IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005124

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	CL[1]
Date of birth:	28 September 1969
Date of death:	13 September 2023
Cause of death:	1(a) Cervical spine distraction 1(b) Hanging
Place of death:	Olympic Park, Southern Road, Heidelberg West Victoria
Keywords:	In-patient admission – risk assessment – discharge planning

[1] This Finding has been de-identified by order of Coroner David Ryan which includes an order to replace the names of the deceased and his family with pseudonyms for the purposes of publication.

INTRODUCTION

1. On 13 September 2023, CL was 53 years old when he was located deceased at a park in Heidelberg West. He had been discharged earlier that day from the Northern Hospital and it was planned for him to reside in share accommodation in Pascoe Vale.

2. CL is survived by his ex-wife, DL, and their children, WL and KL, and his four siblings. He is warmly remembered by family as a smart and funny man with a gentle soul and generous spirit.

BACKGROUND

3. CL grew up with his family in Ballarat. He studied civil engineering at university.

4. In 2001, CL and DL were married. WL was born in 2010 and KL in 2012. In 2016, CL purchased a security door business which he managed with DL's assistance. DL recalled that CL had experienced mental health issues for as long as she had known him.

5. CL's medical history included depression and chronic suicidality. In August 2019, he was referred by his General Practitioner (**GP**) to a private psychiatrist. He had been prescribed medication including mirtazapine, fluoxetine, diazepam, lithium, duloxetine, pregabalin, ketamine, dexamfetamine and brexpoprazole. He also had a history of alcohol abuse and cannabis use.

6. In 2019, CL and DL separated and subsequently divorced in the context of issues in their relationship, family violence and the deterioration in CL's mental health.

7. On 8 January 2020, CL attempted to take his life by hanging at his workplace in Heidelberg. He was transported to the Austin Hospital pursuant to section 351 of the *Mental Health Act 2014* (**the MHA**) where he received treatment as a voluntary patient.

8. In 2022, CL's business collapsed which resulted in debt and a further deterioration in his mental health. He subsequently obtained employment as an estimator in another business.

9. In January 2023, CL moved back in with DL and the family in Preston. During this period, CL was referred to the Acute Community Intervention Service (**ACIS**) for outpatient treatment in relation to a deterioration in his mental health with suicidal ideation. Collateral information was obtained by clinicians from CL's family and his private psychiatrist. After a

period of engagement, he declined further treatment in February 2023 and he reported plans to proceed with a trial of ketamine therapy in consultation with his private psychiatrist.

10. On 12 August 2023 at around 10.40am, CL was driving his vehicle in Sailors Falls when he deliberately steered his vehicle off the road and collided with a tree. He had sent a message earlier that morning to DL advising that he had cleared his debts and expressed his love for his children. CL was transported to Ballarat Hospital where he was treated for his injuries. He also received a mental health assessment and was treated as a compulsory patient under the MHA pursuant to a Temporary Treatment Order made on 18 August 2023, which included the prescribing of antidepressants, antipsychotic medication and lithium. It was recorded that his engagement with staff was poor, and he presented a high risk of self-harm.

11. On 25 August 2023, CL was transferred to the Northern Hospital (which was in his residential catchment area) where he continued to receive compulsory treatment under the MHA. He was diagnosed with depression, social anxiety and Borderline Personality Disorder (**BPD**).

12. On 28 and 30 August 2023, Psychiatry Intern, Dr Emily Greenwood spoke with DL to obtain collateral information. DL reported that CL had moved back in to live with her after his business collapsed. She stated *that "At best of times he can be great, he can be fun. At his worst, he's depressed…cannot see anything around him that gives him joy"*.[2] She advised that she did not want CL to return to live with her.

13. It was recommended by clinicians at the Northen Hospital that CL have Electroconvulsive Therapy (**ECT**). On 29 August 2023, after having initially indicated agreement, CL advised his treating team that he had decided against ECT as he was *"concerned about side effect of memory impairment"*. He was advised that long term memory effects were rare, but he still declined to engage in the treatment. His team assessed that he had the capacity to refuse the treatment, and he continued to decline it throughout his admission.[3]

14. On 1 September 2023, DL advised a family support worker from Northern Health that she did not want to be contacted in relation to CL's treatment as she had received some abusive messages from him and was trying to protect herself and the children from the negative behaviour displayed by CL in the past months.

[2] Medical records, p292.
[3] Medical records, p225-6.

