IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 002294

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	Miss RST[1]
Delivered on:	5 February 2026
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Directions Hearing: 16 July 2024 Inquest: 21, 22, 23, 24 & 25 October 2024
Findings of:	Coroner Sarah Gebert
Counsel assisting the Coroner:	D. Wallis Instructed by Coroners Court of Victoria
Counsel for Mr ACW	C. Eberhardt KC Instructed by Robertson O'Gorman Solicitors

[1] A Proceeding Suppression Order under the *Open Courts Act 2013* was made protecting the Deceased's identity dated 1 August 2024.

Counsel for Ambulance Victoria:	E. Gardner Instructed by Meridian Lawyers
Counsel for Eastern Health:	S. Reid Instructed by Lander & Rogers
Counsel for Triple Zero Victoria:	R. Singleton Instructed by Minter Ellison
Other Matters:	*Adolescent mental health care, Emergency Department, suicide*

Family Impact Statement (extract)[2]

Miss RST was greatly loved by Mrs LRV and myself and our son, Master SRP, as well as our wider family. Despite us residing in Hong Kong, both Miss RST and Master SRP enjoyed visits to Australia a couple of times a year and were close to their grandparents, aunts, uncles and cousins.

Throughout much of this inquest we have heard evidence during the times that Miss RST and our family was in crisis. I will not repeat those issues now.

Prior to her mental health issues emerging from around mid-2020, Miss RST was a very engaging, cheeky, witty and interesting girl.

She had many friends and always wanted to spend time with them, including having sleepovers. She loved sports – playing netball and AFL and participating in gymnastics – she loved going to the beach, baking, rollercoasters (the scarier the better – she definitely takes after her mother there), her fleecy blankets, her guinea pigs, travel, and as she grew older shopping, fashion and make up.

Miss RST had her own unique style.

Mental Health

Mrs LRV and I want to make sure that lessons are learnt from Miss RST's passing. We want to do everything we can to reduce the risk of further suicides.

Miss RST's passing has not only had a profound impact on Mrs LRV, Master SRP and I, but on our family and friends. We know that Miss RST's many friends, now predominantly aged 16- and 17-years old, also continue to feel the loss of Miss RST in their lives.

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[2] Read by Miss RST's father.

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INTRODUCTION

1. Miss RST [3], born [redacted] 2008 was 13 years old at the time of her passing. She is the youngest of two children to Mr ACW and Mrs LRV with older brother, Master SRP.

2. Tragically, Miss RST passed away on 2 May 2021 after falling from the 12th floor of the Avani apartment complex in Box Hill (Melbourne Box Hill Residences), where she was living with her mother.

THE CORONIAL INVESTIGATION

3. Miss RST's death was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as her death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.[4]

The coronial role

4. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death.[5] Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

5. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and making comments and or recommendations about any matter connected to the death they are investigating.

6. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

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[3] Referred to in my finding as 'Miss RST' unless more formality is required.
[4] Another coroner initially had carriage of this investigation.
[5] The exceptions being cases where an inquest was not held, the deceased was not in state care and there is no public interest in making findings as to circumstances: section 67 of the Act. Further, where an investigation is discontinued under section 17 of the Act.

7. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles in *Briginshaw*.[6]

Discretionary inquest

8. Miss RST's family made an application for an inquest to be conducted as part of the investigation.[7] The family were concerned, amongst other things, about the provision of care to Miss RST proximate to her passing as well as any prevention opportunities arising from the circumstances surrounding her death.

9. I subsequently determined that an inquest would be held as part of the investigation.

Sources of evidence

10. As part of the coronial investigation, the Coroner's Investigator, Detective Senior Constable Mark Taylor prepared a coronial brief. The brief includes statements from witnesses, including those present at the scene of the incident, the forensic pathologist who examined Miss RST, ambulance paramedics, investigating police officers and Miss RST's relatives as well as other documentation such as school reports, a Paediatrics Referral Letter (Hong Kong), Closed Circuit Television (**CCTV**) footage (Avani Hotel), VARE transcripts (Miss RST's friends), Ambulance Victoria Patient Care Records, Triple Zero Transcripts (from 2 May 2021), Uniting records (Blackburn Community Services) and scene photographs.

11. The Court also obtained statements from a range of individuals including health clinicians who saw Miss RST (Eastern Health which attached relevant policies), education providers (Avenues Education, Koonung Secondary College, Methodist Ladies College), the Department of Families, Fairness and Housing, Safer Care Victoria, Ambulance Victoria and Triple Zero Victoria, as well as Miss RST's LEAP Records. In addition, Miss RST's medical records were obtained from Eastern Health and Purruna Medical Centre.

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[6] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …".

[7] Enclosed in correspondence from Miss RST's father dated 10 July 2022 and from his legal representatives dated 28 August 2023.

12. To assist my investigation, the Court also obtained an expert report from child & adolescent psychiatrist, Dr Robert Adler, concerning the provision of care to Miss RST[8]. He gave evidence as part of an expert panel with other experts engaged by interested parties including Professor Charles L. Scott[9], Dr Michael Beech[10], and Dr Antony Mark Milch[11].

13. The Court also obtained a report from Professor Olaf Drummer, a Forensic Toxicology Consultant Specialist, regarding matters related to the alcohol and prescribed substances Miss RST had consumed.[12]

Scope of Inquest

14. The scope of the inquest was as follows:

> *Was the health care provided to Miss RST by Eastern Health during the period from 19 February 2021 to 30 April 2021 appropriate?*
> *Was there adequate communication between Eastern Health and Miss RST's family in relation to Miss RST's risks and any strategies to mitigate those risks in the weeks leading to her passing?*
> *Are there any systemic issues in relation to the response to the 000 call made by Miss RST on 2 May 2021 in circumstances where Miss RST nominated an ambulance rather than police when initially asked by Telstra?*

15. The inquest ran for five days and heard evidence from the following witnesses:

    a. Dr Subashini Rudolph, Paediatrician;

    b. Dr Sophie Price, Consultant Child and Adolescent Psychiatrist (Eastern Health);

    c. Dr Fiona Bassed, Child and Adolescent Psychiatrist (Eastern Health);

    d. Allison Hendon, Senior Social Worker (Eastern Health);

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[8] Child & Adolescent Psychiatrist, CB at p.656-669 and Supplementary Report, CB at p.1156-1157.
[9] Chief, Division of Psychiatry and the Law, Professor of Clinical Psychiatry, Department of Psychiatry & Behavioral Sciences, University of California, Davis Medical Center – Sacramento, CB at p 554-629.
[10] Child, Adolescent & Adult psychiatrist, Bensen Street, Specialists Centre, CB at p.636-657.
[11] Child, Family & Adult Psychiatrist, Family in Mind, CB at p.1245-1262.
[12] Victorian Institute of Forensic Medicine, Professor Emeritus, Department of Forensic Medicine, Monash University, CB at p.46-50.

e. David Vasilopoulos, Manager, Emergency Communications Services (Triple Zero Victoria);

f. Matthew Shields, Operational Communications Advisor (Ambulance Victoria);

g. Dr Peter Jordan, Acting Clinical Program Director for Critical Care and Access (Eastern Health);

h. Dr Peter Jenkins, Acting Executive Clinical Director of Mental Health and Wellbeing Program (Eastern Health);

i. Dr Andrew Cheong, Clinical Director of Adult Access (Eastern Health); and

j. As already noted, an expert panel comprising of psychiatrists: Dr Robert Adler; Dr Michael Beech; Professor Charles Scott and Dr Anthony Mark Milch.

16. After the conclusion of the inquest, I received closing submissions from Counsel Assisting[13] followed by written submissions in response from all interested parties.[14] Further responses in reply were then received by all parties as well as Counsel Assisting.[15]

17. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, any documents tendered through counsel (including Counsel Assisting), written and oral submissions of counsel and their replies following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Miss RST's death. I do not purport to summarise all the material and evidence in this finding but will refer to it only in such detail as is relevant to comply with my statutory obligations and necessary for narrative clarity.

BACKGROUND

18. Miss RST was born and raised in Hong Kong. Her family lived in Tsim Sha Tsui. Miss RST resided with her parents, both professional workers, and her older brother who was still a

[13] Dated 13 November 2024.
[14] Ambulance Victoria dated 5 December 2024, Miss RST's father dated 5 December 2024, Eastern Health dated 3 December 2024 and TZV dated 5 December 2024.
[15] Counsel Assisting dated 18 December 2024, Ambulance Victoria dated 20 December 2024, Miss RST's father dated 19 December 2024, Eastern Health dated 19 December 2024 and TZV dated 19 December 2024.

teenager at school. Although described by her mother to be quiet, Miss RST enjoyed an active childhood and nothing particularly unusual was evident.

19. Miss RST completed school at the Australian International School Hong Kong (**AISHK**) from 2013 to 2019 but came to Melbourne in 2020 to commence her secondary schooling as a boarder at Methodist Ladies College (**MLC**).

20. Miss RST's studies were however disrupted by COVID-19 and this necessitated her return to Hong Kong to continue studying with MLC online. Initially the arrangement progressed well, but as other students returned to face to face learning in Australia with quarantine rules being lifted and Miss RST still enrolled at MLC, her ability to participate was affected. She subsequently returned to study at AISHK (also online due to restrictions commencing before the start of Term 3).

21. A significant change in Miss RST's attitude was noted in mid-2020. There was decreased motivation to study, and some conflict in the family, including physical conflict with her father. She was reported to lie about her whereabouts, and be consistently rude and verbally abusive to her parents. Her mother said that there was some violence which usually revolved around her phone use, which became a bargaining tool. Miss RST was also caught shoplifting on two occasions with another girl, despite her having sufficient funds to pay for the items taken. She also started vaping (and was hospitalised on one occasion as a result), drinking (at bars) and refusing to adhere to curfews set by her parents. Miss RST pierced her ears and belly button and got a tattoo. She also lost interest in her pet guinea pig and activities she used to enjoy.

22. There was also school refusal and Miss RST expressed a strong desire to return to MLC where she proposed to resume boarding school.

Assessment in Hong Kong

23. In late December 2020, Miss RST was found on the rooftop of a shopping mall, where she had been drinking and was hospitalised with a fractured right ankle. She was seen by a psychiatrist during her hospital admission. The report prepared by the psychiatrist documented that Miss RST felt her mood was previously *stable and neutral,* and she denied *pervasive low mood or negative cognitions.* She also denied suicidal or *violent ideation.* It was noted that her parents had different parenting styles, with one being stricter than the other. There was also reported to be a long history of sibling rivalry over gaining attention from their

parents. The family had been seeing a counsellor over the past 5-6 years due to increased conflicts in the family.

24. Miss RST reported during the assessment that she did not habitually drink or vape. She said she disliked her family members and that the other three seemed to be closer to each other, while she felt she was the odd one out, and this was more severe since 2019. Miss RST considered that even though she was aware that boarding school in Melbourne would be strict, she preferred it to staying in Hong Kong and dealing with her parents.

25. During the consultation, Miss RST said that if she had 3 wishes they would be, to have chill parents (e.g. no curfews); be rich (e.g. win a lottery); and have more wishes.

26. Following the assessment, the provisional diagnosis was *Oppositional Defiant Disorder* and a differential diagnosis was *Emerging Conduct Disorder*.

Return to Australia

27. Miss RST and her mother travelled to Australia on 7 January 2021, where they spent two weeks in quarantine in Queensland before traveling to Melbourne. The plan was for Miss RST to commence term one at MLC as a boarder. Miss RST's mother said that there were no issues during the quarantine period.

28. On 22 January 2021, they arrived in Melbourne. Miss RST met up with many friends at 'Glenferrie' which was a location in Hawthorn where her friends would meet.

29. Before school commenced, Mrs LRV reported that Miss RST began complaining about the strictness of the school and that she didn't want to go. She did however start school on Monday, 1 February 2021 and appeared initially happy.

30. There were however issues noted in the first week of term including vapes being found in Miss RST's room, and her complaining about school rules, such as the uniform requirements but by 8 February there were reports of an improvement in her behaviour.

31. On Tuesday, 9 February, Miss RST failed to meet the school's curfew following which police were called and subsequently located her. She indicated to her mother that she no longer wished to remain as a boarder at MLC.

32. On Wednesday, 10 February, Miss RST failed to attend class and went missing. She was later found hiding at her friend, [redacted]'s (**referred to as EE**), house by police following being

reported missing. EE was 14 years old. Leading Senior Constable Ruth Habel stated that no *suicidal or self harming thoughts were disclosed* during the incident.

33. From 11 to 12 February, Miss RST was suspended from school. As Mrs LRV was staying with her parents in Blackburn, Miss RST was staying with them as well.

34. There was a COVID lockdown in Victoria from 13 to 17 February 2021, which meant that learning returned to online.

35. On Sunday, 14 February police attended Miss RST's grandparents' home in Blackburn at about 5.29pm for a job related to an assault. The house was described as calm when the police arrived. Miss RST, her mother and her grandparents were all present.

36. Miss RST told police that she had run away from boarding school because she *hated* it, and also *hated* living with her grandparents because they yelled at her, took her phone away and were *super strict.* She admitted to punching her mother whilst she was trying to stop her from running away. She advised police that she hated her parents and now wished to return to Hong Kong because it was *chill* and it would be better than living with her grandparents or attending boarding school. She was described as looking *sad*.

37. Attending police brought Miss RST and her mother together to allow Miss RST to explain how she felt, including her desire to return to Hong Kong.

38. Miss RST's mother did not want to make a statement regarding the assault. Police made referrals as a result of their interaction.

39. Miss RST returned to school at MLC as a day student, but arrived late on Thursday, 18 February 2021. The Junior Secondary School Head (**JSSH**) witnessed an incident where Miss RST pushed past her mother and was verbally rude. She was subsequently rude and uncooperative with JSSH. Mrs LRV described her acting like a *different person*. Miss RST refused to go to class and was taken home. Her phone was confiscated and she ran away. Miss RST was found by her mother at Laburnum station. Her mother said that when she blocked her from boarding the train, Miss RST kicked and punched her.

40. Police received a job at 12.30pm following a report by a train driver who observed a fight between two parties. Senior Constable Connie Gellis attended and spoke to Miss RST and her mother. Information conveyed included that Miss RST was trying to get onto the train to head to the CBD after skipping school and her mother was trying to physically stop her from getting

onto the train. Miss RST had scratched her mother on the legs during the incident. Her mother was not willing to provide police with a statement or formally report an assault. Referrals were offered to both Miss RST and her mother which were accepted.

41. Miss RST was said to have been suffering from some dizzy spells around this time and was advised to take a wellness day from school the following day.

Department of Families Fairness and Housing

42. On 18 February 2021, the Department of Families Fairness and Housing (referred to in my finding as **Child Protection**) received the first report regarding Miss RST and her family. Miss RST was 12 years old at the time of the report. Reported concerns related to Miss RST's challenging and aggressive behaviour towards her mother and maternal grandparents, including assaulting her mother on several occasions and Miss RST's poor behaviour at boarding school, including going missing.

43. On 24 February 2021, Child Protection assessed that protective intervention was not required as no significant concerns were raised for Miss RST. Child FIRST[16] agreed to support Miss RST and her mother while the school was supporting her mother to arrange a paediatric assessment. The case was closed at Intake phase on 24 February 2021.

Referral to Eastern Health and First Emergency Department Presentation, 19 February 2021

44. On the morning of Friday, 19 February 2021 the Eastern Health, Infant, Child and Youth Mental Health Service (**ICYMHS**) access team received a referral from Miss RST's mother[17], on the recommendation of the MLC school counsellor. A comprehensive intake was conducted over the phone.

45. ICYMHS Access informed her that she would receive a response after the case was discussed at the next allocation meeting to be held on 24 February 2021.

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[16] Child and family services information, referral and support teams (Child FIRST) provided a central referral point to a range of community-based family services and other supports within each of the Child FIRST catchment areas. Child FIRST support vulnerable children, young people and their families to access support services. Child FIRST is progressively transitioning to The Orange Door; a new access point for women, children and young people who are experiencing family violence or families who need assistance with the care and wellbeing of children to access the services they need to be safe and supported.

[17] She had called that morning.

46. Consultant Child and Adolescent Psychiatrist from ICYMHS, Dr Fiona Bassed (**Dr Bassed**) advised that,

Safety planning, (including the removal of knives and medications from the house, following up with Child Protection - who had already been involved by the school on mother's behalf, advice to call the Eastern Health Mental Health Afterhours number if requiring further support, and the Police, should there be further physical violence, and to present to hospital via ambulance if Miss RST's behaviour escalated further) was undertaken with her mother.[18]

47. Later that day, Miss RST threatened her mother (to kill by stabbing) and Miss RST agreed for a psychiatric consultation at the Box Hill Hospital Emergency Department (**ED**).

48. Miss RST was taken by her maternal uncle, Mr JLK, at approximately 8.52pm. He was concerned about her violent behaviour towards her mother and grandmother and reported that she had tried to push her mother in front of a train. On mental state examination undertaken by the ED doctor, Miss RST appeared preoccupied by her thoughts of anger towards her mother. Miss RST denied thoughts of self-harm or suicide. There was no evidence of perceptual disturbance.

49. The psychiatric triage clinician provided a secondary consultation and after reviewing the notes concluded that Miss RST's presentation reflected anger management and behavioural issues rather than an underlying psychiatric issue and recommended that Afterhours Child Protection be contacted, which was done by the ED Doctor.[19]

50. Miss RST was discharged from ED into the care of her uncle.

51. Miss RST's mother documented regarding Miss RST's presentation at the ED that her brother, *reports she was pleasant and answered all questions openly.*

[18] CB at p.185.
[19] The secondary psychiatric triage review performed by Wayne Conron.

Second Emergency Department presentation, 22 February 2021

52. On Monday, 22 February 2021, the ICYMHS Access clinician (Olivia Redfern, social worker) noted that Miss RST had presented to ED over the weekend. She contacted Child Protection to follow-up due to the reported risk of safety to the mother and was awaiting a return call.

53. Also on this date, Miss RST's parents made inquiries with the Albert Road Clinic but were advised that she was too young.

54. Later in the day, Miss RST did not want to go to a physiotherapy session and reportedly punched her mother and yelled at her grandparents, but eventually got in the car. On the way however her mother said that she was verbally abusive and refused to get out of the car.

55. Her mother drove to the Box Hill ED. On the way Miss RST threatened to grab the steering wheel and steer the car into traffic. They arrived at about 4.50pm but Miss RST refused to get out of the car. There was a long wait and they remained in the car. At 9.30pm Mrs LRV told Miss RST her mobile data would be switched off at 10.00pm. Miss RST threatened to run away.

56. A nurse went to the car to try to talk to Miss RST but there was limited engagement. Mrs LRV reported that Miss RST had physically assaulted her and had been verbally rude and aggressive to her grandparents, and to her. Miss RST refused to get out of the car to speak to anyone in the ED and told the nurse that she just wanted to go out with her friends and that her mother was too strict.

57. The nurse documented,

> *Quite advanced and inappropriate attitude for child her age. States she 'Just wants to go out with her friends' and thinks her mum is too strict. Tried to convince pt to come inside to speak to team so we can come up with strategies and ways to make things easier. Pt refused. Nil intentions to harm mum or self voiced at this time.*[20]

[20] CB at p.982.

58. The presentation was discussed with the Psychiatric Triage clinician who considered that Miss RST did not appear to have a psychiatric issue (*rather anger management and behavioural*) and recommended that Afterhours Child Protection be contacted.[21]

59. Consultant emergency physician, Dr Peter Jordan (**Dr Jordon**) commented about the ED on 22 February 2021,

> *At the time of Miss RST's presentation, the ED's National Emergency Department Overcrowding Score (NEDOCS) was between 142 and 172. This score reflects the presence of between 55 and 66 patients in the ED and correlates with severe overcrowding. Processing of ED patients was also delayed due to strict COVID-19 protocols. Melbourne's third community lockdown had been lifted on 17 February 2021 (following the implementation of the Victorian Government's Circuit Breaker Action and associated restrictions on 12 February 2021); however, an elevated level of concern for transmission continued to delay care provision in this pre-vaccination period.* [22]

60. At 10.00pm Miss RST's mobile data was turned off and she ran away. At approximately 10.19pm, Mrs LRV informed hospital staff and she was advised to notify police. Mrs LRV called the police and Miss RST was subsequently located at the Box Hill train station.

61. Around this time Miss RST told her mother that she couldn't focus in class, which was new for her. Miss RST confirmed this in a text message to a friend, *I have rlly bad trouble focusing i can't do schoolwork*.

62. Miss RST apparently switched between wanting to go to another school in Melbourne or, at other times, returning to Hong Kong. She did not want to stay with her grandparents and wanted to move into an apartment with her mother.

63. MLC contacted various services to support Miss RST during this time.

64. On Tuesday, 23 February 2021 Miss RST's mother called ICYMHS Access and discussed the ED presentations of 19 and 22 February. She was advised to present Miss RST to ED should

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[21] At approximately 9.54pm, the psychiatric triage clinician, Antoinette Cullivan, documented a secondary psychiatric triage review.

[22] Statement of consultant emergency physician, Dr Peter Jordan, Acting Clinical Program Director for Critical Care and Access, Eastern Health, dated 18 June 2024, CB at p.1049 - 1094. Included were relevant policies including 'Psychiatric Assessments and Outcomes in Emergency Departments', 'Escalation to Triage Consultant Psychiatrist or On-call Consultant Psychiatrist', 'Mental Health Triage ED Assessments Business Rules'.

her behaviour escalate and that the case would be discussed at the allocation meeting the next day.

65. On Wednesday, 24 February 2021, the review meeting was held, and it was determined that Miss RST would be referred to the ICYMHS Intensive Mobile Treatment Team (**IMTT**). She was offered an IMTT appointment on 16 March 2021 and the Safety Plan was reiterated in the interim.

66. On Thursday, 25 February 2021 Miss RST saw paediatrician Dr Subashini Rudolph, Consultant General Paediatrician.[23] This was required before Miss RST could return to MLC.

67. Dr Rudolph stated that at time of her review, Miss RST presented with a number of significant mental health concerns including low mood, oppositionality, anxiety regarding attending school, aggression (primarily hitting her mother), absconding, substance abuse with the use of alcohol and vapes, as well as shoplifting. It was also alleged that Miss RST had threatened to kill herself and kill her mother a number of days prior to the day of initial review.

68. She noted that Eastern ICYMHS (Child and Youth Mental Health Services) had been contacted, and an 'intake meeting' had already been conducted.

69. Dr Rudolph considered that her management needed to be via a comprehensive paediatric mental health team, and supported her care and management by Eastern ICYMHS, so that she had access to all levels of paediatric mental health care, including crisis management, community care and inpatient mental health treatment to optimise her safety. She had no significant physical medical issues.

70. On Monday, 1 March 2021 Miss RST returned to MLC as a day student. The school determined they were willing to support Miss RST and give her a fresh start with support and timeouts if required. Miss RST was however soon found vaping with another student.

