IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001470

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Ingrid Giles
Deceased:	TK[1]
Date of birth:	■■■ 2002
Date of death:	20 March 2021
Cause of death:	1(a) Mixed Drug Toxicity
Place of death:	■■■ Victoria, ■■■
Keywords:	Mixed drug toxicity; overdose; young person; suicide; chronic suicidality; housing; Royal Commission into Victoria's Mental Health System; LGBTIQA+ supports.

[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 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.

INTRODUCTION

1. TK was 18 years old when she died on 20 March 2021 in circumstances suggestive of a prescription drug overdose. TK's parents were QK and DK. In 2015, TK and her brother were removed from her parents' custody. TK resided with her maternal grandparents for the remainder of her childhood, and would also often stay with her paternal grandparents.

2. TK was the subject of three Child Protection reports between February 2012 and May 2018. These reports were in relation to parental drug use and exposure to violence. At the time of TK's death on 20 March 2021, Child Protection was not involved.

3. In the weeks prior to her death, TK left her maternal grandparents' home and was without stable accommodation.

THE CORONIAL INVESTIGATION

4. TK's death 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.

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

6. 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.

7. Coroner Audrey Jamieson initially held carriage of the investigation into TK's death. I assumed carriage in July 2023 for the purposes of finalising the investigation and making findings.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of TK's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of TK including evidence contained in the coronial brief. 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]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

10. TK was admitted to Maroondah Hospital on 13 March 2021 following a suicide attempt. She was discharged on 16 March 2021 to attend a business trip with her employer, Mr BE. She returned from the trip on 18 March 2021 to hotel accommodation.

11. On 19 March 2021, Mr BE attended the hotel and assisted TK with some washing and food preparation. Mr BE messaged TK's father and said she had been in a good mood. TK messaged Mr BE that night at about 8:00pm saying she was doing well and hoped she would have sweet dreams.

12. On 20 March 2021, Victoria Police officers attended the hotel TK was staying at for an unrelated welfare check. While in the reception area they heard screaming. The officers travelled to level three and found TK's parents in a state of distress, having found TK unresponsive in her room.

13. Ambulance Victoria paramedics attended a short time later and confirmed she was deceased. A note was found next to TK, along with packets of prescription medication and a bottle of alcohol.

IDENTITY OF THE DECEASED

14. On 20 March 2021, TK, born ▇▇▇▇ 2002, was visually identified by her father, QK.

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

MEDICAL CAUSE OF DEATH

16. On 23 March 2021, Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Lynch reviewed the

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[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.

Victoria Police Report of Death Form 83, VIFM contact log, scene photographs, and the post-mortem computed tomography (**CT**) scan, and provided a written report of his findings.

17. The post-mortem examination revealed findings consistent with a history provided to Dr Lynch that TK had been found in circumstances suggestive of a prescription drug overdose.

18. The post-mortem CT scan revealed radio-opaque residue in the stomach.[3]

19. Post-mortem toxicology detected ethanol (0.04g/100ml), tramadol (3.3mg/L), oxycodone (0.2mg/L), quetiapine (1.1mg/L), diazepam (0.1mg/L), and nordiazepam (0.2mg/L). The toxicology report determined that the combination of drugs detected may cause death in the absence of other contributing factors.

20. Dr Lynch provided an opinion that the medical cause of death was 1 (a) mixed drug toxicity.

21. I accept Dr Lynch's opinion.

TK'S MENTAL HEALTH BACKGROUND

19. In 2016, general practitioner (**GP**) Dr Graham Guttenberg diagnosed TK with anxiety and depression and referred her to a psychologist under a Mental Health Care Plan in which she engaged well. She was also supported by the school welfare coordinator.

20. In November 2019, TK had two crisis admissions to Box Hill Hospital (**BHH**) Adolescent Inpatient Unit for acute suicidal ideation and gestures due to a relationship breakdown, school exams, and death of a grandparent. TK was discharged to follow-up by Box Hill Child and Youth Mental Health Services (**CYMHS**) who diagnosed her with borderline personality disorder (**BPD**).[4] TK was actively suicidal on several occasions while a client at CYMHS, but this was managed with crisis appointments and safety planning.

21. TK left school in mid-2020 to take up an apprenticeship as an electrician. The owner of the business, Mr BE, became TK's main support person and nominated next of kin.

22. On 28 January 2021, TK was taken by ambulance to BHH Emergency Department (**ED**) at the request of Dr Guttenberg due to not having eaten for five days following a relationship

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[3] This may be reflective of a large number of tablets that have been ingested and not completely digested.

[4] Borderline personality disorder is characterised by a pervasive pattern of instability in interpersonal relationships, efforts to avoid real or imagined abandonment, unstable self-image, impulsive behaviours, recurrent suicidal behaviours or threats, affect instability, chronic feelings of emptiness, inappropriate or intense anger, transient stress related paranoid ideation or severe dissociative symptoms.

breakdown with a young woman she had met on an online dating site. TK denied suicidal ideation, was assessed as medically stable, accepted a referral to CYMHS, and discharged home.

