ms YPM's condition and treatment history.

237. Healthscope, which operates The Melbourne Clinic, submitted an expert opinion by psychiatrist Professor Large.

238. In response to Dr Rakov's concerns regarding the short length of Ms YPM's admission, Professor Large considered that:

- a) Ms YPM likely had chronic or near chronic fluctuating suicidal ideation. As such, it was reasonable to discharge her after a short period of time in circumstances in which she felt better and the intensity of her suicidal ideas had waned;
- b) There is no evidence that hospitalisation prevents suicide and suicide prevention treatments of any type, including those that can be given in hospital, provide a very modest protective effect;
- c) Patients with BPD sometimes require brief crisis admission to contain overtly present suicidal crises. It is widely accepted by Australian psychiatrists that there is little to be gained by a more prolonged admission; and

- d) As opined by Professor Hopwood, Ms YPM's mood symptoms were capable of fluctuation by virtue of her BPD. As such, it is possible that her mental state underwent significant improvement following her brief admission to The Melbourne Clinic in May 2020. It appears this is what occurred, as evidenced by Ms YPM's improved mental state on 12 May 2020.

239. In this respect, Healthscope noted that Ms YPM reported to Ms Lowndes during her consultation on 15 May 2020 following her discharge from The Melbourne Clinic that *'she has not been feeling suicidal, apart from when she was in the Clinic, which made her feel worse'*. Accordingly, Healthscope submitted that the length of Ms YPM's admission and the decision to discharge her on 12 May 2020 was appropriate.

240. Healthscope also noted that in contrast to Dr Rakov's opinion, neither Dr Giuffrida nor Professor Large made any criticisms regarding the risk assessments undertaken by The Melbourne Clinic nursing staff from 11 to 12 May 2020. Further, Professor Large took no issue with the enquiries made by Ms YPM's treating team into her medical and social history in May 2020, and stated that The Melbourne Clinic's assessments accorded with widely accepted Australia peer professional practice.

Adequacy of medication regime

241. Ms YPM's family raised numerous concerns about prescribing practices in relation to certain medications, particularly mirtazapine and Roaccutane (a brand name for *isotretinoin*). The appropriateness of prescribing practices in relation to each of these medications will be discussed in turn.

Mirtazapine

242. Prior to Ms YPM's discharge, Dr Huang prescribed a new anti-depressant medication, mirtazapine. The CPU report noted that it can take up to four weeks for both mirtazapine and Ms YPM's other prescribed medication, agomelatine, to have a full therapeutic effect.

243. Dr Giuffrida considered that it was reasonable to commence Ms YPM on mirtazapine on 12 May 2020; however, it was then necessary to closely monitor her as an inpatient in the intensive care unit. He stated that Ms YPM should have been placed in a bed near or

opposite the nurses' station, and likely should have been placed on a one-to-one nursing special. Reasonable practice, according to Dr Giuffrida, also required the hospital to slowly transfer the patient's antidepressant medication from fluoxetine to mirtazapine on 12 May 2020, ideally in stages over a period of '*several days*' to two weeks.

244. Ms YPM's family submitted that it was concerning that, '*Ms YPM was discharged without information (distributed to her family) regarding the delay in the effectiveness of her medication, and changes that should be monitored prior to the full potency of the medication being realised.*'
245. Dr Rakov considered that it was reasonable to trial Ms YPM on a new antidepressant medication, and disagreed with the view of Dr Giuffrida that monitoring as an inpatient was necessary for the initiation of a new medication, noting that new medication is prescribed for psychiatric outpatients on a regular basis.
246. Professor Large also disagreed with Dr Giuffrida that it was necessary to closely monitor Ms YPM as an inpatient during the initiation of a new medication, noting that patients are switched between antidepressants as a matter of '*routine practice*'. Further, Professor Large noted that in this instance, the suggestion that Ms YPM should have been hospitalised with a bed opposite the nurses' station or one-to-one nursing special is '*impractical, not the standard of peer acceptable care, and would have ... been predictably counter therapeutic for [Ms YPM].*'

Roaccutane (also known as isotretinoin)

247. During her admission to The Melbourne Clinic, Ms YPM was continued to be prescribed isotretinoin (which was a prescription issued by Caulfield Dermatology).
248. Dr Giuffrida opined that Ms YPM's continued treatment with isotretinoin at The Melbourne Clinic is '*a critical issue of a seriously inappropriate treatment with the marked risk of an exacerbation of depression and suicide.*' He considered that it was not reasonable to continue to administer isotretinoin to Ms YPM given the known risks, and that this medication should have been immediately ceased at the time of the patient's presentation to The Melbourne Clinic on 11 May 2020.

249. Counsel for the family also raised concerns that Dr Huang did not communicate with Caulfield Dermatology to discuss the ongoing prescription. Further, there was no discussion or consideration by any of the clinical staff at The Melbourne Clinic despite Ms YPM's presentation and side effects which, according to the submissions, were *'widely known as being attributable to this particular medication'*.
250. In submissions made on 5 September 2025, Ms YPM's mother emphasised that in her discussions with Dr Huang following Ms YPM's death, her impression was that Dr Huang was unaware that Ms YPM was being prescribed isotretinoin by a dermatologist, and that in her view, this prescribed medication was not appropriately factored into the overall medication regime for Ms YPM, including consideration of any heightened risk this may have presented, and whether additional measures were required to monitor Ms YPM's risk profile.
251. Legal representatives for Dr Huang supported advice expressed by the CPU on this issue, namely that a diagnosis of depression is not a contraindication to prescribing isotretinoin and that it cannot be established that the isotretinoin was a contributing factor to Ms YPM's death, noting the Therapeutic Guidelines and MIMS.
252. In the expert report commissioned by the Court, Dr Rakov noted that a high-quality meta-analysis conducted in 2023 found that isotretinoin does not increase the risk of suicide or psychiatric disorders, and may even reduce the risk of suicide attempts in the years following treatment.³¹ However, Dr Rakov noted that Ms YPM's admission to The Melbourne Clinic predated this meta-analysis, and that the prevailing view at the relevant time among psychiatrists was that there could be a tenuous link between isotretinoin use and mood changes or suicide risk.
253. In this context, Dr Rakov considered that clinicians at The Melbourne Clinic did not adequately explore the potential impact of isotretinoin on Ms YPM's mental state, as the medication was not acknowledged as part of her medication regimen upon admission or discharge, and Ms YPM was not asked about any medication changes, which meant that clinicians may not have been aware that her isotretinoin dosage had been doubled in April 2020. According to Dr Rakov, exploring these issues during the initial assessment could

³¹ Tan, N. K. W., Tang, A., MacAlevey, N. C. Y. L., Tan, B. K. J., & Oon, H. H. (2023). Risk of suicide and psychiatric disorders among isotretinoin users: A meta-analysis

have informed a more comprehensive understanding of any precipitants to her increased risk.