71. On Tuesday, 2 March 2021, MLC held an online meeting (as Miss RST's father was in Hong Kong) where it was agreed by all parties that MLC was not the right environment for Miss RST and that the school would remain engaged with the family until the end of term to navigate support services and to assist finding another educational setting. The Head of Junior

[23] Deputy director of the Women's and Children's Clinical Institute at Epworth HealthCare and consulting paediatrician at Austin Health and Mercy Hospital for Women.

Secondary School documented that Miss RST did not want to be at MLC and that MLC counsellors recommended that she return to Hong Kong.[24]

Third Emergency Department presentation, 2 March 2021

72. As a result of MLC no longer being viable, Miss RST's phone was confiscated by her mother. Miss RST apparently appeared surprised that she could not return to MLC. Mrs LRV said that in the afternoon she demanded her phone and when it was not returned, she became increasingly angry and started hitting her. She then went to a knife block and removed a small knife. Mrs LRV said, *she made threats at this time either against herself or me, but I can't recall exactly*. Mrs LRV said that Miss RST wanted to run away and became quite hysterical so she called Triple Zero. Again, Mrs LRV said that she was like a *different person* who was screaming and in an *absolute rage*. Miss RST tried to break a window with her crutches and kicked and punched her mother. Mrs LRV said that she snapped out of it as soon as the police and ambulance arrived.

73. Police arrived at approximately 4.09pm for a job described as a *suicidal female*. First Constable Michael Hill had also attended on 14 February 2021. Miss RST recognised him from the earlier incident. Miss RST advised that she had a verbal dispute with her mother where she tried to break some windows and was restrained by her mother.

74. Police arranged for Miss RST to speak to someone from the Police and Clinician Emergency Response (**PACER**) unit but she declined. Miss RST advised police that she was angry that her mother had taken her phone. Police were made aware that she had been threatening her mother and, that she was threatening to kill herself if her phone was removed.

75. Miss RST was transported to the Box Hill ED under section 351 of the *Mental Health Act 2014* (as it then was) arriving at approximately 6.21pm without Miss RST having access to her phone. She agreed to go with the ambulance to the hospital to speak about her mental health.

76. The Ambulance Victoria Patient Care Record documented the following,

12 y.o. female pt. Pt came back to Australia from Hong Kong to go to High School, pt was set up in a boarding house to go to school (MLC). Pt got expelled from school today due to

[24] CB at p.165.

vaping, mother (who is in Aus currently) states there have been issues with school this year. Today pt has allegedly assaulted her mother and threatened to stab herself and her mother. VicPol called. Pt spoke with AV and states that she wanted to hurt herself today but wasn't sure how to.

Pt also stated that she been feeling very angry and suicidal since returning from Hong Kong. Pt was eventually cooperative. ... [25]

77. An interim family violence order was put in place by police to protect Miss RST's mother.

78. At the ED, Miss RST was assessed by mental health clinician RPN Luke Berndt. The notes document:

Appearance & Behaviour: Casual and appropriate attire. Young female. Eating biscuit during review. Asked mother several times for mobile phone during review. Limited cooperation during review. Eye contact: Avoidant Speech: Soft speech, normal rate and tone Affect: Mildly irritable, calm Thought Stream: Normal Thought Form: Logical Thought Content: Nil bizarre or delusional ideation expressed. Denies ongoing thought to harm others. Suicidal thoughts "I don't know" Perception: Nil perceptual disturbance elicited. Cognition: Not formally assessed, appears appropriate for age. Judgment: Appropriate for age Insight: Limited

79. During the assessment Miss RST denied ongoing thoughts to harm her mother. He sought a secondary consultation with Consultant Child and Adolescent Psychiatrist, Dr Sophie Price (**Dr Price**), who was on call on 2 March 2021.[26]

80. There was no history of Miss RST ever having engaged in deliberate self-harm or suicide attempts previously. She was described as combative, irritable and difficult to engage in the interview. She denied ongoing thoughts to harm others and expressed ambivalence about suicidal thoughts. Dr Price noted that there was no pervasive mood disturbance identified such as depressed or elated mood and no features of a psychotic disorder apparent nor perceptual disturbance. Dr Price considered that as such it was unlikely Miss RST was experiencing a mood disorder or a psychotic disorder that would require treatment in hospital. She noted that Miss RST's mother reported that she feared setting limits around Miss RST's behaviour and

[25] CB at p.493.
[26] Statement of Consultant Child and Adolescent Psychiatrist, Eastern Health Dr Sophie Price dated 26 August 2024, CB at p.1228.

requested that she be admitted to a psychiatric ward. Dr Price said she considered the perspective of Miss RST's mother and her request for admission in making the decision but also considered whether the issue of parental limit setting could be addressed during an inpatient admission.

81. Dr Price noted that for children 12 years and under who live in the eastern region of Melbourne, inpatient psychiatric admissions occur at the Oasis Unit of Monash Children's Hospital in Clayton.

82. The admission occurs with a parent carer and is for 24 to 72 hours. Dr Price said the intention is to provide a safe environment to calm the child and family when this is not possible in the community. She said that at the time of her mental health assessment Miss RST was presenting as calm and her risk to self was assessed as low. As such Dr Price did not believe that an emergency admission was required. Nor did she meet the criteria for treatment under mental health legislation, as her mother was available to consent to mental health treatment on her behalf and it was possible to assess and treat her mental health in a less restrictive manner by way of community treatment.

83. Dr Price stated that she did not believe that an inpatient admission would be helpful given that Miss RST was presenting as low risk. In addition, it may also have been detrimental to Miss RST's engagement with mental health services if she were to be admitted to an inpatient unit with younger children many of whom also have neurodevelopmental disabilities in addition to mental health problems.

84. It was further noted that Miss RST had already been referred for mental health treatment at Eastern Health ICYMHS and had been allocated to the IMTT.

85. Dr Price recommended that the appointment with IMTT be brought forward and recommended a notification to Child Protection. Miss RST was discharged home with her mother. A notification was made to Child Protection.

86. Safety planning was undertaken including advice to secure implements in the home that could be used as weapons and to contact police if there were further violence or threats of violence.

87. On this day (2 March 2021), Afterhours Child Protection received the second report regarding Miss RST and her family. Reported concerns were related to Miss RST’s vaping and alcohol

use at school leading to her expulsion, her threatening her mother with a knife, threatening self-harm with a knife, and assaulting her mother.

88. On Wednesday, 3 March 2021, Child Protection assessed protective intervention was not required as no significant concerns were raised for Miss RST. Miss RST and her mother were engaged with ICYMHS with a further appointment booked for 9 March 2021. Child FIRST made an Intensive Family Service (**IFS**) referral to Anglicare on 3 March 2021 to support Miss RST's mother with Miss RST's challenging behaviour. ICYMHS and Child FIRST also safety planned with her around Miss RST's suicidal ideation. The case closed at Intake phase on 3 March 2021.

89. First Constable Michael Hill spoke to Miss RST on 3 March 2021 (*field interview*) in relation to the unlawful assault against her mother and stated,

> *Miss RST seemed to be in a much better headspace and was cooking with her mum in the kitchen when spoken to.*[27]

90. IMTT case manager, Allison Hendon (**Ms Hendon**), also contacted Miss RST's mother who reported that Miss RST had been settled overnight following discharge and requested earlier support be provided. It was agreed to bring the appointment scheduled for 16 March 2021 forward to 9 March 2021. In addition, the IMTT offered phone support until she could be seen in person on 9 March.

91. In a Family Carer Contact note dated 5 March 2021, Ms Hendon noted that she called Mrs LRV but Mrs LRV's father answered the phone and told her that there was an interim IVO in place and "*otherwise things have been settled*."

First face to face assessment - IMTT

92. On Tuesday, 9 March 2021 Miss RST and her mother were seen at Wundeela Clinic by Ms Hendon. She is a Senior Social Worker. They were seen together and separately for an initial assessment at which time safety planning occurred, and the role of the ED and the Adolescent Inpatient Psychiatric Unit (**AIPU**) were discussed in case of further crises. Miss RST agreed to attend ongoing meetings with Ms Hendon. A Clinical Risk Assessment and Management

[27] CB at p.152.

form (**CRAM**) was completed with risk stated at low to medium and Miss RST was discussed in the weekly IMTT clinical handover meeting.

93. On Thursday, 11 March 2021 Miss RST saw Dr Rudolph for the second and final time. She noted her engagement with ICYMHS, and that she had ongoing challenges with substance use (vaping) and aggression towards her mother was alleged, and she had been expelled from school. She supported her ongoing case management and treatment by ICYMHS. Given Miss RST's Ferritin (iron store) level was borderline low, with a normal Haemoglobin noted on 22 February 2021, she requested a repeat Full Blood Count (FBE) and Ferritin prior to a review in 3 months' time.

94. On Friday, 12 March 2021 Ms Hendon met with Miss RST's mother for a parent session. Safety planning was again discussed including the role of the AIPU with regard to possible future inpatient admissions. School issues were discussed given the need to identify an appropriate new school. Avenues Education (the Education Department school that partners with ICYMHS) involvement was offered and accepted. Miss RST's mother expressed sadness at wanting to be home in Hong Kong and missing her husband and son, and the stress of having to parent Miss RST by herself. Parenting advice and support was given.

95. In her family carer note for this date, Ms Hendon noted, "*Discussed role of AIPU (to be reserved for periods of acute distress or risk) and primary goal to support Miss RST to seek voluntarily when needed*."

96. On Tuesday, 16 March 2021 Ms Hendon had an outreach session with Miss RST at her maternal grandparents' home and then at a café. Miss RST admitted to struggling since June/July 2020 and referenced spending time with older peers, vaping and using other drugs (not named). She reported low mood and suicidal thoughts although said she did not have current thoughts. She said she had attempted self-harm once in the past. Miss RST described boredom and a lack of plans regarding her future. She was aware that her mother wished to live in Hong Kong while she did not. Miss RST reported uncontrollable rage when boundaries such as rules regarding leaving the home or mobile phone use were put in place and a desire to be with her friends. She spoke of her relationship with her parents and that things had improved a little that week as she was allowed to see friends. She stated she would be going with her mother to Hamilton Island the following week.

97. A referral was made by Ms Hendon to Avenues Education (Southeast Victoria Region). Avenues Education provides targeted short-term educational services for individuals and

groups of students experiencing social, emotional, and/or mental health difficulties in accessing education. Avenues Education teacher, Lisa Lahy (**Ms Lahy**) was allocated to assist Miss RST's family to determine appropriate enrolment and support a transition plan into schooling. Avenues Education provided support from 23 March 2021.

Miss RST turns 13 years old

98. Miss RST turned 13 years old on [redacted] 2021.

99. On this day, Ms Hendon contacted Miss RST's mother by phone and was informed that Miss RST had had a reasonable birthday and was engaging more with the family.

100. On Friday, 19 March 2021 Ms Hendon contacted Miss RST's mother who reported there had been no further incidents. She also contacted Miss RST who agreed to attend an appointment with the Avenues Education teacher and herself (and her mother).

101. This appointment subsequently took place on Tuesday, 23 March 2021. They discussed schools for Miss RST who indicated that she did not want to board and did not want to attend a school with strict rules. Her mother indicated that whatever school it would be, it would only be temporary as she needed to return to Hong Kong. The need for stability for Miss RST was highlighted and they offered to support the transition to a new school.

102. Later that day, while her mother was away from the house arranging dinner, Miss RST had an argument with her grandparents and ran away. The incident was reported to police and Miss RST was found at around midnight at McDonald's in Balwyn with her friend. Ms Hendon was later advised.

Move to Avani Apartment

103. In the final week of March 2021, Miss RST and her mother moved into a two bedroom apartment in Box Hill on the 12th floor. Her mother said that Miss RST really liked having her own room and bathroom as well as a gym and pool.

104. On Wednesday, 31 March 2021 Ms Hendon conducted an outreach session with the family. She took Miss RST to a café. She said she preferred living in the apartment but was frustrated that she had not started school yet. Miss RST reported a better relationship with her mother since the move but reported chronic low mood. She agreed to meet with a psychiatrist the following week.

105. Her mother reported to Ms Hendon that Miss RST had run away from home the previous week in the context of an argument with her maternal grandparents. She had been found with friends and returned home. Her mother was concerned about Miss RST over-exercising although her eating behaviour had not changed. She advised that she and her husband had decided to establish Miss RST in a school in Melbourne, with the plan of her mother returning to Hong Kong. Her mother explained that they were concerned that Miss RST may enter the youth criminal justice system if she returned to Hong Kong and that psychiatric services there were institutionalised. Miss RST's mother was concerned that Miss RST was consistently depressed.

Fourth presentation to Emergency Department, 6 April 2021

106. On Tuesday, 6 April 2021 Miss RST was found intoxicated in the grounds of a church in Rose St, Hawthorn East. Police arrived at about 3.26pm following a request for a welfare check on a group of young females. The police noted that the girls appeared to be alcohol affected. One of the girls presents was Miss RST's friend, EE. Police described Miss RST as very distressed crying and saying that she could not go on anymore. Ambulance paramedics attended. They advised police that while Miss RST was being assessed in the ambulance, she disclosed to them that she wanted to jump in front of a train. Miss RST stated she had drunk 500 ml of Vodka.

107. Miss RST was taken by ambulance pursuant to section 351 of the *Mental Health Act 2014* to the Box Hill ED.

108. The Ambulance Victoria Patient Care Record documented, amongst other things, the following,

O/A Patient alcohol intoxicated, states she drank 500ml vodka, denys drugs use today, very emotional. Patient screaming 'kill me, kill me', patient stating she wants to die, patient stated she had a plan to jump in front of a ?train/tram.

It is unknown as to the trigger for today although, patient stated she was having ?flash backs of her father.

Patients non intoxicated friend on scene also stated patient had a very minor fall from a seated position on the ground, she states patient was leaning back with head approx 30cm from the

concrete before she fell backwards with a ?very minor headstrike with concrete (NOT FROM STANDING HEIGHT).

109. Ms Hendon documented in her clinical records that Miss RST's mother contacted her while Miss RST was being transferred to the hospital. Ms Hendon advised that she would notify the psychiatric triage in case Miss RST was referred. Ms Hendon subsequently contacted the psychiatric triage service and provided a basic handover regarding Miss RST's presentation and confirmed that Miss RST's psychiatric review with IMTT was scheduled on 8 April 2021.

110. Miss RST was admitted to the ED Direct Access Short Stay Unit for observation. Whilst in the ED it was documented that she was difficult to engage but reported feeling low in mood and more down recently. She expressed chronic suicidal ideation which had increased lately due to the stress regarding school and her relationship with her mother. Miss RST's mother reported that she had scratches and bruises on her neck which she said were from her hair straightener. Her mother expressed concern regarding living on the 12th floor and being unable to lock the balcony door. During assessments overnight, Miss RST denied current suicidal ideation or intent.

111. A discussion occurred with Child and Adolescent Psychiatrist, Dr Claire Chakman (**Dr Chakman**), who was on-call and determined that Miss RST was not for admission. Miss RST was to be discharged home with safety planning and follow up by IMTT. Dr Chakman noted that, based on her usual practice, she came to discharge Miss RST with IMTT follow up, based on the following,

'*Miss RST was only 13 years of age and had not had an inpatient admission before.*

The inpatient units can provide excellent care and a place of safety, however, can also be challenging places particularly for younger people and are not without their own risks. For example, there can be older adolescents with major mental illness requiring restrictive intervention due to aggression and violence, there can be disinhibited patients, admission also provides an opportunity for connection with older adolescents and there can be others engaging in self harm and restrictive eating practises on the ward.'[28]

[28] Statement of Consultant Child and Adolescent Psychiatrist, Eastern Health Dr Claire Chakman dated 26 September 2024, CB at p.1223.

112. In addition, Dr Chakman commented that the above noted presentations can not only be frightening for younger patients but they can also result in the development of maladaptive coping strategies (i.e. worsening of self-harm, disordered eating etc) and that risk can actually increase in admission particularly as discharge approaches with increased anxiety about external stresses.

113. She commented that if Miss RST was not wanting admission and was admitted against her will, *my experience is that this has a negative impact on engagement with mental health services and is detrimental to care overall.*[29]

114. She further noted that,

> *At the time of review, Miss RST was denying a suicide plan and intent and was assessed as low risk. While she presented to the ED with a plan to jump in front of a train, it is very common that these thoughts/plans are short lived, particularly in young people and when people are no longer intoxicated. Additionally, the process of assessment, feeling heard and having a plan to follow can change risk.*[30]

115. According to Dr Chakman, Miss RST did not meet the criteria for use of an assessment order under mental health legislation due to denial of acute risk at the time of assessment and the ability for her to be assessed and managed in a less restrictive manner through IMTT.

116. A discussion took place with Miss RST's mother regarding securing medications and implements that could be used as weapons, contacting CM business hours/triage after hours, Triple Zero as required.

117. An offer was made by the ED Associate Nurse Unit Manager (**ANUM**) for Miss RST to remain in ED and be discharged in the morning if she was more comfortable with this. Miss RST's mother agreed for this to occur.

118. In the morning of 7 April 2021, Ms Hendon rang Miss RST's mother at home who reported that Miss RST was planning on sleeping today and raised concerns about the bruises on her neck. Ms Hendon also raised with Miss RST's mother the issue of being on the 12th floor and recommended that the family move to the ground floor. Mrs LRV stated that there were no

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[29] CB at p.1223.
[30] CB at p.1224.

apartments on the ground floor and this would necessitate moving again. Discussion about the risks occurred and her mother stated that Miss RST had never threatened to jump from the building. It was discussed with her mother to encourage Miss RST to share her feelings and continue to monitor the risk. The option of referral to Eastern Health ICYMHS Groupworx (a day program for adolescents) was discussed. Miss RST's mother advised that Child Protection had closed their referral but had referred her to Anglicare for family support.

First face to face consultation with psychiatrist

119. On Thursday, 8 April 2021 Miss RST had her first session with Dr Bassed, who also met with her mother. Dr Bassed stated,

> *Miss RST described depressed mood and suicidal ideation first occurring early in 2020 and becoming worse from June 2020. She reported that her mood deteriorated further with her spending time with peers engaging in stealing, vaping and drinking and with the increased conflict at home. She reported being hit by her father on more than one occasion. She reported her mood improving on returning to school in February 2021 however then her mood deteriorating again in the context of behavioural difficulties at school and increased conflict with her mother. She described low mood which was worse at night, suicidal ideation with thoughts of stabbing herself, at times not sleeping until 3am but sleeping during the day. She denied current suicidal ideation and stated she would not kill herself. She expressed hope that things would improve once she returned to school. She was eating erratically but denied loss of weight and menstruation was regular. On attempting to explore her alcohol and drug use she became more guarded. Bruises were noted on her arms but she denied anyone harming her and denied any harm to her by others while under the influence of alcohol. She denied any other drug use and did not engage in conversation around her drug and alcohol use but looked tense when this issue was raised. She agreed that she may be able to talk about this to her case manager and was encouraged to do so.*[31]

120. According to Dr Bassed, Miss RST's mother presented as tearful and said she missed living in Hong Kong and her husband and son. She said that COVID was *a disaster* for Miss RST and discussed plans for Miss RST to remain in Australia where she felt there was more support

[31] CB at p.188.

for her. Dr Bassed stated that they discussed the complex picture with Miss RST of Oppositional Defiant Disorder but also the comorbid diagnosis of Major Depressive Disorder.

121. It was documented that Miss RST's parents were keen to trial anti-depressant medications for Miss RST. Dr Bassed said that fluoxetine was discussed with both Miss RST and her mother, including the possible side effect of increased thoughts of self-harm. Written information about fluoxetine was given to Miss RST in an adolescent format and in an adult format to her mother. Another psychiatric appointment was organised to discuss the role of medication and Miss RST's father was invited to attend.

122. On Tuesday, 13 April 2021 Miss RST and her mother attended the follow up appointment with Dr Bassed and Ms Hendon. Miss RST's father attended this appointment by phone. Dr Bassed stated the following,

Miss RST was first seen on her own and presented as somewhat guarded. She was unsure if her depressed mood had commenced before or after engaging with the peers in Hong Kong who were drinking and stealing but she said she was uncomfortable with the behaviour of this group of friends. She again described low mood since mid-2020 with diurnal variation, poor motivation, irritability and felt her personality had changed to becoming more rebellious. She had suicidal ideation and thoughts of overdosing but was guarded when attempts were made to explore this further. The Psychiatrist discussed with Miss RST the diagnosis of Depression and treatment of psychological support and possibly medication. Miss RST had read the information provided at the previous Psychiatrist's appointment and the possible risk of increased thoughts of self-harm were discussed again and the importance of letting people know if this occurred. We discussed that Miss RST's mother would need to hold the medication for safety and the importance of compliance. Miss RST wished to commence Fluoxetine and also said she was planning on commencing Koonung Secondary College for Term 2. Miss RST's mother joined the session and her father by phone, and they agreed with the impression that Miss RST was depressed and they felt this had occurred since mid-2020. We discussed the potential role of Fluoxetine and possible side effects including increased thoughts of self-harm; it was confirmed that her mother had the contact details of the case manager and the after-hours triage service in case the risk increased. We discussed the importance of compliance and her mother holding the medication because of the risk of overdose. Miss RST's father was provided with the website to access information about Fluoxetine. Her mother confirmed that she had read the literature previously provided. Both parents were keen for Miss RST to commence a trial of Fluoxetine. We also discussed follow up by the case

manager weekly and parent support …. Miss RST was commenced on ½ a tablet (10mg) of Fluoxetine in the morning with the plan for the case manager to ring in seven (7) days to review how this was tolerated and then increase to 20mg if tolerated and no concerns.[32]

123. On Wednesday, 14 April 2021, Miss RST started to take fluoxetine. Her mother stated that when it was prescribed, she and her husband were warned about possible side effects being stomach cramps, as well as possible increase in suicidal thoughts. They were advised to try and monitor her mood and that Miss RST had been asked to tell her parents or support if that side effect became apparent.

124. On Monday, 19 April 2021 Mrs LRV's mother advised Ms Hendon that there had been no side effects from the fluoxetine and the plan was to increase to 20mg.

125. On Tuesday, 20 April 2021 Ms Hendon conducted an outreach appointment with Miss RST at their apartment. She was in bed at the time but did engage a little in conversation. She had just increased the fluoxetine to 20mg and reported no side effects. Miss RST denied any increase in thoughts of self-harm and denied any current thoughts. Ms Hendon attempted to ask about the incident of intoxication and presenting with bruising 2 weeks earlier however Miss RST refused to talk about it. Miss RST also reported reluctance and anxiety about commencing at Koonung Secondary College. Support through IMTT and Avenues Education was offered and accepted.