15. On 4 September 2023, Dr Greenwood spoke with CL's sister, MN to obtain collateral information. MN advocated for her brother, expressing frustration at the limited communication to family members and clearly conveyed her concern that her brother was a suicide risk.

16. On 5 September 2023, CL was transferred to the Intensive Care Area after reporting an active suicidal plan. Also on this day, Consultant Psychiatrist Dr Suresh Yadav telephoned CL's private psychiatrist, Dr Matthew Warden, to obtain collateral information. He advised that he had been treating CL's depression with multiple medications (including ketamine) without any major improvement. Dr Warden considered that his condition was *"biological in nature and treatment resistant"* and that *"ECT may be the best option"*.[4]

17. On 8 September 2023, CL was transferred back to the Low Dependency Unit after his mood reportedly improved.

18. On 11 September 2023, CL's Temporary Treatment Order was revoked by Dr Yadav due to his improved insight, mood and reduced suicidal ideations. It was recorded that CL was accepting of ongoing treatment as a voluntary patient.

19. Also on 11 September 2023, CL had a session with a psychologist to discuss safety planning. She assessed him to be an ongoing and elevated risk due to *"ongoing psychosocial factors and mental health challenges that are unlikely to resolve in the near future"*.[5] Safety planning was discussed, including Dialectical Behaviour Therapy (**DBT**). CL did not provide consent for details of his safety plan to be provided to MN although it was emphasised the importance of him sharing this information with her upon his discharge. She provided a handover to Dr Yadav.

THE CORONIAL INVESTIGATION

20. CL'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.

21. 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

[4] Medical records, p233.
[5] Medical records, p315.

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.

22. 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.

23. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of CL's death. The Coroner's 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 evidence directly from Northern Health (including medical records) and obtained an expert report from a psychiatrist. Correspondence was also received from DL and extensive submissions were also received from CL's sister, MN and brother, BL.

24. Mention hearings were conducted in Court on 8 December 2023 and 28 May 2024.

25. This finding draws on the totality of the coronial investigation into CL's death of 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.[6]

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

Circumstances in which the death occurred

26. On 13 September 2023 at around 12.15pm, CL was discharged from the Northern Hospital. He was referred to ACIS with follow-up from his GP and Dr Warden.[7] A safety plan had also been completed with a psychologist. CL reported to clinicians that he was nervous about his discharge and although his mood remained low, he denied suicidal thoughts and appeared to

[6] 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.

[7] It was also planned for CL to be referred to the Hospital Outreach Post-suicidal Engagement (**HOPE**) as a *"step-down"* from ACIS once his situational crisis settled.

be help-seeking and willing to engage with ACIS. However, it was noted that CL could be impulsive and labile.

27. Accommodation with family was not available or appropriate for CL after he was to be discharged and accordingly, the Social Work team at the Northern Hospital had assisted him with liaising with Centrelink and arranged accommodation at a rooming house in Pascoe Vale. The accommodation had been funded for three weeks. CL also reported to the Social Work team that he had some savings to cover food and groceries.

28. At around 10.10am that morning, MN contacted the Northern Hospital and spoke with a mental health nurse who advised her that CL was being discharged with a plan for referral to Prevention and Recovery Centre[8] (**PARC**) and HOPE.

29. At around 11.44am, Dr Greenwood telephoned MN and advised her that CL would be discharged that day. The records disclose that Dr Greenwood advised that CL had not provided consent for any further information to be provided but that he was happy for MN to contact him. MN was understandably frustrated and distressed by the barriers which limited the information she was able to receive from medical staff in relation to CL's discharge.

30. Dr Yadav noted that:
"due to personality vulnerabilities and stressful psycho-social factors, and recent high lethality attempt of suicide, he [CL] remains at high risk of attempting and completing suicide. Unfortunately, longer admission will not be helpful to improve his situation. Also, he does not fulfil the criteria of the Mental Health Act or involuntary ECT".[9]

31. Dr Yadav discussed CL's presentation with a number of his senior colleagues who agreed with his assessment and plan. Dr Vinay Lakra suggested that a *"step down"* admission to the PARC may be beneficial for CL. Dr Yadav made inquiries with PARC but was advised that an admission was not possible as CL did not have secure accommodation to where he could be subsequently discharged. Dr Yadav then sought to have the accommodation secured by the Northern Hospital made available to CL upon a potential discharge from PARC. However, he

[8] PARC aims to support people experiencing a significant mental health problem but who do not need or no longer require a hospital admission. In the continuum of care, they sit between acute psychiatric inpatient units and a client's usual place of residence. PARC aims to assist in averting acute inpatient admissions and facilitate earlier discharge from inpatient units.
[9] Medical records, p245.

was advised that the funding was only available for accommodation required immediately after discharge from the Northern Hospital and not from an intervening in-patient service.