254. In his supplementary report, Professor Hopwood also noted that the extent of the association between isotretinoin and an increased suicidality was being challenged even at the time of Ms YPM's admission to The Melbourne Clinic. He stated that in this instance, it was difficult to determine with certainty on the basis of the information available whether it was a contributing factor to her mood symptoms, but that he did not see sufficient evidence to clearly warrant its cessation at the time of Ms YPM's last admission.
255. According to Professor Large, the purported association between isotretinoin and depression and suicide is '*a matter of now discredited clinical folk law and has no place in contemporary medical opinion*'. In contrast to Dr Rakov, Professor Large considered that this discreditation had been demonstrated prior to 2023 in a wide range of studies conducted over the last 20 years, including meta-analyses published in 2016 and 2017 and a well-known 2019 study. On this basis, Professor Large considered that it was '*well within reasonable psychiatric practice*' at the relevant time of Ms YPM's admission to The Melbourne Clinic not to cease isotretinoin in circumstances where a patient was experiencing suicidal ideation. Further, even if the treating team had ceased the medication, Professor Large opined that this would not have changed the outcome given that isotretinoin has '*little or no association with suicide*'.

Decision to discharge on 12 May 2020

256. Ms YPM was discharged on the afternoon of 12 May 2020, following an assessment in which she was determined not to meet the criteria for an Assessment Order.
257. Ms YPM's family considered that the decision to allow Ms YPM to be discharged on 12 May 2020 was '*illogical*' in circumstances where Dr Huang had considered that she required admission to an inpatient unit the previous day, Ms YPM had made an active attempt to engage in self-harm in the intervening period, and had demonstrated '*no apparent improvement*.' They considered that in circumstances where Ms YPM presented an ongoing risk of suicide and had withdrawn her voluntary cooperation with treatment, there was no less restrictive means available and so an Assessment Order

(inpatient or community) was required for Ms YPM to be assessed by an authorised psychiatrist.

258. In particular, Ms YPM's family raised concerns that Dr Huang's decision relied on Ms YPM's apparent willingness to continue treatment with her longstanding treatment team and that she had identified supports she was willing to call upon. Yet, despite the apparent importance of such factors in Dr Huang's decision-making process, the provision of discharge summaries to treating clinicians was delayed and none of her identified supports (including her parents, ex-boyfriend and a female friend) were provided with information they considered was critical for them to provide appropriate support and supervision, including information regarding Ms YPM's episodes of self-harm during her admission and warning signs which might indicate further deterioration in her condition. In this context, Counsel for the family submitted that it is difficult to see how Dr Huang's decision not to place Ms YPM under an Assessment Order could be considered '*reasonable in the circumstances*.'
259. Dr Giuffrida too considered there were '*monumental reasons*' why Ms YPM should not have been discharged on 12 May 2020, as he considered that her suicide risk remained imminent and ongoing. Dr Giuffrida provided that in his opinion, even outpatient follow-up with Dr Huang and Ms Lowndes would not have ameliorated or mitigated Ms YPM's risk of suicide.
260. Dr Rakov considered that at the time of requesting discharge, Ms YPM did appear to meet the criteria for an Assessment Order had she refused ongoing treatment, and that a more restrictive approach '*might*' have been appropriate given her circumstances. In particular, Dr Rakov highlighted that Ms YPM posed a significant risk to herself, taking into account her recent overdose, continued suicidal ideation, stated intent to '*find a way out*', and the recent incident in which she was seen tying a scarf while adjusting a 'manhole'. Dr Rakov noted that her refusal to involve family further limited her available support system.
261. In these circumstances, Dr Rakov considered that discharge was inappropriate, noting in particular that there had not been adequate verification of Ms YPM's safety and support system at home. This is because the discharge plan relied heavily on Ms YPM's self-report and verbal reassurance. Further, Dr Rakov noted that since Dr Huang's assessment

on 11 May 2020 that Ms YPM was *'quite unwell'*, there had not been clear evidence of improvement and no substantive intervention had been undertaken. In addition, Ms YPM's refusal to involve her family in discharge planning should have raised concerns in circumstances where there was an intention was to discharge her home.

262. In these circumstances, Dr Rakov considered that the appropriate course of action would have been to extend Ms YPM's admission at The Melbourne Clinic for further observation and stabilisation. This would have allowed clinicians to monitor her newly prescribed medications, assess whether her reported improvement was sustained, to discuss the necessity of continued treatment and to address her refusal to involve family. Dr Rakov considered that involving Ms YPM's family and broader support network would have been necessary in order to provide *'a reliable, comprehensive and safe discharge plan'*.
263. Professor Hopwood stated that he shared the concerns of Dr Giuffrida and Dr Rakov in relation to Ms YPM's discharge so soon after a recent overdose and the incident involving apparent preparatory behaviour for an attempted hanging at The Melbourne Clinic on 11 May 2020, and noted that Dr Huang's discussion on the day of discharge indicated that he too would have desired a longer admission. However, Professor Hopwood emphasised that the *'practical issue'* was whether or not Ms YPM met legislative criteria for compulsory treatment. Dr Hopwood considered this was a *'difficult decision'* as there were *'no doubt very many concerning factors in the case at that moment in time.'* However, he considered that in circumstances where clinicians had secured a reasonable set of initial outpatient plans, and Ms YPM was engaged in that post discharge plan, the decision not to make Ms YPM an involuntary patient at this time was *'reasonable'*.
264. Professor Hopwood further speculated that had the alternative decision been made and Ms YPM been made an involuntary patient, it is likely that she would not have been detained involuntarily for any extended period and therefore that such a decision may not have altered the tragic outcome. In this respect, Professor Hopwood noted that Ms YPM's presentation to Ms Lowndes on 15 May 2020 was consistent with her having an improved mood and shows that Ms YPM did continue to engage with her treating team.
265. Professor Large commented that:

- a) Reasonable practice did not require The Melbourne Clinic to formally assess Ms YPM under an Assessment Order at any stage on 11 or 12 May 2020. In particular, at discharge, she did not exhibit any significant disturbance in her mental state and therefore might not have been regarded as having a mental illness; she did not appear to need immediate treatment to prevent a serious deterioration in her health or serious harm to herself or another; and treatment in the community was a reasonable and less restrictive option.
- b) Even if The Melbourne Clinic had reached what Professor Hopwood considers was the ‘*(incorrect) conclusion*’ that Ms YPM did meet criteria for involuntary detention, The Melbourne Clinic staff were not obligated to detain her if they considered that such detention was ‘*not the best clinical option in the longer term.*’ In the circumstances that Ms YPM did not want to be in hospital, is unlikely that any hospital admission would have benefited her or avoided her death.
- c) Professor Large commented that, ‘*[i]n reality, there was no safe and effective way of treating [Ms YPM], who posed an ongoing and significant risk to herself at all times after she commenced her pattern of repeated overdoses.*’
- d) Had Ms YPM been detained involuntarily, there was a significant risk that this might have damaged her long-term therapeutic relationships with Dr Huang and The Melbourne Clinic, or increased her suicide risk, with little benefit in terms of either short-term risk mitigation or her long-term prognosis. In this respect, Professor Large noted that:
 - i. Suicide rates in psychiatric hospitals are very high (in recent years some 50 times global suicide rates) – such that it is impossible to believe that they provide significant immediate protection from suicide;
 - ii. Suicide rates in the first week of discharge are even more elevated;
 - iii. Suicide rates are not significantly reduced by more prolonged psychiatric admissions;
 - iv. The positive predictive validity of suicidal ideation for suicide among psychiatric patients (the proportion of people who go on to suicide) is very

low and in the order of 5% over periods of years. Over clinically meaningful periods of weeks, the positive predictive value of suicidal ideation is commensurately lower – such that psychiatrists would have to admit thousands of patients with suicidal ideation to a hospital in order to admit one person with suicidal ideation who would have suicided within the period of hospitalisation. An even greater number of people would need to be admitted to prevent one suicide because there is no evidence that hospitalisation prevents suicide and suicide prevention treatments of any type, including those that can be given in hospital, provide a very modest protective effect, reducing suicide rates by about 10%;