126. Ms Hendon spoke with Miss RST's mother who expressed anxiety that Miss RST would not attend school. She reported that Miss RST had condoms which she discussed with her. Ms Hendon noted that the service would follow up on sexual health risks with Miss RST and also asked her mother to encourage Miss RST to go to her general practitioner around this concern and also consider contraception.

Miss RST commences school at Koonung Secondary College, 21 April 2021

127. On Wednesday, 21 April 2021 Miss RST commenced at Koonung Secondary College (**Koonung**). Her mother said that she was excited about starting at the school. The school, in consultation with Avenues Education, developed a safety plan for Miss RST.

[32] CB at p.189.

128. The principal of Koonung, Andrew McNeil (**Mr McNeil**) commented that Miss RST *seemed to engage with staff and peers and create connections to her peers*.[33] Koonung College Counsellor, Ella Cogger (**Ms Cogger**) made herself available to Miss RST on her working days, and arranged for another staff member for Miss RST to reach out to on her non-work days.

129. On Miss RST's first day Ms Cogger met with her and explained the school's wellbeing process and the wellbeing team.

130. During that afternoon Miss RST told the school nurse that she was feeling upset and had self-harmed for the first time. The wound was assessed but did not need dressing. The nurse brought Miss RST to see Ms Cogger. Miss RST also told her that it was the first time she had self-harmed and she thought it was because she felt sad and overwhelmed with the new school. Miss RST also disclosed she was on new medication to help her anxiety and depression, and she believed she may have self-harmed because one of the possible side effects of her new medication was self-harm. Miss RST did not express any suicidal thoughts to Ms Cogger or the school nurse. Miss RST wanted to attend school assembly and wanted to sit with her classmates and new buddy. Miss RST had been buddied with two other Year 8 students.

131. At a session with Ms Cogger on Thursday, 22 April 2021 (the following day) Mr McNeil reported the following,

> …. *Miss RST talked to Ella about her difficulties with moving between Hong Kong and Australia in 2020, for her schooling with COVID-19 impacting her ability to continue schooling in Australia. Miss RST was a boarder at Methodist Ladies College, she disclosed that she found it difficult because the rules were very rigid and she would run away to spend time with friends. Miss RST also said she found school boring and preferred spending time with her friends.*[34]

132. Ms Cogger met with Avenues Education and Ms Hendon and sought guidance on how the school could help support Miss RST with her care and treatment. Following a report on the previous day's interactions with her, Mr McNeil stated,

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[33] CB at p.159.
[34] CB at p.160.

Allison and Lisa agreed that everyone should be alert to Miss RST but not to panic or overwhelm Miss RST more. Lisa and Allison agreed with Ella's suggestion to include Miss RST on the school "blue card" system for students who needed time out to go to the wellbeing space. Allison noted Miss RST was aware that she could reach out to Allison if she was ever in distress. Allison also advised that she would be updating Miss RST's mum and seeing Miss RST once a week to continue to support her.[35]

133. This meeting had been arranged by IMTT where Ms Cogger reported that Miss RST had self-harmed at school and informed her that her medication had caused her self-harm thoughts to increase. Ms Hendon had already been informed by text from Miss RST that she had self-harmed and Miss RST had sent a picture of her forearm with multiple superficial scratches she said she had done in class. Miss RST also informed her that she hated school and did not want to go. Ms Hendon offered to call Miss RST, but she declined.

134. At 3.15pm on Friday 23 April 2021 Ms Hendon texted Miss RST offering to talk to her by phone. Miss RST again declined stating that she was with friends.

135. On Saturday 24 April 2021, Mrs LRV said that this was the first time she became aware that Miss RST was self-harming. She said that Miss RST was open with her about the cutting, and that it made her 'feel better'.

136. Mrs LRV said that Miss RST was coming home a bit later than curfew during this time and complained about her mother being strict. Mrs LRV said that she did not appear intoxicated. She also said that that despite this Miss RST's *behaviour seemed to be a bit better and* [she] *was hopeful that the fluoxetine was starting to help her mood.*

Miss RST requests an inpatient admission for the first time, 26 April 2021

137. On Monday 26 April 2021, Ms Hendon called Miss RST's mother who reported that she found out on the weekend that Miss RST was self-harming by cutting with the metal part of a pen at school and then at home over the weekend. Miss RST stated this was due to finding class boring. Ms Hendon re-emphasised the goal of supporting Miss RST to communicate through words before self-harming and they discussed the Safety Plan which included trying to avoid an excessive response to the self-harm in order to avoid her associating self-harm with receipt

[35] CB at p.161.

of care and of being able to leave school when she wants. Ms Hendon advised Miss RST's mother to take Miss RST to her GP for medical attention or to ED in an emergency.

138. Mrs LRV commented that she, *had noticed an apparent change (for the positive) in* [Miss RST's] *mood.*

139. However, later that day, Miss RST reported to student wellbeing that she had self-harmed on her left forearm. Miss RST disclosed that she had self-harmed at school the week before and at home over the weekend. Miss RST also said that she had daily suicidal thoughts and that she had had suicidal thoughts since October 2020. Koonung took immediate action towards Miss RST's safety, which included calling the Eastern Health Crisis Assessment and Treatment Team, calling Miss RST's mum to collect her from school, and developing a safety plan to keep her safe when attending school. Staff were notified immediately that Miss RST was experiencing distress and staff were informed about safety protocols to comply with while the safety plan was being finalised.

140. Ms Hendon phoned Miss RST's mother to discuss Miss RST's behaviour. The safety plan was again discussed with her mother who was encouraged to support Miss RST to communicate distress through words rather than by self-harming. Ms Hendon also called Miss RST who reported that she disclosed her self-harm to her school counsellor, she was having suicidal thoughts and she wanted to discuss hospital admission with IMTT. Ms Hendon organised an appointment for the same day and subsequently met with Miss RST at the Wundeela Clinic for a crisis appointment.

141. Miss RST reported that she felt an increase in thoughts of self-harm in the context of commencing school. She reported that she did not like anything about school. She also reported past thoughts of suicide by overdosing but denied any current plans. Miss RST stated that she felt she would self-harm again and asked for an admission to AIPU. The pros and cons of admission were discussed with Miss RST's parents and they felt it was important for her to feel listened to. On ringing the AIPU Ms Hendon was advised that the unit was unlikely to have a bed that day and to await further contact.

142. After returning to Miss RST and her mother, Miss RST stated that she now did not wish to be admitted and wanted to see friends and attend PE at school. Miss RST and her mother were engaged in safety planning and Miss RST agreed to go home with her mother rather than out with friends and to let her mother know if she had thoughts to self-harm again.

143. A mental health safety plan was sent to the school with the plan for Ms Hendon to make phone contact the next day. Dr Bassed was contacted about the proposal and agreed with the plan and an option of reducing the fluoxetine to 10mg was also discussed. Dr Bassed offered an appointment on Thursday, 29 April 2021.

144. Ms Hendon contacted the school counsellor and provided a written Mental Health Safety Plan to the school. Ms Hendon had completed a CRAM risk assessment on 26 April 2021 which updated the assessment conducted on 11 March 2021, and a Mental Health Assessment Report based on her previous six assessments of Miss RST on 9 March, 16 March, 23 March, 8 April, 13 April and 20 April 2021.

Tuesday, 27 April 2021

145. On Tuesday, 27 April 2021 Miss RST went to school a little late, but returned home by 6.00pm as agreed. Miss RST's mother said that [i]*t was like we were making progress.*

146. Ms Hendon spoke with Miss RST's mother who expressed relief that she had gone to school.

147. Miss RST's mother had also met with IFS that afternoon.

148. Also on this day, Miss RST's care was discussed at the Clinical Review meeting with IMTT where it was noted that Miss RST's engagement was improving with IMTT and that her mother had engaged well in parent support with IMTT and Anglicare. The concern around her recent deliberate self-harm in terms of the commencement of fluoxetine and school was discussed, and it was felt school was the main precipitant to this. The plan for a psychiatric review on 29 April was discussed and the possibility of decreasing fluoxetine to 10mg if she was experiencing side effects. It was noted that the instability of housing, school and relationships was an ongoing stress for Miss RST. The plan to continue to work with Miss RST and her mother were discussed as well as providing parent support to Miss RST's father, support to the school and regular psychiatric reviews.

149. It was noted that Miss RST was yet to engage formally in an individual recovery plan (**IRP**) but informal goals had been identified including returning to school, improving mood, managing her anger and improving the parent-child relationships. The IRP was to be developed collaboratively in the coming weeks. It was documented that Miss RST presented with significant difficulties including oppositionality, aggression and mistrust. She also reported chronic suicidal ideation.

Wednesday, 28 April 2021

150. On Wednesday, 28 April 2021 Miss RST was dizzy and refused to go to school. Her phone was not working and she was happier when her mother was able to get a replacement phone.

151. Ms Hendon phoned Miss RST's mother who reported Miss RST was complaining of dizziness and had not attended school that day. Miss RST declined to speak with Ms Hendon. She had reduced Miss RST's fluoxetine to 10mg. Miss RST had gone out to see a friend in the afternoon then returned home. She had then informed her mother that she was going for a swim but left to provide support to a friend who was intoxicated. Miss RST and her mother had a discussion about this. Her mother also discussed boundaries around Miss RST's phone use.

152. Ms Hendon also spoke with the IFS worker who was providing support for Miss RST's mother and they discussed supporting her in relation to setting boundaries for Miss RST.

Thursday, 29 April 2021

153. On Thursday, 29 April 2021, Miss RST went to school and met with Ms Hendon, Ms Lahy and Ms Cogger. It appeared Miss RST had a good day at school and her feedback was positive. She reported that she had found maths challenging but had made many friends at the school. Discussion around how they could support her occurred. Miss RST also said she continued to have suicidal thoughts occasionally.

154. Ms Hendon then met with Miss RST individually. Miss RST reported she had had no deliberate self-harm thoughts since her mother had taken her blade the day before. She described intermittent suicidal ideation but none at present. She felt things had improved over the last few days and that spending time with friends had been helpful. Miss RST reported that she had a boyfriend who was the same age and that her mother did not know about this. She said that she had not had a sexual relationship with him or kissed and denied ever having intercourse. Sexual risk and safety were discussed and she was encouraged to go to the GP if she was thinking of engaging in a sexual relationship. Miss RST spoke of being with friends that were like her, and clarified this by saying *they drink and vape*. She said that she drank alcohol on weekends and that she had drunk until she vomited on several occasions. Safety planning was discussed with Miss RST and she was encouraged to seek help if needed. She was also encouraged to speak to her mother. Miss RST agreed to an appointment with Ms Hendon at school the next week.

155. Ms Hendon received a phone call from Miss RST's mother who was distressed and crying after having technical issues and not being able to set up parental controls on Miss RST's phone and feeling overwhelmed. She allowed Miss RST's mother time to express her frustration. She confirmed with Miss RST's mother that Miss RST would not be attending the psychiatric review at IMTT that day as Miss RST had chosen to go to school instead.

156. Miss RST did not attend a scheduled physiotherapy session but met with her friends and returned home at the agreed time.

Friday, 30 April 2021

157. On Friday, 30 April 2021 Miss RST did not want to go to school as she had a maths test and did not feel confident. Her paternal grandfather looked after her in the morning and she returned to school in late afternoon, where she met with Ms Cogger. Mrs LRV stated that,

The feedback from Ella was that Miss RST engaged well, and that there were no red flags.

158. It was further documented that,

Ella reported she had seen Miss RST on Friday last week for an hour. She came into school and chose not to go to class but spent the time with Ella. Miss RST was reportedly bright and spoke about wanting to attend every day next week. Ella reported she had no concerns at that time for Miss RST's mental state and felt she was in a good head space.

159. Ms Hendon had a Telehealth session with Miss RST's father (who was in Hong Kong). He spoke of trying to understand Miss RST's difficulties and wondered if he had spent more time with Miss RST's brother than Miss RST, and the possible impact of this. They discussed the balance of parental boundaries and also collaboration with Miss RST. He spoke of the difference in the parenting approaches, the difficulty of COVID making it not possible for him to come to Melbourne and the lack of clarity around longer term plans. A plan for a parent session the following week was discussed.

160. The retrospective case notes of this conversation documented the following,

10.30am- telehealth meeting with Mr ACW (in Hong Kong)

Discussed his concerns- he wanted to discuss the reasons why Miss RST is having difficulties.

He spoke about feeling like he spent more time with Master SRP than Miss RST because Master SRP was well-engaged and easier to manage. He wondered if this had an impact.

Discussed Miss RST's poor self-image in that she sees herself as naughty or too difficult to manage and the importance of not anticipating she will behave like this.

Discussed need for clear boundaries and also need for collaboration with Miss RST with focus on the parent-child relationship.

....

Reflected on different parenting styles and emphasised the helpfulness of parents coming together to respond to Miss RST and also supporting each other. ....[36]

161. Miss RST's mother texted Ms Hendon stating that Miss RST had refused to attend school that day but had had a very positive day yesterday. She rang Miss RST's mother who explained that she was going out to dinner that night and had organised for Miss RST's paternal grandfather to be with Miss RST.

162. That evening Miss RST went out with friends and came home on time with EE and [redacted] (**referred to as AA**). AA was a 13 years old boy. Mrs LRV got a phone call from EE's grandmother while she was at dinner. She was at their apartment and advised that EE was drunk, refusing to leave and had wanted to jump from the balcony.

163. Mrs LRV arrived home at 11.00pm, and was able to convince EE to go home with her grandmother. She did not locate any alcohol in Miss RST's room. Miss RST was not observed to be intoxicated. Miss RST told her mother that she had been scared when EE told her she had wanted to jump, so she contacted EE's grandmother. Mrs LRV said that they spoke about school and Miss RST said she was going to try to go to school all of the following week.

164. It was further documented about Miss RST that Friday night,

Miss RST's Grandfather had remarked to Mrs LRV how very mature and open Miss RST had been in handling the situation and that he had stated that Miss RST was "like the old Miss RST".[37]

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[36] CB at p.799.
[37] CB at p.792.

Saturday, 1 May 2021

165. Miss RST spent much of the day with her mother, but also met up with some of her friends. Mrs LRV described Miss RST as *good* and *really positive.* They spent the evening together, sharing takeaway and later face masks and skin care, which Miss RST *loved.*

CIRCUMSTANCES OF DEATH

Sunday, 2 May 2021

166. In the morning of Sunday, 2 May 2021 Miss RST was given a massage by her mother in bed. They later went to Doncaster Shopping Centre whether Miss RST got her eyelash extensions re-filled, and they shared a bagel. They returned to the apartment at 1.00pm.

167. Miss RST planned to meet with some friends at Box Hill Central which is situated at Main St, Box Hill, for lunch but agreed to be home by 6.00pm. Her mother was going to a football match and planned to be home at 7.00pm. Mrs LRV said,

I had offered to arrange for one of her grandparents to come over in the late afternoon, but we thought there would only be an hour or so until I was home. She was agreeable to this, and I mentioned that I'd make a quick dinner when home which she said sounded nice.

168. Mrs LRV described Miss RST's mood as, *excellent, and she was quite chatty and we were joking around.*

169. Mrs LRV left at about 1.45pm while Miss RST was getting ready to meet her friends.

170. Mrs LRV planned to keep an eye on Miss RST's movements as she had access to her phone's location.

171. After Mrs LRV left Miss RST walked to Box Hill Central where she met AA. He described their relationship as boyfriend and girlfriend for a week or so.

172. At 2.18pm, Miss RST texted her mother to ask how much money was on her debit card.

173. CCTV from the Avani showed that Miss RST and AA returned to her apartment at approximately 2.55pm, where they used their mobile phones and various social networking applications.

174. Miss RST took several videos on her phone in her bedroom with AA (3.43pm, 3.46pm, 4.18pm, 4.20pm and 4.23pm). She appeared to be having fun and appeared happy but also alcohol affected.

175. At 4.02pm her mother asked how she was going by text, and Miss RST responded *Good.*

176. CCTV showed Miss RST and AA exit a 12th floor lift at about 4.29pm and EE arriving via the lift at about 4.31pm with Miss RST and AA.

177. The trio subsequently left the apartment at about 4.47pm. Miss RST appeared to be very unsteady on her feet at this time. AA boarded a tram for home and Miss RST and EE walked to the Box Hill Gardens where they meet [redacted] aged 13 years (**referred to as MM**) and [redacted] (**referred to as AB**), aged 14 years. Both were students at Koonung. They returned to Miss RST's apartment at about 5.12pm, without EE, as she was asked to leave.

178. At 5.46pm, Miss RST's mother texted her and advised that she would be home by 6.00pm. She did not receive a response. She also did not receive a response from Miss RST to a text she sent at 6.02pm.

179. At about 5.49pm, AB and MM are captured on CCTV leaving Miss RST's apartment. There was no evidence to suggest that anything unusual or untoward occurred during their visit with Miss RST. Miss RST had apparently rushed them out, saying she needed to do something before her mother came home.

180. At 5.50pm, Miss RST took a photograph on her mobile phone of her left wrist. The photo shows approximately 14 horizontal cuts with blood coming from each of them. There is other visible scarring from previous cuts on the same inner wrist.

181. At 5.51pm, Miss RST took a video using her mobile phone. The video is 6 seconds long and shows her crying and saying, '*I can't do it, I'm sorry*'. She appeared to be outside sitting on the concrete slab attached to the balcony.

182. At 5.51pm, Miss RST took another video using her mobile phone. The video is 4 seconds long and is of herself crying and distressed saying, '*I can't*'.

183. At around 5.52pm, Miss RST called 131114 (lifeline). The phone call lasts 13 seconds. There is an initial interactive voice response before a person is connected to an operator. Calls are

only recorded once connected to an operator but not prior. Consequently, there is no recording of the call Miss RST made.

184. At around 5.52pm, Miss RST called Triple Zero. It is apparent that there was a miscommunication in relation to her age, as she was asked by the call-taker on a couple of occasions to clarify her age and the call-taker heard and recorded 19 years of age. During the call she said, *I'm gunna jump*, and queried if she would die if she jumped off the balcony.

185. At 5.54, 5.56, 5.58 and 5.59pm, Miss RST took photographs on her mobile phone. Her left wrist had several more horizontal cuts since the previous photograph. She appeared to be crying and distressed.

186. At 6.04pm, Miss RST took a video using her mobile phone. The video is 2 seconds in duration and is of her crying.

187. Also at this time, Miss RST's mother received a message advising her to call urgently and that Miss RST was about to jump off the balcony.

188. In her last video, at 6.04pm, Miss RST took a video which is 4 seconds in duration showing her crying and saying, '*I'm killing myself I'm sorry I can't do it*'.

189. At 6.06pm, a witness on the 10th floor contacted Triple Zero to advise that somebody had jumped off the balcony above him. He believed the person had jumped and not fallen. Before they jumped, he heard a female voice say, *I can't do this anymore* twice. Then he heard her say, *Sorry*. He described the voice as *upset and crying* while she spoke.

190. Between 5.00pm and this time, Miss RST sent a number of messages via Snapchat. She contacted AA, EE and [redacted] **(referred to as AL).** AL was Miss RST's best friend who resided in Hong Kong.

191. During her contact with AA, he repeatedly begged her not to take her life or do anything to harm herself, to stop drinking, to wait for help (as EE was coming to help) and that he loved her and would come to her. She said amongst other things, '*I'm going now, I'm really sorry*.'

192. During her contact with EE, EE repeatedly asked if Miss RST was okay and said that she was coming to help immediately.

193. During her contact with AL, AL begged Miss RST to wait for EE, and not do anything and, that she loved her very much.

194. At about 6.18pm, EE and her grandmother attended the 12th floor but could not gain entry into Miss RST's apartment. They went to reception for assistance.

195. At about 6.22pm, EE called Triple Zero with her concerns about Miss RST. The operator advised that they had already received calls regarding Miss RST's welfare.

196. Also, at about 6.22pm, police and Ambulance Victoria arrived at the 12th floor of the Avani building and entered Miss RST's apartment following which she was discovered deceased having fallen to a floor below.

Police investigation

197. Police immediately commenced an investigation and discovered Miss RST's Apple iPhone Mobile Device on the balcony. Located the following day was a 700ml bottle of Smirnoff vodka in an unlocked safe in Miss RST's bedroom cupboard. Approximately 1/5 of the contents remained. There were two razor blades 'face shavers' apparently with blood on them, in Miss RST's en suite bathroom.

Contents of various phones

198. The Coroner's Investigator interrogated Miss RST's phone as well the phones of her friends who were with her on 1 May 2021 and provided the following information,

> *Miss RST made several comments in the weeks prior to her death to various friends that she was going to self-harm or kill herself. This was often done using the term 'kys' (kill yourself). This was almost always met with disapproval from her friends, who would tell her not to hurt herself or think about killing herself.*

199. Other text messages from Miss RST included the following,

a. in relation to her mother becoming aware of her cutting, *she's worried but that's good i can manipulate her.*

b. in relation the prospect of being in the AIPU, likely on 26 April 2021, *i refused to go to hospital it seems shit u cant have ur phone.*

c. in response to why she may want to kill herself, *Idk I'm stressed i hate life.*

d. she disclosed an undated incident.

e. there were many references to Miss RST saying she was overweight and unattractive.

200. Also, of note via text messages to a friend, Miss RST referred to something *bad* having happened at MLC, *and its fucked my whole life.* She then explained about her being expelled and regretting it so much (*i got expelled and i regret it sm*). She refers to missing her friends and *like just everything* and that ending her life would take the *pain* away.

201. All the children (four) who were with Miss RST on 1 May 2021 were interviewed with adults present.

Interview with AA

202. Miss RST met AA through mutual friends in the Glenferrie hang out area. According to his VARE interview, Miss RST said she had *depression* and was on antidepressants; that she *would starve herself some days;* she would *complain how she's dizzy 'cause she wasn't eating; she thought she was fat so she would, ..., not eat* and in relation to Miss RST's cutting – *she said she deserves it.* AA was at the hotel for a short period of time on the Friday night before Miss RST's passing (30 April 2021) and he said that mainly EE was drinking.

203. AA said that when he first met Miss RST on the day of her death, she *seemed really happy* but when they returned to her apartment she started drinking. He told EE not to drink as *she needed to take care of Miss RST.*

Interview with EE

204. According to EE's VARE interview, Miss RST had only started cutting herself recently (*first day she started at Koonung*). EE said that when she first met Miss RST on the day of her death, *she was happy.* In the afternoon however she described Miss RST as *drunk.* She had seen her drink four times before and Miss RST had spoken to her about two or three times before about taking her own life.

Interview with AB

205. According to AB's VARE interview, Miss RST described her cutting as *satisfying.* He described her mood on the day of her death as *completely out of it .... didn't know what was going on.* He said Miss RST was happy until the end of their visit, when she rushed them to leave saying that she had to do something before her mother got home.

