IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006346

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Danielle Julie Kaye Thomson
Date of birth:	8 July 1981
Date of death:	4 November 2022
Cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	35 Eastwood Street, Bakery Hill, Victoria
Keywords:	Chronic pain – mental illness – substance abuse – suicide

INTRODUCTION

1. On 4 November 2022, Danielle Julie Kaye Thomson was 41 years old when she was located deceased in Bakery Hill, Victoria.

2. Danielle was an intelligent and gifted woman with diverse interests and a strong commitment to social justice. She is warmly remembered and deeply mourned by her family.

BACKGROUND

3. Danielle had a long and complex medical and mental health history which included cervical dystonia, osteoporosis, bipolar affective disorder, borderline personality disorder, anxiety, depression, movement disorder, chronic pain, eating disorder and alcohol use disorder. Danielle had experienced childhood sexual abuse and also had a history of suicidal ideation. She was prescribed medication, including buprenorphine, baclofen and mirtazapine, desmethylvenlafaxine and topiramate.

4. Danielle's struggled to manage her complex medical and mental health conditions over many years, dating back to 2007. Her parents were a constant support for her and shared in her experiences of frustration and despair as she sought to navigate the public health system.

5. On 29 September 2021, Danielle presented to the Monash Medical Centre (**MMC**) due to confusion and chronic neck pain following a low-speed car accident in which she had hit her head on the steering wheel. She was found to have a gastrointestinal bleed and she discharged herself after a period of treatment on 5 October 2021.

6. On 22 October 2021, Danielle presented to MMC in the setting of delirium and psychosis associated with alcohol withdrawal and was admitted as an inpatient. She was managed pursuant to treatment orders under the *Mental Health Act 2014* which were reviewed by the Mental Health Tribunal. Her treatment during this admission included a number of medical reviews after Danielle experienced several unwitnessed and witnessed falls, including a fall on 26 October 2021 where she struck her head, resulting in a nosebleed and fractures to ribs and the left nasal bone. She also reported to staff that she had been sexually assaulted during this period.

7. Danielle self-discharged from MMC on 20 November 2021 but was readmitted to the Emergency Department (**ED**) the following day, intoxicated.

8. On 15 January 2022, Danielle was made the subject of a 26-week inpatient treatment order due to persistent psychosis and she was subsequently admitted to the Dandenong Secure Extended Care Unit (**SECU**).

9. On 1 June 2022, Danielle was transferred to the Monash Health East Bentleigh Community Care Unit (**CCU**). During her admission to the CCU she was referred to Addiction Psychiatrist Dr Zarrar Chowdary.

10. Dr Chowdary reviewed Danielle on 6 September 2022 and she told him that she was hoping to transfer to a long term rehabilitation facility for her alcohol use in the coming weeks to months. Dr Chowdary considered that it was important for Danielle to continue to engage with alcohol and other drug services and considered a long-term rehabilitation placement to be sensible. He remained guarded about her prognosis and *"feared that there was a chronic risk of misadventure"*. He recommended to her General Practitioner (**GP**) that she be referred to a neurologist and neuropsychologist.[1]

11. In terms of pain management, after a request by Danielle, Dr Chowdary increased Danielle's Norspan[2] patch from 40 to 60mcg per hour. He advised Danielle that if her pain was to persist at unbearable levels, then opioid replacement therapy should be considered. He encouraged Danielle to *"keep an open mind about opioid replacement therapy, and mentioned that her pain was chronic and unlikely to disappear"*.[3] He also increased her dosage of baclofen to act as a relapse prevention agent regarding her alcohol use disorder.

12. On 22 September 2022, Danielle was discharged from the CCU following an incident whereby she returned to the facility heavily intoxicated. Her drug and alcohol counsellor, Kim Ruhl, recalled that she was *"clearly upset"* about the eviction but *"understanding at the same time that she really needed to be in treatment"*.[4]

13. There was instability and uncertainty in relation to Danielle obtaining secure accommodation during this period and Ms Ruhl was very diligent in seeking to coordinate relevant services to ensure continuity.