- e) While it would have been reasonable for Ms YPM to remain in hospital on 12 May 2020 as a voluntary patient, this option was not available in circumstances in which Ms YPM sought to be discharged. Accordingly, The Melbourne Clinic had no choice but to discharge Ms YPM, in circumstances in which she was a voluntary patient and could not be detained under the MHA; and
- f) Even if an Assessment Order had been made, it is likely that the short-term instability of mood caused by Ms YPM's BPD would have soon resolved to the point that she would have been shortly released from the Alfred Hospital, and that this brief further stay would not have altered the eventual outcome. Further, Professor Large considered that it is improbable that the Alfred would have accepted Ms YPM as an involuntary patient on 12 May 2020.

266. Overall, Professor Large opined that focusing on whether Ms YPM might have been subject to compulsory assessment or treatment under the MHA *'runs the risk of misunderstanding the chronic, severe, and untreatable risks that [Ms YPM]'s eating disorder and personality posed.'* Professor Large continues, *'No hospitalisation of any length could have alleviated this decade-long risk because psychiatric hospitalisation provides limited, if any, short term protection from suicide, and does not alter the long-term trajectory of suicide.'*

267. Further to the opinion of Professor Large, Healthscope submitted that:

- a) While Dr Rakov asserts that the criteria for an Assessment Order had been met, she appears to have based her opinion on Ms YPM's mental health history prior to her

admission to The Melbourne Clinic, rather than her presentation on the day of 12 May 2020; and

- b) While Dr Rakov appears to assume that Ms YPM's suicide risk would largely have been mitigated with an extended inpatient admission, this seems unlikely based on the chronicity of Ms YPM's condition.

Conclusion as to adequacy of care provided to Ms YPM at The Melbourne Clinic on 11-12 May 2020

Medication regime

Mirtazapine

268. In relation to Dr Huang's prescription of mirtazapine to Ms YPM, I accept the opinions of Dr Rakov and Professor Large that the approach adopted was reasonable and appropriate in the circumstances and that no further intensive monitoring of the newly-prescribed mirtazapine was required. In this respect, I accept that new antidepressants are prescribed for psychiatric outpatients as a matter of '*routine practice*', and that the prescription of mirtazapine in Ms YPM's circumstances did not raise any basis to require closer monitoring in an inpatient setting, as opined by Dr Giuffrida. I note further that the issues raised by Ms YPM's family in relation to the communication of medication risks are dealt with below.

Isotretinoin

269. In relation to the prescription of isotretinoin, I accept on the basis of expert evidence provided by Dr Rakov and Professor Large, noting the studies cited, as well as the advice of the CPU, that it has been established that depression is not a contraindication to prescribing isotretinoin and that there is no evidence that the continued prescription of isotretinoin was a factor contributing to Ms YPM's poor mental state or her decision to take her own life.

270. However, I consider that, as Dr Rakov opined, the prevailing view in 2020 was that there could be a '*tenuous link*' between isotretinoin use and mood changes or suicide risk, which I consider to be supported by the advice provided by Ms YPM's dermatologist, Dr McNally, that Ms YPM's mood should be monitored following commencement of the

drug.³² I consider that, on the basis of the state of knowledge relevant to clinicians at the time of providing treatment to Ms YPM, this possibility of a link underscored a need to ensure that Ms YPM's treating clinicians had an accurate picture of her medication regime *in toto*, an issue that I address further below.

271. For completeness, I note that Dr Giuffrida's comments on the '*known risks of continuing to prescribe Roaccutane in Ms YPM's high-risk case*' are not underpinned by any cited studies or guidelines, or basis for what was purportedly '*known*' either as at 2020 or at the time of his report regarding the risks of isotretinoin use, and I have therefore not been persuaded by his opinion on this issue.

Medication regime as a whole

272. In terms of Ms YPM's medication regime as a whole, I consider that it was essential that the effects of this relatively new prescription (isotretinoin) were monitored by her treating team alongside her other medications, noting that at least two of these (olanzapine and mirtazapine) were very newly-prescribed indeed.
273. I accept the opinion of Dr Rakov in this connection that Ms YPM does not appear to have been asked at The Melbourne Clinic about any impacts of changes made to her isotretinoin dosage (the prescription of which was also omitted from her discharge summary) or her previous cessation of psychotropic medications, and I consider that this reflected a lost opportunity to ensure all treating clinicians had a clear picture of her overall medication regime, which was critical in ongoing assessment of the risk she presented. I note that this issue was also raised by Ms YPM's family in their additional submissions to the Court on 5 September 2025, referred to above, and I accept the proposition that Ms YPM's treating team required a clear picture of her currently-prescribed medications (and their dosage changes) to appropriately assess her level of risk.
274. Of further importance to the monitoring of her medication regime is the question of whether Ms YPM had been taking agomelatine as of 11 May. Dr Huang appears to place

³² In the lead-up to her presentation to The Melbourne Clinic on 11 May 2020, I note that Dr McNally (dermatologist) had previously '*counselled [Ms YPM] about the side effect profile, interaction with alcohol and tetracycline, and the need for double contraception while on isotretinoin*' and communicated to Airlie Women's Clinic on 20 April 2020 that her '*mood had been stable*' since commencing the drug.

some emphasis on the fact that she was taking agomelatine at the time of her inpatient admission on 11 May 2020,³³ though it is unclear to me on the available evidence whether Ms YPM, while she self-reported recommencing agomelatine, had in fact been doing so.³⁴

275. Given this issue is not capable of resolution, I consider it to be relevant only to the extent of emphasising the importance of clinicians having a clear picture of Ms YPM's medication regime as a whole in the context of her risk profile and discharge planning, which is addressed further below.

Overall adequacy of the care provided to Ms YPM on 11-12 May 2020

276. Drawing conclusions about the overall adequacy of the care provided to Ms YPM on 11-12 May 2020 has been an exercise I have given careful and anxious attention to.
277. I consider that it is telling that I have four expert reports before me containing, at parts, such disparate opinions; from Dr Giuffrida opining on one hand that the care provided to Ms YPM was replete with '*critical failures*' (including on the part of Dr Huang), to that of Dr Rakov opining that Ms YPM appeared to have met the MHA criteria on at least two occasions and required a longer period of inpatient care (including as of 12 May 2020, when she was discharged from The Melbourne Clinic), to that of Professor Hopwood concluding that Ms YPM received an '*acceptable level of care*', to that of Professor Large opining that there is no evidence to suggest that any care provided by clinicians at The Melbourne Clinic "*did not accord with widely accepted Australian peer professional practice.*'

³³ Supplementary statement of Dr Huang, 18 November 2022, p. 1.