32. Upon discharge at around 12.15pm, CL caught a taxi to the accommodation that had been arranged for him in Pascoe Vale. He then collected his vehicle from DL's house.

33. At the point of discharge, CL was referred by Northern Health to ACIS with a default classification of "Category D". This signified that the referral was semi-urgent with follow-up contact within 72 hours.

34. At around 2.35pm, CL telephoned MN while he was driving and told her that he had been discharged from hospital. She stated that he was "*distressed that no family were offering him accommodation, that he felt he had failed, and felt he had no support from the hospital"*.[10]

35. At 3.20pm, CL purchased a chain, Stanley knife and pliers from Bunnings in Preston.

36. At 6.03pm, CL sent a text message to MN stating, among other things, *"I'm swinging from a tree at the Heidelberg soccer field car park Southern Road end. Tell the kids I loved them and died of a heart attack"*. MN immediately contacted emergency services.

37. At around 6.05pm, a nurse at the Northern Hospital also contacted emergency services after being notified by a patient that they had received a text message from CL which suggested he may have been considering self-harm. The nurse also attempted to contact CL on his mobile telephone.

38. At around 6.09pm, two passersby observed CL hanging from a tree next to a ladder. They immediately contacted emergency services.

39. Victoria Police arrived at the scene at 6.17pm and located CL hanging from a chain that had been tied around his neck and affixed to a branch of a tree. While lifting CL to relieve the pressure on his neck, they used the ladder to remove the chain. CL was then lowered to the ground and police commenced cardiopulmonary resuscitation (**CPR**). Ambulance Victoria and Fire Rescue Victoria attended shortly afterwards. Despite the best efforts of all first responders, CL could not be revived, and he was pronounced deceased at 6.34pm. It is clear from the evidence that the attending Victoria Police members who were first on the scene

[10] Statement of MN dated 15 November 2023.

performed a commendable job in difficult circumstances and demonstrated compassion and commitment to their duty.

40. Victoria Police located handwritten notes in CL's vehicle in which he expressed his sorrow, frustration and despair and indicated an intention to take his life.

Identity of the deceased

41. On 19 September 2023, CL, born 28 September 1969, was visually identified by his ex-wife DL.

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

Medical cause of death

43. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine, conducted an examination on 15 September 2023 and provided a written report of her findings dated 27 September 2023.

44. Toxicological analysis of post-mortem samples identified the presence of diazepam (and its metabolite),[11] mirtazapine,[12] olanzapine[13] and paracetamol.

45. Dr Iles provided an opinion that the medical cause of death was 1(a) Cervical spine distraction; and 1(b) Hanging.

46. I accept Dr Iles's opinion.

FAMILY CONCERNS

47. Separate concerns have been submitted to the Court separately on behalf of DL, and MN and BL. They are extensive and detailed and reflect their distress and frustration at the care and treatment provided to CL by Northern Health and their response to his death. They have been of assistance to the Court and demonstrate their ongoing commitment to advocate for CL.

48. Some of the concerns relate to matters which, although clearly relevant to the care and treatment received by CL throughout his difficult journey, are not sufficiently connected to

[11] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[12] Mirtazapine is indicated for the treatment of depression.
[13] Olanzapine is an antipsychotic drug and is also indicated for mood stabilisation and as an anti-manic drug.

the cause and circumstances of his death to require investigation and resolution by this Court.[14] I have confined my investigation to the care and treatment received by CL after his admission to the Northern Hospital in late August 2023.

49. The concerns raise many questions about CL's care but not all of them will be required to be answered as part of the coronial process. My investigation requires that I obtain sufficient clarity from the evidence to enable me to make the findings necessary under section 67 of the Act together with any associated comments and recommendations. Those matters which remain of concern to the family and have not been addressed by the coronial process can be pursued by other means, including directly with Northern Health or through the Mental Health and Wellbeing Commissioner.

50. The relevant concerns raised separately by DL, MN and BL broadly relate to the following:
    a) Whether CL should have been provided ECT;
    b) The sufficiency of collateral information obtained from family and his private psychiatrist;
    c) The discharge process; and
    d) The inadequacy of Northern Health's response to CL's death.