Interview with MM

206. According to MM's VARE interview, Miss RST said that *the pills that she was taking, like, antidepressants or something, just made her really sad and just made her do stuff like that.* [referring to cutting]. When he and AB left, Miss RST *didn't seem upset, really, at all.*

IDENTITY OF THE DECEASED

207. On 2 April 2021, Miss RST born [redacted] 2008 was identified by her grandfather, Mr ZLE.

208. Identity is not in issue and required no further investigation.

CAUSE OF DEATH

209. On 5 May 2021, Dr Joanne Ho, medical practitioner and registrar in forensic pathology at the Victorian Institute of Forensic Medicine, conducted an autopsy and prepared a report of her findings dated 16 September 2021.[38]

210. Dr Ho's findings were consistent with the reported circumstances. There was no significant natural disease which may have caused or contributed to death. There was no injury to suggest third party involvement.

211. Dr Ho noted that on the anterior aspect of the left forearm, there were multiple linear multidirectional incisions over an area of 18 x 5 cm, ranging in size from approximately 1.5 cm up to 7 cm.

212. Postmortem toxicology detected ethanol in blood in the amount of 0.10 g/100mL (in Vitreous Humour in the amount of 0.09 g/100mL). In addition, fluoxetine was detected in blood at ~ 0.07mg/L, and its metabolite norfluoxetine in blood at ~ 0.1 mg/L. The results of the latter are consistent with therapeutic use.

213. Dr Ho formulated the cause of death as "*1(a) Multiple Injuries sustained in a Fall from Height".*

214. I accept Dr Ho's opinion.

[38] With supervising pathologist, Dr Joanna Glengarry.

EXPERT TOXICOLOGICAL REPORT

215. The Court obtained expert advice regarding the toxicology findings from Forensic Toxicology Consultant Specialist, Professor Olaf Drummer (**Professor Drummer**). Professor Drummer's report dated 6 March 2023 is detailed below.[39]

216. Miss RST was prescribed fluoxetine 20 mg daily on around the 13 April 2021 as Zactin 20mg tablets.[40] The photograph of the package at the scene showed the medication was dispensed on 13 April 2021. Of the 28 tablets that were originally present 14 remained, indicating that she probably had taken 14 tablets over the period of 19 days since the script was dispensed until her death.

217. Professor Drummer noted the partially full bottle of vodka located at the scene. He further noted that Miss RST was found to weigh 50kg at autopsy.

218. Professor Drummer made some general comments about alcohol and fluoxetine including the pharmacokinetic properties and the usual effects of the substances.

Alcohol

219. Alcohol (chemically ethanol) is present in alcoholic beverages and once consumed is rapidly absorbed over 30 min, although large amounts may take up to 2 hours for complete absorption.

220. One glass of standard alcohol which normally contains 10 g of alcohol raises the blood alcohol concentration (**BAC**) by about 0.033 g/100mL % in a 50 kg female.

221. This would apply to vodka, providing a "standard measure" was consumed which is about 30 mL. Consumption of 3 measures (30 grams alcohol in 90 mL) could produce a BAC of about 0.10%. Some variation will occur depending on a number of factors including whether food was co-consumed with alcohol and individual characteristics.[41]

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[39] VIFM, CB at p.45-50.
[40] In fact, she commenced taking 10mg on 13 April 2021 and this was increased to 20mg on 20 April 2021. On 28 April 2021, she again reduced her intake to 10mg.
[41] This calculation does not include any alcohol had had previously been consumed and eliminated by the body or any alcohol that had been consumed but had not yet been absorbed.

222. Persons who regularly consume alcohol (daily 3 or more drinks, or numerous drinks over most days per week) will develop an increased capacity to remove alcohol from their bodies and can have a higher elimination rate and develop some tolerance to its effects.

223. Alcohol is a depressant of the central nervous system (**CNS**) which can adversely affect a variety of important functions in the brain. Slurred speech and unsteadiness on the feet are tell-tale signs of alcohol intoxication. Alcohol will impair the ability to think clearly and act rationally. Alcohol also causes disinhibition and increased self-confidence and is often associated with persons who commit suicide.

Fluoxetine

224. Fluoxetine is a prescription anti-depressant belonging to the serotonin reuptake inhibitors (**SSRIs**). It is also prescribed for the treatment of obsessive compulsive disorder and premenstrual dysphoric disorder.

225. Recommended daily doses are one tablet daily to as much as four for long term use, if needed. A daily dose of 20 mg is a common starting dose.

226. Patients on a daily dose of 20mg give serum concentrations of fluoxetine that range from 0.01-0.26 mg/L with a median of 0.08mg/L. The corresponding blood concentrations tend to be about 20% lower than that seen in serum. The metabolite norfluoxetine has similar concentrations and has somewhat higher concentrations with repeated use of the drug, about 20-40%, depending on individual characteristics. Post-mortem drug concentrations of fluoxetine will be increased due to redistributive processes.

227. Maximum therapeutic effect may not be achieved until at least one month from initiation of therapy.

228. Fluoxetine can produce side-effects, such as anxiety, agitation, headache, dizziness, impulsivity and sleeplessness, but does not usually interact strongly when alcohol is co-consumed in social amounts. Larger amounts of alcohol (over 0.05%) can increase symptoms of anxiety, increase sedation and reduce the anti-depressive effects of fluoxetine.

229. Professor Dummer advised that the post-mortem blood concentration of fluoxetine and its metabolite norfluoxetine are consistent with the usual therapeutic use of fluoxetine, however this does not necessarily mean that Miss RST was taking her medication as prescribed. There is considerable variation in blood concentration between individuals let alone when she last

consumed a tablet. More importantly, there are variable changes in blood concentration that occur after death; these are usually increases as already noted.

230. Professor Drummer said that the tablet audit suggested she may have either missed some daily doses, started days after the script was filled or stopped taking the medication some days before her death, however, it is apparent that Professor Drummer was not aware of the reductions and increases in her consumption.

231. On the basis of there being 14 tablets consumed over 19 days with Miss RST commencing taking 10mg on 13 April 2021, increasing the dose to 20mg on 20 April 2021 and then reducing it again to 10mg on 28 April 2021, this suggests that she complied with the amount prescribed up until her death.

232. However, given the long duration of action of the drug, even with the occasional missed dose this may not impact significantly on the longer term effects of the drug, in any event.

233. Professor Drummer said that the co-consumption of alcohol, while not contra-indicated, is ill-advised since alcohol, as a depressant drug, can reduce any benefit obtained from the anti-depressant medication. The combination can also increase levels of anxiety and produce drowsiness. In addition, the consumption of alcohol in depressed people is more likely to worsen mood, rather than to improve it.

Professor Drummer's conclusion

234. In summary, Professor Drummer provided an opinion that, it is difficult to be precise on the actual effects of this combination of alcohol and fluoxetine on Miss RST given the variable effects seen between persons, and that much less is known on the effects of this combination in young teenagers.

235. However, he considered that it is likely that the relatively high amount of alcohol in her body would cause some form of disinhibited behaviour and have reduced her ability to make rational and informed decisions.

FURTHER INVESTIGATIONS

Emergency Response

236. A number of statements were obtained relevant to the emergency response to Miss RST's call to Triple Zero. They included a statement on behalf of Ambulance Victoria from Andrew

Keenan, Director of Patient Safety and Experience[42] and statements on behalf of Triple Zero Victoria (**000Vic**, formally ESTA) from Melvin Bent, Manager, Emergency Communications Services.[43]

237. The following details are drawn from the abovementioned statements.

Triple Zero calls

238. When calls are made to Triple Zero, they are presented to Telstra's E000 service and answered by the first available Emergency Call Person (**Telstra E000 Operator**). The Telstra E000 Operator will then ask the caller which emergency service is required before transferring the call through to a 000Vic call-taker trained in the relevant emergency service area. Where a caller does not nominate which emergency service is required, the call will be transferred to a 000Vic police call-taker.

239. At around 17.52pm on 2 May 2021, Miss RST made a call to Triple Zero stating that she felt suicidal and when asked, requested ambulance rather than police or fire services.

240. Miss RST's call was transferred by the Telstra E000 Operator to a 000Vic Ambulance call-taker who answered the call at around 17:53:25 hours.

241. 000Vic call-takers, regardless of the agency, are required to ask the caller a number of preliminary questions to determine the event location and to gather initial information relevant to the incident to determine the appropriate emergency response. This is described as the beginning of *event verification*.

242. Following Miss RST's call, the Ambulance call-taker triaged the call in accordance with the Medical Priority Dispatch System (**MPDS**) algorithm, which is a unified system used to dispatch appropriate aid to medical emergencies including systemised scripted Key Questions (**KQs**) and prearrival instructions.[44] The MPDS is contained within an emergency dispatch software known as ProQA.

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[42] Dated 23 November 2023, CB at p.203 – 214.
[43] Dated 19 June 2023, CB at p.215 – 251 and supplementary statement dated 7 June 2024, CB at p.674 – 683.
[44] A structured question and answer methodology as set out by the International Academies of Emergency Dispatch (USA).

243. The Ambulance call-taker will enter information based on the answers received from the caller in response to the structured questions into ProQA and these responses are then automatically populated into the Computer Aided Dispatch (**CAD**) system.

244. The Ambulance call-taker can select from 32 MPDS protocols in ProQA and will select the appropriate protocol based on the *Chief Complaint* description provided by the caller, applying the rules of protocol selection.[45]

245. In Miss RST's case the Ambulance call-taker recorded that the presenting problem was "SUICIDAL, ON BALCONY" and, based on the information provided selected Protocol 25: *Psychiatric/Abnormal Behaviour/Suicide Attempt*. The Ambulance call-taker then proceeded to ask Miss RST the Key Questions presented by ProQA for Protocol 25.[46]

246. Mr Bent advised the Court that this was *the only suitable protocol for selection* based on the information provided. That is, where a person is threatening suicide or self-harm with a weapon or by jumping.

247. The Key Questions are specific to the selected protocol and are designed to obtain relevant information from the caller and assign a Determinant Code (**event type**). The answers to the Key Questions entered by the Ambulance call-taker determine which subsequent questions are prompted by ProQA. The ultimate series of questions therefore that a caller will be asked will depend on the answers that the caller provides in response to each question.

248. At 17:56:14, the Ambulance call-taker, selected the event type "25B3W – AP – PSYCH, THREATENING SUICIDE (Weapons)" and this was recorded in CAD (*the ambulance event*).

249. When an emergency ambulance event is generated in CAD by an Ambulance call-taker, the event will present to a 000Vic Ambulance dispatcher who is managing the dispatch group for that geographical area. The event is managed in accordance with the 000Vic Ambulance Standard Operating Procedures.

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[45] The Chief Complaint is the reason a person is seeking medical care (in some cases being only the mechanism of injury). It must contain sufficient information to allow categorisation of the incident into one of the 32 MPDS protocols.

[46] Key Questions provide a secondary caller interrogation. The answers to these questions help the call-taker access scene safety, prioritise the response, and provide pertinent information to responders. Individual agencies assign specific responses to each code based on local resources and needs.

250. The priority of the event is pre-determined by Ambulance Victoria and the required response is pre-assigned to the event in accordance with Ambulance Victoria's Clinical Response Model.

251. The standard emergency ambulance event priorities are as follows (Priority 0 being the highest and most urgent and Priority 5 being the least urgent): Priority 0 – Most critical events requiring an immediate response (lights and sirens); Priority 1 – Time critical events requiring an immediate response (lights and sirens); Priority 2 – Acute events requiring an urgent response; Priority 3 – Non-urgent events, sent through to AV's Triage Services for secondary triage; and Priority 4 and 5 – Non-emergency events where there is no available non-emergency ambulance resource.

Ambulance Victoria's Secondary Triage Services (Refcomm)

252. The event type 25B3W is automatically assigned a Code 3 (Priority 3) response. Code 3 responses are non-acute/non-urgent, with a target response timeframe of within 60 minutes and are deemed suitable for further triage by Ambulance Victoria's Secondary Triage Services (**Refcomm**) as per Ambulance Victoria's Clinical Response Model.

253. Refcomm is staffed by Referral Service Triage Practitioners (**RSTP**). RSTPs are Ambulance Victoria staff including paramedics, registered nurses and mental health triage nurses.

254. Once an assessment has been completed by a RSTP, Refcomm may update an event priority or response. Refcomm can also provide self-care advice to the caller or refer them to alternative service providers, if after assessment, it has been identified that an event is suitable for such a response or that an emergency ambulance is not required.

Multi-Agency Events

255. Multi-Agency Events are generated automatically based on the event type assigned to the event when the call-taker has completed triaging the call.

256. Multi-Agency Events mean that more than one emergency service will be notified at the same time upon accepting the event in the CAD.

257. In this case as the Ambulance call-taker chose the event type, '25B3W – Psych, Threatening Suicide (weapons)', this event type is a Multi-Agency Event that automatically notifies 000Vic Ambulance and Police dispatchers and generates police event type '594 – AP EM-

THR PSYCHIATRIC PATIENT' (assigned a priority 3 response) which is presented on CAD to a 000Vic Police dispatcher.

258. At 17:56:14, a Multi-Agency Event requiring Victoria Police was automatically generated.

259. The benchmark dispatch times for Victoria Police events are as follows: Priority 1 – Dispatch time 160 seconds (2min & 40 secs); Priority 2 – Dispatch time 300 seconds (5 mins); and Priority 3 – Dispatch time 900 seconds (15 mins).

260. It is important to note that the primary purpose of the priority selection for an event is setting a time frame for the event to be initially actioned by the Police dispatcher, not the actual response of any unit dispatched.

261. 000Vic advised the Court that at 17:56:19, in accordance with the 000Vic Ambulance Standard Operating Procedures, the ambulance event was held for a period of 30 minutes by the Ambulance dispatcher, to allow a RSTP to triage the event.

262. Following the ambulance event being accepted into CAD, the Ambulance call-taker remained on the call with Miss RST to gather and record relevant information in the CAD event remarks, including the following:

    a. At 17:56:41 ACT-1 recorded: "@@ AVANI HOTEL";

    b. At 17:56:51 ACT-1 recorded: "@@ LEVEL 12, 1207"; and

    c. At 18:01:30 ACT-1 recorded: "PT CURRENTLY STANDING ON BALCONY, THREATENING TO JUMP, TRANS TO REFCOMM".

263. At 17:59:55, the RSTP assigned the event to themselves in CAD and the call was answered at 18:01:15 by a RSTP.

264. The RSTP initiated a phone conversation with Miss RST for 2 minutes 39 seconds following which Miss RST terminated the call. During the conversation, after confirming that she was on the 12th floor balcony, the RSTP tried to encourage Miss RST away from the balcony, including attempting to distract her away from the balcony by asking her to go to the kitchen and get a drink of water. The RSTP also told Miss RST that an ambulance was being organised.

265. 000Vic advised the Court that, given Miss RST's apparent distress the RSTP upgraded the event from '25B3W' to 'REF02' to denote a Priority 2 (from a Priority 3) response by Ambulance Victoria. As noted above, Priority 2 events are acute but not time critical, and do not require a 'lights and sirens' response. The Key Performance Indicator for a Priority 2 response is for ambulance arrival within 25 minutes under normal driving conditions.

266. At around 18:01:33, a 000Vic Ambulance dispatcher reviewed the upgraded priority ambulance event and attempted to resource the event via the "recommend unit" function. It is recorded in the event remarks in CAD at 18:01:46, that there were no nearby units available for the event, so the ESTA Ambulance dispatcher "held" the event for five minutes at 18:01:50 hours, in accordance with the 000Vic Ambulance Standard Operating Procedures.

267. The RSTP recorded into the CAD system at 18:02:39 that the *'P*[atient]*T HAS TERMINATED THE CALL and IS STILL STANDING ON THE BALCONY*.'

268. At 18:02:42, the case was brought to the attention of Ambulance Victoria Duty Manager and the event was further upgraded from 'REF02' to 'REF01' at 18.02.48 hours which is a Priority 1 event. Priority 1 events are for patients who require urgent paramedic assessment, with a Key Performance Indicator of ambulance arrival within 15 minutes for 85% of events (state-wide). As noted above, Priority 1 events are responded to under emergency *'lights and sirens*' driving conditions.

269. The RSTP made a number of calls back to Miss RST which went unanswered (18:06:27 and 18:07:50).

270. At 18:03:14, the RSTP recorded the following in the event remarks in *CAD: PT +++ DISTRESSED AND IS ON THE 12TH FLOOR // REF …*

271. At 18:03:14, an Ambulance Victoria Mobile Intensive Care (**MICA**) Single Responder was dispatched responding to the Priority 1 event with 'lights and sirens' and arrived at 18.08.04.

272. At 18:03:32, another Ambulance Victoria crew, an Ambulance Victoria Advanced Life Support paramedic crew were dispatched to assist the MICA Single Responder and arrived at 18:20:59.

273. At 18:06:19, a rendezvous location was selected (at Arnold and Nelson Streets, Box Hill) for Ambulance Victoria paramedics to meet up with police. 000Vic advised that this indicated

Ambulance Victoria requested to rendezvous with police prior to attending the scene and would not attend the incident without police presence.

274. At 18:08:02, another Triple Zero call was received in relation to Miss RST from a third party (person not at scene). Ambulance Victoria patient care records documented that the third-party caller was a friend of Miss RST (EE), who later attended the scene.

275. At approximately 18.10pm, the MICA paramedic and police were noted to have arrived at scene where they were met by the second Triple Zero caller (EE). The MICA paramedic and police proceeded to the apartment on the 12th floor and attempted to contact Miss RST by phone, but she had already jumped off the balcony.

Ambulance Victoria Review

276. On behalf of Ambulance Victoria, Mr Keenan advised the Court that their Patient Safety team reviewed the case after Miss RST's passing and *no concerns were identified.* Ambulance Victoria considered that the call-taking and dispatch of ambulance to the case was appropriate and in accordance with their policies and procedures.

277. It was however noted that there seemed to be a call-to-answer delay of two minutes 40 seconds when the initial call was being transferred from Telstra to 000Vic.

278. Mr Keenan advised the Court that the intent for cases referred to Refcomm is to have the caller speaking with a clinician and/or mental health trained call-taker immediately and while waiting for assistance.

279. Mr Bent on behalf of 000Vic also clarified that, on further consideration, it was his view that the event type '*25-B-4-W – JUMPING (THREATENING) WEAPONS*', would have been the most appropriate event type to be assigned based on the information provided by Miss RST. He explained that this event type 25-B-4-W is more specific than event type 25-B-3-W as it includes the possibility of jumping. Both event types are a subset of Protocol 25 with the only difference being that 25-B-4-W includes the event type description of a patient actively threatening to jump. However, he noted that in Miss RST's case, this information was still recorded by Ambulance call-taker in the event remarks at 18:01:30 to accurately reflect the situation.

280. He further noted that the assignment of event type 25-B-4-W would have resulted in the same response as the response to event type 25-B-3-W because:

a. both event types are pre-assigned a priority 3 response, as pre-determined by Ambulance Victoria;

b. both events are deemed suitable by Ambulance Victoria for triage by REFCOMM; and

c. the same Multi Agency Event for police would have been automatically generated (event type 594) and would have remained a Priority 3 response, as pre-determined by Victoria Police.

What if Miss RST had selected a different agency, that is, police rather than ambulance services?

281. I queried how the emergency response would been managed if Miss RST had advised the Telstra E000 operator that she required a police response rather than an ambulance response, or she did not nominate a service.

282. In these circumstances, the Telstra E000 operator would have transferred her emergency call to a 000VIC police call-taker rather than an ambulance call-taker and, assuming that the same information was provided by her, Mr Brent noted the following about the emergency response:

a. The police call-taker would have selected event type *'597 – P – EME – THR ATTEMPT SUICIDE. OR THREAT SUICIDE*' which is pre-assigned a Priority 1 response by Victoria Police.

b. Once the police call-taker had obtained all information from Miss RST during the SCT process, her call would have been transferred to a Police Communications Liaison Officer (**PCLO**) (Victoria Police employee) on site at one of the three 000VIC State Emergency Communications Centres who would remain on the phone to Miss RST until police arrived on scene. Any further information provided by her would have been recorded by the PCLO, and provided to attending police members as necessary.

c. If the police call-taker ascertained that she had sustained injuries prior to or during the call, Ambulance Victoria would have been notified by a police call-taker which did occur in this case once Miss RST had jumped.

Presence of a weapon

283. I further noted that once Miss RST disclosed during the Key Questions to the Ambulance call-taker that she was armed with a weapon, the event was now one where Ambulance Victoria would not have attended without police presence (although the reverse may not have been the

case). In these circumstances, I asked whether the protocol allowed for the Ambulance call-taker to transfer the call, once this information was provided, to Victoria Police for management of the emergency response as the predominant agency responding.

284. It was clarified at inquest that as Miss RST was actively threatening suicide, a Multi-Agency Event was generated and would have been generated irrespective of whether or not she had disclosed she had a weapon. And further, in circumstances where a patient is known or suspected to be violent or suicidal or is demonstrating a propensity for violence or self-harm, it is standard practice for Ambulance personnel to request Victoria Police attendance at an event.

285. The Court was advised that it is not part of Protocol 25 for an Ambulance call-taker to transfer a call to a Police call-taker for management of the emergency response where a Multi-Agency Event has already been generated.

286. It was noted that if the Ambulance call-taker was required to transfer Miss RST's call to a Police call-taker at the conclusion of the call, the RSTP from REFCOMM may not have been able to speak to her and upgrade the event at 18:01:15.

287. At inquest, David Vasilopoulos (**Mr Vasilopoulos**), Manager, Emergency Communications Services (000Vic), noted that for police dispatch, the timeframe and the priority only dictates the benchmark time for the dispatchers to action the event (as noted above) and he did not believe police had a (unit) response time, which is consistent with the understanding of the Court.

288. Mr Vasilopoulos considered that in circumstances where Ambulance Victoria becomes aware of some key information that leads to them upgrading the priority, it is information that ideally should be conveyed to the police. Police dispatchers would however have visibility in the notes, but there is no system that makes direct contact with the police dispatcher to advise of the upgraded priority. He indicated that such a mechanism could be useful.

289. If Miss RST's call was taken by a police call taker, he was unable to say with any certainty whether a unit would have got to her any quicker.

290. Mr Vasilopoulos further indicated at inquest that the problem with a Multi-Agency Event is that it doesn't allow for the particular circumstances. For example, it is not triaged by the call-

taker from the alternate service who would ask more questions and possibly *assign it relative to the priority of what's actually happening at the time*.

291. In the context of responses to mental health crisis, reference was made to Recommendation 10 (*Supporting responses from emergency services to mental health crises*) of the Royal Commission into Victoria's Mental Health System which provided that the Victorian Government:

> *1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.*
>
> *2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe:*
>
> *a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and*
>
> *b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).*
>
> *3. ensure that mental health clinical assistance is available to ambulance and police via:*
>
> *a. 24-hours-a-day telehealth consultation systems for officers responding to mental health crises;*
>
> *b. in-person co-responders in high-volume areas and time periods; and*
>
> *c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.*

292. The current response appears to be consistent with the above recommendation in terms of the availability of the Refcomm system, as well as a preference for an ambulance led response, noting the qualifier of *wherever possible and safe*.