³⁴ It is unclear to me whether Ms YPM had indeed recommenced taking agomelatine at this time, noting that at her presentation to Alfred Health on 9 May 2022, she reported having '*suddenly stopped her medication 3 weeks ago (Fluoxetine 80mg and Valdoaxn [sic]), blames medication for making her feel "dull"*'. – Alfred Health records, p. 4/94. There are also clinical notes from Dr Shannon from 4 May 2020 indicating that Ms YPM had presented to '*discuss results. All ok for now. Needs all back before restarting medication. Seeing Dr Huang this Friday for next review*' (emphasis added) and no prescription noted on this date except for diazepam. There are no notes for the consultation with Dr Shannon on 5 May 2020. In addition, a letter from Dr Huang to Dr Shannon written on 8 May 2020 notes that he had '*urged [Ms YPM] to have her bloods checked in particular her liver enzymes and if these are clear, she has agreed to resume taking [agomelatine]*' (Airlie Women's Clinic notes p. 293/327), suggesting she may not yet have recommenced it on this date. I note also for completeness that agomelatine was not detected upon post-mortem toxicological testing, though it has a short half-life.

278. Clearly Ms YPM's presentation, care and treatment needs during this period involve issues upon which reasonable (expert) minds can differ.
279. Having considered these expert opinions in conjunction with the advice from the CPU, I accept that Ms YPM's presentation and her co-occurring mental health conditions, which included BPD, anorexia and major depressive disorder, meant that she was at chronic risk of suicide, a factor emphasised by Professor Large, who remarked upon the high mortality rates of patients with such presentations, and who noted that '*[t]his mortality often cannot be prevented by psychiatric care.*'
280. In his supplementary report, Professor Large also observed that '*suicide is always unpredictable, and there is very little that mental health services can do to prevent suicides among people who recurrently present to hospitals with significant suicidality.*'
281. It is certainly the case that Ms YPM, over the span of several years, had multiple presentations to EDs following multiple overdoses, and at least ten in-patient admissions to The Melbourne Clinic, as well as ongoing appointments during her time as an outpatient in the community. She was being treated by a long-established care team, including not only psychiatrist Dr Huang, GP Dr Shannon, and psychologist Dr Lowndes, but also a dietician, a dermatologist and other specialists over the years. While there are certain issues in communication between members of her treating team in the final days before her death (which I will address further below), it remains that Ms YPM had a deep well of supports to draw upon to manage her mental health issues, even in the face of their chronicity.
282. She also had longstanding care from her family, who remained supportive, loving and were repeatedly referred to in medical records as '*protective factors,*' despite Ms YPM's decision to limit their involvement in her care in the period leading to her death.³⁵

³⁵ I note that Ms YPM reported to clinicians that she was reluctant to involve her family in her care in the period leading to her death due to finding their involvement stressful, and that she had at times a fractious relationship with her mother. This was relevant to clinicians in determining whether, and how, to appropriately involve Ms YPM's family in her care. I consider that such evidence does not detract from the overall conclusion that Ms YPM was loved and supported by her family. In this regard, I have witnessed in many investigations before me, that young adults may commonly determine to exclude their parents (or other close supports) from their care at moments of need. I consider that such actions may reflect a variety of impulses: a push towards independence; a desire to protect loved ones from the full extent of their struggles, or to free from the perceived burdens of providing care; or an impulse towards self-destruction, and in some cases, sadly towards death. I recognise that such actions may be challenging for family to grasp in the wake of a loved one's death.

283. It is devastating that Ms YPM suicided in the face of this well of supports.
284. In my view, it is tempting to attribute her suicide, at one end of the spectrum, to purported failures in care and communication by her treating team, and at the other end, to characterise the chronicity of her condition as one in which her suicide would not – and could not – ever have been preventable in the long-term.
285. In my view, the answer lies somewhere in between. It requires, amongst other things, a careful analysis of Ms YPM’s care and discharge on 11-12 May 2020 in light of: (i) the MHA requirements; and (ii) acceptable clinical practice based on the information known to clinicians at that time, giving due consideration to the expert evidence before me on these issues.
286. To this end, I share Professor Hopwood’s concern (also emphasised in the opinions of Drs Rakov and Giuffrida) regarding the discharge of Ms YPM from The Melbourne Clinic so soon after both a recent overdose and ‘*the apparent preparatory behaviour for attempted hanging the previous evening within The Melbourne Clinic*’, which significantly raised Ms YPM’s risk profile and which, regardless of the explanation she subsequently attributed to it, demonstrated an escalation in her self-harming behaviours.
287. I consider that the ‘scarf incident’ on 11 May 2020, on the back of an overdose in the days prior that required attendance at the Alfred Health ED (and which Ms YPM was now admitting to Dr Huang represented a suicide attempt, a characterisation she denied to Alfred Health clinicians), coupled with concerning comments made to Dr Huang on 11 May 2020 that Ms YPM ‘*was depressed, didn’t want to be alive, tried to cut [herself] ... looked for a rope and then decided to be out of it so [she] swallowed a lot of Valium*’ warranted consideration of a longer inpatient admission than that of just over 24 hours. It also warranted Dr Huang’s team seeking collateral information from The Alfred on the recent reported overdose where this had not otherwise been provided by The Alfred.
288. This is particularly the case on the back of what clinicians knew about Ms YPM’s self-cessation of her psychiatric medications three weeks earlier, the trialling of new medications by Dr Huang (including, for the first time, an anti-psychotic) and evidence known to clinicians that Ms YPM had been using alcohol in excessive quantities (noting

for example the tequila taken with prescribed medications on 9 May, self-reported to Dr Huang by Ms YPM).³⁶

289. Notwithstanding, it appears that the benefits of a longer inpatient admission for Ms YPM, as of 12 May 2020, were recognised by the treating team at The Melbourne Clinic. As Professor Hopwood notes, Dr Huang advocated for a longer admission for Ms YPM at The Melbourne Clinic but Ms YPM wished to leave. The issue then became one of whether she met the criteria for involuntary treatment under the MHA, which would have required a transfer from The Melbourne Clinic to a public facility (such as Alfred Health).
290. At a point where Ms YPM was reported as settled, was denying suicidality and expressing a strong desire to leave The Melbourne Clinic, and the section 29 criteria had to be assessed at that particular point in time, it is opined by Professors Large and Hopwood that the criteria for an assessment order were not met on 12 May and so Ms YPM could not have been transferred as an involuntary patient to a public mental health facility.
291. Overall, I accept that if there was a less restrictive means to treat Ms YPM, namely in the community – which I consider there appeared to be, based on her stated willingness to attend further appointments in the community with Drs Huang, Shannon and Ms Lowndes – then the strict requirements for an Assessment Order were not met.
292. However, given the variability of her risk – a factor that is common amongst patients with BPD and/or borderline personality traits, who may demonstrate impulsivity – I consider that Ms YPM’s recent concerning behaviour, her refusal to involve her family in her care, and changes to her medication regime amplified the need for rigorous discharge planning which ought to have included discussions with Ms YPM regarding the importance of her family or another loved one being involved in her care, and exploring in some depth the reasons why she was refusing the same.