[1] CB66.
[2] Buprenorphine.
[3] CB65.
[4] Statement of Kim Ruhl dated 23 May 2023.

14. On 22 September 2022, Danielle was admitted to a Monash Health Community Residential Withdrawal Unit for withdrawal management from alcohol and cannabis.

15. On 28 September 2022, Danielle was reviewed by Neurologist, Dr Mina Ghaly for her painful cervical dystonia. He suggested that she commence mirtazapine to help her insomnia and arranged for Botox injections in the active cervical muscle which he performed on 13 October 2022. He also referred her to a pain specialist for her ongoing musculoskeletal pain and updated her GP.

16. On 29 September 2022, at a clinical review meeting, it was decided to remove Danielle's Norspan patch and replace it with a Sublocade[5] injection as part of opioid replacement therapy. It was recorded that Danielle agreed to this course. She was also commenced on mirtazapine.

17. On 3 October 2022, Danielle was discharged from Monash Health after completing her withdrawal program and admitted to the Geelong Clinic to participate in their 28 Day Addictive Behaviour Program. Danielle engaged with most of the scheduled activities at the Geelong Clinic, was active in the decision-making processes and appeared to be happy with the program. She consistently denied experiencing suicidal ideation and remained abstinent from alcohol during her stay.

18. Danielle was seen regularly by Consultant Psychiatrist, Dr Sharada Devarakonda and received individual psychotherapy from Psychiatry Registrar Dr Jessica Hickmott, in addition to the input of a psychologist during group sessions and regular nursing contact. Dr Devarakonda reported that Danielle engaged well in the group program and in individual psychotherapy, and demonstrated *"a good insight into her difficulties and she was motivated to change behaviour"*.[6]

19. In late October 2022, at Danielle's request, Dr Devarakonda prescribed Norspan patches to manage her chronic pain in place of the Sublocade injections. Dr Hickmott consulted with Dr Chowdary who stated that it would be preferable for Danielle to continue with Sublocade as *"otherwise, her pain was likely to escalate"*. He stated that the *"second best option"* could be a high dose Norspan patch.[7] Ms Ruhl also discussed with clinicians at the Geelong Clinic the possibility of a *"sidestep"* transfer for Danielle to the Epworth Hospital for further

[5] Buprenorphine injected as a liquid.
[6] CB46.
[7] CB68.

investigation of her increase in pain and decrease in functional capacity. There is no evidence that this option was actively considered by staff at the Geelong Clinic.

20. On 20 October 2022, while she was at the Geelong Clinic, Danielle had a phone consultation with her GP who referred her to a neurosurgeon to review her chronic neck pain and posture and also to the Epworth Hospital.

21. On 30 October 2022, Danielle reportedly visited the Splashdown Leisure Centre in Geelong where she injured her neck.

22. On 31 October 2022, Danielle was discharged from the Geelong Clinic and at that time she was not observed to have any active suicidal risk.

23. Dr Devarakonda acknowledged that a family meeting had not been organised during the admission at the Geelong Clinic which had been an oversight. She conceded upon reflection that such a meeting would have been beneficial for Danielle and her family.

24. Danielle was scheduled to complete a 90-day residential drug and alcohol rehabilitation program at the Windana Drug and Alcohol Recovery Centre in Ballarat (**Windana**). Danielle was given a tour of the facility when she arrived on 31 October 2022 and informed that she would have a "grace" period of three days on which to "*ground herself in the program"*.[8]

25. On 2 November 2022, Ms Thomson expressed concerns to Windana staff about her neck movement but declined immediate medical attention. After speaking with her parents later in the day, she arranged for an appointment with a GP the following day.

THE CORONIAL INVESTIGATION

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

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

[8] Statement of Douglas Shaw dated 15 March 2022.

28. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

29. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths.

30. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Danielle's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. The Court also obtained further evidence, including from a number of experts and considered detailed submissions from Danielle's parents and the other interested parties.

31. At a mention hearing conducted on 2 March 2023, I advised the parties that I would be focussing the scope of my investigation on the care and treatment received by Danielle at the Geelong Clinic in October 2022; at Windana between 31 October and 3 November 2022; and her presentation to the Ballarat Hospital between 3 and 4 November 2022. I determined that the earlier periods of Danielle's care and treatment were not sufficiently connected to the cause and circumstances of her death to attract the jurisdiction of the Court.