293. In addition, it was noted at inquest, that the Ambulance Victoria response time is measured from the start of the call, that is, the time a call is initially answered by the Triple Zero call-taker including throughout the event regardless of whether the priority is changed or not. I note that in this case, the Ambulance call-taker took the call at 17:53:25 hours and a MICA

paramedic arrived at the scene at 18.08.04 hours which is within the 15 minute Key Performance Indicator for a Priority 1 event which are responded under emergency lights and sirens driving conditions.

294. The fact that Miss RST was in a very distressed state on the edge of a balcony expressing an immediate intention to kill herself was raised as an issue at inquest.

295. It was proposed in these circumstances, that during the Refcomm triage, the police could be dispatched to the scene first and the case downgraded if Miss RST had been talked off the ledge. Mr Vasilopoulos again noted that in Multi-Agency Events the protocol questions don't take into account that this was someone who was actively at that time standing on the balcony threatening immediate action.

296. The system is however designed to prevent too much priority being given to a job, in order to enable the limited resources to be available to attend the most urgent of jobs.

297. It was noted that the Box Hill police station was 850 metres from where Miss RST's death occurred and that police responded within four minutes that night once she had fallen.

298. It was apparent that the chronology in CAD is to a large extent able to be seen by both Victoria Police and Ambulance Victoria, but not necessarily all of the information is able to be seen by both agencies.

299. At inquest, Matthew Shields (**Mr Shields**), Operational Communications Advisor (Ambulance Victoria), when considering whether Miss RST's call be considered a higher priority, advised the Court that available evidence as to the clinical acuity of patients who are categorised similarly to Miss RST in the vast majority of cases, do not progress to the same outcome. That is, a clinically evidence-based approach has been adopted.

300. He confirmed in relation to Refcomm that Ambulance Victoria paramedics and nurses are able to undertake an individual clinical assessment by a health professional of the circumstances of that patient and upgrade or downgrade the response based on what they find.

301. He noted that the reverse danger is that by over-responding to every case, they put themselves in a position of not being able to meet the needs of people with higher priority and, that within a couple of minutes of the RSTP talking to Miss RST, the case was made a high priority event.

302. He did however agree that at the moment Miss RST was on the balcony the case is treated with exactly the same priority as if she was in a loungeroom talking about ending her life with tablets.

MENTAL HEALTH CARE

303. At the time Miss RST sought mental health treatment, the relevant legislation in Victoria was the *Mental Health Act 2014*.

Applicable provision regarding compulsory care

304. The following criteria for the making of an assessment order under section 29 of the *Mental Health Act 2014* are relevant when considering whether Miss RST *could* have been compulsorily detained:

(a) the person appears to have mental illness; and

(b) because the person appears to have mental illness, the person appears to need immediate treatment to prevent—

(i) serious deterioration in the person's mental or physical health; or

(ii) serious harm to the person or to another person; and

(c) if the person is made subject to an Assessment Order, the person can be assessed; and

(d) there is no less restrictive means reasonably available to enable the person to be assessed.

PROVISION OF CARE - EASTERN HEALTH

305. A number of comprehensive statements were provided by Eastern Health which further clarified Miss RST's care from 19 February.

306. Episodes of care included four Box Hill ED presentations, already detailed above, which occurred on 19 February, 22 February, 2 March and 6 April 2021. Although I note that Miss RST refused to get out of her mother's car and ran away on 22 February.

307. It is also apparent that a referral was made to ICYMHS on the morning of 19 February which coincided with Miss RST's first ED presentation, and the care provided by ICYMHS through IMTT extended up until Miss RST's passing.

Emergency Hospital Presentations

Management of mental health and behavioural disturbances in young people under 14 years

308. Dr Jordan on behalf of Eastern Health advised that adolescents presenting to ED with mental health and behavioural disturbances are assessed by an ED nurse and an emergency doctor to determine the background to the presentation and features to assist with the development of a diagnosis and preliminary risk assessment. He noted that sometimes a young person may already be receiving treatment in the community.

309. Where an ED clinician has concerns regarding suicidal ideation, severe depression, acute psychosis or any other red flags for serious accidental or intentional harm a referral is made to a mental health clinician from ED Response (ED Response clinician), and if appropriate, they will provide further mental health assessment and management.[47]

310. If an inpatient admission is required, the Box Hill Hospital has the AIPU onsite. The ED clinician also has the power to make an Assessment Order for the patient mandating an in-person assessment by a psychiatrist prior to discharge from the service.[48]

311. At inquest, Dr Jordon advised that the longer a patient spends in an ED, the worse their mental state becomes due to the environment, which is overstimulating, noisy, brightly lit and loud, and there can be interruptions from other patients with behavioural disturbance. He said there were a whole manner of stimuli which tended to have a negative impact on anxious or depressed patients.

ED Response and Secondary Consultations

312. Consultant psychiatrist and Clinical Director of Adult Access, Eastern Health, Dr Andrew Cheong (**Dr Cheong**),[49] advised that the ED Response is staffed by a multidisciplinary team of health practitioners including mental health nurses, allied health practitioners and

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[47] Sometimes referred to as 'psychiatric triage' in the medical record.
[48] Guidelines are also set out the process for the ED Response clinician to escalate and seek the input of the Access psychiatry registrar or consultant psychiatrist in circumstances where the ED Response clinician has clinical concerns. This process is also available to an ED clinician with clinical concerns regarding any aspect of assessment and/or management of a mental health patient.
[49] Statement dated 19 June 2024, CB at p.1095, Including a number of relevant policies such as Triage ED Assessments Business Rules, Mental Health Program Intake and Entry Guideline, Psychiatric Assessments and Outcomes in Emergency Departments Guideline, 'Escalation to Access Consultant Psychiatrist or On call Consultant Psychiatrist Guideline'.

psychiatrists who provide mental health assessment and support each of their hospital EDs (Box Hill, Maroondah and Angliss).

313. Dr Cheong advised that an ED Response clinician who receives a referral will review the referral information and also has access to the hospital's documentation platforms including the Electronic Medical Record (**EMR**), Clinical Patient Folder, and the Client Management Interface (**CMI**) to consider the patient's history. The referral is then triaged in the context of the other referrals already in progress. An ED Response clinician often receives multiple referrals, which are triaged in order of priority.

314. Dr Cheong advised that reliance is placed on the clinical judgment of the ED Response clinician as to whether there are psychological/psychiatric issues underpinning aggressive or oppositional behaviour in a young person under 14 years.

315. Dr Cheong noted that there are resource constraints in EDs, and the reality is that there may be wait times for the assessment to occur, as conducting a face to face mental health assessment and formulating a management plan for each patient is a lengthy process.

316. Dr Cheong further noted that the major factor determining if a patient is assessed or provided a secondary consultation[50] is the exercise of clinical judgement. An ED Response clinician will determine whether a secondary consultation or face to face assessment is required, or in some cases, whether the referral to ED Response itself is appropriate.

317. Dr Cheong noted that a patient's age <u>does not</u> influence whether or not a face to face assessment occurs.

318. He further indicated that it was not feasible to prescribe within a hospital policy or guideline the circumstances when a secondary consultation or a face to face assessment should or should not be performed. He stated,

The nature of clinical psychiatry is such that the boundaries cannot be easily defined, and that any behavioural or psychological abnormalities on face value may be considered for referral to ED Response, even if at times it may not be necessary (e.g. acute delirium, or substance intoxication without acute psychiatric symptoms) or inappropriate behaviour (e.g. anti-social

[50] A secondary consultation involves the ED Response clinician assessing the referral and providing advice to the referring ED clinician based on the collated information without a face to face assessment of the patient.

or criminal). The range of diagnostic possibilities is limitless, and any attempt to codify such will result in confusion, inefficiencies and overall compromise in patient care.[51]

319. At inquest, Dr Cheong considered, in hindsight, that he would have preferred a face to face assessment by a clinician at Miss RST's first presentation and agreed that documentation as to reasons could have been clearer.

320. Dr Jordon also agreed that the severity of Miss RST's first presentation warranted a face to face assessment with the mental health specialist, but did not consider her presentation acute enough to require admission. He considered that the mental health clinician in this case had adequate information based on the comprehensiveness of the assessment done by the ED staff.

321. Dr Jordon also agreed that the medical notes could have contained more detailed information, but noted that in an emergency setting, or an emergency triage setting, the clinician is primarily focussed on whether mental health conditions would benefit from admission rather than community treatment. He considered that appropriate advice and management was given to Miss RST and her uncle in relation to her first presentation.

322. Consultant child and adolescent psychiatrist and Clinical Director, Dr Peter Jenkins (**Dr Jenkins**),[52] considered that whilst he could see the value in some of the entries in the medical records being longer, they are partly written within the service where it is obvious what colleagues are meaning.

323. It was his view that based on the initial intake assessment interview on 19 February 2021 by ICYMHS Access, this would not have formed the basis for Miss RST being seen on that day. He further noted that Miss RST was under the supervision of a psychiatrist from that day and if there had been a greater need, appointments would have been brought forward.

324. Dr Bassed said that when an ED clinician interviews a young person and does not specifically document that they are presenting as depressed, it should be interpreted as a comment on the severity of the presentation and whether it immediately warrants an inpatient admission, and in Miss RST's case she did not present with severe depression.

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[51] CB at p. 1098.
[52] Acting Executive Clinical Director of Mental Health and Wellbeing Program, Eastern Health, provided as statement dated 18 June 2024, CB at p.684.

325. Of the presentation on 19 February, Dr Bassed said that *it warranted her being seen by the psychiatric triage*, but this is unlikely to have changed the outcome in terms of what occurred *but certainly seeing young people who present, it's very helpful to see someone who's got skills in that area*.

326. Dr Bassed further commented that it is very complicated meeting with a young person and diagnosing them. It is also hard to fit young people into *neat diagnostic categories*. She agreed that it is very difficult to undertake assessments and make diagnosis in the ED, although it is possible to do a risk assessment and consider diagnoses that are very obvious such as a psychosis. In addition, it is not the purpose or role of an emergency psychiatric clinician to make a diagnosis.

327. Dr Price who assessed Miss RST on the 2 March 2021 stated that she did think there was an underlying mental health concern that required further assessment in the ED and there were features suggestive of possible symptoms of depression but it is a complicated diagnostic process, in order to diagnose a young person with a major depressive disorder.

328. Dr Price noted that there were a number of stressors for Miss RST at that time in her life, which could explain her symptoms. In addition, she noted that for children, a very common presentation, included threats of violence, attempts to harm others, as well as suicidal ideation and suicidal threats.

329. She also clarified that the role in providing assistance during the secondary consultation is to assist with the streaming of a patient into the appropriate treatment pathway, and not to formulate any conclusive definitive diagnosis in relation to a patient in ED.

ED follow-up procedure

330. According to policy, the ED Response clinician is required to document the outcome of the secondary consultation in the patient's CMI. The guideline also provides a follow-up process where assessments completed by ED Response clinicians are reviewed the next working day by a consultant psychiatrist (on business days) and/or senior triage team member (on weekends). The outcome of the clinical review is also documented on CMI.

331. Dr Cheong observed that ED Mental Health clinicians provided secondary consultations at Miss RST's first two presentations to the ED and described her issues as behavioural with no apparent psychiatric issues. On the other two occasions, she had direct assessments.

332. Dr Cheong advised that on reviewing Miss RST's CMI, it appears that the ED Response clinicians on 19 and 22 February 2021 did not document the secondary consultations in her CMI, and therefore the follow-up process did not occur for the secondary consultations performed on these days.

333. He considered that there was no material adverse outcome despite the follow-up process not occurring. He noted amongst other things that, it would have been open for the reviewer to conclude that no further action was required, noting a referral to Child Protection had been made, there was an existing ICYMHS referral that was in process and a meeting scheduled within days of her presentation.

Treating Depression in Adolescents

334. Dr Jenkins advised that to successfully treat depression in children and adolescents a treatment plan needs to not only focus on treating the depression but also the associated adversities experienced by the young person. That is, a treatment plan may need to prioritise more urgent needs to achieve a degree of stability before other treatments can be effective. He said that psychological interventions for treating depression in young people are not prescriptive and must be tailored to the young person following a detailed assessment of their needs.

335. Dr Jenkins further observed that *individual psychological therapies and family therapy are unlikely to achieve change over a short period. Change occurring over months is more realistic than over days and weeks.*

336. Dr Jenkins indicated that following a thorough review, the treating team formulates an individual recovery plan (**IRP**) in collaboration with the young person and their family to identify areas of concern and agree on interventions to support the identified recovery goals. A combination of interventions will be chosen to support the young person to work towards their identified recovery goals which may include individual and family therapies, psychiatrist review, medication, group based therapies, psychoeducation and clinical case management. The treating team refines and clarifies the young person's assessment and individual recovery plan on an ongoing basis.

337. Dr Jenkins confirmed that the ICYMHS does provide psychotherapy to young people diagnosed with depression and that the ICYMHS employs clinicians trained in cognitive behaviour therapy, cognitive analytical therapy and dialectical behaviour therapy. They also

work in collaboration with other agencies as required such as Avenues Education, paediatric services and Child Protection.

338. Dr Jordan disagreed with any suggestion that there was no treatment given to Miss RST, and noted the step wise progression being made in order to make a difference for Miss RST. He noted that there was a cognitive element to finding a school placement. He also considered that in the scenario presented, treatments other than medication, would be more important. He further noted that the intention of every interaction with clinicians is to increase the sense of emotional containment for Miss RST and some of that would have been through her mother.

339. At inquest, Dr Bassed clarified that Miss RST did not have a severe depression, noting that she still had some reactivity of her mood, was still enjoying things, was not hopeless and was still future directed.

Clinical considerations when deciding whether or not to admit a 13-year-old person to a mental health facility

340. The AIPU is a 12-bed ward located at Box Hill Hospital for adolescents aged 13-17 years.[53] In general, admissions to the AIPU are fairly brief and would be provided to supplement the young person's community care. Inpatient treatment would be seen as a more restrictive treatment option.

341. Dr Jenkins stated that,

> *The main indication for admission is when it is assessed that safe and effective clinical care cannot be provided to the young person in the community. Other considerations include weighing the risks and benefits of admission and whether an inpatient admission would disrupt the young person's positive progress in the community and their engagement with services more generally.*[54]

342. Dr Jenkins noted that a young person requesting an inpatient admission would not by itself be a sufficient basis for one to occur. The reasons for requesting admission and any concerns they held regarding their own safety would be explored with the young person and their parents. This would include review and consideration of the options available for the young

[53] Two of these beds are located in the intensive care area of the AIPU, which is a more secure area with a higher nurse to patient ratio.
[54] CB at p.688.

person (including community options) to feel safe; the views of the parents would be considered as part of this review. The clinician would also conduct a mental state examination and a risk assessment and consider whether the young person would be safe in the community.

343. The risks of admission to the AIPU for any young person were noted to include the risk that they may learn new forms of self-harm (from other patients, despite the efforts of staff to prevent this) and the risk that the young person may subsequently seek admission inappropriately (for instance to socialise on the unit with other adolescents they have met during previous admissions). Dr Jenkins advised that these risks are common to AIPUs.

344. He further noted that if a bed is not available in the AIPU and a clinician considered that a young person could not be safely managed outside hospital, they would ask the family to present to the relevant hospital's ED and wait until a bed was available. I note that one expert observed that in the context of seeking admission *a lack of immediate availability of appropriate inpatient beds is a common event*.

Potential admission on 26 April 2021

345. Dr Jenkins considered that a crisis admission was not immediately required for Miss RST on 26 April 2021. He noted that Ms Hendon updated the clinical risk screening and ongoing assessment and developed a detailed mental health safety plan, which she provided to the school, and she had close contact with Miss RST, her family and school between 26-30 April 2021. Miss RST's fluoxetine dosage was reduced from 20mg to 10mg on 28 April 2021.

346. In addition, Ms Hendon reviewed Miss RST at school on 29 April 2021. Miss RST reported that she had intermittent suicidal intent (but not at the time of assessment) and no thoughts of self-harm. Miss RST reported that she felt things had improved over the last few days and elected for her case manager to return for an individual session the following week.

347. Dr Jenkins further noted that if a young person under 14 years refused a clinical recommendation for an admission to the AIPU and the clinician assessed that the young person could not be safely managed outside of hospital, a mental health clinician can make a compulsory inpatient assessment order if the criteria for making an assessment order are satisfied. The need for an assessment order would first be discussed the young person's parents.

COVID-19

348. Dr Cheong noted that during COVID lockdowns, EDs saw a significant increase in presentations of distressed young people (often without an established psychiatric diagnosis) who could not access their usual social or professional supports. He said that consequently, there was an enormous burden on ED Response clinicians, in the absence of a proportionate increase in the workforce, to exercise their judgement to ensure there was an equitable use of resources, and secondary consultations were a part of that equation.

349. Dr Cheong further observed that at the time of Miss RST's two ED attendances in February 2021, the Box Hill Hospital had experienced an enormous increase in the number of young people presenting to ED with challenging behaviours during COVID Stage 3 and 4 restrictions and lockdowns. He stated,

> *Young people at this time were disenfranchised and dislocated. Aggressive and oppositional behaviours were in many instances being driven by this social dislocation. Throughout this period, it was not unusual for a young person to present demonstrating high levels of anger and making threats towards their parent/s at this time. These behaviours were not necessarily driven by mental illness. On 12 February 2021, Victoria had entered a snap lockdown with Stage 4 restrictions. On 15 February 2021, three major hospitals in Melbourne were in quarantine resulting in a marked increase in pressure on the Hospital's ED.*[55]

350. In addition, it was noted that on 19 February 2021, the ED Response received 15 referrals from the Box Hill ED and half of those presentations were for young people under 18 years. On 22 February 2021, the ED Response received at least 18 referrals and the majority of these were for very young people. There were a range of presentations including suicide attempts and psychosis.

EASTERN HEALTH INTENSIVE MOBILE TREATMENT TEAM - IMTT

351. The IMTT provide the most intensive and flexible community care for young people requiring Infant, Child and Youth Mental Health Service support. The IMTT manages young people aged 12-25 who present with high mental health risks, complex system involvement and/or are at risk of disengagement from mental health treatment. The team is made up of

[55] CB at p.1100.

multidisciplinary professionals including Occupational Therapists, Psychologists, Social Workers, Psychiatric Nurses, Psychiatric Registrars and is led by a Consultant Psychiatrist.

IMTT Case Management

352. Miss RST's IMTT Case Manager and Senior Social Worker, Ms Hendon, had specific training in the provision of various modalities of psychotherapy including Cognitive Analytic Therapy, Mentalisation Based Therapy, Dialectic Behavioural Therapy, Cognitive Behavioural Therapy and Exposure and Response Prevention Therapy.[56]

353. The Court was informed that the IMTT work closely as a team to assess young people over a period of approximately 6 weeks to assess for any mental health conditions and develop a treatment plan. Ms Hendon noted that during the period of IMTT assessment with Miss RST a comprehensive treatment plan was developed and the treatment plan (with reference to her Mental Health Assessment Report 26 April 2021) was to include reviewing Miss RST weekly to start developing rapport noting that this would be challenging given she was particularly guarded. Parent sessions with Miss RST's mum (as the primary care giver) were planned fortnightly and Miss RST's father on a monthly basis. IMTT made a referral to Avenues Education, to support her reengagement with school including regular liaison with the school's wellbeing team. Also recommended was regular psychiatric reviews including the commencement of an anti-depressant medication. It was also recommended that Miss RST maintain her paediatric and GP appointments. It was further recommended that there be the development of a mental health safety plan, which is a verbal and/or written agreement developed collaboratively with Miss RST, her carers and relevant stakeholders and that IMTT had undertaken safety planning directly with Miss RST and her carers.

Safety Planning

354. Ms Hendon noted that safety plans are developed by identifying risks through clinical observations and client or parent-reported issues and ideally working together to plan what strategies can be utilised to mitigate risks. The purpose of a safety plan is to provide guidance to young people and their carers when needing to respond to risk issues.

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[56] Statement of Allison Hendon, Senior Social Worker employed at Eastern Health in the Intensive Mobile Treatment Team (**IMTT**) dated 26 August 2024, CB at p.1207.

355. Ms Hendon noted however in relation to safety plans,

> *While it is an important goal of safety planning to mitigate risks of harm, it is also important to acknowledge two common misunderstandings in relation to safety planning; that suicide can be predicted in any given individual and that safety planning is able to eliminate the risk of harm. Neither is accurate. Suicide cannot be predicted at an individual level and for safety planning to eliminate risk of suicide in any individual would require controlling and coercive measures that would likely be unethical and/or undermine the young person's healthy development of autonomy and self- efficacy, and would, quite possibly, increase the longer-term risk of harm*.[57]

Complexity of Miss RST's Presentation and Engagement

356. Ms Hendon noted that there was *a general risk of instability given the context of her family situation* and stated,

> *Miss RST did not want to return to Hong Kong where her family lived, and her family did not think Hong Kong was the best place for her. However, given her family lived in Hong Kong, there was a dilemma about whether Miss RST remaining in Melbourne was permanent. Miss RST spoke to her school counsellor about Koonung Secondary College not being 'permanent', and there was a general awareness that the longer-term plan for where Miss RST and Mrs LRV were going to live was incredibly uncertain.*

357. In addition, there were different parenting styles, and tension around this, so IMTT *undertook parent sessions with an overall plan to help the parents work together with the goal being to create more cohesive parenting for Miss RST*.

358. Dr Jenkins further commented on the complexity of Miss RST's presentation noting the following,

> *Having reviewed the materials, it is my view that depression is likely to have been one of several contributing factors leading to Miss RST's presentation. Other factors included uncertainty in her living and schooling arrangements, instability in family relationships and an absence of robust social connections. All required careful consideration in developing a treatment plan. Miss RST was a young girl who had re-located from Hong Kong in January*

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[57] CB at p. 1209.

2021 to attend a Melbourne private school as a boarder, after COVID-19 had thwarted her commencement at the school in 2020. Her father and brother remained in Hong Kong. She presented with a number of vulnerabilities including oppositional behaviour, risk taking behaviours and at the time of her first appointment with the ICYMHS on 9 March 2021 she did not have a stable school placement or living situation following her expulsion from her private school (on 2 March 2021) and relational problems between her and her parents had emerged.[58]

359. Dr Jenkins referred to the *predicament that Miss RST was in,* noting that, *a lot seemed to hinge on coming to Australia and the boarding school*. Dr Jenkins referred to the losses that Miss RST experienced, the hope for boarding school and the friendships, relationships and peers. He noted the cost and the investment from the family as well as *the huge emotional investment* for Miss RST and *then that evaporates*.