³⁶ Also of relevance, which I have noted already above, is what her treating clinicians did not have a clear picture of. I find the opinion of Dr Rakov compelling in her observation that there is a paucity of clinical records at The Melbourne Clinic documenting recent changes in Ms YPM’s circumstances that could have impacted her mental state. Dr Rakov opines, and the evidence supports: ‘*The clinical notes do not demonstrate any detailed inquiry into her cessation of psychotropic medications, increased isotretinoin dosage, relationship conflicts, or family tensions - factors necessary to understanding her risk profile and mental health*’.

293. Despite the efforts of her treating team, I consider that there were deficiencies on this front, including in pre- and post-discharge communication, to which I will now turn.

Communication regarding discharge from The Melbourne Clinic on 12 May 2020

294. As previously discussed, Ms YPM's family has raised extensive concerns regarding the adequacy of communication at the time of, or following, Ms YPM's discharge from The Melbourne Clinic, including communication with:

- a) Ms YPM's family;
- b) Ms YPM's GP, Dr Shannon; and
- c) Ms YPM's psychologist, Ms Lowndes.

295. I will consider each issue in turn.

Communication with Ms YPM's family

296. Ms YPM's family felt that the absence of any communication with family upon discharge was concerning. In particular, given that support from family formed '*an integral part of the decision to discharge Ms YPM,*' the absence of information provided to Ms YPM's family left her '*vulnerable and without the necessary supports to function in the community*'.

297. The provision of information to Ms YPM's family, including information regarding her episodes of self-harm during her admission and warning signs that may indicate a further deterioration, was '*critical to Ms YPM's ongoing support that those who would be in a position to recognise changes in Ms YPM's condition and respond to any potential deterioration be informed as to her recent history and measures that should be implemented as a family.*' Instead, Ms YPM's mother stated that the short duration of Ms YPM's admission and Dr Huang's failure to return Ms YPM's call on 13 May 2020 left her family '*in the dark*' and '*under the impression that there were no elevated concerns about her health*'.

298. Dr Giuffrida's considered that it was a '*critical failure*' for Dr Huang not to have communicated with Ms YPM's family before or at the time of her discharge on 12 May 2020, given her '*known extreme risk*' and reliance on continued outpatient treatment. In

particular, Dr Giuffrida considered that Ms YPM's family should have been advised of all the circumstances (including her previous overdose on 8 or 9 May 2020, her attempted hanging the previous day, and the associated risks of her prescription of isotretinoin), the change in treatment and level of supervision required, and what action they should take in the instance that Ms YPM showed signs indicating suicidal ideation or behaviour. Dr Giuffrida further noted that Ms YPM's family should have been given the opportunity to ascertain whether they were prepared to adequately care for and supervise Ms YPM, such that if they did not feel prepared then it may not have been appropriate to proceed with discharge.

299. Legal representatives for Dr Huang submitted that Dr Huang did not communicate with Ms YPM's family on the basis that she was an adult who gave clear instructions that she did not consent to him speaking to her family and also reported that she found it stressful to include her family in her care.
300. Dr Rakov considered that involving Ms YPM's family was '*essential*' because they were part of her support system and management plan at home, given her high risk indicators. In circumstances where Ms YPM explicitly refused to let Dr Huang communicate with her parents, '*Dr Huang should have emphasised to [Ms YPM] that, without informing her family of her mental state and risk factors, creating an effective treatment plan that ensured her safety would be difficult. He needed to clarify that family involvement was not optional but necessary for managing her immediate crisis and providing comprehensive support.*'
301. However, in circumstances where Ms YPM retained the capacity to refuse consent, Professor Large stated that reasonable psychiatric practice required The Melbourne Clinic to refrain from providing information to Ms YPM's parents about her admission. Professor Large considered that the '*scarf incident*' was not sufficiently concerning so as to warrant a breach of Ms YPM's confidentiality in this regard, particularly in circumstances where she had consented to stay in hospital that evening, and noted that to breach confidentiality may have harmed the therapeutic relationship that Dr Huang had cultivated with Ms YPM. Overall, Healthscope considered that it was reasonable for Dr Huang and The Melbourne Clinic to refrain from notifying Ms YPM's family about her discharge on 12 May 2020, in accordance with her expressed request.

Communication with Dr Shannon

302. On 13 May 2020, Dr Georgina Tuck sent correspondence to Ms YPM's GP, Dr Shannon, which provided a summary of her background, admission and progress, discharge medications and follow up plan. Although this correspondence contained similar information, it appears that Dr Shannon was not provided with the formal discharge summary document as this was not completed until 18 May 2020. Dr Shannon was also not informed of the incident on 11 May 2020 involving an apparent attempt at hanging.
303. Counsel for Ms YPM's family raised concerns regarding the delay in providing information to Dr Shannon, stating that such delay '*cannot be justified and is wholly unacceptable*' in circumstances where Ms YPM had actively expressed suicidal intention and made multiple attempts of self-harm and suicide.
304. Dr Rakov agreed that communication with Dr Shannon should have been more prompt and comprehensive. While Dr Rakov noted Dr Tuck's correspondence provided a summary of care and was provided the day after discharge, she considered it would have been more appropriate to directly inform Dr Shannon of the rationale for discharge on the day itself given her role in arranging the urgent admission. This would have allowed for better continuity of care and preparation for follow up. Dr Rakov provided an opinion that the delay of one day may have affected Dr Shannon's ability to effectively support Ms YPM post-discharge.
305. In submissions to the Court, The Melbourne Clinic and Dr Huang expressed competing views as to who held responsibility for communicating a discharge summary to Ms YPM's other treaters. In this regard, legal representatives for Dr Huang submitted that the forwarding of the discharge summary was ordinarily done by The Melbourne Clinic staff. In contrast, Healthscope submitted that Dr Huang was '*primarily responsible*' for any communications with Dr Shannon and Ms Lowndes following discharge on 12 May 2020, as he was the senior VMO consultant and her admitting specialist.

Communication with Ms Lowndes

306. Dr Huang noted that he had no communication with Ms Lowndes regarding Ms YPM's admission or her discharge on 12 May 2020.

307. Counsel for the family submitted that given a reason for discharge was Ms YPM's assurance she would keep her appointment with Ms Lowndes, *'such a lack of communication is particularly egregious'*.
308. Dr Rakov considered that given Ms Lowndes was included in the follow up plan documented in the discharge summary, it would have been relevant and courteous for her to receive the summary of Ms YPM's stay at The Melbourne Clinic.
309. Healthscope noted that The Melbourne Clinic's practice at the time was to provide a copy of a patient's discharge summary to their treating psychologist in the community, provided this was requested and consented to by the patient. Medical records suggest that Ms YPM did not specifically request that a discharge summary be provided to Ms Lowndes, and as a result, she was not provided with a copy of the discharge summary.
310. Further, Healthscope submitted that given that Ms YPM did attend Ms Lowndes on 15 May 2020 to discuss the reason for her admission, there is no causal significance associated with the failure to provide the discharge summary.

