IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002022

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	JVM
Date of birth:	2002
Date of death:	13 April 2022
Cause of death:	1(a) multiple injuries sustained in a train incident
Place of death:	Railway Tracks Between Hartwell and Willison Railway Stations
Keywords:	Suicide, mental health services, carer support

INTRODUCTION

1. On 13 April 2022, JVM was 19 years old when she died in circumstances suggesting suicide. At the time of her death, JVM was residing with her grandmother in Port Melbourne, Victoria.

THE CORONIAL INVESTIGATION

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

3. 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.

4. 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.

5. Victoria Police assigned Constable Kobi Kruger to be the Coronial Investigator for the investigation of JVM'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.

6. This finding draws on the totality of the coronial investigation into the death of JVM including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] 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.

BACKGROUND

7. JVM was described as an intelligent and motivated student who excelled in her studies and had a wide circle of friends. She attended three different schools, where she engaged in a range of activities including netball, basketball, athletics and running. She also enjoyed singing and participated in school musicals.

8. When JVM was in Year 10, however, her parents noticed that she began to have trouble making decisions and began to struggle with her emotions. Over the following years her mental health declined, and she began having difficulty sleeping and experiencing panic attacks.

9. To assist her to manage her mental health concerns, JVM began attending upon a General Practitioner (**GP**) for management of depression and anxiety. In September 2019, JVM also began seeing a psychiatrist, who noted that her presentation met the threshold for a major depressive disorder. JVM commenced taking low-dose fluoxetine[2].

10. In the following month, JVM began expressing suicidal ideation. On 28 October 2019, she commenced a voluntary psychiatric inpatient admission at the Albert Road Clinic for treatment of a panic disorder and major depressive disorder. Her fluoxetine was weaned and ceased at this time.

11. During this admission, JVM disclosed acute suicidal ideation with plan, refused oral medication and made threats to abscond from the unit. As a result of this, on 5 December 2019, she was placed on an Inpatient Assessment Order, discharged from the Albert Road Clinic and referred to the Alfred Hospital Emergency Department (**ED**). After completing a psychiatric assessment of JVM, the Alfred Hospital referred her on to the Austin Hospital where she was admitted to the Marion Drummond Adolescent Psychiatry unit from 5 to 18 December 2019.

[2] Fluoxetine is a selective serotonin reuptake inhibitor (**SSRI**) class of antidepressant used to treat depression, obsessive-compulsive disorder, and premenstrual dysphoric disorder. It is the recommended first line antidepressant for adolescents and young adults.

12. During this admission, JVM was commenced on sertraline,[3] quetiapine[4] and diazepam[5]. Following her discharge from the inpatient unit, JVM received support in the community from the Child and Adolescent Mental Health Service (**CAMHS**) until March 2020, when she elected to be discharged from their care.

13. Whilst under the care of CAMHS, JVM commenced taking melatonin to assist with her sleep and reported that she had self-ceased taking quetiapine as she felt it made her groggy.

14. Upon discharge from CAMHS, JVM's recommended medication regime was sertraline 150mg daily, and quetiapine 25-50mg as needed at night to assist with sleeping. Treating clinicians recommended that she minimise the use of quetiapine and the prescription for this medication was not renewed.

15. In February 2020, JVM began engaging with Headspace Hawthorn.

16. During this time, JVM also explored options to return to school to complete Year 12. She ultimately decided not to finish her schooling and formally withdrew in March 2020.

17. On 8 March 2020, JVM called '000' and expressed suicidal ideation. Victoria Police conveyed her to the St Vincent's Hospital (**SVHM**) ED for a mental health assessment, utilising their powers under section 351 of the *Mental Health Act 2014* (Vic) (**MHA**). A mental health assessment was completed for JVM, and it was noted that she had no current suicidal intent, or acute risk to self or others. Her diagnosis was listed as an emotional disorder. JVM was discharged home with a referral to CAMHS.

18. Between 28 April 2020 and 30 April 2020, JVM was again admitted to the adolescent acute inpatient service at the Austin Hospital after expressing suicidal ideation and worsening symptoms of anxiety and depression. The principal diagnosis during this admission was dysthymia[6].