360. Dr Jenkins also considered that the violence noted in Miss RST's case, needed to be seen in the context in which it occurred, that is, where some *catastrophic* type things were happening in Miss RST's world. Her treating team therefore needed to focus on interventions to stabilise her situation and address her immediate needs including supporting her re-enrolment and reintegration into a new school.

361. Dr Bassed noted in addition to the change in mood she had experienced in the middle of the previous year,

we see a lot of young people who experience trauma too and we were left wondering around her statements that she had been with peers who were older and engaging in behaviours that actually she was not comfortable with and in exploring it she became more guarded and looked more down about that but said that she was not happy with what was going on around her.

362. Dr Bassed noted that Miss RST was not easy to engage with and had a past history of not engaging and not trusting people, noting that she had declined family therapy and psychology whilst in Hong Kong. She considered it unrealistic to think that Miss RST was going to talk more to a psychiatrist (had she been detained) than for example, the psychiatric triage clinician in an ED setting.

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[58] CB at p.691.

363. Ms Hendon also commented that her presentation emerged over time (since 9 March) as she was really guarded and that it was becoming more evident how low her mood was, and that she was also expressing it more articulately. Dr Bassed said the best time to engage with a psychiatrist, is once the patient has been engaged and has a relationship with the case manager. In addition, a good assessment should be undertaken before a decision can be made to start medication and in young people, there is some evidence that it's effective, but it doesn't work for every patient.

364. At inquest, Dr Jenkins advised that four to six weeks is a fairly standard period to get to see a psychiatrist.

Risks when commencing fluoxetine

365. Ms Hendon stated that the IMTT discussed and monitored the possible risks of increased suicidal ideation or thoughts to self-harm when commencing an anti-depressant. She noted that Dr Bassed informed Miss RST and her mother of these risks during the psychiatric review on 8 April 2021 and 13 April 2021. She then provided regular follow up about potential medication side effects and continued to monitor the risks.

366. Ms Hendon noted that concerns were raised from 23 April 2021 about the potential of self-harm and suicidal thoughts increasing so the IMTT increased their monitoring by increasing calls to Miss RST's mother to enquire about side effects and checking in with Miss RST during their individual sessions.

367. She noted that on 27 April 2021 following consultation with Dr Bassed, it was suggested that Miss RST's dose of medication could be reduced from 20mg to 10mg if there were concerns about side effects. On 28 April 2021, Miss RST reported dizziness so the dose was reduced back to 10mg. A medical review was offered for 29 April 2021, but IMTT were advised that Miss RST decided against attending the review as she wanted to go to school instead. Ms Hendon subsequently arranged to meet her at school on that day.

368. Ms Hendon advised that as with all their cases, there was regular consultation amongst the team during Miss RST's care (the entire team was aware of her risks and presentation and provided input about plans to support her) and engagement with Dr Bassed.[59]

Assessment for admission

369. Ms Hendon advised that part of the case manager's role is to assess mental state at every point of contact with Miss RST, so assessment for admission is actively considered.

370. She noted that there were two instances where Miss RST was directly assessed for admission to the AIPU. The first on 6-7 April 2021, where following consultation with Dr Bassed, she liaised with the triage clinician and provided advice that the planned Consultant Psychiatric review was for the next day and suggested, given the chronicity of Miss RST's risks and also that the bulk of her risks required community-based responses (that is, inpatient admissions would not change the risks relating to her school disengagement, issues with peers, oppositional issues, environmental stressors etc.) that IMTT were happy to continue supporting her in the community. In this context, the ED assessment was that there were not any immediate risks that required inpatient treatment and IMTT agreed with this assessment noting that no immediate risks were reported or assessed by the mental health clinician in ED.

371. Ms Hendon noted in relation to inpatient treatment, that there is a need to ensure that the decision is consistent with the least restrictive intervention being utilised (as stipulated in the then *Mental Health Act 2014*),

> *to support patient autonomy and self- efficacy, to support community based interventions where considered safe to do so to support young people to develop skills to manage their mental health outside of controlling and restrictive settings like an inpatient unit and to consider that young people can be particularly vulnerable to the influence from other unwell peers in inpatient settings*.

[59] She said this included during the initial stages of treatment when she was assaulting her mother, when she had presentations to the emergency department, when she engaged in self-harm and when she attended their clinic requesting an admission.

372. She said that they had an early impression of what was going on for Miss RST and if they had an immediate or acute concern, then they should act on those, but otherwise, IMTT should manage Miss RST in the community where her underlying issues could be treated.

373. The second occasion where Miss RST was directly assessed for admission to the AIPU was on 26 April 2021 after Ms Hendon arranged a crisis appointment at the clinic to review her in accordance with the IMTT's usual practice, when someone is in crisis.

374. Ms Hendon said that when she assessed her, Miss RST was articulating suicidal ideation with her suicidal thinking being 8/10 with no clear plan. She advised her that she had self-harmed at school and was struggling to concentrate and reported a concern she would self-harm again if not admitted. She and Dr Bassed discussed the risks of admission versus non admission, and that Dr Bassed was concerned about her age and potential vulnerability within an inpatient unit where she would be one of the youngest. She said that given their knowledge that Miss RST's self-harm was a recent development and that it was relatively minor, they were concerned about her being admitted to an acute unit with other young people who may be in for more severe forms of self-harm. In addition, they were concerned about the way she interacted with her peers and were especially concerned that an admission could potentially create greater risks. At the same time, the importance of supporting her adaptive care-seeking and promoting this was discussed. The risks were to be discussed with Miss RST's parents.

375. Ms Hendon commented that the fact that Miss RST later changed her mind, *was not considered to be unusual as it is common for the suicidal impulse or urge to recede quickly for patients if a supportive or validating response can be provided*.

376. She further commented that while inpatient treatment could potentially provide immediate safety from acute suicidal thinking or self-harm, it would not directly treat the causes of her ongoing risks which included *environmental issues, relational issues, school disengagement, negative peer associations and defiant behaviours* and that to effectively treat Miss RST's *issues, this required community-based responses that* [they] *were actively engaged in*.

377. In addition, less restrictive treatment as stipulated by the legislation, in circumstances where Miss RST expressed her preference, was required noting that she could be supported in the community.

378. At inquest, Ms Hendon noted that it is common for people (*a common misconception)* who are not involved in the mental health system, to think that inpatient units *provide a magical*

cure to very complex risk issues and that isn't the case[60] or that inpatient treatment is the most helpful intervention to manage risks.

379. Dr Bassed also commented at inquest in relation to Miss RST's request for admission on 26 April 2021, that

> *Miss RST's presentation had changed from when she was first coming into the Emergency Department, so it showed us that she was engaging and actually help-seeking with Allison Hendon, which we thought was a positive thing for her, and it also showed that she was able to ask for help, which we thought was a positive thing, and also I was kind of able to identify that she needed a break from what was happening for her at the time, and so we were happy to consider an admission...*[61]
>
> *It's also not unusual once the young person has had a space to be listened to, to change their mind .... and decide actually, 'I don't want an admission now.' That's not unusual for that to happen.*[62]

380. She noted that they did in fact make the decision for Miss RST to have an admission as a voluntary patient and sought a bed once this assessment was made.

Final IMTT assessment on 29 April 2021

381. Ms Hendon noted of 29 April 2021 that,

> *Based on what would turn out to be my last assessment of Miss RST, there was no indication that she was at acute risk of suicide, and in fact, her parents would later agree with us that she was showing the first obvious signs of improvement (i.e. increasing her school attendance, engaging with IMTT and asking for help, engaging with school counsellor, reporting an improvement in mood).*

Intention to suicide in a 13 year old

382. Given Miss RST's age, I sought advice from Dr Adler about her capacity to suicide. He provided the following comments,

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[60] T 276
[61] T177 L22-30
[62] T178 L11 -15

At the time of her death Miss RST was just over 13 years old. It is now generally accepted that most young people do not attain adult cognitive or emotional maturity until their mid-twenties. This means that, despite their considerable abilities, young people are prone to impulsive, risk-taking behaviour that may lead to their untimely death and they are less likely to anticipate the consequences of their actions.

Young people, even adolescents, may have a limited concept of the permanence of death and that there is no return from suicide. There may be cognitive dissonance between their theoretical understanding of death and its application to themselves when in a heightened and distressed emotional state. This does not mean that a 13 year-old cannot form the intention to kill themselves but they may be under the misapprehension that they can return once the circumstances that led them to wanting to die have changed.

Some impulsivity and risk taking is a common characteristic of young people, even those without any history of psychiatric or mental health problems. The risk of engaging in dangerous/suicidal behaviour, without fully considering the consequences, is likely to be greatly increased if the young person is in a heightened emotional state and has been drinking or using other illicit substances. This certainly seems to have been the case for Miss RST.[63]

Summary of Expert Advice on the provision of care – Reports provided

383. Four experts gave their opinion about the provision of care to Miss RST.

Dr Robert Adler

384. The Court's expert, Dr Robert Adler[64] provided two expert reports to the Court and gave evidence as part of an expert panel.

Comments regarding behavioural rather than underlying psychiatric or mental health problems

385. Dr Adler was concerned about Miss RST's presentations on 19 and 22 of February potentially being dismissed as *behavioural* and not indicative of underlying psychiatric or mental health problems, as he considered it was unhelpful and potentially stigmatising. He stated that this

[63] CB at p.665-666.
[64] Child & adolescent psychiatrist, Expert report of Dr Robert Adler, child & adolescent psychiatrist, dated 11 February 2024, CB at p. 656.

can lead to a patient's difficulties being trivialised and to negative attitudes towards the patient by staff.

386. Dr Cheong on behalf of Eastern Health considered these comments were speculative and did not apply to Miss RST, who did not have a formal diagnosis at ED and received mental health input at the ED on all four occasions (two secondary consultations and two direct assessments).

387. Dr Cheong noted that all the hospital's clinicians, across all areas of the Mental Health Program and ED, exercise clinical judgment to determine the appropriate care and management dependent on the assessment of the patient's presentation and level of risk, and do not dismiss a patient's presentation due to the presence of a behavioural disorder. In both of Miss RST's face-to face assessments at the ED (on 2 March and 6 April 2021), discussions between the ED Response clinician and the on-call child and adolescent psychiatrist took place in accordance with the relevant guideline.

Limitation of CRAMS – suicide predictability

388. Dr Adler was concerned that there were limitations with clinicians using the Clinical Risk and Assessment and Management (**CRAM**) tool[65], and this was a view shared amongst clinicians and other experts. It was noted that no tool is reliable when it comes to predicting the risk of suicide but it was not Eastern Health's practice to rely solely on the risk score produced as a result of completing the CRAM tool.

389. It was also noted that the CRAM may assist clinicians in gathering relevant information; however, the clinician is ultimately required to exercise their clinical judgment, having regard to their training, experience and other relevant clinical information, regarding the young person's risk of suicide.

390. During the expert panel, Dr Beech commented that Queensland Health clinicians were moving away from the use of instruments such as CRAM because there are clinicians who take them at face value and you can end up with a score (for suicide risk) which is low. He further

[65] Mental Health Program Clinical Risk Assessment and Management Practice Guidelines (applicable in February 2021) formed part of the CB.

explained that they are moving towards a therapeutic risk assessment and formulation model which is more dynamic.

391. Dr Adler in his report further advised,

> *The other major challenge, …., is the difficulty of predicting such an infrequent outcome as suicide in young females. Based on the data provided by Hill et al., (2020) there were about six suicides by 10-14 year-old females each year throughout Australia between 2006 and 2015 making prediction well-nigh impossible. A more appropriate approach is to focus on a therapeutic risk assessment, formulation, and risk management utilizing evidence-based treatment approaches.*[66]

392. Dr Jenkins agreed *that suicide is notoriously difficult to predict and preventing individual suicides is extremely difficult*. He said that death by suicide for a person as young as Miss RST is highly unusual and, in his 17 years as Clinical Director of the ICYMHS, Miss RST is the youngest person managed by the service who has suicided.

Miss RST's violence towards her mother

393. Dr Adler commented that it may have been appropriate to give greater priority to strategies for dealing with Miss RST's anger towards her mother.

394. In response, Dr Jenkins noted that Miss RST's level of violence to others had decreased since they had moved into the apartment and that, in addition to the IVO that was in place, there was a plan for Triple Zero to be called in the event of further violence. In addition, FIS had become involved to support Miss RST and her mother, the IMTT case manager was providing intensive case management and treatment with antidepressant being initiated.

Dr Adler's broad conclusion regarding care

395. Dr Adler stated that overall,

> *…. the management of Miss RST by IMTT seems to have been appropriate with regular contact with Miss RST and her parent(s); recording of a safety plan including details for contacting her case manager (Allison Hendon) and out of hours contact arrangements; and*

[66] CB at p.667.

warnings regarding the possible increased risk of suicidal ideation associated with the introduction of fluoxetine.[67]

396. He further provided advice that,

It is important to state, in conclusion, that it is easy to be critical of the care provided to a young person like Miss RST with the benefit of hindsight and the knowledge of her tragic suicide.

I believe the care provided to Miss RST throughout the involvement of BHH, whether in the ED or by the IMTT, was of a high standard and was well documented throughout the records. In the body of the report I have included some suggestions where the care may have been improved.

The question remains whether admission to the AIPU may have prevented Miss RST's suicide. It is likely that admission would have reduced the likelihood of suicide in the short term, allowing more time for management strategies to address some of Miss RST's underlying difficulties. It is impossible to know whether admission would have changed the long-term risk.

Finally, I believe that the restrictions surrounding Covid-19 in 2020 almost certainly contributed to the deterioration in Miss RST's mental health, albeit indirectly. This led to Miss RST returning to Hong Kong and having to continue on-line learning in Hong Kong after other pupils in Hong Kong and Australia were allowed to return to school. To this extent, Covid-19 was a significant factor in the deterioration in Miss RST's mental health, culminating in her death in May 2021.[68]

Dr Charles Scott

397. Dr Charles Scott provided an opinion to the Court on behalf of the family[69], and considered that Miss RST's care deviated from a reasonable standard of care in several aspects.

398. Dr Scott concluded that,

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[67] CB at p.664.
[68] CB 667-668.
[69] Chief, Division of Psychiatry and the Law, Professor of Clinical Psychiatry, Department of Psychiatry & Behavioral Sciences, University of California, Davis Medical Center – Sacramento Expert report of Professor Charles Scott, Professor of Clinical Psychiatry, dated 12 August 2022, CB at p. 554

A reasonable medical practitioner would have recognized that her increasing escalation with homicidal threats and attempts to harm her mother, her suicidal ideation and stated suicidal plans, her alcohol misuse and intentional overdose, her deterioration in the school environment, her frequent absconding, the inability of law enforcement to manage or deter her behaviors, and the limited family resources mandated a higher level of care since she first presented for an evaluation in February of 2021.

Dr Michael Beech

399. Dr Michael Beech also provided an opinion to the Court on behalf of the family and stated,[70].

In my opinion, retrospectively, Miss RST had developed a major depressive episode. It was characterised by irritable and hostile mood, sadness, psychosocial decline, suicidal thoughts and self-harm, and externalising behaviours. As noted in The Clinical Practice Guidelines for Mood Disorders of the Royal Australian and New Zealand College of Psychiatry 2020 (the RANZCP Guidelines), Major depression in children and adolescents can have an insidious onset. In contrast to adult presentations, the major effect may be one of irritability. There is often a variable fluctuating presentation. I believe that Miss RST displayed a highly labile presentation, appearing at times to have improved but prone to severe depressive swings, suicidal thinking, and impulsive or reckless acts. The RANZCP Guidelines note, treatment for children and adolescent depression is difficult. The recommended treatments include individual therapy (such as cognitive behavioural therapy or interpersonal therapy), family therapy, and medication. The initial antidepressant of choice is fluoxetine. It is an SSRI antidepressant. There is an associated risk that SSRI medications can increase suicidality in depressed adolescents. The modus for this is uncertain, but it may include activation of thinking before improvement in mood per se. For that reason, it is recommended that clients and families are informed of the risk and advised to monitor and report any changes. With MDE [Major Depressive Episode]*, even when treatment commences, the patient often remains prone to depressive swings.*[71]

400. Dr Beech considered that Miss RST was given a lot of agency in some of her treatment decisions and that a focus on the ODD she displayed meant that her depression was not prioritised (certainly in the early stages).

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[70] Benson Street, Specialist Centre Expert report of Dr Michael Beech, Psychiatrist, dated 21 June 2023, CB at p.636
[71] CB at p.653.

401. Dr Beech stated that,

> *In retrospect, and with the benefit of hindsight, Miss RST had displayed a significant period of turmoil and deterioration over the three months before her death and there had been significant indications that she was at high risk of suicide. It is very difficult in these circumstances, day-to-day, to assess the level of immediate risk. However, I believe that assessments that her risk was low or moderate minimised the severity. There was there no accurate way to predict the moment of her death because of her fluctuating state*.[72]

402. Dr Beech noted that there were two salient opportunities to intervene being 6 and 26 April 2021, when he said, *Miss RST should have been admitted to the hospital for further assessment and management, diagnostic clarification and the commencement of targeted treatment.*[73]

403. He did however accept that this was *a retrospective assessment in hindsight with the bias that brings,* and again, *day to day, it would have been difficult to assess Miss RST's risk.* He further noted that admission may have altered the trajectory, *but that is not definite.*

Dr Antony Milch

404. Dr Antony Milch provided an opinion to the Court on behalf of Eastern Health[74] and considered that on each occasion Miss RST presented at ED, she received an appropriate assessment by the attending ED staff and there had been a referral to ICYMHS as well as Child Protection.

405. In relation to case management, Dr Milch considered that Ms Hendon diligently assessed Miss RST's presentation, challenging and volatile behaviour; had regularly liaised with the parents; and had appropriately engaged with the clinicians and relevant stakeholders.

406. He considered that appropriate and comprehensive assessment and management plans were developed and implemented. In addition, the management had been appropriate with ongoing monitoring of Miss RST's mental state, a safety plan and treatment plan developed, ongoing discussions with relevant parties and planning for her re-entry into school.

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[72] CB at p.654.
[73] CB at p.654.
[74] Expert report of Child, Family & Adult Psychiatrist, Dr Antony Milch, CB at p.1245.

407. Following review of the documentation, Dr Milch considered that the focus of care had been on engagement with Miss RST and her family, repeated assessments, monitoring of her mental state, planning for school placements, addressing the family's challenging circumstances and managing risk, including her drinking behaviour and interactions with peers. He said that this *had been addressed in an exemplary manner given Miss RST's challenging social circumstances*.

408. Dr Milch noted that it was uncertain whether evidence-based emotional regulation strategies had been implemented, under the rubric of Dialectal Behavioural Therapy (**DBT**), to assist with emotional regulation strategies, but this would have been challenging to implement given Miss RST's emotional volatility and lack of consistent engagement.

409. Dr Milch considered that it was reasonable for the Box Hill ED to conclude that Miss RST's mental health care was being appropriately managed by IMTT in the community.

410. Given the least restrictive principle in the Victorian mental health legislation and taking into account the entirety of Miss RST's presentation and circumstances, it was his view, that it was reasonable for Miss RST's mental health care to be managed by the IMTT in the community. He noted that the iatrogenic risk of harm from a psychiatric admission had been a focus of the treating clinicians, including the potential risk posed by an older inpatient cohort, where there was evidence that Miss RST had been vulnerable to influence by her peer group in her drinking, vaping, oppositional, sexual and at-risk behaviour.

411. He further considered that it was evident that there had been extensive and repeated discussion with Miss RST's parents regarding risk management.

412. Dr Milch referred to extensive research documenting the difficulty in accurately predicting suicidality and considered that it was evident that the IMTT had appropriately considered the full range of Miss RST's experience and potential risk within the framework of the CRAM which had informed their decision making, including around admission.[75]

[75] Dr Milch noted further in the context of seeking admission, and in particular on 26 April 2021, that *a lack of immediate availability of appropriate inpatient beds is a common event*.

413. Dr Milch referred to evidence of heightened suicide risk and other negative outcomes during and immediately following hospitalisation.[76] He said that these factors were relevant considerations when recommending mental health care in the community.

Expert Advice on the provision of care – Concurrent Evidence

414. The expert panel further clarified the opinions provided in their reports via concurrent evidence. I have set out matters which I consider are significant in relation to these views (and not already articulated) and the closing submissions made by Counsel Assisting, where appropriate.

415. I note that Counsel Assisting highlighted the limitations of the role of a psychiatric assessment in an ED, noting that it is not to make a diagnosis, and that the environment is not conducive to these assessments.

416. In relation to Miss RST's first presentation on 19 February 2021, the weight of the expert panel's opinion suggested that a face-to-face assessment of Miss RST *was* indicated and that had this occurred an application for an assessment order *could* have been made.

417. Counsel Assisting noted that a significant factor in the panel's consideration appeared to be Miss RST's reported attempt to push her mother in front of a train with intent to end her life. He did however refer to the evidence of Dr Bassed, who did not consider that Miss RST presented as a homicidal teenager who wanted to kill her mother. Dr Bassed considered Miss RST became distressed and got angry with her mother.

418. Counsel Assisting considered that it is unclear whether any different action at the presentation on 19 February, would have altered the outcome.

419. In relation to Miss RST's presentation on 22 February 2021, the evidence suggested that a more thorough assessment of Miss RST would have been of benefit but it was noted by Counsel Assisting that the circumstances of her presentation (refusal to leave the vehicle) made such an assessment close to impossible in practical terms.

[76] The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research. Ward-Ciesielski, Erin F., Rizvi, Shireen L. (Clinical Psychology: Science and Practice, Vol 28(1), Mar 2021, 60-71.

420. Drs Adler and Milch commented in the context of Miss RST's presentations on the problem with a binary view that someone either has an anger management/behavioural issue or a psychiatric issue noting that there is commonly an overlap.

421. In relation to Miss RST's presentation on 2 March 2021, Counsel Assisting noted there was a range of views from the experts about the approach taken but submitted that the evidence suggested a comprehensive assessment had been undertaken by a registered psychiatric nurse which included input from a psychiatrist. He noted that although some experts considered an argument could be made for an assessment order, the fact that Miss RST had been referred to IMTT by this point likely served as a reassuring factor for Eastern Health and likely represented a reasonable ongoing management plan.

422. Counsel Assisting submitted in relation to this presentation that the evidence does not permit a conclusion to be reached as to whether an assessment order could have been justified at this time or whether such an assessment order would have made any difference to the ultimate outcome.

423. In relation to Miss RST's presentation on 6 April 2021, Counsel Assisting again noted that there was divergence in the views of the expert panel in that both Drs Adler and Milch considered the treatment and plan for assessment within the community to be appropriate (with Dr Adler's reservation/concern in respect of the management of Miss RST's alcohol use), whereas Dr Beech and Professor Scott considered more ought to have been done on this occasion with there being no guarantee that Miss RST would turn up to her appointment scheduled for 8 April 2021 with Dr Bassed. Counsel Assisting commented that in such circumstances *this may represent a situation about which reasonable medical minds can differ*.