23. On 31 January 2021, TK visited her girlfriend's home, became distressed and collapsed. TK was taken by ambulance to BHH ED. She denied suicidal thoughts and was discharged home with planned follow-up by CYMHS.

Box Hill Hospital inpatient admissions

24. On 4 February 2021, after going missing for several hours from her grandparents' house, TK was found by police in a park displaying a reduced level of consciousness, and was taken to BHH ED. She was assessed by a psychiatrist as in crisis after an impulsive overdose following further issues in TK's relationship with her girlfriend. TK was admitted as a voluntary patient to Upton House.[5] The plan was to admit TK for containment with a structured discharge plan, supported by her GP and possible case management with the Hospital Outreach Post-Suicidal Engagement (**HOPE**) service.[6]

25. TK was transferred to Ward 1 East on 5 February 2021.[7] TK was disappointed her suicide attempt had not succeeded and planned to overdose again after discharge. The absence of protective factors was noted, and she was assessed as high risk of suicide and diagnosed with BPD in crisis, generalised anxiety disorder,[8] and complex post-traumatic stress disorder (**CPTSD**).[9]

26. During the admission, it was reported that Mr BE had been sexually involved with TK. TK requested no visits from Mr BE, her next of kin was changed to her girlfriend, and she was assisted to apply for Centrelink so she did not need to return to work with Mr BE. She was linked with Eastern Domestic Violence Service (**EDVOS**)[10] and Eastern Centre Against Sexual Assault (**ECASA**)[11] but there are no records that she accessed these services.

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[5] Upton House is the adult psychiatric inpatient unit located at Box Hill Hospital.

[6] HOPE provides intensive, person-centred support for people leaving an ED or hospital ward following an attempted suicide. Individuals are contacted within 24-hours of hospital discharge and can be supported for up to three months.

[7] The psychiatrist recommended Ward 1 East as it was considered lower acuity and more suited to TK given her history of trauma.

[8] The main feature of generalised anxiety disorder (**GAD**) is excessive anxiety and worry which occurs more days than not for at least six months.

[9] CPTSD may develop following prolonged or repeated trauma such as childhood abuse. All diagnostic requirements for PTSD must be met along with severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. BPD symptoms can overlap with CPTSD symptoms.

[10] EDVOS is a specialist family violence service in the Eastern Metropolitan Region.

[11] ECASA provides free counselling and support service to people who have experienced sexual assault either recently or in the past.

27. TK's condition gradually improved on quetiapine, and she no longer reported suicidal ideation.

28. TK did not want to return to her maternal grandparents' home due to their difficult relationship but agreed to short-term accommodation with her paternal grandfather and was referred to a youth homelessness service. Dr Guttenberg was advised to refer TK to CYMHS in the relevant catchment once her accommodation was settled.

29. TK was discharged on 12 February 2021 and described by a medical officer as *"a healthy young woman emerging from a crisis with a growing confidence to take ownership of her future direction in life."*[12] She denied suicidal ideation though remained anxious and guarded. She was provided with weekly pick-up of medication to reduce the risk of overdose and agreed to a safety plan that included using helplines, distraction and self-soothing strategies, and identification of warning signs. TK was also provided with the contact details for Frontyard Youth Services.[13]

30. The following day, TK was admitted to BHH Intensive Care Unit (**ICU**) following a polypharmacy overdose with alcohol that appeared to be related to relationship issues with her girlfriend. When medically stable, she was transferred to Ward 1 East as a voluntary patient.

31. On 14 February 2021, TK stated she had lost hope, had no one to talk to, no family or friends, and there was no longer any point in living. She indicated that Mr BE was her only support and retracted the claim that he was sexually abusing her. Documentation in the nursing notes indicated that *"TK is very high risk of suicide if not DC* [discharged] *with appropriate accommodation and mental health community support"*.[14]

32. On 17 February 2021 TK confirmed that Mr BE had been sexually inappropriate towards her but "*not as bad*" as had been previously described. She indicated that she had spoken to him about it and did not think it would continue.

33. Five days into the admission TK was allowed escorted leave (with staff) without issue, but on 20 February 2021 she fled from her escort, booked a hotel room, and purchased a rope with intention to hang herself. She reported not being able to carry out the action so contacted Mr BE and asked him to take her back to hospital. TK reported not being able to *"see when things will get better"*.[15]

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[12] Eastern Health medical records (CPF) p.674/912.

[13] Frontyard Youth Services are part of Melbourne City Mission and provide multidisciplinary holistic programs for young people who are at risk of or experiencing homelessness.

[14] Eastern Health medical records (EMR) p.349/561.

[15] Eastern Health medical records (EMR) p.340/561.

34. The treating team considered transferring TK to Upton House, which was a more secure environment, but TK was distressed by this plan, stated she felt safe at Ward 1 East and regretted her actions. She was allowed to stay on the ward, but her leave was revoked.

35. Several medication regimes were trialled until TK felt they appropriately managed her anxiety and dysregulation. TK's mental health gradually improved and she actively engaged in ward activities.