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[3] Sertraline is an SSRI antidepressant used for the treatment of major depression, obsessive-compulsive disorder, panic disorder, social phobia, and premenstrual dysphoric syndrome.

[4] Quetiapine is an atypical antipsychotic used to treat schizophrenia and bipolar affective disorder, treatment resistant major depression and generalized anxiety disorder. It causes sedation and is often chosen for that property and taken at night.

[5] Diazepam is a long-acting benzodiazepine with anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects. It is indicated in the short-term management of anxiety, and agitation, acute alcohol withdrawal, muscle spasms, sedation, and status epilepticus. In addition, it is accepted for use in acute behavioural disturbance, night terrors, sleepwalking, panic disorder, sleep disorders, seizures and acute barbiturate or benzodiazepine withdrawal.

[6] Now known as persistent depressive disorder - a depressive disorder that persists for two years or more. The criteria for major depressive disorder may also be present for none, a part of all of the two year period. When criteria for both persistent depressive disorder and major depressive disorder are met, this is often referred to as double depression.

19. JVM began attending upon a new psychiatrist on 14 July 2020. She continued to see this psychiatrist until 22 February 2022, during which time she attended 57 sessions, generally on a weekly or fortnightly basis. The psychiatrist assessed JVM as having a Major Depressive Disorder with fluctuations in anxious distress, psychotic symptoms, and borderline traits when distressed, including feelings of emptiness, intense anger, and transient paranoid ideation. The psychiatrist stated that he did not diagnose JVM with psychosis or a psychotic illness during the time she was in his care.

20. The psychiatrist stated that during his treatment of JVM her medications included desvenlafaxine[7], lamotrigine[8], lurasidone[9], oxazepam[10], diazepam[11], propranolol[12], and ziprasidone[13].

21. On 20 July 2020, JVM called '000' expressing suicidal ideation at a bridge close to her home and was again conveyed by Victoria Police to the SVHM ED for a mental health assessment. The assessing clinician noted an impression that JVM may have borderline personality disorder (**BPD**)[14] with depressive features, and JVM's diagnosis was listed as depression. JVM requested to be discharged into the care of her parents, with a plan to engage with a private psychiatrist for ongoing management.

22. On 14 November 2020, JVM again called emergency services from the bridge close to her home and expressed suicidal ideation. She was conveyed by Victoria Police to the SVHM ED for a mental health assessment. Following this presentation, JVM was discharged with a

[7] Desvenlafaxine is a serotonin and norepinephrine reuptake inhibitor (**SNRI**) antidepressant used for the treatment of major depression.
[8] Lamotrigine is an anticonvulsant indicated for the treatment of partial (focal) and generalised seizures and accepted for treatment of bipolar disorder.
[9] Lurasidone is an antipsychotic medication used in the treatment of schizophrenia and other psychotic disorders. It is also used to treat low mood in people with bipolar affective disorder.
[10] Oxazepam is a medium acting benzodiazepine. It is indicated in the treatment of anxiety, panic disorder, sleep disorders, seizures acute behavioural disturbance and acute alcohol, barbiturate or benzodiazepine withdrawal.
[11] Diazepam is a long-acting benzodiazepine with anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects. It is indicated in the short-term management of anxiety, and agitation, acute alcohol withdrawal, muscle spasms, sedation, and status epilepticus. In addition, it is accepted for use in acute behavioural disturbance, night terrors, sleepwalking, panic disorder, sleep disorders, seizures and acute barbiturate or benzodiazepine withdrawal.
[12] Propranolol is a beta blocker indicated in the treatment of hypertension, angina, tachyarrhythmia, control of symptoms in anxiety/hyperthyroidism, prevention of migraine and essential tremor.
[13] Ziprasidone is an antipsychotic drug that is indicated in the treatment of schizophrenia, related psychosis, and acute mania.
[14] Borderline personality disorder is characterised by a pervasive pattern of instability in interpersonal relationships, efforts to avoid real or imagined abandonment, unstable self-image, impulsive behaviours, recurrent suicidal behaviours or threats, affect instability, chronic feelings of emptiness, inappropriate or intense anger, transient stress related paranoid ideation and severe dissociative symptoms.

referral to the Hospital Outreach Post-Suicidal Engagement (**HOPE**) program, who she remained under the care of until 18 February 2021.