REVIEW OF CARE

Northern Health review

51. As required by section 741 of the *Mental Health and Wellbeing Act 2022* (**the MHWB Act**), Northern Health notified the Office of the Chief Psychiatrist (**OCP**) of CL's death.[15] They have confirmed with the Court that they have received no follow-up correspondence from the OCP.

52. Northern Health have confirmed with the Court that they did not report CL's death to Safer Care Victoria (**SCV**) as a Sentinel Event as they did not consider that it met the necessary criteria.[16] Health services across Australia are mandated to report and review Sentinel Events to ensure public accountability, transparency and drive national improvements in patient

[14] Eg ACIS referral in January/February 2023.
[15] MHWA 125 Notice of death dated 20 September 2023. Notification is required in circumstances which include when a person dies within 24 hours of discharge from a mental health inpatient unit; The MHWB Act came into operation on 1 September 2022, replacing the MHA.
[16] A Sentinel Event is an unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious psychological injury to a patient as a result of system and process deficiencies at the health service entity; See *Health Services (Quality and Safety) Regulations 2020*; Reg 3A.

safety. A report requires the health service to convene a panel and conduct a review which meets certain minimum standards of quality and content which is reviewed by SCV. It should involve consultation with family and include recommendations.

53. A Sentinel Event will also fulfil the definition of a serious adverse patient safety event (**SAPSE**) under the *Health Services Act 1988* which imports a statutory duty of candour and the requirement to provide family with certain information and to conduct a review which attracts certain protections.

54. SCV has published a guide to assist health services in determining whether an event meets the criteria for notification as a Sentinel Event.[17] Health services are expected to take a proactive and consumer-focused approach when determining if an event meets the criteria for notification. In some areas, the guide is open to interpretation and it is not explicitly clear from its terms that CL's death was a Sentinel Event.[18] There is no evidence that Northern Health consulted with SCV to seek guidance as to whether CL's death ought to be reported as a Sentinel Event.

55. Northern Health conducted a review in relation to the circumstances leading to CL's death and produced a Community Mortality Audit Report. The report found that the care provided to CL could have been better in the following context:
"The diagnostic impression seemed to have changed from depression to one [of] a man with maladaptive/poor coping in crisis. The rationale for this was poorly documented and it is unclear how the BPD diagnosis was made as there is limited evidence".

56. The Community Mortality Audit Report was not thorough or detailed and lacked rigour. It also does not appear to meet the criteria provided in the SCV *Adverse Patient Safety Event Policy*. Adverse Patient Safety Events[19] which do not fulfil the requirements to be reported as Sentinel Events are still required to be the subject of detailed and rigorous review processes (eg. SAPSE reviews or In-depth Case Reviews).

Expert report

[17] Victorian sentinel event guide (Version 2), February 2024.
[18] See Category 11, subcategory 4, which refers to adverse events relating to self-harm that involve healthcare provision (or lack thereof), leading to serious harm or death.
[19] An Adverse Patient Safety Event (**APSE**) is an incident that results, or could have resulted, in harm to a patient or consumer (SAPSE and Sentinel Events are a subset of APSE).

57. The Court obtained an expert report from Consultant Psychiatrist Professor Richard Newton who reviewed the relevant evidence (including the concerns raised by CL's family) and provided an opinion in relation to the standard and adequacy of the mental health treatment provided to CL during his admission at the Northern Hospital.[20]

58. Professor Newton considered that the evidence demonstrated in general that CL received a good standard of care during his admission at the Northern Hospital. He stated that the documented mental health assessments disclosed *"a thorough approach to important clinical information gathering and patient care"*.

59. Professor Newton noted that CL was reviewed regularly and *"in considerable depth"* by Dr Yadav and Dr Greenwood and there was clear evidence that his *"predicament and risks were of great concern"* to them. Further, he stated:

> *"The clinical record demonstrates repeated and prolonged conversations with Mr CL where the team attempted to connect meaningfully with him and understand his experiences. Prior to discharge Mr CL did maintain a consistent position that he was feeling somewhat better in his mood despite having anxiety about the future and facing enormous social stressors. He did appear somewhat future focussed although he and the team acknowledged that he did not have many protective factors and that he would be at risk when discharged from hospital"*.