36. On 25 February 2021, an occupational therapist (**OT**) met with TK to commence development of a safety plan. TK said she had done these before and not found them helpful, nor had she found phone helplines useful when she was feeling unwell but would work with the OT to explore other mental health support tailored to the lesbian, gay, bisexual, trans and gender diverse, intersex, queer / questioning and asexual (**LGBTIQA+**) communities.

37. TK's time to discharge was significantly longer than medical staff anticipated due to difficulties in acquiring Centrelink support and obtaining suitable accommodation. Supported accommodation was deemed most appropriate, specifically Youth Residential Recovery (**YRR**) services, but no beds were available so temporary accommodation was needed.[16] TK was also required to be stable in the community for at least two months before she could be accepted into a YRR service.

38. On 1 March 2021, a medical officer noted a plan to refer TK to CYMHS on discharge. TK was eager to resume contact with CYMHS due to her previous positive experience with the service, but the medical officer later noted that referral could not be made from the ward due to TK not having a fixed address.

39. On 10 March 2021 TK was reviewed by a psychiatrist. Her mental state had improved, mood was described as *"pretty good"*, and insight and judgment fair, and she denied thoughts of self-harm or suicide. She was considered to be at chronic risk of misadventure and self-harm but not at acute risk.

40. Arrangements were made to discharge TK to one-week's accommodation at a hotel followed by Youth Transitional Housing for up to seven weeks.[17] TK twice voiced discontent to nursing staff about going to a hotel. She was reminded to use the emergency contact details if she felt unsafe and nursing staff flagged with medical officer, Dr Simone McCallum, the need for a risk management conversation with TK before discharge. BE also told allied health staff he was

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[16] Youth Residential Recovery (YRR) services are integrated therapeutic communities (ITC) that provide psychosocial rehabilitation support to young people 16-25 years of age with a psychiatric disability.

[17] TK had researched Youth Transitional Housing and was aware they had youth workers to support residents.

concerned about TK being discharged to a hotel. He was assured adequate support would be provided. Mr BE was supported to set boundaries with TK and provided emergency contact details.

41. On the morning of her discharge (11 March 2021), TK reported her mood was "*okay*" and she denied suicidal plans. Around 11.15am, a dietitian discussed strategies for healthy eating and budgeting with TK. An OT provided information on supports available from the Eastern Diversity Group and attempted to develop a sensory plan with TK, but TK indicated the strategies would not work for her and declined. The allied health clinicians noted TK was guarded and irritable and her mood was described as *"shit"*.[18] She was preoccupied with thoughts of discharge but appeared future-focused. The allied health staff walked with TK to the hotel around 2pm.

42. The discharge plan included weekly pick-up of medication to reduce overdose risk and follow-up by her GP within one week. TK was to call CYMHS and self-refer when she had clarity about the location of her accommodation, and maintain weekly GP appointments. She was also referred to Towards Wellbeing.[19] Her Centrelink claim for financial support was being processed and she had a booked appointment with them.

Maroondah Hospital inpatient admission

43. That evening, 11 March 2021, a friend called an ambulance after noticing TK's slurred speech and admission of taking an overdose. A suicide note, multiple medications and noose were found in TK's room. She was initially taken to BHH ED where her level of consciousness deteriorated and she was intubated and transferred to Angliss Hospital ICU.[20] TK later indicated she had taken tramadol, diazepam, alprazolam and temazepam with alcohol.

44. At review by a psychiatry registrar on 12 March 2021, TK was not sufficiently medically stable to enable full mental health assessment but following liaison with TK's previous treating team at Ward 1 East, the plan was to admit her as a voluntary patient once stable, with low threshold for an Assessment Order (**AO**) under the *Mental Health Act 2014* (as then applied).

45. Once medically stable, TK was assessed by a mental health clinician as experiencing BPD in crisis with a very high chronic risk of suicide that was currently elevated from baseline. She

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[18] Eastern Health medical records (EMR) p.188/561.

[19] Towards Wellbeing provides psychosocial support to people with complex needs aged 16-65 years through EACH who do not have NDIS supports.

[20] No ICU beds were available at Box Hill Hospital.

accepted treatment and was transferred to Maroondah Inpatient Psychiatry Unit (**IPU**) as a voluntary patient on 13 March 2021. On admission, TK denied suicidal ideation, plan or intent.

46. At review by the on-call psychiatrist on 14 March 2021, TK expressed dislike of Maroondah Hospital and wanted to know when she would be discharged, as she was concerned about the impact of an inpatient stay on future accommodation. Despite this evidence of future-focus, suicidal ideation was present though no active plan or intent. An AO was to be considered if TK attempted self-discharge. The on-call psychiatrist recommended the treating team advocate for CYMHS or the Intensive Mobile Treatment Team (**IMTT**) to provide case management of TK at discharge.[21]

47. At review on 15 March 2021, TK denied suicidal ideation and requested discharge. TK was considered to be a very high risk of suicide (though not at immediate risk)[22] and high risk of disengagement from mental health services. The plan was a short-stay admission with social work involvement and safety planning. Consideration was given to short term accommodation with Mr BE and GP management until TK was able to be seen by CYMHS. TK informed treating psychiatrist Dr Capelluto that she could not attend CYMHS until she had a permanent address but the doctor indicated they would further investigate. Dr Capelluto documented that *"length of stay in hospital does not confer any protection or benefit regarding her suicidality, as evidenced by her two admissions at 1 East this year*".[23]