23. Whilst under the care of the HOPE program, JVM was diagnosed by a consultant psychiatrist as experiencing an anxiety disorder and features of BPD. The psychiatrist recommended that JVM receive treatment for anxiety and undertake dialectical behaviour therapy (**DBT**) for emotional regulation.

24. On 7 December 2020, JVM was again conveyed to SVHM ED by police after expressing suicidal ideation at the bridge close to her home. Medical records from this admission indicate that JVM was noted to be experiencing ongoing anxiety and suicidal thoughts, with no plan or intent. It was noted that JVM was supported by the HOPE program and her supportive parents were a protective factor. JVM reported that she felt safe to go home and she was discharged home from the ED with a referral for the HOPE program to follow her up the following morning.

25. In the first half of 2021, JVM was compliant with her prescribed medications and her mood and behaviour appeared to stabilise.

26. On 22 June 2021, JVM's psychiatrist commenced her on ziprasidone[15] (10mg) after she expressed distress over family dynamics and paranoid ideation regarding her parents' expectations, as well as fear of people on the streets and in public transport. The psychiatrist stated the ziprasidone has *"been noted in medical literature as beneficial for anxious depression and major depressive disorder and its rather lower risk of weight gain. Alternatives such as Asenapine or Brexpiprazole were also considered"*.

27. On 31 August 2021, the psychiatrist increased JVM's dosage of ziprasidone to 20mg. He stated that *"this increase was part of a plan to establish a tolerable dose"* and noted that if JVM was truly suffering from a psychotic illness, *"it is unlikely a low dose of 10 or 20mg would have resolved her issues"*.

28. JVM's psychiatrist stated that JVM expressed doubt that the ziprasidone was effective but acknowledged improvements in functioning and reduced fear. He noted that, despite encouragement, JVM's compliance with the medication remained inconsistent and the dosage was not further increased.

[15] Ziprasidone is an antipsychotic drug that is indicated in the treatment of schizophrenia, related psychosis, and acute mania.

29. In June 2021, JVM commenced employment at a local McDonald's. She reportedly enjoyed this employment.

30. JVM's mother, Mrs RNY, stated that JVM's mental health began to decline from July to December 2021. In December 2021, JVM ceased her employment at McDonald's.

31. Statements submitted by JVM's friends indicate that they observed a decline in the state of her mental health over the year preceding her death.

32. JVM re-engaged with Headspace Hawthorn from 8 December 2021. During this engagement, JVM alleged that she was experiencing family violence at home and was provided with the phone number for SafeSteps. After contacting SafeSteps, JVM left the family home and moved into a youth refuge.

33. JVM was discharged from Headspace on 21 December 2021, with a plan for her to receive follow up and ongoing treatment from her private psychiatrist.

34. JVM's family stated that her allegations about experiencing abuse in the home were untrue and, they believe, delusional. They stated that her mental health declined significantly during the time she lived in the refuge, where she did not have access to the support of her family.

35. In late January 2022, JVM met with her family and discussed accommodation options with them. She agreed to stay with her grandmother in Port Melbourne and moved in with her shortly afterwards. Around this time, JVM reportedly also began self-weaning from her medication.

36. In February 2022, JVM moved into share house accommodation with two friends. JVM's family stated that she experienced a noticeable decline in the state of her mental health following this move.

37. On 4 February 2022, JVM attended a review with her psychiatrist. During this review, JVM indicated that she wanted to move to a different treating psychiatrist and reduce her medication whilst under supervision. Because of her risk of relapse, the psychiatrist requested her to continue to attend weekly follow-ups with him until she could access a new psychiatrist. JVM planned to contact a DBT therapist, to continue to see a drama therapist, and to reduce her desvenlafaxine and lamotrigine whilst continuing to take her prescribed propranolol and ziprasidone.

38. On 14 February 2022, JVM consulted with a new GP. During this consultation, she denied any suicidal thinking and reported that she was seeing her regular psychiatrist. She indicated that she wanted to wean off her medications and be assessed for a possible eating disorder. The GP requested consent to access her previous medical records, and asked JVM to make another appointment to arrange a referral to a psychologist and to complete a GP Eating Disorders Plan if required.