32. As stated by the Full Court of the Supreme Court of the Australian Capital Territory in *R v Doogan; ex parte Lucas-Smith & Ors* (2005) 158 ACTR 1 at [29]:

> *"A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in March v E & MH Stramare Pty Ltd (1991) 171 CLR 506. The application of that test will obviously depend on the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame."*

33. Danielle's parents urged me to broaden my inquiry to include their daughter's treatment with Monash Health from late 2021 and also her time at the Bentleigh CCU. As explained at the mention hearing, Danielle's experience during this period is clearly relevant to their broad

concerns about the quality of care and treatment she received for her complex physical and mental health conditions. It is also part of her challenging story, which was shared and endured by her family as they sought to support her. However, I consider that this period is too remote from the cause and circumstances of Danielle's death to be considered in this investigation. Further, it is open for Danielle's parents to raise their concerns during this period with other investigative bodies such as the Mental Health and Wellbeing Commission (**MHWC**) and they have done so (see below).

34. This finding draws on the totality of the coronial investigation into Danielle's death including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[9]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

35. On 3 November 2022, Danielle had an appointment with GP Andrew McDonald at Ballarat Group Practice. She disclosed to Dr McDonald that she thought her neck pain was getting worse and she was not sure that she should remain at Windana. Dr McDonald provided some prescriptions for Danielle's regular medications and contacted staff at Windana to discuss her management.

36. Later on 3 November 2022, Danielle reported extreme neck pain and worsening involuntary neck movements. Staff at Windana contacted Nurse On-Call and on their recommendation, arranged for Danielle to be transferred to hospital. While awaiting an ambulance, Danielle reported worsening anxiety about her physical condition and ongoing stay at Windana. In particular, staff recorded that she spoke of *"being stuck with this condition permanently"* and that *"while euthanasia isn't an option, she can't imagine living like this and she feels her body is falling apart"*. Danielle appeared to be receptive to reassurances and encouragement from Windana staff.

37. Ambulance Victoria arrived at approximately 8.40pm and assessed Danielle before transferring her to Ballarat Hospital. Danielle reported experiencing worsening neck pain and

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

spasms consistent with previous episodes of cervical dystonia. Paramedics provided her paracetamol for her pain. Opioid analgesia was withheld given her participation in a drug rehabilitation program. Windana staff were unable to accompany Danielle to hospital due to Covid restrictions. They provided the hospital with a letter containing their contact details and advising that she should not be prescribed opioid medication without consultation with her treatment team.

38. Danielle arrived at the ED at Ballarat Hospital at 9.43pm and was assessed by a triage nurse and her vital signs were taken. There is no evidence that Danielle reported any suicidal ideation. She was triaged as Category 3 on the Australian Triage Scale which is *"semi-urgent"* such that ideally, she would be seen within 30 minutes. Danielle was then asked to wait in the waiting room for further treatment.

39. At 12.40am on 4 November 2022, ED staff noted that Danielle was no longer in the waiting room and had left the hospital. She had not spoken with staff before her departure.

40. At approximately 10.40am on 4 November 2022, Windana staff sought an update from the hospital but were advised that Danielle had self-discharged against medical advice. Windana staff expressed concerns to hospital staff that they were not informed of her discharge from hospital.

41. At approximately 11.16am on 4 November 2022, a member of the public was walking along Eastwood Street in Bakery Hill. As they looked towards a building at number 35 Eastwood Street, they observed a person—later identified as Danielle—to the side of the building, hanging from a downpipe by an electrical cord. It appears that Danielle purchased the electrical cord after leaving the ED.

42. The witness contacted emergency services and with the help of an employee from a nearby business, cut the cord and lowered Danielle to the ground.

43. Ambulance Victoria and Victoria Police arrived a short time later. Responding paramedics were unable to find signs of life and pronounced Danielle deceased at 11.46am.