48. On 16 March 2021, Dr Capelluto reviewed TK and noted her mood had improved and she was pleasant and engaging. She was considered a chronic high suicide risk, though denied suicidal ideation, plan and intent. TK again requested discharge as she wanted to go on what was described as a "*business trip*" with BE. Dr Capelluto reported that TK said *"she doesn't think she will try and kill herself again and she definitely won't hurt herself while she is with her boss* [Mr BE]*".*[24]

49. Dr Capelluto agreed to discharge TK, noting she did not meet criteria to be treated under the *Mental Health Act 2014* as she was *"agreeable to my* [Dr Capelluto's] *suggestions and discharge planning".*[25] Dr Capelluto reiterated that *"length of hospital stay has not conferred any additional protection towards her suicide risk in the past".*

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[21] The Intensive Mobile Treatment team (IMTT) is an intensive outreach service for young people.
[22] On 15 March 2021, the psychiatric registrar described TK as being at chronic high risk of impulsive suicide.
[23] Eastern Health medical records (CPF) p.443/912.
[24] Eastern Health medical records (CPF) p.444/912.
[25] Eastern Health medical records (CPF) p.444/912.

50. As part of discharge planning, staff confirmed that TK was registered with Centrelink and Community Housing and the psychiatry registrar undertook safety planning with Mr BE. He confirmed he would take TK with him on a business trip after which she could stay with him, her parents or for short-term stays with her grandparents while more permanent accommodation was arranged.[26] The registrar explained that TK was a chronic high risk of suicide and it was noted in the medical record that Mr BE was *"a bit nervous about her discharge"* but felt it best for her mental health that she accompany him on the business trip.[27]

51. A referral was made to CYMHS for follow-up and on 16 March 2021, a clinician provided a verbal handover to Dr Guttenberg although there was a discrepancy about what transpired during this conversation. The IPU medical record indicated the *"GP [was] supportive of [the] plan"*.[28] However, Dr Guttenberg stated he informed the hospital he did not think it was safe to discharge TK, but they replied that there were insufficient grounds to keep TK as an involuntary patient.[29] Dr Guttenberg indicated he could not see TK until 22 March 2021 and this was accepted by the IPU medical officer.

52. TK was discharged into Mr BE's care on 16 March 2021. She was assessed as a chronic high risk of suicide but denied a plan or intent, was calm and co-operative.

53. On 17 March 2021 there is a note in the medical record of a meeting to discuss TK's initial consultation, presumably with Box Hill CYMHS.[30] It acknowledged that TK was going away on a business trip and the plan was to call her to ascertain if she was still willing and available to engage with the service.

54. On Friday 19 March 2021 a CYMHS clinician phoned TK to see if she still wanted support from the service. TK reported she had just returned from a three-day trip with Mr BE and had no thoughts of suicide while away. She appeared happy, mentioned going on another work trip to Bendigo the following week, and was agreeable to case management by CYMHS as it had previously been helpful. TK agreed to CYMHS contacting her on Monday with an appointment. The CYMHS clinician confirmed that TK had the emergency mental health number, if required.

55. On Saturday 20 March 2021, TK was found deceased in her hotel room by her parents and police. She had left a suicide note.

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26 TK returned to hotel accommodation after this trip. It is not clear why these options were not used.
27 Eastern Health medical records (CPF) p.472/912.
28 Eastern Health medical records (CPF) p.472/912.
29 Statement of Dr Graham Guttenberg, Coronial Brief, p.42/77.
30 The service who made this notation was not named. Eastern Health medical records (CPF) p.44/912.

CPU REVIEW OF CARE

56. At the Court's request, the Coroners Prevention Unit (**CPU**) reviewed the care and treatment provided by Box Hill Hospital and Maroondah Hospital to assist my investigation.

57. The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

Treatment provided by Box Hill Hospital (BHH)

58. TK had two admissions to BHH in the six weeks before her death. The CPU found that on each occasion, appropriate consideration was given to managing TK in an environment that was suited to her needs as a young person with a significant trauma history.

59. The CPU considered that, at TK's initial presentation on 4 February 2021, she was appropriately admitted for containment with development of a suitable discharge plan.[31] The CPU further found that the treating team sensitively and appropriately managed the information (which was not substantiated) that Mr BE may have been sexually inappropriate with TK.

60. With regards to the information provided by TK that Mr BE may have been sexually inappropriate with her, I requested Eastern Health to provide any relevant policies that might touch upon the appropriateness of involving a person in treatment and discharge planning where there have been allegations made by the (young) patient of sexual abuse in relation to that person. Eastern Health provided the Court with its 'Promoting Sexual Safety and Responding to Sexual Activity on Acute Inpatient Unit Practice Guideline 2021'.