60. After considering CL's risk of suicide and the most appropriate setting to manage his ongoing treatment, Professor Newton agreed with the treating team's assessment that management in the community as opposed to hospital was appropriate. However, Professor Newton emphasised the significant limitations associated with any risk assessment process, noting that 5% of people identified as a high risk of suicide go on to take their life within two years. He stated that a *"high risk suicide rating per se should not be an absolute barrier to community management rather that in-patient care"*.

61. Professor Newton considered that the treating team had accurately and appropriately identified CL as being a high risk of suicide but that given the contribution of significant psychosocial factors to that risk, it was unlikely to be significantly reduced by a prolonged hospital stay. Professor Newton noted that this was a considered decision by Dr Yadav who

[20] Report of Professor Richard Newton dated 5 July 2024.

recognised the complexity of CL's case and consulted with his colleagues and the Clinical Director which he considered *"represents a very good level of practice and standard of care"*.

62. Professor Newton noted that the treating team shared Dr Warden's view that ECT would be an appropriate treatment for CL given his treatment resistant depression. However, he considered that the record of CL's communications with his treating team on the issue indicated that he had capacity to give informed consent to receiving ECT, and he had explicitly not provided that consent. In this circumstances, Professor Newton concluded that it would have been inappropriate to involuntarily seek to proceed with ECT through the relevant process under the *Mental Health and Wellbeing Act 2022*.[21]

63. Professor Newton stated that the process for CL's discharge from the Northern Hospital was *"somewhat rushed and not adequate for Mr CL's needs, circumstances and risk"*. In particular, he noted that PARC was not made available to CL *"despite it being a much more appropriate step down option from the ward for him"* and despite agreement by the treating team that it was a suitable option in the circumstances.

64. Further, Professor Newton considered that the failure to refer CL to ACIS earlier in the discharge planning process represented a significant breakdown in clinical handover. He stated as follows:

"The clinical team's decision to discharge him to community care was considered and not unreasonable. However, it would be expected as a reasonable standard of care for someone who was regarded as such high risk to have a very carefully organised discharge plan as outlined in the Chief Psychiatrists Discharge Planning and Transfer of Care guidelines. This might have included Mr CL attending the rooming house prior to discharge to confirm that it was acceptable to him, the ACIS team meeting Mr CL on the ward prior to discharge and subsequently ensuring there was a firm appointment made for follow up within 24 hours of discharge, appointments being made with the GP and or a firm arrangement being made for ongoing care with a private psychiatrist and ensuring that Mr CL had an income stream to support him in the community and involvement of relevant carers. These things did not occur".

65. Professor Newton noted that the medical records disclosed regular attempts by the treating team to communicate with CL's family. He considered that the discharge process would have likely been enhanced had CL's family had an opportunity to contribute their views and

[21] The successor to the *Mental Health Act 2014*, which came into operation on 1 September 2023.

advocacy. However, he also noted the difficult and challenging relationship between CL and his family and that ultimately, despite the issue being revisited on a number of occasions by the treating team, CL provided consent for only limited information to be provided to them, particularly in relation to the discharge process. This understandably has been a significant source of distress and frustration for his family.

66. Professor Newton considered that the review conducted by Northern Health did not seem to be a sufficient or appropriate response to the circumstances of his death. He commented that a more formal and higher level review (such as is required in response to a sentinel event) would have enabled Northern Health to potentially identify improvement opportunities and may have given CL's family some more comfort.

67. I accept the expert evidence of Professor Newton.

FINDINGS AND CONCLUSION

68. CL struggled with depression for much of his life and unfortunately it proved to be treatment resistant. He represented a chronic risk of suicide in the months before his death which did not abate despite the care and support of his family and the provision of medical treatment from various services, including from his private psychiatrist and during inpatient admissions. Having considered all of the circumstances, I am satisfied that CL intentionally took his own life.

69. CL's family sought to support him through his difficult journey and understandably his death has left them devastated. Further, their involvement with health services was clearly a frustrating and unsatisfying experience for them. However, generally, I am satisfied that the care and treatment provided by the mental health clinicians at the Northern Hospital during CL's admission in August and September 2023 was reasonable and appropriate. They were acutely aware that he was a complex and challenging patient which was reflected in the way that they managed CL's treatment and assessed his risk.

70. Notwithstanding that CL was assessed as a chronic risk of self-harm, I am satisfied that the decision of the treating team to discharge him from hospital was reasonable, given the assessment that he would not benefit from further treatment in an inpatient setting, and this opinion was reached after consultation with senior clinicians. Further, I am satisfied that it was not appropriate to seek to provide ECT without CL's consent noting that he declined the treatment while being reasonably assessed as having decision-making capacity.