39. On 22 February 2022, JVM advised her psychiatrist that she was seeing a new GP, and a psychologist for anxiety and treatment of complex post-traumatic stress disorder (**PTSD**). JVM advised the psychiatrist that she preferred weekly consultations with her GP and monthly consultations with her psychiatrist. After this consultation, the psychiatrist provided an update to the GP, along with alternative referral options which included Spectrum,[16] and the name of an alternative psychiatrist who could be suitable for JVM.

40. On 24 February 2022, JVM advised her GP that she would not see her psychiatrist again, that she had a medication weaning plan and that she was organising to see a psychologist.

41. JVM attended upon a psychologist on 22 and 25 February 2022 via telephone. The psychologist stated that JVM denied having any suicidal plans or intent during these consultations. JVM reported plans for the future, and a desire to access further treatment. The psychologist offered Cognitive Behavioural Therapy (**CBT**), however JVM indicated she did not wish to pursue this treatment option, so the psychologist offered referrals to a range of other psychologists and services.

42. On 1 March 2022, JVM advised her GP that she wanted to see a different psychologist. She denied suicidal thinking and was given pathology requests to complete prior to returning for a review. However, JVM did not attend upon this GP clinic again.

43. On 30 March 2022, JVM visited her partner in Doncaster. During this visit she came into contact with a person who tested positive for COVID-19. As a result of this, JVM remained in isolation with her partner and his family at their home for several days.

44. During this time, JVM experienced a decline in her mental health and sent text messages to her family expressing suicidal thinking.

[16] A mental health service specialising in Personality Disorder and Complex Trauma.

45. On 31 March 2022, Mrs RNY and her husband, Mr RNY saw JVM's GP and expressed their concerns about their daughter's declining mental health.

46. On Thursday 7 April 2022, Mr RNY contacted JVM's GP about text messages that JVM had sent him, which appeared to express suicidal ideation. The GP advised Mr RNY to contact the local mental health service.

47. At approximately 4.10pm, Mr RNY contacted the St Vincent's Mental Health Service (**SVMHS**) Psychiatric Triage phone line. He expressed concern that JVM had been sending increasingly distressed text messages expressing suicidal ideation.

48. Mr RNY also disclosed that JVM was currently isolating at a residence in Doncaster East, due to COVID-19 exposure, and was planning to stay with her grandmother in Port Melbourne after her isolation period ended. Mr RNY was advised to contact the Alfred Hospital Mental Health Service and was provided with their psychiatric triage number, as Port Melbourne fell within the catchment area of that service. Mr RNY was also advised to contact '000' if there was any imminent risk of JVM harming herself.

49. In a statement summarising JVM's engagement with SVMHS, the Clinical Director of Psychiatric Triage, Emergency Department Mental Health and the Crisis Assessment and Treatment Service, provided an overview of this call. They stated that Mr RNY indicated that JVM was suffering from BPD and Attention-Deficit Hyperactivity Disorder (**ADHD**) and provided a list of her medications during this call. Mr RNY denies that he provided this information during the call.

50. On Friday 8 April 2022, Mr RNY advised JVM's GP that JVM was calmer and had fleeting thoughts of self-harm but no acute intent. She was not replying to her father's texts and was indicating that she did not want any professional help. The GP advised Mr RNY to access professional mental health assistance for JVM. The GP also tried unsuccessfully to contact JVM directly.

51. Later that day, JVM returned to the family home. She appeared to be in a highly distressed state and was expressing suicidal ideation.

52. At approximately 9.55pm, Mr RNY contacted the SVMHS Psychiatric Triage phone line. He reported that JVM had returned to the family home in East Kew, that she had informed her family that she had a suicide plan which she intended to carry out, but she would not disclose that plan to her family.

53. Mr RNY stated that he provided the clinician with a full list of JVM's current medication at this time, including ziprasidone. However, SVHM notes of this phone call referenced only desvenlafaxine and lamotrigine. Mr RNY also reported that JVM had self-ceased most of her medications. After discussing options for support, Mr RNY agreed to bring JVM to the SVHM ED for a face-to-face assessment.