Conclusion as to adequacy of communication regarding Ms YPM's discharge from The Melbourne Clinic

Communication with family

311. I accept the opinions of Professors Hopwood and Large that, based on the discussions that appear to have been had between Ms YPM and her treating team, it is justifiable to assert that there was no basis to breach doctor-patient confidentiality by disclosing information to her family against her will. Ms YPM did not consent to her mother being called by Dr Huang, she was being treated as a voluntary patient, and none of the aforementioned MHA notification provisions applied.
312. However, as opined by Dr Rakov, I consider that Dr Huang, in light of the significant risk Ms YPM had posed in prior days, should have emphasised to Ms YPM that, *'without informing her family of her mental state and risk factors, creating an effective treatment plan that ensured her safety would be difficult. He needed to clarify that family involvement was not optional but necessary for managing her immediate crisis and providing comprehensive support'*.

313. There is no documented evidence before me that such a robust discussion occurred. I accept the evidence of Dr Huang that Ms YPM had expressed that, at times, involving her parents in her care was stressful, and that this was a likely factor in her refusal to allow him to contact them on 12 May 2020. However, in circumstances in which she was to reside with her parents – a critical pillar in her discharge planning – it was important that Dr Huang considered whether it was sufficient for the purposes of discharge that only the fact of her admission was known to her parents, as opposed to apprising them of further details regarding her medication changes, fluctuating risk levels and recent attempts on her life. This ought to have been canvassed more comprehensively with Ms YPM. The absence of any clinical records of the same suggests that this did not occur.
314. The lack of family involvement in her care also underscored the importance of Dr Huang following up the missed telephone call made the following day by Ms YPM, even if it was not ‘*out of character*’ for her to be out of contact for a period of time.

Communication with Dr Shannon

315. I consider that, as opined by Dr Rakov, communication with Dr Shannon could have been prompter and more comprehensive, including details in the discharge summary of the ‘scarf incident’ and the concern that this represented a suicide attempt. It would have been best practice for direct communication to occur on the day of discharge. However, I consider that the faxed correspondence that occurred the following day did not represent a significant departure from professional standards and would have constituted a sufficient basis to inform Dr Shannon of the fact of Ms YPM’s admission, the treatment plan, and her newly-prescribed medications.

Communication with Ms Lowndes

316. I consider that, as opined by Dr Rakov, Ms YPM would have benefited from Ms Lowndes being provided with a copy of the discharge summary, given that The Melbourne Clinic expected she was to be involved in Ms YPM’s ongoing care (as referred to in the letter of 13 May 2020 to Dr Shannon).
317. I also adopt here the advice of the CPU that, when a psychologist is part of a long-standing community-based treating team, especially in circumstances of chronic mental illness and associated high risk behaviours, it is reasonable that the treating psychologist

who is included as the practitioner nominated in the discharge summary to provide the follow up care after discharge (and are essentially delegated ongoing responsibility to enact the discharge plan) should receive a copy of the discharge summary.

318. Provision of the discharge summary to Ms Lowndes, in addition to GP Dr Shannon, would be a step beyond the usual expected level of clinical communication and does not, in this instance (and contrary to submissions of the family, which do not cite a basis for same) represent a departure from accepted clinical practice.
319. However, the CPU noted that it is increasingly the experience of the Coroners Court that when a patient is already engaged with a private community-based psychologist, the discharge planning frequently suggests the patient consult with them, and that patients will often do so prior to seeing the involved medical practitioners, as occurred here. I intend to make the recommendations proposed by the CPU to address this gap (below).
320. In addition, to the extent that there appears to be a different view as to who is responsible for provision of a discharge summary (The Melbourne Clinic or Visiting Medical Officer, Dr Huang), I will make a further recommendation aimed at ensuring this issue is clarified.

Conclusion as to adequacy of care provided at The Melbourne Clinic

321. Overall, I consider that there is insufficient evidence to find that treating clinicians erred in determining that Ms YPM did not meet the requirements for an Assessment Order on 12 May, and that Ms YPM should therefore have been transported to a public mental health facility rather than discharged into the care of her family. However, I consider that the care, treatment and management of Ms YPM at The Melbourne Clinic on 11-12 May could have been optimised in a number of respects. These include:

- a) Ms YPM's treating team conducting and documenting a thorough exploration into the recent changes in her circumstances that could have impacted her mental state, including her cessation of psychotropic medications, increased isotretinoin dosage, relationship conflicts, and family tensions – all of which impacted her risk profile and mental health, as opined by Dr Rakov;
- b) Ms YPM's treating team conducting a more robust assessment and discussion with her on 12 May about the importance of involving her family in her care and informing them of her level of risk, current treatment plan and list of medications;

- c) Upon her presentation to The Melbourne Clinic on 11 May, seeking collateral information from The Alfred about her presentation there on 9 May 2020 (noting in this connection that I consider The Alfred ought already to have provided a handover to Dr Huang, per its own discharge plan, and this discharge summary should already have been available to him);
- d) Informing Dr Shannon, via letter or, ideally directly, in a more timely and more comprehensive manner about Ms YPM's inpatient episode of care at The Melbourne Clinic, including the scarf incident that was a suspected a suicide attempt; and
- e) Informing Ms Lowndes of Ms YPM's episode of care at The Melbourne Clinic, given she formed part of the treatment plan in the community.

322. I emphasise that these factors, which have been identified with the benefit of hindsight, outside of a busy clinical environment in which COVID-19 restrictions were new to Melbourne, are those that would have optimised Ms YPM's care.³⁷ I turn now to whether they would have been capable of preventing her death some five days later.

Conclusion as to preventability of Ms YPM's death

323. Dr Giuffrida opined that Ms YPM's suicide would have been '*more probably than not avoided*' if a reasonable standard of care had been provided to her in the lead-up to her death in May 2020.

324. In contrast, Dr Rakov notes that it is '*important to distinguish between the lack of adherence to best practices - such as the absence of notes from a consultant psychiatrist - and outright failures to meet the standard of care required in specific instances, which could potentially inform a link [between] inadequate care [and] adverse outcomes*'.

325. In a similar vein, and as discussed in detail above in relation to the decision to discharge, both Professors Hopwood and Large opined that even if Ms YPM had not been discharged on 12 May 2020, it is likely that she would not have been detained compulsorily for any extended period and therefore that such a decision would not have prevented her death. According to Professor Large, this is particularly the case given that

³⁷ I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*" - *Adamczak v AlSCO Pty Ltd (No 4)* [2019] FCCA 7, [80].

Ms YPM presented with '*chronic, severe and untreatable risks*' and evidence indicates that '*psychiatric hospitalisation provides limited, if any, short term protection from suicide, and does not alter the long-term trajectory of suicide.*'

326. Overall, Professor Large concluded that he saw '*no evidence*' that The Melbourne Clinic did '*anything other than its best over many years, including on 11 and 12 May 2020*'. He noted that sadly, BPD and anorexia nervosa are both independently associated with several decades of premature mortality, much of it due to suicide, and this mortality often cannot be prevented by psychiatric care. While people with BPD may sometimes require brief crisis admissions to contain overtly present suicidal crises, Professor Large considered that it is widely accepted by Australian psychiatrists that there is '*little to be gained*' by a more prolonged admission. He concluded, '*On the 11 and 12 of May 2020 and concerning [Ms YPM], there was nothing about the Clinic's assessment, admission, reassessment, decision not to invoke the MHA, move to mental health intensive care, pharmacological management, discharge, and follow-up that did not accord with widely accepted Australian peer professional practice.*'
327. Legal representatives for Dr Huang also submitted that it is relevant to take into consideration that the toxicology report showed the presence of cocaine, ketamine and methylenedioxymethamphetamine (MDMA or what is commonly known by its street name, 'ecstasy'), and that her acute polysubstance intoxication on the night of her death may have affected Ms YPM's judgment and decision making.
328. The weight of the expert evidence leads me to conclude that, while there were deficiencies in aspects of her care in the preceding period, I cannot make a finding that Ms YPM's death could have been prevented by her clinicians as at 12 May 2020.
329. This conclusion is supported by the evidence which demonstrates that, following Ms YPM's discharge from The Melbourne Clinic and in the days prior to her death, she reportedly presented as calm, relaxed and motivated to engage with the treating team, as well as her family and friends. She attended her appointment with Ms Lowndes on 15 May 2020, and during this appointment denied suicidality and engaged in future planning by making a further appointment for 18 May 2020 and discussing her plans to return to work. Ms Lowndes did not consider that Ms YPM presented as at increased or imminent risk of suicide.