44. Victoria Police subsequently found a video recording on Danielle's phone in which she apologised to her family but expressed helplessness and frustration in relation to her *"predicament"*. She stated that it *"wasn't planned"* and "*I was sitting in emergency and it just came over me that I had my phone and I could get card-less cash and do this"*.

Identity of the deceased

45. On 9 November 2022, Danielle Julie Kaye Thomson, born 8 July 1981, was visually identified by her father, John Thomson.

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

Medical cause of death

47. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine, conducted an external examination and reviewed a post-mortem computed tomography **(CT**) scan. She prepared a report of her findings dated 9 November 2022.

48. Consistent with Danielle's history of injury, the CT scan revealed remote rib, pelvic and vertebral fractures.

49. Toxicological analysis of post-mortem samples identified the presence of buprenorphine,[10] desmethylvenlafaxine,[11] topiramate[12] and paracetamol.

50. Dr Zhou provided an opinion that the medical cause of death was 1(a) Neck compression; 1(b) Hanging.

51. I accept Dr Zhou's opinion.

[10] Buprenorphine is indicated for moderate to severe chronic pain and for the treatment of opioid addiction.
[11] Desmethylvenlafaxine is the major active metabolite of venlafaxine indicated for major depression.
[12] Topiramate is an effective anticonvulsant.

FAMILY CONCERNS

52. Prior to her death, Danielle and her parents directed several concerns regarding her care to the MHWC. In their complaints to the Commissioner, Mr and Mrs Thomson expressed concerns regarding the management of their daughter's medical and mental health conditions by her treating teams from 2020. In particular, the complaints relate to Danielle's admissions with Monash Health in 2021 to 2022 and in relation to experience at the CCU in Bentleigh. The MHWC has been working with Monash Health in relation to the complaints and they have not yet been finalised.

53. Pursuant to section 7 of the Act, it is not appropriate for me to duplicate the investigation of MHWC in relation to Danielle's treatment and management by Monash Health. Further, I do not consider that they are sufficiently connected to the cause and circumstances of her death.

54. In their extensive written concerns submitted to the Court, Mr and Mrs Thomson levelled criticism at multiple health services from which their daughter received treatment, including Monash Health, Ballarat Health, Windana and the Geelong Clinic.

55. In particular, Mr and Mrs Thomson were critical of their daughter's discharge planning and the level of communication with them throughout her admissions, inadequate falls risk management as well as what they perceived to be a failure of her various treating clinicians to adopt a holistic and coordinated approach to her care.

56. Mr and Mrs Thomson also expressed concerns regarding the care their daughter received immediately prior to her death, namely the assessments of staff at Ballarat Hospital as to her mental state and that Windana staff did not accompany her to hospital or arrange to be notified upon her discharge.

REVIEW OF CARE

57. Danielle's parents have had significant experience with Victoria's health system both professionally and in the context of supporting Danielle. Their experience and perspective are valued in the Court's investigation process. As stated in the report of the Royal Commission:

"Families, carers and supporters have much to contribute to a future mental health and wellbeing system, with lived experience knowledge gained from years (sometimes decades) of

navigating a complex system – and for many, a passion and personal commitment to making the system better for others in the future".[13]

58. I have considered the detailed submissions prepared by Danielle's parents about the standard of care provided to their daughter throughout her arduous journey with the health system, but my focus is on her experience proximate to her death. Further, it is appropriate that I am also informed and guided by relevant expert evidence.

59. The Court obtained expert opinions from Addiction Psychiatrist Dr Basanth Kenchaiah dated 22 April 2024 and Pain Medicine Physician Dr Eric Visser dated 7 July 2024. They were provided with relevant evidence upon which to base their opinions, including the submissions of Danielle's parents. I am satisfied that they are suitably qualified to provide their expert opinions on the treatment provided to Danielle within the scope of the investigation. They were also provided with a copy of the Code of Conduct for Expert Witnesses and did not disclose any conflict of interest or pre-existing relationship which would disqualify them from providing an opinion.