61. The guideline provided refers to sexually inappropriate activity which takes place within the unit, and thus does not have a bearing on the situation that TK reported herself to be in with respect to Mr BE; however, I consider that the staff at BHH did appear to validate TK's reported experience and make appropriate referrals, including to ECASA. In this regard, there is nothing to suggest that TK had impaired decision-making capacity.

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[31] The Clinical Practice Guideline for the Management of Borderline Personality Disorder (NHMRC, 2013, p.109/182) indicate that inpatient care is appropriate for short-term crisis intervention for people at high risk of suicide.

62. However, TK was a vulnerable young person being discharged into an alleged potentially unsafe environment. The complexity of this situation suggests that guidelines on managing discharge planning when a patient is considering going to a sexually unsafe environment include discussions about how the patient can feel safe after discharge. I will make a recommendation in this regard.

63. The CPU considered that many of the factors contributing to TK's suicidality were complex and enduring, yet she had no assertive outreach in place on discharge. It is unclear why referrals were not made to services such as HOPE or IMTT. However, there is no certainty that such services would have made contact with her in the brief time before she made another suicide attempt.

64. The CPU found that the decision to discharge TK on 12 February 2021 was reasonable. She was future-focused, denied suicidal ideation, and there were no behavioural or verbal indicators to suggest she might overdose the following day.

65. At her second admission following a more lethal overdose (13 February 2021), TK was again identified as experiencing BPD in crisis and at very high risk of suicide. The CPU advised it was appropriate to re-admit her for containment.

66. Medical staff were concerned about the length of TK's admission but there were delays in obtaining financial support from Centrelink and post-discharge accommodation.[32] Lengthy wait lists and the requirement to be stable in the community for at least two months prevented supported accommodation from being an immediate post-discharge option. The CPU noted it is not clear what other housing options could have been considered as prevention and recovery care (**PARC**) does accept persons aged 16 and over for supported residential accommodation following an acute admission, but they must have an acceptable discharge address available to them during the PARC stay.[33] TK would therefore not have been eligible for this service.

67. Medical staff initially considered TK was not suitable for crisis accommodation but discharge to a hotel appeared to be the only option available pending transfer to Youth Transitional Housing, then a YRR service if she remained stable. TK and Mr BE both raised concerns about

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[32] The Clinical Practice Guideline for the Management of Borderline Personality Disorder (NHMRC, 2013) reports there is a lack of evidence about the role of long-time inpatient care but clinical literature suggests lengthy hospitalisation is generally not recommended for people with BPD. A major risk of a long-term inpatient stay is loss of independence and decreased capacity to take responsibility for one's own safety, but the Guidelines do consider there are rare circumstances where such care is indicated. TK's situation (homeless, no financial income and few support people) required a long stay.

[33] Eastern Health website: https://www.easternhealth.org.au/site/item/112-maroondah-prevention-and-recovery-care-parc#eligibility-criteria (accessed 23 August 2023).

the suitability of hotel accommodation but ward staff assured them she would have adequate support. Some supports were initiated though not all appear to have met TK's needs. In particular, no referral was made for assertive outreach. Again, this was not optimal, but it is unlikely any service would have made contact with TK prior to her making another suicide attempt on the evening she was discharged.

68. On the day of discharge, allied health staff did hold concerns about TK's wellbeing and planned to inform medical staff, but it remains unclear if this eventuated. However, TK had denied suicidal thoughts on the day (and for several previous days) and there is no certainty it would have altered plans to discharge her that day.

Treatment provided by Maroondah Hospital In-Patient Unit

69. TK's final admission to a psychiatric inpatient unit was at Maroondah Hospital where she had been transferred on 13 March 2021 following medical stabilisation subsequent to another high lethality overdose on the evening of the day she was discharged from BHH. The CPU considered her admission for containment was appropriate and the treating team contacted TK's psychiatrist at BHH to obtained collateral that informed their management plan.

70. On 15 and 16 March 2021 TK denied suicidal ideation and requested discharge. Dr Capelluto considered TK did not meet criteria to be detained under the *Mental Health Act 2014* as she willingly accepted the recommended treatment and discharge plan.

71. TK had a long-term pattern of suicidality such that her baseline risk was chronically high, escalating to acute levels at times. The CPU noted that managing such situations presents a challenge for mental health clinicians. Clinical Guidelines emphasise that for some people with BPD, when risk for suicide is constantly high for long periods of time, there may be acute episodes when short-term admissions are necessary to ensure the person's safety but the focus should be on the treatment of BPD (and other co-occurring mental health conditions) while monitoring for the appearance of any new symptoms or behaviours that might indicate an increase in risk.[34] There was nothing to suggest the emergence of any new issues of concern at this admission and on the day of discharge, TK denied suicidal ideation. The CPU considered the decision to discharge TK was therefore reasonable, even though she remained in a state of relatively high risk, as long as she had assertive follow-up and treatment.

[34] The Clinical Practice Guideline for the Management of Borderline Personality Disorder (NHMRC, 2013), p.142/182.