71. I am satisfied that the treating team sought to obtain relevant information from CL's family but were constrained in the extent of their communications by CL's specific wishes in circumstances where he was reasonably assessed to have decision making capacity.

72. However, as identified by the clinicians, I consider that CL was likely to have benefited upon discharge from the *"step down"* care and treatment provided by PARC and that there needed to be greater flexibility in the eligibility criteria to enable CL to access the service despite his challenges in obtaining ongoing and stable accommodation.

73. Further, I also consider that more care needed to be taken in CL's discharge planning with a referral to ACIS within sufficient time to ensure meaningful engagement with the service before he left the hospital and ensuring an appointment with his GP. Also, there should have been earlier engagement with the accommodation manager where CL was staying so that he could assess and familiarise himself with the environment to reduce his anxiety.

74. Finally, I consider that the prevention opportunities that emerge from CL's death would have been more appropriately revealed and explored by Northern Health had they conducted a more thorough and detailed review process consistent with SCV's Sentinel Event review process or the *Adverse Patient Safety Event Policy*. Early guidance from SCV should have been obtained to inform structure and content of the review process. I do not consider that the Community Mortality Audit Report was an adequate response to CL's death. A more rigorous review process by Northern Health and a more forthcoming and detailed response to a request for evidence from the Court would have provided greater comfort to the family and promoted confidence in the process.

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

    a) the identity of the deceased was CL, born 28 September 1969;

    b) the death occurred on 13 September 2023 at Olympic Park, Southern Road, Heidelberg West, Victoria, from cervical spine distraction and hanging; and

    c) the death occurred in the circumstances described above.

COMMENTS

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

76. The reasons contributing to a person making the decision to take their own life are complex and multi-factorial. The assessment of risk by mental health clinicians is a process that is

constrained by limitations. The discharge from hospital of a person after a reasonable risk assessment performed by a competent clinician can seem obviously inappropriate and inadequate where that person subsequently takes their life soon afterwards. However, that tragic outcome does not automatically lead to the conclusion that the risk assessment performed by the clinician was inadequate. In many cases it is a function of the limitations of the process itself, the complex nature of suicide and the difficulty in predicting its likelihood in any particular case.

77. This case highlights the potential limitations on the risk assessment process as it applies to patients who struggle to engage with clinical staff. Risk assessment is a shared responsibility that is informed by multiple sources, including the patient, clinical staff and family. The process is enhanced when it is informed by the views of family who have often travelled along the challenging path with their loved one and supported them at various stages along the way. This was recognised by the Royal Commission into Victoria's Mental Health System. Unfortunately, there will be occasions when patients with capacity do not provide sufficient consent to enable medical staff to obtain the best information to inform their assessments or to communicate fully with family in relation to treatment options and discharge planning.

78. The case also highlights the importance of a planned and measured discharge process after a lengthy inpatient admission to provide continuity of care in the community and ensure that patients are able to access suitable accommodation to enable appropriate support.

RECOMMENDATIONS

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

1. That Northern Health review its accommodation support services provided to eligible patients after discharge from hospital, to ensure that they are available to be allocated towards accommodation that may be required subsequent to an intervening *"step down"* admission to the Prevention and Recovery Centre (**PARC**).
2. Northern Health review their discharge process for mental health in-patients, and associated policies and procedures, to ensure that they are consistent with the Chief Psychiatrist's guideline: *Transfer of care and shared care* and the Department of Health's guideline: *Transfer of care from acute inpatient services*.
3. Safer Care Victoria review Category 11 (Subcategory 4) of the Victoria sentinel event guide (Version 2) to consider explicit inclusion of suicide deaths that occur within 24 hours of discharge from an inpatient facility.

4. Northern Health review their policies and procedures in relation to the reporting of Sentinel Events to ensure they are consistent with Safer Care Victoria's *Victoria sentinel event guide (Version 2)*.
5. Northern Health review their policies and procedures in relation to their reporting obligations in response to patients who have died by suicide within 24 hours of discharge to ensure they are consistent with Safer Care Victoria's *Adverse Patient Safety Event Policy*.

I convey my sincere sympathy to CL'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:

MN, Senior Next of Kin

DL

CL's sister-in-law

Northern Health

Office of the Chief Psychiatrist

Safer Care Victoria

Constable Trent Dal Molin, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 16 December 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.