60. Dr Kenchaiah expressed the opinion that the overall quality of care provided to Danielle was reasonable *"given the barriers within our health system in terms of integrated management"* of mental health, chronic pain and addiction conditions. He stated that he shared many of the broader concerns raised by Danielle's parents around the lack of integrated care within the public mental health services and difficulty in accessing detox and rehabilitation services.

61. Danielle's parents were disappointed with Dr Kenchaiah's report and disagreed with his opinion. They have sought to focus in detail on the forensic and therapeutic decisions of Danielle's carers and treating team in support of a submission that, with the exception of Ms Ruhl, the standard of care provided was inadequate.

62. Dr Visser expressed the opinion that there were no major deficiencies in Danielle's pain management. He agreed with Mr and Mrs Thomson that the treatment of Danielle's chronic pain would ideally have involved multidisciplinary (multimodal) assessment and treatment but that it is unlikely that she would have effectively engaged with the treatment "*due to the distracting effects of her mental health condition and psychoactive medications, on her cognition, concentration, alertness, memory etc"*. He stated that, *"it is a very common and unfortunate clinical dilemma (a 'catch-22') that patients such as Ms Thomson who experience*

[13] Final Report of the Royal Commission into Victoria's Mental Health System, Vol 3, p70.

chronic pain along with severe mental health problems (and substance abuse), do not respond effectively to multidisciplinary pain management, until their mental state is stabilised".

63. Danielle's parents expressed frustration with Dr Visser's report in terms of his view as to the effectiveness of pain management strategies for those who also suffer mental illness with substances abuse issues. Further, they considered that the questions posed by the Court were too simplistic to effectively illicit his views as they related to Danielle's treatment.

The Geelong Clinic

64. Dr Kenchaiah considered that the management of Danielle's mental health issues, alcohol and opioid use disorder, and chronic pain, was for the most part appropriate and of adequate standard. He did however note that Danielle was not admitted to a pain management program and there was no evidence that the prescribing of Naloxone[14] was discussed.

65. Dr Kenchaiah stated the opinion that the Geelong Clinic had access to relevant information which was sufficient for Danielle's participation in the Addiction Behaviour Program. In particular, he noted that the referral letter from Monash Health dated 2 September 2022 and the discharge summary dated 3 October 2022 summarised her presentation reasonably well and identified her medication regime.

66. In terms of pain management medication, given Danielle had elected to cease Sublocade injections, Dr Kenchaiah considered that the gradual increasing dose of Norspan patches by the Geelong Clinic was appropriate to prevent withdrawal symptoms while also providing some pain relief. However, Dr Visser was of the view the doses of buprenorphine and baclofen prescribed to Daneille were too high without an assessment by a pain medicine physician.

Windana

67. Dr Kenchaiah noted that Danielle had been happy with the therapeutic community at Windana and that the standard of care and treatment offered appeared adequate.

68. Windana stated that they were shocked and saddened by Danielle's death and conducted an internal review to investigate her *"treatment journey"* and identify any *"failings"* and *"learnings"* which resulted in a number of recommendations.

[14] Naloxone is an opioid antagonist.

69. Windana confirmed that for emergency transfers to hospital in an ambulance, their policy is that staff do not accompany the resident to hospital. Rather, clinical handover is provided to paramedics along with copies of a transfer letter and medication chart.

70. One of the recommendations was to update the Windana transfer letter to accompany residents to hospital to remove the exclusion for opioid administration and to request communication from the hospital in the event the resident is discharged or had absconded.

Ballarat Base Hospital

71. Grampians Health have advised that a total of 141 patients presented to the ED at Ballarat Hospital on 3 November 2022, which was not an unusually high number of presentations. Staffing levels were lower than anticipated due to unexpected sick leave. At the time that Danielle presented to the ED, the hospital was experiencing access block which meant that patients were remaining for longer periods in the ED as there were no beds available for them to be transferred to in the wards. At 10.00pm, there were a total of 53 patients in the ED with 21 of those patients in the waiting room. A total of 24 patients left the ED without having been seen during the course of the day.

72. Dr Kenchaiah noted that Danielle had not been seen three hours after presenting to the ED. However, he considered that the scenario of Danielle leaving the hospital before being seen was not something one would have expected as she had successfully completed two recent inpatient stays and there was nothing in her history to suggest she would avoid seeking pain management input.