72. Discharge planning was considered appropriate by the CPU in that it included confirmation of Centrelink and housing arrangements, communication with Dr Guttenberg, and engaging both TK and Mr BE in adequate safety planning. Unlike the previous inpatient episodes at BHH, TK was referred to a specialist mental health service and a CYMHS clinician contacted TK three days after discharge to organise a first appointment. TK presented to the clinician as happy and future-focused, with no evidence of suicidality. They likely could not have predicted she would suicide the next day.

73. Unlike the previous discharges from BHH, TK left the ward to accompany Mr BE on a business trip. The few days she spent with Mr BE were the longest time she had spent in the community without making a suicide attempt since 4 February 2021. When CYMHS phoned TK she stated she had not had any suicidal thoughts while away suggesting that social support while on the trip may have provided her with some degree of protection from suicidality.

74. TK's treating team was under the impression that on her return from the trip, TK would stay with Mr BE or family until the youth accommodation was in place. The CPU stated that it is not clear why this did not eventuate, and instead TK returned to the hotel where, within one day, she took the fatal overdose. It is not known what transpired after TK's return to the hotel, but relationship issues had triggered each previous suicide attempt and it is possible something occurred to trigger an overwhelming emotional response and impulsive and lethal behaviour.

Eligibility criteria for accommodation services

75. The CPU obtained statements from Neami and EACH[35] regarding eligibility criteria and waitlists for Youth Residential Recovery (**YRR**) services that existed at the time of TK's discharge. They also provided information of the processing of TK's nomination to the YRRs.

Eligibility and intake process

76. EACH and Neami are Mental Health Community Support Services (**MHCSS**) Intake Assessment Providers (**IAP**) for Victorian-based YRRs and manage all processes related to the nomination process for bed-based services. Rather than a waitlist, they operate a 'nomination register' that is a repository for information about a consumer. The IAP facilitates independent selection panels to assess nominations on the basis of eligibility, level of psychiatric disability, and informed consent.

77. Eligibility criteria for the 12-month residentially-based mental health support service is:

[35] Neami operates Hawthorn Youth Residential Recovery (**YRR**), Mind Australia operates Rosanna YRR, and EACH operates Box Hill and South YRR.

- Be 16-25 years of age;
- Have a disability that is attributable to a psychiatric condition;
- Have impairment or impairments that are permanent, or a likely to be permanent;
- Have an impairment or impairments that results in substantially reduced psychosocial functioning in undertaking one or more of the following activities: communication, social interaction, learning, self-care, self-management; and
- Have an impairment or impairments that affect their capacity for social and economic participation.

78. Priority is given to young people who are the most disabled by their psychiatric condition. Reasons to decline a referral include behavioural or risk management issues.[36]

79. The Neami YRR Intake Guideline (dated January 2021) explains that young people need to have established some ways to manage/live with their mental health concerns to reduce the impact it may have on other residents when they are struggling with symptoms, and they exclude people with no professional supports in place.

80. Given the YRRs provide a 12-month residential program, time on the nomination register can vary drastically.

TK's nomination for Youth Residential/Recovery services

81. TK was nominated for a YRR by the social worker at Box Hill Ward 1 East on around 9-10 March 2021, with the preferred locations being Hawthorn, Rosanna, Box Hill, or South. At the time, there were no vacancies at the sites. The Box Hill/Hawthorn Panel did not progress TK to a comprehensive assessment but did consider her a candidate for the program in the near future if she could demonstrate her engagement in recovery in the community while waiting for a vacancy. An email was forwarded from the Selection Panel to the referring social worker explaining the decision of the Panel:

> *"…the panel would like to see a minimum of 2 months crisis free presentations, engagement with CYMHS and an updated assessment report/risk management and safety plan in place to support* [TK] *with her mental health support needs…"*[37]

82. On 16 March 2021, at the request of TK's treating team and in the context of TK's ICU admission and transfer to Maroondah Hospital acute inpatient unit, her nomination was placed

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[36] YRR Selection Panel Terms of Reference Summary 2020.

[37] Statement from Dean McCaughan, Program Stream Manager Youth Mental Health and Wellbeing Services, EACH, p3.

on hold to enable establishment of support through CYMHS. TK's nomination to the Rosanna YRR was due to go before the Mind Rosanna YRR Selection Panel on 25 March 2021.

83. TK was significantly disabled by her psychiatric condition and displayed several factors that would have raised her priority for selection compared to people at the same level of disability. However, the Selection Panel was concerned that TK had displayed active suicidality with intent during her current admission and appropriately noted that the YRR was not resourced to provide crisis support. According to the EACH Intake Coordinator, the Panel was also concerned that TK was being discharged "*without sufficient community supports*" required for a YRR placement.[38]

84. The CPU noted that TK's situation highlights the difficulty of accessing suitable accommodation for young people experiencing homelessness and serious mental health concerns, who do not require acute inpatient care but struggle to be sufficiently mentally well for acceptance to a YRR.

85. The demand for YRR beds also continues to exceed capacity. As of October 2023, there were 12 young people on the Combined Eastern YRR Selection Panel (Box Hill YRR, Hawthorn YRR, Wantirna YRRR) nomination register and nine on the Combined Northern nomination register.[39] Brad Aylan-Parker from Neami also noted that the number of YRR places and affordable housing/accommodation for young people in Victoria was inadequate in 2021 and remains so.