54. At approximately 10.21pm, JVM presented to the SVHM ED with her father. She was medically assessed by an ED physician and underwent a mental health review performed by a psychiatric nurse.

55. An ED Physician assessed JVM and noted that she was guarded and unwilling to reveal her plan. The ED physician noted that JVM reported she had previous diagnoses of bipolar affective disorder[17], depression, anxiety and BPD. Her current psychiatric medications were listed in the medical notes as desvenlafaxine (200mg), lamotrigine (200mg) and propranolol (20mg). The ED physician medically cleared JVM and transferred her to the Mental Health/Alcohol and Other Drugs Hub (**the HUB**) with instructions to call a Code Grey if she left the area before her mental health assessment.

56. An ED Mental Health Clinician reviewed JVM and described her as withdrawn but engaged. JVM reported that she had experienced ongoing emotional abuse from Mrs RNY, that she did not feel safe anywhere, that she was unemployed, a recluse, and that she did not have specific triggers for the suicidal thinking she experienced. JVM was described as exhausted, somewhat guarded, hopeless and helpless, with low self-esteem, low mood, and experiencing familial conflict. She was noted to be at *"chronic elevated risks of misadventure or death secondary to maladaptive coping mechanisms, emotional dysregulation and low tolerance to stress"*[18].

57. It was noted JVM had an undisclosed plan and *"questionable"*[19] intent, however it is unclear how this was established. JVM stated that her previous involvement with the HOPE program had been unhelpful and that she had an appointment with a Somatic Experiencing Therapist on Monday 11 April 2022.

58. The ED Mental Health Clinician discussed three options with JVM, including a voluntary admission to the acute inpatient unit, a private psychiatry admission elsewhere, or for her to remain in the HUB overnight and be discharged home in the morning with a crisis assessment

[17] Bipolar affective disorder is a mental illness characterised by episodes of mania and/or depression that last for weeks or months at a time.
[18] Coronial brief, page 16.
[19] Coronial brief, page 16.

and treatment team (**CATT**)[20] follow-up. It was noted that JVM did not consider a public or private admission helpful, and she agreed to stay overnight in the HUB with a plan to receive community follow up from the CATT following discharge.

59. The following morning, on Saturday 9 April 2022, JVM was reportedly settled, cooperative, alert, and agreeable to a referral to the CATT. Mr RNY contacted the ED and spoke with a Senior Mental Health Clinician, who stated that Mr RNY supported the plan for JVM to be discharged and agreed to attend the hospital to pick her up at 11.00am. I note that this conflicts with the account provided by JVM's parents, who state that they requested that JVM not be discharged.

60. At approximately 11.00am, JVM's parents and grandmother attended the St Vincent's ED. Whilst in the waiting room, Mr RNY advised she Senior Mental Health Clinician that JVM had sent more text messages whilst she was in the ED indicating that she wanted to die. JVM's family reported that they were very concerned about JVM's safety.

61. JVM was returned to the HUB and referred to a Psychiatric Registrar for review. At approximately 1.00pm, a Psychiatric Registrar reviewed JVM, who was noted to be tearful and unable to control her emotions. JVM reported weight loss, disturbed sleep, and that she was feeling depressed with intense feelings to die but no immediate intention or plan. She acknowledged she had sent the text messages to Mr RNY about dying. She reported that diazepam calmed her, but other medications were unhelpful. She also stated that her boyfriend had recently taken a break from her.

62. JVM was self-recriminating, critical, and expressed envy of the family support her now ex-boyfriend received from his family, as she felt she had no one. The Psychiatric Registrar noted JVM to have a depressed mood, that she was devaluing and splitting her family, and was unable to cope with future tasks and responsibilities. She denied suicidal intent or plans.[21]

63. The Psychiatric Registrar stated that she interviewed JVM's family[22] and noted they were exhausted and felt hopeless. Their concerns about JVM's suicidal thinking had been supported