424. Counsel Assisting further submitted that whilst Miss RST's alcohol use was clearly one of concern for the expert panel, the evidence of Ms Hendon was to the effect that she was addressing the issue of Miss RST's alcohol use, as part of case management. In addition, Miss RST was due to see Dr Bassed on 8 April 2021.

425. Ultimately, Counsel Assisting was of the view that the care was reasonable and that the evidence does not permit a conclusion that an admission would have made any difference to the ultimate outcome.

426. In relation to case management, Dr Beech stated that

I thought it was exemplary case management … You stand in awe when you see case management like that. It's a gold standard I would have thought. …, she was pre-emptive, she brought stuff for the case, you know the case forward …, she engaged with a very difficult client …., and took time. She …, assessed, she spoke with her mother regularly. The assessments were done at cafés, at home. She acted on things such as engaging the school. …. , I think she readily identified …. , the psychosocial thing that needed to be stabilised and she acted on them. …, and from what I can see, she had a busy caseload and she had meetings and she had to develop the mental health care plans and all those kind of things and yet she was available for crisis assessments …. when people phoned so …. I don't think I can fault the case management.[77]

427. Counsel Assisting considered that the panel was in agreement that the case management was outstanding but that Dr Beech expressed a preference for Miss RST to have been assessed by a psychiatrist earlier than she was, but submitted that the weight of the evidence suggests that the care provided to Miss RST by Eastern Health during this period was appropriate.

428. With respect to the possible admission on 26 April, whilst some members of the panel were concerned that Miss RST was given too much agency in the decision making, there was again significant divergence in the views of the experts.

429. Dr Adler described Miss RST's change of mind, as very typical adolescent behaviour. Professor Scott considered that the concern about iatrogenic harm, if hospitalised, was over estimated, given she was already undertaking self-injurious behaviour.

430. Dr Milch considered that there were lots of signs of Miss RST being increasingly engaged in care noting that she was compliant with treatment in that she was taking her anti-depressant and was well engaged with the case manager and spoke about what she was wanting to do and what she was motivated to do next, and after discharge home her mother continued to identify further signs of improvement.

431. Ultimately, there was no consensus that had Miss RST been detained on this occasion that the outcome would have necessarily changed.

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[77] T622 L1-17

432. Dr Adler commented that there is a continuing risk of suicide within a psychiatric unit and also an increased risk within the week after discharge from a psychiatric unit.

433. Dr Milch commented that, if involuntarily detained, on discharge after a very limited period of time, Miss RST would be returning to the same apartment and still be vulnerable to binge drinking which was clearly the precipitant and, that was an ongoing background risk of misadventure.

434. Counsel Assisting highlighted that care must be taken to avoid hindsight bias in any analysis and the reality appears to be that Miss RST was ultimately unwilling to be admitted and there must be real doubt about whether an admission could be justified given the need to afford care to Miss RST in the least restrictive setting.

435. Counsel Assisting submitted that the care provided to Miss RST by Eastern Health at this time was appropriate and that even if she had been admitted at this time, it is not possible to say whether this would have made any difference to the ultimate outcome.

436. With respect to the reasonableness of communication, Dr Milch considered that the communication between the case manager and the parents was exceptional noting that not only did she communicate primarily with the mother who had day-to-day care and control of Miss RST but also included the father despite him being in Hong Kong. Dr Milch noted that there was every indication of a collaborative approach to care whereby there was both a focus on an individual therapeutic approach to Miss RST's care and a family systemic approach.

437. Counsel Assisting submitted that the evidence supports the conclusion that the level of communication between Eastern Health and Miss RST's parents was appropriate throughout the entire period of care.

438. As to the role of fluoxetine, Dr Adler did not believe that it played a critical role in the outcome but stated that he did not think medication should be seen in any way as a cure all for a young person like Miss RST.

439. Counsel Assisting noted that the expert panel cautiously expressed the view that alcohol likely played a role on the day of Miss RST's death. He further noted that Miss RST's alcohol use was clearly appreciated by her case manager and discussed directly with Miss RST but submitted that this was an ongoing process and part of Miss RST's treatment which was still being explored at the time of her death. Counsel Assisting submitted that the evidence does

not permit a conclusion to be drawn as to whether adequate consideration was given to the question of substance/alcohol abuse and, whether this was or was not addressed adequately by the IMTT.

440. Dr Milch stated in relation to this issue:

I think it would be highly unlikely that the clinicians had never made any comment about the issue of alcohol. … It was in the documents and that there were issues of risk of misadventure associated with the use of substances. There was repeated reference to that and the fact that it wasn't – there wasn't a line saying, advised not to drink or that you know, that issue wasn't addressed. … I think that's speculative because my assumption is and it's an assumption, that you know, clearly issues around alcohol and drinking behaviour was a significant risk factor.[78]

441. Counsel Assisting ultimately submitted that whilst there may be some aspects of Miss RST's care which could have been undertaken differently, on the whole the care provided by Eastern Health between 19 February 2021 and 30 April 2021 was appropriate.

Reply submissions on behalf of Mr ACW

Human Rights

442. On behalf of Mr ACW submissions were filed which in part relate to the *Charter of Human Rights and Responsibilities Act 2006* (**the Charter**) in the context of the care provided to Miss RST.

443. Courts and tribunals must interpret all Victorian laws in a way that upholds the human rights outlined in the Charter, as far as this is possible. In addition, the Court in its capacity as a public authority must act compatibly with human rights and give proper consideration to human rights when making decisions.

444. A number of rights are relevant in the course of an investigation and inquest conducted by a coroner, such as a right to a fair hearing.

[78] T666 L9-20

445. In addition, if a coroner considers that issues related to the Charter require further interrogation, this can form part of the scope of an inquest.

446. The Act provides that the coroner holding the inquest determines the witnesses to be called and the relevant issues for the purposes of the inquest.[79]

447. I note that a draft scope of inquest and witnesses was distributed to interested parties, including representatives for Mr ACW, and, following various submissions I determined the scope of inquest and the witnesses to be called.

448. Absence of reference to the Charter in the final scope should not be interpreted to mean that the Charter was not part of my decision making.[80]

449. I note that Mr ACW was legally represented throughout the course of the investigation and inquest, and Senior Counsel appeared during the inquest as well as at least one directions hearing, where the proposed scope and witnesses were discussed.

450. The proper avenue for challenging any decision made during that process (including whether statements were to be obtained) was not taken up at the time, despite those avenues being available.

451. I note that submissions are now made after the completion of the inquest and the close of the evidence related to the Charter, that were not raised through any manner or means, including submissions regarding scope, questions of any witness from Eastern Health or indeed questions of the expert panel, including the two experts engaged by Mr ACW. Indeed, I note that guidelines provided by Eastern Health included in the Coronial Brief specifically refer to the Charter and the requirement that decisions and actions must be compatible with relevant human rights.[81]

452. The submissions filed on behalf of Mr ACW include assertions against parties which would be regarded as unexpected criticism related to alleged breaches of the Charter in circumstances where these matters were not raised with any witness when questioned, and as such no witness was given an opportunity to respond to those criticisms.

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[79] Section 64 of the Act.
[80] It should be noted with respect to some of the references in submissions made by Mr ACW, that Miss RST was not in the custody or care of the State at the time of her death.
[81] CB at p.1059, p.1078, p.1114, p.1123, p.1132 and p.1153.

453. The above mentioned submissions were made, despite those submissions also including a recitation on the meaning of *procedural fairness*.

454. I make no further comment in relation to these matters.

CONCLUSION

Provision of Care

455. Miss RST was a 13 year old girl who tragically died on 2 May 2021 after she jumped from the balcony of the 12th floor apartment where she resided with her mother. Toxicological analysis of post-mortem blood showed alcohol in the amount of 0.10 g/100mL as well as Miss RST's prescribed fluoxetine for depression.

456. Miss RST was born and raised in Hong Kong but came to Melbourne with her mother in January 2021 to recommence school as a boarder at MLC. She was 12 years old at the time and had a history of defiant behaviour with a recent diagnosis of *Oppositional Defiant Disorder*. Miss RST wanted to attend school in Melbourne and her parents agreed. It was apparent that her parents had difficulty managing her behaviour in Hong Kong which included alcohol intoxication, disengagement from school, failing to abide by curfews and minor offending such as shop theft, amongst other things. Miss RST told a clinician that her *father would become very angry and stated he 'punched me a few times' although would not give specifics.* There were differing parenting styles and there is evidence that Miss RST felt like the odd one out in her family unit which included her parents and older brother. Miss RST complained that her parents were too strict and she strongly resisted any prohibition of her phone use or desired activities. The plan was for Miss RST to remain in Melbourne as a boarder and for her mother to return to Hong Kong to continue living with the rest of the family unit.

457. It was agreed by Miss RST and her parents, that there was a distinct change in Miss RST's demeanour in mid-2020.

458. It was also apparent that Miss RST's world was impacted by COVID, including her ability to effectively participate in her schooling. COVID was accurately described as "*a disaster*" for Miss RST.

459. Despite wanting to board at MLC, Miss RST became apprehensive about the school rules once in Melbourne and within days of commencing on 1 February 2021 was caught with

vapes, did not meet school imposed curfews on occasion, and police were involved in locating her at times when she went missing and was usually found with friends. There were also incidents of violent behaviour by Miss RST towards her mother and grandparents, particularly when her choices were curtailed. Miss RST was suspended from school (11 to 12 February 2021), became a day student and then was effectively asked to leave MLC on 2 March 2021. The MLC counsellor recommended that Miss RST return to Hong Kong.

460. It was documented that Miss RST was surprised that she could no longer return to MLC. This appears confirmed by text messages to her friend later discovered where she refers to something *bad* having occurred at MLC which *fucked my whole life.* She further explained to her friend that she got *expelled* and *regretted* it so much.

461. With the benefit of this information, which was only available after her passing, the effect of MLC being no longer available appears to have had huge personal significance for Miss RST who was likely to have relied on the move to Australia to positively transform her circumstances. The flow on effect however was life altering and created instability in all aspects of her life, ranging from where she would live (both short and long term), the future of her family unit (with her understanding that her mother initially had no plans to stay in Melbourne and wanted to return to Hong Kong), and no school to attend in the immediate future (having lost the school of her choice). In addition, the implication of the texts was an understanding that she had been responsible for the loss of MLC.

462. Further, all this was occurring on the background of Miss RST experiencing depression and an inability to concentrate in school, in addition to what may have been the effects of her *oppositional defiant disorder*. It is also clear that Miss RST wanted to do the things she was interested in, like hanging out with friends and vaping, and did not like having boundaries around her. Clinicians noted persistent themes of Miss RST feeling triggered and feeling controlled. She also reported intentionally doing the wrong thing in order to elicit a controlling response despite knowing the rules made her escalate.

463. Between 19 February and 6 April 2021, Miss RST presented four times to the Box Hill Hospital Emergency Department with various presentations including aggressive behaviour, suicidal ideation, and homicidal ideation towards her mother, although on one occasion (being 22 February), Miss RST refused to leave the car despite a clinician talking to her at the vehicle to encourage her to do so. The final presentation on 6 April was in the context of intoxication.

464. Miss RST's presentations often coincided with a significant event or boundaries being placed around her, including the return to day school rather than boarding (which meant she resided with her grandparents) and her effective expulsion from MLC on 2 March 2021.

465. After almost each presentation, there is evidence that her distress significantly reduced.

466. Evidence further suggested that at the time, given the presence of COVID and snap lockdowns in Victoria, Emergency Departments were overstretched, with young people being particularly distressed. The Court was advised that it was not considered an unusual presentation at an Emergency Department for a young person to be threatening to kill their parents or expressing suicidal ideation.

467. On the morning of 19 February 2021, the date of Miss RST's first Emergency Department presentation, her mother contacted the Eastern Health, Infant, Child and Youth Mental Health Service access team where a comprehensive intake was conducted over the phone and it was determined on 24 February that Miss RST would be referred to the Intensive Mobile Treatment Team (**IMTT**). IMTT is the most intensive community treatment in Victoria available for adolescents such as Miss RST.

468. IMTT case manager, Allison Hendon was in contact with Miss RST's mother from at least 3 March 2021[82] and managed Miss RST's case within the IMTT with oversight from Child and Adolescent psychiatrist Dr Fiona Bassed[83] until Miss RST's passing. The detail of the care provided is set out in my finding. I note that Miss RST's final presentation to the Emergency Department on 6 April, occurred post IMTT engagement.

469. Miss RST's family were also supported by various services which included Integrated Family Services, school counsellors (once she commenced school) and Avenues Education as well as a general practitioner. Miss RST's father was also engaged by IMTT remotely from Hong Kong.

470. Miss RST turned 13 on [redacted] 2021 and moved into a two bedroom apartment in Box Hill on 12th floor with her mother, in the final week of March. She appeared happy about the move.

[82] First face to face consultation on 9 March 2021.
[83] First face to face consultation on 8 April 2021.

471. Miss RST commenced fluoxetine on 13 April 2021; the dose was monitored and altered as needed. It appears that she took the medication as recommended, suggesting that she was help-seeking and wanted to address the depression she was experiencing. The evidence also suggests that Miss RST and her parents were appropriately informed about the potential risks of commencing fluoxetine and were agreeable for the medication being prescribed to treat Miss RST's depression. Dr Bassed confirmed that this medication can be effective, but this is not always the case.

472. Miss RST needed to find a school from early March 2021, which she did with the assistance of IMTT who engaged Avenues Education. She commenced at Koonung on 21 April (being a Wednesday) but experienced reluctance and anxiety before doing so.

473. The evidence suggests that she was very well supported at Koonung noting meetings between the school counsellor, IMTT and Avenues Education, on site and with Miss RST, as needed. There appeared to be constant communication about what was going on with Miss RST and how she should be supported, as well as safety planning.

474. It was apparent however that whilst Miss RST enjoyed being with and making friends at her new school, she almost immediately struggled and began cutting (albeit minor) on the first day, an activity that was new for her. She immediately informed the school and advised her case manager, despite a history of reluctance to engage.

475. On Monday, 26 April 2021, which was the fourth day at her new school, Miss RST expressed a desire for an admission whilst at school, following which a crisis appointment was convened by IMTT, involving engagement with Miss RST and her parents, and her psychiatrist. IMTT determined that a voluntary admission was appropriate, but Miss RST later changed her mind. This was not considered unusual for a young person, once they were listened to allowing their distress to recede. She was then closely monitored by IMTT and the school for the remainder of the week.

476. There were no red flags at any of the follow up meetings with Miss RST that week, which included with her IMTT case manager on Thursday and the school counsellor on Friday afternoon. I note that at the Thursday meeting, Miss RST said that she felt things had improved over the last few days and that spending time with friends had been helpful. At the Friday afternoon meeting which lasted an hour, Miss RST was reported to appear bright and spoke about wanting to attend school every day the following week.

477. Whilst at home on Friday evening however, Miss RST's friend was drinking and threatening to jump from the 12th floor balcony. Miss RST was not drinking and undertook a responsible role by calling her friend's grandmother to assist. Her grandfather, who was supervising Miss RST that evening, later commented that the *old* Miss RST was back (and *she seemed really happy*). Her mother described that Miss RST was shaken up but said she would try to go to school every day the following week.

478. There was general agreement that Miss RST was improving with her being increasingly engaged in care, being compliant with treatment in that she was taking her anti-depressant medication and was well engaged with the case manager and her school counsellor.

479. At inquest concerns regarding the care provided to Miss RST in the Emergency Department were explored. These concerns included her first presentations being characterised as *behavioural*; that her first presentation warranted a face to face assessment; and concern that she should have been admitted either to the Oasis Unit (when she was 12 years old) or the AIPU (when she was 13 years old).

480. Similarly, the inquest explored concerns raised about the care provided to Miss RST by the IMTT. These concerns included whether the care was progressed quickly enough (for example, the provision of formal therapies and the timing of the first consultation with a psychiatrist thus affecting the commencement of fluoxetine); the sufficiency of risk discussions, and whether Miss RST should have been involuntarily detained on 26 April 2021.

481. At the outset, it is important to recognise the effect of hindsight bias when examining the decision making of clinicians. Hindsight bias is the tendency to overestimate the foreseeability of an outcome once it is known.

482. Indeed, some experts stressed that their comments about Miss RST's care needed to be considered in this light. Court expert, Dr Adler commented *that it is easy to be critical of the care provided* with the benefit of hindsight and the knowledge of her tragic suicide.

483. I further note that the experts did not have the opportunity to observe and interact with Miss RST when that decision making was being undertaken, in contrast to other clinicians including her case manager and psychiatrist who interacted with Miss RST over many weeks. It was clearly evident that her case was complex, she was difficult to engage with, she was keen on having her way and she was being treated during a period of significant upheaval and instability in her life. I agree that it was a catastrophic time for Miss RST. It is also apparent

that Miss RST's full picture in terms of her presentation and things that may have been affecting her, were slowly emerging and were yet fully known.

484. In assessing these matters, I have had the opportunity to examine medical records, the detailed statements provided on behalf of clinicians and the evidence given at inquest by both clinicians and experts. Having done so, I consider that Ms Hendon and Dr Bassed were sincere witnesses who did their best to explain their decision making based on their interactions with Miss RST and her family, multiple considerations affecting Miss RST during the course of care, and how/why mental health services were delivered in those circumstances.

485. Of the broader question of the reasonableness of the care provided by Eastern Health, I prefer the opinions of Drs Adler and Milch after considering the basis for the opinions they articulated. Having said that there was agreement amongst the experts in many areas including that it would have been preferrable for Miss RST to have had a face to face assessment at her first presentations, the lack of utility of the CRAM with respect to the assessment of suicide risk, the high quality of case management provided by IMTT, the lack of predictability of the outcome in this case, and, that it was not possible to say whether detainment on 26 April would have changed the outcome.

486. I agree that it is unacceptable for a patient to be denied appropriate care in an Emergency Department setting as a result of their presentation being characterised as behavioural (when it was not) and thus being stigmatised in this manner.

487. The Court was advised in the context of Miss RST's case, that this characterisation was meant to denote that her presentation (19 and 22 February) was such that it did not require immediate admission, and that she may have had an underlying mental health issue that required further assessment, which ought to be undertaken in a community setting.

488. I note that some experts also commented that there is a problem with a binary view that someone either has an anger management/behavioural issue or a psychiatric issue noting that there is commonly an overlap. This appeared evident in Miss RST's case.[84]

489. The Court was also advised that it is not the role of an Emergency Department clinician to diagnose patients, rather the Emergency Department responds to acute presentations. In addition, the Emergency Department is not conducive to such assessments and it would

[84] I note her comment by text to a friend that she could *manipulate* her mother, once she found out about her cutting.

require a young person to be there for a long period of time in circumstances where it is considered that the longer a patient spends in an Emergency Department, the worse their mental state becomes.

490. I also note that in addition to the experts, a number of Eastern Health clinicians also agreed that it would have been preferrable for Miss RST to have been seen face to face at her first presentation, but they did not think this would have changed the outcome of that assessment.

491. I agree that a face to face assessment would have been appropriate given Miss RST's presentation on 19 February 2021. It does follow however, that an assumption can be made that Miss RST would have revealed more, had a face to face consultation taken place.

492. With respect to the question of detention under mental health legislation, the Court was advised that not only are there risks involved in any detention both during and after, but it is also unclear how Miss RST's risks and underlying issues were able to be treated whilst detained for a brief period. That is, those risks and underlying issues would remain on release, after what would be brief admissions. In addition, it is unclear how Miss RST would have reacted to an admission, noting her history of responses to boundaries being set around her, including removal of her phone.

493. The Court was further advised that an admission should not be considered a magic cure or intervention.

494. Regardless of these matters, clinicians are required to apply the applicable Victorian mental health legislation, which requires that the least restrictive treatment must be provided and, on each occasion, clinicians involved in Miss RST's care in the Emergency Department, who saw and interacted with her, concluded that an admission was not warranted.

495. I note with respect to Miss RST's presentation on 19 February 2021, clinicians interacted with her and made their own assessment about her care and whether admission was appropriate. Her uncle reported that Miss RST *was pleasant and answered all questions openly*. Whilst, the violence and aggression Miss RST demonstrated towards her mother should not be minimised, it is unclear whether an admission (where Miss RST's mother was required to stay with her), would have assisted and dealt with her underlying risks and issues. This included

her aggressive behaviour which reduced with time, after moving to an apartment and engagement with services.[85]

496. Regarding her presentation on 22 February 2021, whilst a face to face assessment would have been preferrable, I agree with Counsel Assisting that it was not possible in the circumstances. An Emergency Department clinician did however speak to Miss RST at the car and formed a view based on the responses provided (Miss RST indicated, my mother is too strict and I want to be with friends). I note that police later located Miss RST and there is no evidence that they considered her presentation warranted them utilising their powers under mental health legislation at that time.

497. I note that at her presentation on 2 March 2021, a comprehensive assessment was undertaken by a psychiatric nurse with input from a psychiatrist who formed the view that an admission to the Oasis Unit was not warranted as the criteria under the mental health legislation was not met.

498. Having reviewed the circumstances, I do consider that it would have been preferrable for Miss RST to have been assessed face to face by a psychiatrist or psychiatric registrar, however there is no basis to conclude that the outcome of this assessment would have been different. Miss RST had already been referred for mental health treatment at Eastern Health and allocated to the IMTT. The psychiatrist on 2 March, recommended that the appointment with IMTT be brought forward (and it was).

499. On the following day (3 March), police report that Miss RST seemed to be in a much better headspace and was cooking with her mother in the kitchen.

500. I note that a medical assessment took place in relation to her presentation on 6 April 2021, she was admitted to the short stay unit (until 7 April), there was a psychiatric triage review and a secondary consultation with a child and adolescent psychiatrist, who determined that an admission was not warranted in the circumstances. I further note that there was input from IMTT and Miss RST was scheduled to see Dr Bassed on 8 April 2021.

501. With respect to the care provided by IMTT, I accept the detailed accounts and reasoning set out by Miss RST's case manager and psychiatrist in relation to the manner and treatment

[85] On the following day (20 February), Miss RST's mother noted that Miss RST refused to go to dinner with family friends because she was unhappy with her eyelashes.

provided. They had the opportunity to engage with Miss RST over many weeks. I again note that Miss RST was a complex patient, who had recently suffered some life altering events which required immediate attention and she was difficult to engage with. I note that it was not considered unreasonable for a patient to be seen by psychiatrist within four to six weeks of being referred, noting that the care being provided by IMTT was already being discussed and overseen by Dr Bassed. The Court was further advised that a treating psychiatrist benefits from the patient engaging with the case manager initially, who builds rapport and trust with the young person, gathers information and is able to deal with urgent matters such as finding a school.