330. In this context, whereby Ms YPM's mental state had clearly improved since the time that she was discharged from The Melbourne Clinic on 12 May 2020, and where Ms YPM was known to be at chronic risk of suicide, it would not be reasonable to draw any causal link between the level of care provided during her final admission to The Melbourne Clinic and the apparent re-emergence of her suicidal ideation on the night of her death, some five days later.
331. Nor is it reasonable to draw a causal link between the level of care provided by Ms Lowndes on Friday, 15 May 2020 and Ms YPM's suicide that weekend. Ms Lowndes reported that Ms YPM was future-focussed and making plans to return to work. In circumstances in which Ms YPM was of low mood, anxious about her return to work but otherwise not exhibiting signs of suicidality or distress, I consider that Ms Lowndes' treatment and follow-up plan was appropriate and considered.
332. Moreover, and as is not uncommon in the suicides I have investigated, the post-mortem toxicological testing suggests Ms YPM almost certainly experienced a degree of intoxication at the time of her death. In the absence of a reported or longstanding history of ingesting illicit substances (and thus having a degree of tolerance to the same), this likely affected her judgment and decision-making and influenced the course of action she ultimately chose.

FINDINGS

333. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Ms YPM born [REDACTED];
 - b) the death occurred on 17 May 2020 at [REDACTED], Caulfield South, Victoria, 3162 from *1a) Hanging*; and
 - c) the death occurred in the circumstances described above.
334. Having considered all of the circumstances, including the lethality of the means chosen, I am satisfied that Ms YPM intended to take her own life on a background of long-term mental ill health, chronic suicidality and interpersonal, financial and work stressors, in the context of the nascent COVID-19 pandemic in Melbourne.

335. Having carefully considered the actions of Ms YPM's treating clinicians in the lead-up to her tragic passing, I consider that several aspects of her care could have been optimised.
336. In particular, my investigation has revealed opportunities to improve systems of communication between clinicians involved in the care of patients such as Ms YPM, that will help to improve the treatment provided to patients with complex presentations who may be interfacing with multiple services in a short period of time. Pertinent recommendations will follow.
337. With regard to risk assessment and mitigation, I consider that it would have been optimal for Ms YPM's treating clinicians in May 2020 to conduct more robust discussions with her regarding recent changes in her circumstances that could have impacted her mental state, including her recent self-cessation of psychotropic medications and changes in medication dosages, relationship conflicts, and family tensions, and emphasised the importance of involving family in her treatment. Conducting such robust discussions might optimally have afforded greater consideration to those factors such as family involvement in determining appropriate discharge planning.
338. Despite this, I am not satisfied on the available evidence that any clinician treating Ms YPM in May 2020 erred in their assessment under the *Mental Health Act 2014 (MHA)*, including with regard to compulsory assessment or treatment. While further discussions with Ms YPM may have assisted in key aspects of discharge planning and safety netting, such as regarding involvement of her family, it is not possible to assess retrospectively whether such enquiries may have shifted the legislative balance. Overall, I accept that Ms YPM's clinicians engaged in a reasonable approach to risk management and that their conclusion – that compulsory assessment was not appropriate in Ms YPM's circumstances – was justifiable based on the information available to them at that time.
339. With regard to preventability, I consider that it is not open on the evidence available to find that Ms YPM's death could have been prevented had all aspects of her care been optimised. In circumstances where Ms YPM was at chronic risk of suicide and had a history of multiple incidents of self-harm and overdoses over a number of years, and presented as settled and relaxed in the days leading up to her death, there is insufficient

evidence to find that there was a causal link between her suicide and the level of care provided to her by clinicians in May 2020.

340. Nonetheless, I am hopeful that clinicians today may be better supported in the complex endeavour of risk formulation as the result of a recently-released resource produced by the Office of the Chief Psychiatrist. Pertinent comments will follow.
341. Finally, while the above findings are necessarily narrow in focusing on those immediate circumstances leading to her death, I recognise that Ms YPM's life was far greater than her struggles. Ms YPM had chosen a career in the law, was highly creative, loved, and full of promise. Her mother describes her as someone who lived a '*productive and meaningful life*'. Her loss is one that is no doubt keenly felt by those who loved and cared for her, but also by our broader community, which has lost a young, bright, intelligent person with enormous potential. I add my voice to the many that grieve such a loss.

COMMENTS

342. In September 2023, the new *Mental Health and Wellbeing Act 2022* (MHWA) commenced. Approximately one year later, in October 2024, the Office of the Chief Psychiatrist released a resource entitled '*White paper: On the principles of mental health risk assessment*' (**White Paper**),³⁸ the purpose of which is to assist mental health practitioners in conducting risk assessments, noted therein to be '*a foundation skill for all mental health clinical practice*'.³⁹ 'Risks' are defined to include self-harm, suicide, misadventure or risks to other people or the community.
343. While recognising the value of improved guidance for clinicians in moving toward a standardised approach, the White Paper also recognises the inherent complexities and tensions involved in any process of risk assessment. In particular, the White Paper emphasises that no risk assessment tool or scale can reliably and accurately predict self-harm and suicide, and that relying on such tools alone to determine access to treatment or hospital care is not warranted. Further, the White Paper underlines that tensions will inevitably arise between key principles of risk assessment, and so best practice requires clinicians to move beyond a one-size-fits-all approach toward a more nuanced model of

³⁸ November 2022, Available: <https://www.health.vic.gov.au/sites/default/files/2024-11/chief-psychiatrist-white-paper-on-the-principles-of-mental-health-risk-assessment.pdf>

³⁹ White Paper, p. 4.

risk formulation ‘*with an emphasis on the person and what we can do to address their individual needs*’.