86. In May 2021, the Department of Health commenced the Youth Outreach Support (**YORS**) program to address the limited availability of support. YORS leverages and extends the YRR delivery platform by providing young people with access to programs and activities available to clients in the YRR service on a day program basis. Access can be post-discharge from a YRR, pre-entry to a YRR while on the nomination register, or as an alternative to a YRR if residential arrangements are unsuitable. The CPU noted this is likely to provide some support for young people like TK who are awaiting a bed at a YRR.

87. However, young people living with mental illness and experiencing homelessness will be better served by greater availability of supported housing options. As Brad Aylan-Parker from NEAMI National indicated:

[38] DHS Category 1 Incident Report 30 March 2021, EACH Intake Coordinator, p3.
[39] Statement from Mr Dean McCaughan, Program Stream Manager Youth Mental Health and Wellbeing Services, EACH, p.5.

> *"The shortfall in accommodation options for young people with mental health challenges has implications for their ability to access, and receive continuity of, support services. Having a secure "home" is integral to people's recovery. Without it, young people disengage from services, as securing a place to live takes priority".*[40]

Availability of LGBTIQA+ specific supports

88. TK was in a same-sex relationship for a period of time proximate to her passing, and on this basis I sought advice on the availability of LGBTIQA+ supports to young people such as TK facing mental health issues and experiencing suicidality. The higher rates of suicide among LGBTIQA+ people are well acknowledged, though likely an underestimate.[41] Both international and Australian survey data suggests this cohort are at greater risk for suicidal ideation and suicide attempts. A recent Australian survey[42] of cisgender LGBQ people reported social inclusion was associated with lower suicidal ideation and number of attempts, and that improving inclusiveness in health services is an important strategy to reducing suicide risk for LGBQ people.

89. In TK's case, efforts were made to support her cultural safety at BHH and she reported she felt safe there. Staff discussed LGBTIQA+ supports with TK who reported some previous negative experiences with such groups. She was linked to QLife (peer-to-peer support) and went on to contact the Eastern Diversity Group. After she did not hear from them, staff progressed her contact with the group, and TK appeared to engage well. It is unknown if TK felt culturally safe at Maroondah Hospital Inpatient Psychiatry Unit.

90. The Royal Commission into Victoria's Mental Health System **(RCVMHS)** identified the need to improve inclusiveness of mental health services for LGBTIQA+ people. Recommendation 27 included: *"develop initiatives to support people at risk of experiencing suicidal behaviour, by co-producing an aftercare service for lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning people following a suicide attempts".*

91. The CPU considered that such an aftercare service of this nature may have been helpful for TK. The Department of Health has advised the Court that this recommendation is being progressed and an aftercare service is being developed. I consider this to be of critical

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[40] Statement from Brad Aylan-Parker, Service Manager, Hawthorn Youth Residential Rehabilitation, Neami National, p.4.

[41] *Suicide among LGBTIQ+ people,* Coroners Court of Victoria, 14 October 2022.

[42] *Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among lesbian, gay, bisexual, pansexual, queer, and asexual (LGBQ) people in Australia: Correlates of suicidality among LGBQ Australians,* Lyons et al, Journal of Affective Disorders, 296 (2022) 522-531.

importance to LGBTIQA+ people presenting in the manner that TK did, noting that a suicide attempt is the most significant risk factor for further suicidal behaviour, and that tailored, compassionate aftercare can reduce further suicide attempts and suicide deaths.

CPU conclusions

92. By 2020, it was evident that TK's suicidality had become chronic, a common feature of BPD, but by early 2021, the risk frequently escalated to acute with multiple episodes of suicidal behaviour using lethal means.

93. The CPU noted that TK had multiple risk factors for suicide including a history of childhood trauma, being a member of the LGBTIQA+ community, history of previous attempts, history of mental disorder, recent psychiatric admissions and a history of lack of efficacy of hospitalisation in reducing risk. Some risk factors were dynamic and fluctuated in intensity including impulsivity and feelings of hopelessness. Overlaying these risk factors were recent adverse life events including homelessness with few protective factors other than the support she received from Mr BE.

94. Chronic and acute suicide risk are treated differently, and it was appropriate that TK's acute exacerbations were managed with hospital admissions to ensure her safety at the time. However, the admissions appeared to do little to reduce her chronic high risk and ongoing susceptibility to intense emotional distress and impulsivity. TK was increasingly reluctant to engage in strategies to support self-regulation, safety planning and help-seeking. At each admission, TK's suicide risk fell from an acute level to a chronically high baseline. The CPU found that good practice would have been to ensure she had assertive and comprehensive outreach in place on discharge. No such referrals were in place following her discharges from BHH though on each occasion, TK made suicide attempts very soon after leaving the hospital and it is unlikely any service would have been able to engage with her in time.

95. The treating team at BHH recognised that crisis accommodation was not suitable for TK but were unable to obtain a place in more appropriate accommodation. CPU is not aware of other supported accommodation options that could have been considered by BHH.