502. I note that IMTT agreed for a voluntary admission on 26 April 2021, but Miss RST changed her mind. I agree that in doing so she articulated future plans and focus and was advised that this was not unusual. This followed a crisis assessment, collaboration with family and a discussion regarding risks. I accept the reasoning set out by Miss RST's case manager and psychiatrist in relation to this matter, including whether the criteria under the applicable legislation would permit involuntary detainment. Miss RST wanted to return to school and engaged with safety planning. It is apparent that comprehensive risk planning with Miss RST, Miss RST's mother and the school took place and there was to be increased monitoring, details of which have already been outlined. It appeared that Miss RST was continuing to respond well to safety planning, was engaging with IMTT and with her school counsellor and was reporting an improvement in mood.

503. It is also apparent from a review of the available evidence, that there is no information in the days that followed Monday, 26 April to suggest that Miss RST required an admission or, that an admission was warranted under mental health legislation.

504. In addition, the available evidence supports a conclusion that the care provided by IMTT and in particular the case management, was exemplary. Dr Beech, an expert engaged on behalf of Mr ACW, commented that it was *gold standard* and *exemplary*. The expert panel agreed that it was outstanding.

505. I further consider that the evidence demonstrates that appropriate safety planning was undertaken with Miss RST's mother, including a recommendation that the family move from the 12th floor, if possible. At every contact, a risk assessment was undertaken by IMTT to determine amongst other matters, whether an admission was necessary, and every contact was considered an opportunity for engagement.

506. In reality however, safety planning cannot eliminate all risks, and access to lethal harm (eg. a train) could have occurred anywhere, including outside Miss RST's apartment and at anytime.[86]

507. One of the challenges with this case is the unpredictability of the outcome, noting that the suicide of such a young person is a highly unusual event, and therefore extremely difficult to predict. It is also very common in young people that their mood and risk can fluctuate quite quickly.

508. Experts commented on the rarity of such an event in our community and therefore its impact on predictability. Dr Jenkins from Eastern Health commented that in his 17 years as clinical director of the Infant, Child and Youth Mental Health Service, Miss RST is the youngest person managed by the service who has ever taken her own life.

509. Putting aside the rarity of such a death, the evidence suggests that that IMTT engaged in detailed risk identification and planning, which was extensively documented.

510. It is also apparent from Miss RST's presentation on the morning of her passing that she appeared happy with no apparent signs of distress, again highlighting the unpredictable nature of her subsequent act.

511. There were comments on the Friday night, that Miss RST was back to her old self. The Saturday followed without any red flags or events. On the day of her passing, Miss RST spent the morning with her mother and was reportedly in a good mood. Miss RST's mother monitored her whereabouts via a phone app. Miss RST spent the afternoon with friends, appearing in mobile phone videos to be intoxicated but happy. However, as soon as they left the apartment, she took photos and videos of herself showing evidence of recent self-harm and was clearly in considerable distress.

512. She was however help seeking and called both Lifeline and then Triple Zero saying she wanted to jump off the balcony. Miss RST sent several messages to friends using Snap Chat saying she was going to kill herself; her friends tried desperately to dissuade her from jumping.

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[86] For example, Miss RST spent time unsupervised with friends out of her apartment on the previous afternoon (1 May 2021), where she could potentially have gained access to alcohol and another means of harm].

513. It appears that central to her distress and subsequent actions was her consumption of alcohol that day. I note that her mother had no idea that Miss RST was keeping alcohol in the safe in her bedroom.

514. Professor Drummer commented that aside from reducing its effectiveness, the combination of alcohol and antidepressants can increase levels of anxiety and produce drowsiness. In addition, the consumption of alcohol in depressed people is more likely to worsen mood, rather than to improve it.

515. In summary, Professor Drummer considered that it is likely that the relatively high amount of alcohol in Miss RST's body would have caused some form of disinhibited behaviour and have reduced her ability to make rational and informed decisions. I accept his advice on this matter.

516. I note that during the call to Triple Zero, Miss RST said, *I'm gunna jump*, and queried whether this would cause her death. Despite Miss RST's age, I consider that she had formed the intention to take her own life, although I note it was both impulsive and likely affected by the alcohol she had consumed.

517. I have already noted that there may be some aspects of Miss RST's care which could have been undertaken differently, but following consideration of the breadth of the evidence I consider that the care provided by Eastern Health between 19 February 2021 and 30 April 2021 was appropriate in the circumstances. Options about what could have occurred with aspects of her treatment require a degree of speculation and, the benefit of hindsight.

518. It is likely that Miss RST's mental health symptoms and behavioural issues were best managed with psychotherapy (individual and family), parenting support, school involvement, and possibly psychotropic medication. Psychotherapy is however best progressed in the community rather than an inpatient facility. At the time of the fatal incident, it is apparent that IMTT was working towards finalising a comprehensive assessment of Miss RST and her family and fully implementing a multi-faceted approach to treatment. This work was taking time; however, this was the result of multiple factors including the need to develop a therapeutic working relationship with Miss RST that appears could not be forced to 'go faster', and to suggest otherwise appears inconsistent with what has been described by experts as the exemplary case management in this case.

519. I have made comments and recommendations directed at the delivery of mental health services arising from this investigation, but could not be confident that they would have averted the outcome in this case.

520. I further note that Miss RST's father was concerned about Miss RST's access to her phone including the influence of social media on her mental health, noting amongst other things her preoccupation with her appearance.

521. It is worthwhile to document in my finding that as of 10 December 2025, Australia implemented world-first legislation banning children under 16 from holding social media accounts to protect their mental health. This includes platforms like Facebook, Instagram, Snapchat, Threads, TikTok, Twitch, X, YouTube, Kick and Reddit. Such a ban would clearly have applied to Miss RST whilst in Australia, had the ban been in place at the time.

Emergency Response

522. Both 000Vic and Ambulance Victoria's responses to Miss RST's Triple Zero call were consistent with the policies and procedures relevant at the time.

523. The Court was advised that the process by which Ambulance Victoria determines its response to an event occurs within a complex system that is based on clinical evidence arising from empirical evidence and data from within Australia and overseas. It also sets out response times based on the priority determined for an event.

524. A clinical evidence-based approach prevents too much priority being given to a job so that resources can be utilised by Ambulance Victoria appropriately across the range of emergency events.

525. Having said that, I note that Ambulance Victoria's response time is measured from the start of a call, even when the priority is changed.

526. The intent for cases referred to Refcomm, as in Miss RST's case, is to have the caller speak with a clinician and/or mental health trained call-taker quickly. This also appears consistent with Recommendation 10 of the *Royal Commission into Victoria's Mental Health System*, which encourages a health led response to a mental health crisis, rather than a police led response, where safe to do so.

527. In contrast to Ambulance Victoria, whilst Victoria Police set priorities for an event, these priorities do not relate to response times for attendance at that event. A response to a Triple Zero call which is made to police will be dependent on the police dispatcher, and their considerations may include the urgency of an event, the availability of police resources to respond and competing demands.

528. Arising from the response to Miss RST's Triple Zero call and to explore whether there was a prevention opportunity, I posed the question whether police would have responded sooner had she elected for this emergency service, instead of Ambulance Victoria.

529. Whilst I noted the close proximity of the local police station to Miss RST's apartment, given there are no set target times for police to respond to an event and, the other considerations noted above, I am unable to say with certainty that the police response on that night (and at that time) would have been quicker.

530. Another issue related to the operation of the Multi-Agency Event. The evidence at inquest was unclear as to whether the current system would alert a corresponding agency, in this case police, to an upgrade in priority by Ambulance Victoria. Given the state of the evidence, it was submitted that it is not possible to conclude there was a systemic issue in relation to how information is presented from one agency to another. I agree with that assessment.

531. Despite this uncertainty however, I consider that an issue has been raised which warrants further consideration by the appropriate agency or agencies. In particular, I note the comments of Mr Vasilopoulos on behalf of 000Vic who considered that a mechanism could be useful in circumstances where Ambulance Victoria becomes aware of some key information that leads to them upgrading the priority.

532. I also note that Mr Vasilopoulos indicated at inquest that the problem with a Multi-Agency Event is that it doesn't allow for the particular circumstances of a case to be considered. For example, it is not triaged by the call-taker from the alternate service who would ask more questions and possibly assign it a priority relative to what was actually happening at the time. He indicated that such a mechanism could be useful.

533. This is particularly relevant where the event is urgent, noting that the Court was advised at inquest that a person threatening suicide in their loungeroom via ingestion of pills, was assigned an event similar to a person on the edge of a balcony, threatening to jump. In addition,

where ambulance require police attendance before they attend at event (because of the presence of a knife), as in this case.

534. I accept that police dispatchers are not trained in ambulance event types or the priorities assigned to ambulance events. I also understand that the priorities assigned by Ambulance Victoria have entirely different meanings to those of Victoria Police.

535. I would however urge, that consideration be given to these matters, so that the operation of a Multi-Agency Event is optimised to ensure that it is as effective as possible, noting the constraints already recognised.

536. I propose in these circumstances to make the recommendation raised by Counsel Assisting for TZV to confer with appropriate stakeholders including other relevant emergency service providers to consider whether the software used in response to Triple Zero calls can be improved so that an upwards change in priority in a Multi-Agency Event is flagged in a conspicuous manner for all relevant agencies.

537. I acknowledge that recommendations directed to potential changes to the software used in response to Triple Zero calls, may be complex or not possible from a technological perspective.

538. In addition, consideration be given for police to be dispatched immediately in a Multi-Agency event, in circumstances such as Miss RST's where the situation is time critical, so that the most accessible agency can respond to a scene, whilst Ambulance Victoria's Refcomm is speaking to a caller. These are circumstances where a person is actively threatening suicide and the lethality of the circumstances is high, given the current procedure does not appear to distinguish these circumstance as noted above. In addition, where ambulance require police attendance before they attend at event, due to the presenting circumstances.

COMMENTS

539. Accordingly, pursuant to section 67(3) of the Act, I make the following comments connected with the death:

540. The number of young adolescents who die by suicide in Victoria remains relatively low. Between 2015 and 23 October 2025, 33 children aged 12-14 years old died by suicide, with

two-thirds of those 14-years old.[87] This represents less than 17% of the suicides of young people 12-17 years of age.

541. Clearly, a single death of a young person in our community by means of suicide, is one death too many, and is not only devastating for family, friends and the community but has other far reaching ramifications.

542. While self-harm and suicidal ideation are not uncommon among young adolescents, many Emergency Department staff are likely to have limited experience in identifying who amongst this cohort is most at risk of suicide and managing this risk. Given the low number of young adolescents who complete suicide, every effort should be made to avoid the possibility that the risk of suicide by someone in this age group is minimised or not taken as seriously as it may be for older adolescents and adults.

543. It can be particularly difficult to quantify suicidal intent in the context of self-harm, high-risk behaviours and suicide attempts in younger people[88]. Moreover, while evidence is building to distinguish risk factors for suicidal ideation from risk factors for suicide attempts in adolescents in general[89], little is known about the risk and protective factors specific to young adolescents and children. Experts consider that extrapolating from what is known about adolescent suicide, in general, can be unwise because of the substantial difference in physical, sexual, cognitive and social development between older and younger adolescents and children[90].

544. In addition to many Emergency Department health professionals having limited experience in working with this cohort, the situation is compounded by a limited age-specific evidence-base to guide risk formulation and decision-making.

545. I also note that Dr Jordon advised that the longer a patient spends in an Emergency Department, the worse their mental state becomes due to the environment, which is overstimulating, noisy, brightly lit and loud, and there can be interruptions from other patients

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[87] Data from Victorian Suicide Register (VSR) provided by Jeremy Dwyer on 24 October 2025. See Attachment A.
[88] Cleary, M. et al (2019) Complexity of youth suicide and implications for health services. *Journal of Advanced Nursing, 75*: 2056-2058. https ://doi.org/10.1111/jan.14095
[89] Etherson, M.E. (2025) Exploring risk and protective factors which distinguish suicidal and self-harm behaviours from suicidal and self-harm ideation in young people: A systematic review. *PLOS One, 20(9):* e0326381. https://doi.org/10.1371/journal.pone.0326381
[90] Headspace School Support (undated) *Understanding suicide, suicide attempt and self-harm in primary school aged children – evidence summary.* https://headspace.org.au/assets/download-cards/02-HSP254-Suicide-in-Primary-Schools-Summary-FA-low-res.pdf

with behavioural disturbance. He said there were a whole manner of stimuli which tended to have a negative impact on anxious or depressed patients.

546. While there are few age-specific guidelines in relation to assessing and managing suicide risk in children and adolescents in Emergency Departments, Suicide Prevention Australia has investigated young people's experience of Emergency Departments when presenting with risk of suicide.

547. The *In Their Words*[91] project identified strong consensus among young people that Emergency Departments, often the first point of contact for initiating care, are not suited to meeting the needs of young people who have self-harmed, made a suicide attempt or are at a point of suicidal distress. Young people recommended the following reforms:

- The use of both place-based and response team models
- The staff must be able to provide both medical assistance and compassionate support
- There should be clear processes and choice
- They should be accessible to all and safe
- Place-based services should be designed and located to protect privacy and have an environment that feels safe and focussed on mental health and wellbeing.

548. Suicide Prevention Australia proposed a series of recommendations to promote trials of models of alternatives to Emergency Departments. They also suggested existing Emergency Department environments could be made more acceptable by having:

- Clearer processes
- Improved accessibility
- Further staff training on suicide and self-harm
- Specific suicide response staff including youth peer workers

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[91] *In Their Words: How to support young people in suicidal distress.* Suicide Prevention Australia (August 2022). https://www.suicidepreventionaust.org/wp-content/uploads/2022/08/SPA_Youth-Report_In-your-words_12-August-2022.pdf

- Reduced waiting times and the provision of support while waiting
- Provision of alternative waiting areas
- Increased privacy
- Improved follow-up support.

549. Importantly, the young people consulted for the Suicide Prevention Australia report emphasised that not enough attention was placed on the acute mental distress experienced at the point of contact with Emergency Departments. Similarly, a recent Spanish study[92] concluded that mental pain is a key factor in suicidal behaviour by young adolescents and must be considered as part to the assessment process.

550. Miss RST is likely to have been experiencing acute mental distress that led to some or all of her attendances at the Emergency Department and her experience may have been enhanced if the Emergency Department experience for adolescents across Victoria provided greater acknowledgement and management of this distress in an appropriate setting. A more positive experience of the Emergency Department may also have fostered greater willingness for ongoing help-seeking and therapeutic engagement.

551. This comment is not intended to be critical of Box Hill Emergency Department at the time Miss RST attended, which would have been similar to any Emergency Department experience in Victoria, but applies to all Emergency Departments generally.

552. Drawing on the work of Suicide Prevention Australia, I propose three recommendations which align with the Black Dog guidelines for managing suicide-related crises in Emergency Departments.[93]

553. The guidelines are general in nature and provide no specific guidance for managing children and young adolescents who present to Emergency Department. However, they do emphasise that trauma-informed care is a critical component of supporting people in Emergency Departments who are in suicidal distress and that the approach to assessment and management

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[92] García-Ormaza, J. et al. (2025) Mental pain and lifetime suicide attempts in early adolescence: a preliminary study. *Child and Adolescent Psychiatry and Mental Health,* 19:30.

[93] Hill N.T.M. et al. (2023) *Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings.* Sydney, Black Dog Institute. https://www.blackdoginstitute.org.au/wp-content/uploads/2024/07/BDI_ED_Guidelines-2024-Final.pdf

must be relational, warm, empathic and acknowledge the person's distress in a non-stigmatising way. The guidelines also emphasise the importance of peer support workers in Emergency Departments to work with the clinical team to connect with the person, offer support and comfort, accompany the person while awaiting assessment and support them to communicate with staff. It also seems reasonable to suggest that youth peer workers be engaged to undertake this role with children and young adolescents.

554. In addition, I note Recommendation 6 of the Interim Report of the Royal Commission into Victoria's Mental Health System (**RCVMHS**)[94] called for more lived and living experience workers at all levels of the mental health and wellbeing system. There has been considerable investment in developing and supporting this workforce in Victoria but it is unclear the extent to which investment has occurred in youth peer workers, and more specifically, in making them available to support young adolescents when they present to Emergency Department.[95]

555. For someone like Miss RST, who was easily engaged with other young people, a youth peer worker in the Emergency Department, may have improved her experience and engagement. Accordingly, I intend to make a recommendation regarding the trial of a youth peer worker in the Emergency Department.

556. I further note that the RCVMHS recommended the establishment of a Suicide Prevention and Response Office, led by a State Suicide Prevention and Response Adviser, reporting to the Chief Officer for Mental Health and Wellbeing, in the Department of Health. The Office operates in governmentwide governance structures that encompass all government departments and relevant agencies. The Office is responsible for establishing a system-based approach to suicide prevention and response; co-producing a new suicide prevention and response strategy for Victoria with people with lived experience of suicidal behaviour or bereavement by suicide[96]; and working closely with the Commonwealth Government to ensure suicide prevention and response efforts in Victoria are coordinated with, and complement, national approaches.

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[94] State of Victoria (2021) *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21 (document 1 of 6). https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report.

[95] The Royal Children's Hospital has a carer peer worker to support parents and carers as part of the HOPE program, including contact with ED. Youth peer workers are engaged by various community-based services.

[96] There is now a 'Suicide prevention & response strategy 2024-34' that presumably is what is referred to on their website as being 'co-produced' (ie work has been done)

557. It was noted that suicide prevention and response requires a system based approach which means looking at all of the systems that can influence suicidality. This is based on the idea that no single action, service or treatment will work in isolation, requiring a concerted and continuous effort.

558. In addition, the *Adopting Zero Suicide Framework Initiative,* driven by the Mental Health Improvement Program (**MHIP**) at Safer Care Victoria (**SCV**), focuses on partnering with multidisciplinary improvement teams within healthcare services to build capability for implementation of the Zero Suicide Framework into practice. SCV provides support in a tiered approach through facilitation of service self-evaluation against the framework and offering coaching to teams in how to test, track, evaluate, implement, and sustain meaningful improvements over time.

559. The Court was advised that this training package will be developed over the next 12-18 months in collaboration with the Centre for Mental Health Learning, with the aim to be ready for delivery and broad dissemination in late 2025. It will address suicide risk formulation and will be made available to clinical and non-clinical healthcare workforce across Victoria, including those working within emergency departments. The package will also include training modules tailored for those working with young people aged 0 to 25 years old. The initiative aims to scale and spread to support all Victorian healthcare services to adopt the Zero Suicide Framework by 2031.

560. Given the important role undertaken by the Suicide Prevention and Response Office I propose to forward this finding to the office for their consideration, including the recommendations made.

RECOMMENDATIONS

561. Accordingly, pursuant to section 72(2) of the Act, I make the following recommendations connected with the death:

Recommendation 1

The Victorian Collaborative Centre for Mental Health and Wellbeing[97] develop and deliver training and awareness programs for Emergency Department staff on the risks or possibility of death by suicide by children and young adolescents, particularly within the context of acute severe behavioural disturbance. The training should be delivered jointly to Emergency Department clinicians and emergency mental health staff. Such training should be made available to all Emergency Department staff and emergency mental health clinicians in Victoria.

Recommendation 2

The Victorian Collaborative Centre for Mental Health and Wellbeing develop and deliver training on trauma-informed responses to children and young adolescents presenting to Emergency Departments in states of distress and serious behaviour dysregulation. The training should be delivered jointly to Emergency Department clinicians and emergency mental health staff. Such training should be made available to all Emergency Department staff and emergency mental health clinicians in Victoria.

Recommendation 3

The Victorian Government consider resourcing a trial of the use of youth peer workers in an Emergency Department environment to support young adolescents who present with suicidal ideation and serious behaviour dysregulation. The trial would need to take place in an Emergency Department that could provide an appropriate safe, quiet, comfortable place where a young adolescent can await medical attention and be assessed with appropriate levels of privacy. A well-designed evaluation of the trial, inclusive of the voices of the young people who use the service (and their families) and the youth peer workers should inform a potential expansion of the model across Victoria.

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[97] Discussions with the Office of the Chief Psychiatrist indicated that training (such as that suggested in recommendations 1 and 2) might best be delivered by The Victorian Collaborative Centre for Mental Health and Wellbeing.

Recommendation 4

TZV confer with appropriate stakeholders including other relevant emergency service providers to consider whether the software used in response to Triple Zero calls can be improved so that an upwards change in priority in a Multi-Agency Event is flagged in a conspicuous manner for all relevant agencies.

Recommendation 5

Ambulance Victoria confer with Victoria Police to enable consideration to be given for police to be dispatched immediately in a Multi-Agency event initiated by Ambulance Victoria, in circumstances such as Miss RST's where the situation is time critical, that is, a person is actively threatening suicide and the lethality of the circumstances is high, so that the most accessible agency can respond to a scene, whilst Ambulance Victoria continues its response to the emergency event (for example, utilisation of Refcomm).

FINDINGS

562. Pursuant to section 67(1) of the Act I find as follows:

(a) the identity of the deceased was Miss RST, born [redacted] 2008;

(b) who died on 2 May 2021 at 12-14 Nelson Rd, Box Hill VIC 3128, from *1(a) Multiple Injuries Sustained in a Fall from Height*; and

(c) the death occurred in the circumstances described above.

563. Having considered all of the circumstances, I am satisfied that Miss RST intentionally took her own life, but note that this decision occurred in the context of her experiencing depression and is likely to have been both impulsive and significantly affected by the alcohol she had consumed.

564. Miss RST's passing is an incomprehensible tragedy, which has touched all who knew her and those involved following her passing.

565. In these cases, it is important that I recognise the grief of first responders and Victoria Police officers who attended the scene, and I acknowledge the assistance provided to this investigation in these most challenging of circumstances.

566. I also acknowledge the health providers who assisted Miss RST and came before this Court to give evidence, who were also profoundly affected by her passing. Their attendance before this Court would have been extremely difficult.

567. To her parents, I note that that the death of a child has been described as a death like no other, where the grief is not only painful, but profoundly disorienting. A child's death is simply not supposed to happen.

568. I again extend my heartfelt condolences to Miss RST's family for their loss and acknowledge the traumatic circumstances in which her passing occurred.

569. It is apparent that Miss RST was a beautiful young spirit whose impact was immense and she is very much missed by many.

ORDERS

Pursuant to section 73(1) of the Act, I order that this finding (in redacted form) be published on the internet.

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

Mr ACW and Mrs LRV, Senior Next of Kin

Robertson O'Gorman Solicitors

Triple Zero Victoria (care of MinterEllison)

Ambulance Victoria (care of Meridian Lawyers)

Chief Commissioner of Police

Safer Care Victoria

Office of the Chief Psychiatrist

Suicide Prevention and Response Office, Department of Health

Mental Health Ministerial Advisory Committee

Victorian Collaborative Centre for Mental Health and Wellbeing

Detective Senior Constable Mark Taylor, Coroner's Investigator, Victoria Police

Signature:

SARAH GEBERT
CORONER
Date: 5 February 2026