344. In this context, the White Paper sets out nine key principles of self-harm and suicide risk assessment that it posits may help clinicians in formulating risk. Of particular relevance in relation to Ms YPM’s care, in my view, the White Paper provides that:

- a) Risk cannot be eliminated but may be mitigated.
- b) Overall risk is a balance between short-term and long-term risks. It is important to recognise that short-term risk-reduction measures might compromise long-term recovery goals. Strategic planning for long-term safety therefore needs a balanced approach that considers both immediate safety and future recovery needs, adjusting as needed.⁴⁰
- c) There needs to be a balance between perceived risks against the likelihood of outcomes alongside the person’s values, needs and context.⁴¹
- d) Therapeutic risk taking is important to elevating agency and long-term recovery. A commitment to therapeutic risk taking does not ensure a positive outcome but does uphold agency. Agency, relationships and trust enhance the potential for longer term safety.⁴²
- e) Families, carers and supporters may struggle to see the potential of therapeutic risk due to concern for the immediate safety of a loved one. Clinicians should strive to involve them in the risk assessment process, hear their concerns, work towards a shared understanding of the risk formulation and, ideally, engage them in a joint approach to therapeutic risk taking to support their loved one’s growth and ultimate recovery.⁴³
- f) Bringing in family or friends to the relationship and to awareness about risk can change the trajectory of individual decision making. At times the acuity of the risk may merit breaching privacy or consent to support safety. The extent to

⁴⁰ Principle 4.

⁴¹ Excerpts from Principle 5.

⁴² Excerpts from Principle 6.

⁴³ Excerpts from Principle 6.

which this is done needs to be limited and balanced against the principles of dignity of risk and autonomy.⁴⁴

345. The White Paper also includes at Appendix 2 a specific risk assessment model intended to assist clinicians in managing risk of self-harm or suicide in individuals diagnosed with Borderline Personality Disorder (**BPD**).⁴⁵ The purpose of this model is to assist clinicians to differentiate between patients who present with low versus high self-harm risk, and chronic versus acute risk, so as to provide clarity about treatment decisions and assist clinicians to identify appropriate interventions. Specifically, the objectives of the model as described by its authors are: *‘twofold: to more readily identify BPD patients who are at risk of high-lethality self-harm that may result in accidental death, and to reduce unnecessary hospitalisation of BPD patients who engage in high lethality self-harm behaviour.’*
346. In applying the principles contained in the White Paper to the circumstances in which Ms YPM wished to leave The Melbourne Clinic on 12 May 2020 (and noting my previous comments on Ms YPM’s diagnosis by Dr Huang of borderline personality traits versus BPD), the complexities and tensions faced by Dr Huang are clearly evident. Best practice risk formulation in these circumstances, according to the White Paper, involved a complex endeavour of balancing competing considerations, including Ms YPM’s recent risk pattern in a context of chronic risk, the value of patient autonomy, her family’s expectations, the potential protective value of family involvement, Ms YPM’s human rights, and benefits of preserving longstanding therapeutic relationships. This task, I would suggest, is an inherently complex one, which might reasonably result in differing conclusions, the appropriateness of which cannot fairly be measured on outcome alone.
347. I also note that for clinicians dealing with patients with chronic and fluctuating risk, the point-in-time assessment entailed by application of mental health legislation can appear to lead to arbitrary outcomes. Does such assessment occur in a vacuum in which risks

⁴⁴ Excerpts from Principle 2.

⁴⁵ This model was developed by Sathya Rao, Anna Correia, and Robert Trett Source, senior staff at Spectrum, Eastern Health, a specialised health service which provides treatment and support for people with personality disorder and complex trauma. See: Rao S, Broadbear JH, Thompson K, Correia A, Preston M, Katz P and Trett R (2017) ‘Evaluation of a novel risk assessment method for self-harm associated with borderline personality disorder’, *Australasian Psychiatry*, 25(5):1–6. Rao S, Broadbear JH, Thompson K, Correia A, Preston M, Katz P and Trett R (2017) ‘Evaluation of a novel risk assessment method for self-harm associated with borderline personality disorder’, *Australasian Psychiatry*, 25(5):1–6.

posed in the lead-up to the point in time at which the assessment is conducted are not also considered? Can a patient who is deeply suicidal one minute be taken at their word an hour later when they are guaranteeing their safety in the community? How is the issue further complicated where a patient is assessed to be at ongoing risk to themselves but where repeated periods of hospitalisation may be considered counter-therapeutic by clinicians and even deleterious in the context of the underlying mental illness they are suffering?

348. These are questions faced by mental health professionals across Victoria on a daily basis. They are complex questions. Five years on from Ms YPM's tragic death, I am hopeful that the White Paper issued by the Office of the Chief Psychiatrist, including the BPD-specific model at Appendix 2, may provide clinicians with a useful set of principles to assist in broaching the multi-faceted dimensions of risk formulation to make highly complex decisions in relation to members of our community who are often the most vulnerable.

RECOMMENDATIONS

349. Pursuant to section 72(2) of the Act, I make the following recommendation:

Recommendation One: To the Chief Psychiatrist & Alfred Health

The Chief Psychiatrist and Alfred Health consider the feasibility of routinely providing private psychologists who are involved in a patient's care as part of a long-standing community-based treating team, and who are nominated in the emergency department /short stay discharge plan to provide community follow-up, with a timely copy of the discharge summary.

Recommendation Two: The Melbourne Clinic

The Melbourne Clinic work with the admitting private psychiatrists to consider the feasibility of routinely providing private psychologists who are involved in a patient's care a part of a long-standing community-based treating team, and who are nominated in the discharge plan to provide community follow-up with a timely (same day) copy of the discharge summary.

Recommendation Three: The Melbourne Clinic

The Melbourne Clinic develop and circulate to all staff and Visiting Medical Officers (VMOs) a clear policy or practice guide on who is responsible (e.g. clinical staff or VMOs) for provision of discharge summaries to treating practitioners in the community.

ACKNOWLEDGEMENTS

350. I offer my most sincere condolences to Ms YPM's loved ones, and in particular, to her brother, father and mother, whose strenuous advocacy has assisted in achieving a deep and thorough coronial investigation. I acknowledge that they have waited a long period of time to receive this finding, and that such a lengthy investigation would have been far from easy in the wake of their devastation at losing their daughter and sister. I hope that the finalisation of the coronial proceedings will afford some small measure of closure in the wake on their ongoing grief and loss, whole conscious that the prospect of any legal proceedings providing 'closure' is somewhat of a chimera.
351. I also acknowledge the pain and suffering of Ms YPM's friends at losing a peer at such a young age. While I did not require statements to be provided by her friends for the purposes of this investigation, I am acutely aware of the distress that her untimely death will have caused to her peer group, and of how loved and vibrant she was even in the face of her struggles. I acknowledge too the impact of Ms YPM's death on her clinicians, who provided her with treatment, support and care over a span of many years, and who have no doubt been deeply impacted by her death.
352. Finally, I acknowledge the work of the CPU and of then-Deputy State Coroner Hawkins, who worked tirelessly to progress this investigation prior me assuming carriage of it.

ORDERS AND DIRECTIONS

I order that a de-identified copy of this finding be published on the Court's website in accordance with the Rules.

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

Senior Next of Kin

Dr Chia Huang, Psychiatrist, c/- Avant Lawyers

The Melbourne Clinic / Healthscope

Dr Alexandra Shannon, GP

Ms Janet Lowndes, Psychologist, c/- Kennedy's Lawyers

Alfred Health

Mr Thomas Scully, Dietician, c/- Barry Nilsson Lawyers

Dr Jaqueline Rakov

Office of the Chief Psychiatrist

Acting Sergeant Robyn Hickey, Coroner's Investigator, Victoria Police

Signature:



INGRID GILES

CORONER

Date: 16 October 2025



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 6 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.