96. TK's suicide attempts during 2021 occurred either within a day of being discharged from hospital to temporary accommodation or within a day of returning to hotel accommodation from a trip with BE. There is no certainty that being discharged to a supported youth residential service that provided psychosocial rehabilitation support would have prevented TK's death, but it was an option that was not made available to her.

97. The RCVMHS identified the limited availability of appropriate accommodation for young people living with mental illness and experiencing homelessness and recommended improved access to housing, specific to young people, that is supported by an appropriate level of integrated, multidisciplinary, and individually tailored mental health treatment and support. A pertinent comment will follow.

98. Based on the available information, in relation to TK's tragic passing, no direct prevention opportunities were identified.

99. I accept the findings of the CPU.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was TK born [redacted] 2002;

   b) the death occurred on 20 March 2021 at [redacted] Victoria, [redacted] from mixed drug toxicity; and

   c) the death occurred in the circumstances described above.

2. Having considered all of the circumstances, I am satisfied that TK intentionally took her own life. I note the findings of the CPU in this regard that, by 2020, it was evident that TK's suicidality had become chronic, which is a common feature of borderline personality disorder, and that by early 2021, the risk frequently escalated to acute with multiple episodes of suicidal behaviour using lethal means.

3. CPU noted, and I so find, that TK had multiple risk factors for suicide including a history of childhood trauma, a history of previous suicide attempts, a history of mental disorder, recent psychiatric admissions and a history of lack of efficacy of hospitalisation in reducing risk.

4. I find that overlaying these risk factors were recent adverse life events including homelessness with few protective factors other than the support she received from Mr BE. I must also consider the possibility that Mr BE's support might have been problematic, given TK's previous reports of sexual abuse in relation to this person who was ultimately involved in her discharge planning and care, and at times, nominated as her next of kin (although it is noted that these reports were not substantiated, nor can I make any such finding on the evidence). A pertinent recommendation will follow.

5. While CPU has raised the issue of a lack of comprehensive supports provided for TK upon discharge, with which I agree, I find that the care provided to TK by Eastern Health and the other services involved in her treatment to have been appropriate and comprehensive. It cannot be found that provision of any further community supports would have prevented the ultimate outcome, given it is unlikely any service could have effectively intervened in the short time frame between TK being discharged and making another attempt on her life.

6. Notwithstanding, I consider that this brings into sharp relief the need for readily-available community-based supports for those facing chronic suicidality, including for those who are from communities at higher risk of self-harm and suicidality, such as the LGBTIQA+ communities. Such supports must be provided in a culturally-safe and culturally-specific manner, such as through the peer-led LGBTIQA+-specific aftercare service being delivered under Recommendation 27 of the Royal Commission into Victoria's Mental Health System.

7. I also find that there were limited housing options available to assist those caring for TK to address her need for stability and a platform for support in the community. Comments will follow.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Implementation of Royal Commission Recommendation 25

1. The Department of Health (**the Department**) advised the Court that they were working in partnership with Homes Victoria to implement recommendation 25 of the Royal Commission into Victoria's Mental Health System (**RCVMHS**), including the six sub-recommendations.

2. Recommendation 25.4 calls for the establishment of an additional 500 new short-medium term (up to two-years) supported housing places for young people aged between 18-25 who are living with mental illness and experiencing unstable housing or homelessness.

3. In 2022, the Department commissioned a youth supported housing co-design project that has identified principles to guide housing and complementary supports including a consistent care team, highly trained staff, adaptable supports, and connections to amenities, public transport, and natural environments.

4. I note that TK's experience of homelessness underpinned the circumstances leading to her tragic death. The health services involved in TK's care identified her need for supported accommodation but were unable to procure it.

5. I endorse recommendation 25.4 of the RCVMHS and consider its implementation should be urgently progressed. I will provide a copy of this finding to the Department of Health and Homes Victoria who are charged with implementing recommendation 25.

6. I will also provide a copy of this finding to the Mental Health and Wellbeing Commission as the entity responsible for monitoring and reporting on government progress in relation to the implementation of the recommendations made by the RCVMHS.

RECOMMENDATIONS

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

1. To the **Office of the Chief Psychiatrist:** Noting that mental health and wellbeing services need to minimise the risk of harm to patients being discharged to sexually unsafe environments, I recommend the Office of the Chief Psychiatrist consider extending the 'Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units guideline' (2012) to incorporate managing situations

whereby vulnerable patients may be discharged into environments whereby their sexual safety may be at risk.

I convey my sincere condolences to TK's family and loved ones for their immeasurable loss.

ORDERS AND DIRECTIONS

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

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

QK and DK, Senior Next of Kin

Mr BE

Eastern Health

Homes Victoria

Secretary of the Department of Health

Alexandra Krummel, Director of Statewide Programs & Implementation, and Katherine Whetton, Deputy Secretary, Mental Health & Wellbeing Division, Victorian Department of Health

Office of the Chief Psychiatrist

Senior Constable Brooke Miller, Coroner's Investigator

Signature:

INGRID GILES

CORONER

Date: 4 October 2024

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.