73. In terms of the staff at Ballarat Hospital not notifying Windana after they noted that Danielle had left the ED, Dr Kenchaiah stated that while it is *"ideal to contact the referrer and update them, the reality on the ground could be very different, especially on a busy day with few resources"*.

74. I referred the care and treatment received by Danielle at the Ballarat Hospital to the Coroners Prevention Unit.[15] They reviewed the relevant evidence and advised that in their view the treatment Danielle received at the Ballarat Hospital was reasonable in the circumstances.

[15] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner.

75. I accept the evidence of Dr Kenchaiah, Dr Visser and the advice of the CPU in relation to the care and treatment received by Danielle at the Geelong Clinic, Windana and the Ballarat Hospital. I am satisfied that the care and treatment provided to Danielle was generally reasonable and appropriate.

FINDINGS AND CONCLUSION

76. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Danielle Julie Kaye Thomson, born 8 July 1981;

    b) the death occurred on 4 November 2022 at 35 Eastwood Street, Bakery Hill, Victoria, from neck compression and hanging; and

    c) the death occurred in the circumstances described above.

77. In the circumstances, I am satisfied that Danielle intended to take her life. It is clear that her decision was made in the context of her feelings of hopelessness in her struggle to manage her chronic pain while she also battled with mental illness and substance abuse.
78. Danielle was an intelligent, articulate and caring person who was deeply loved by her family. Her ongoing struggle with her mental and physical health was relentless and exhausting for her. Her parents' involvement with various health services as they supported their daughter through her difficult journey was clearly a frustrating and unsatisfying experience for them and understandably her death has left them devastated.

COMMENTS

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

79. Living with chronic pain, which is often associated with mental illness, is a significant risk factor for suicide. Its unrelenting and persistent nature has the capacity to wear down those who are afflicted and result in overwhelming feelings of hopelessness and distress.
80. The Commonwealth Department of Health and Aged Care has developed a National Strategic Action Plan for Pain Management which referred to this issue in the following terms:

    "Chronic pain and mental health problems, particularly depression, commonly occur together. Major depression in patients with chronic pain is associated with reduced functioning, poorer treatment response and increased health care costs. High

The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

rates of generalised anxiety disorder, post traumatic stress disorder and substance misuse are also reported in people with chronic pain. Moreover, suicide is reported to be two to three times higher in those suffering chronic pain compared to the general population, and it is associated with depression. This may be due to opioid related deaths, but there is a lack of research in this area'.[16]

81. In response to the Royal Commission into Victoria's Mental Health System, the Victorian Government established the Suicide Prevention and Response Office within the Department of Health. The office drives systemic and evidence-informed change in collaboration with people with lived experience of suicide.
82. It is in the public interest that there be an exploration of the relationship between chronic pain, mental illness, substance abuse and suicide to seek to identify strategies that may be available to address the clinical dilemma facing clinicians that people who experience chronic pain along with mental illness (and substance abuse) often do not respond effectively to treatment of their chronic pain.

RECOMMENDATIONS

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

83. That the Suicide Prevention and Response Office of the Department of Health examine the relationship between chronic pain, mental illness, substance abuse and suicide to seek to identify strategies that may be available to address the clinical dilemma facing clinicians that people who experience chronic pain along with mental illness (and substance abuse) often do not respond effectively to treatment of their chronic pain.
84. The Suicide Prevention and Response Office liaise with the Commonwealth Department of Health and Aged Care regarding the National Strategic Action Plan for Pain Management to identify areas of mutual interest concerning the relationship between chronic pain, mental illness, substance abuse and suicide.

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

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

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

[16] *National Strategic Action Plan for Pain Management*, 17 May 2021, p6.

John & Julie Thomson, Senior Next of Kin

The Geelong Clinic

Windana Drug and Alcohol Recovery

Grampians Health

Monash Health

Mental Health & Wellbeing Commission

Suicide Prevention and Response Office of the Department of Health

Constable Peter Sharp, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 07 October 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.