[20] Also known as the 'Crisis Assessment and Treatment Service' (**CATS**).
[21] Emotional dysregulation is a complex collection of processes that may include a lack of awareness, understanding, and acceptance of emotions; a lack of adaptive strategies for regulating the intensity and duration of emotions; an unwillingness to experience emotional distress whilst pursuing desired goals; and an inability to engage in goal-directed behaviours when experiencing distress. Gratz, K. L., & Roemer, L. 2004. Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioural Assessment,* 26(1), 41–54.
[22] Coronial brief page 18.

by concerns of her ex-boyfriend's mother, who had contacted them. JVM's family confirmed what history was known by SVMHS, and that she had been seeing a Somatic Experiencing Therapist. This differs from the account of this interaction which was provided by JVM's parents. They stated that they showed the Psychiatric Registrar the text messages from JVM, but no further information was gathered by the Psychiatric Registrar from them.

64. The Psychiatric Registrar's assessment was that JVM was presenting with a psychological crisis on a background of BPD. She had a vulnerable mental state and suicidal ideation and was a moderate risk to herself but was agreeable to safety planning.

65. Following this review, JVM initially agreed to a voluntary psychiatric inpatient admission. However, after being advised that she would not be able to leave the ward until the following Tuesday due to a current suspected COVID-19 case within the Acute Inpatient Service, JVM withdrew her agreement to an admission.

66. JVM agreed to stay with her grandmother and father at her grandmother's residence in Port Melbourne and to contact the SVMHS Psychiatric Triage or reattend the ED if needed. The Psychiatric Registrar requested a referral to the SVMHS CATT, with the intent that the CATT would contact JVM the following day to assess her mental state and risk, as well as her adherence to medications and general wellbeing.

67. JVM's family held significant concerns about her safety at this time. Such was this concern that, following JVM's discharge from the hospital and return to her grandmother's house, Mr RNY slept on the floor in JVM's room.

68. At 1.24pm on Sunday 10 April 2022, a CATT Clinician unsuccessfully phoned JVM and was unable to leave a voicemail. JVM's grandmother was also called but there was no answer, so a voicemail was left asking for a return call from JVM or her grandmother.

69. At 2.20pm, the CATT Clinician called Mr RNY who reported that he and JVM were still in Port Melbourne and would remain there for a few more days. According to Mr RNY, JVM's acuity appeared to have decreased; however, JVM's grandmother contradicted this view. Mr RNY reported further that they were researching options for support groups, including private programs.

70. According to JVM, she was not changed from her presentation in the ED. She continued to experience acute thoughts of suicide with a plan which she would not disclose, poor sleep, feelings of dread and anxiety, and exhaustion. JVM said she would be safe until a medical

review the following day, and that she would tell someone if she was unsafe. Options were discussed with JVM, including a medical review by SVMHS at her parent's home in East Kew or the Hawthorn Community Mental Health clinic the following day, or a referral to Alfred Health CATT for follow-up while she remained in Port Melbourne. JVM agreed to a review at Hawthorn, and this was explained to Mr RNY, who reportedly agreed.

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

Circumstances in which the death occurred

71. At 2.00pm on Monday 11 April 2022, JVM was reviewed by a Psychiatric Registrar, Psychiatric Nurse, and a student. JVM was initially reviewed on her own, with her parents invited to participate towards the end of the session.

72. JVM was described by the Psychiatric Registrar as a reluctant participant in the interview, but her prior history and recent living arrangements were discussed, including her preference to stay with her ex-boyfriend's mother. It was noted that she did not want to return to East Kew to live with her family.

73. The Psychiatric Registrar stated that JVM's self-ceasing of the mood stabiliser and reduction of the antidepressant was discussed, and JVM reported that she did not find medications helpful other than diazepam. It was noted that *"JVM does not acknowledge that she has been feeling worse as she lowers her dosages, but reluctantly agrees to an increase in her desvenlafaxine"*. JVM's desvenlafaxine dosage was accordingly increased to 100mg.

74. JVM indicated that she was sick of mental health clinicians, and they had not been helpful. Her suicidal thinking was explored, which revealed daily passive suicidal thinking, with more specific thoughts when she was under stress. Although JVM refused to explore the more recent suicidal thoughts in detail, she thought they were different, and with elements of planning.

75. JVM was teary, and had lost her sense of identity, values and purpose. She stated that she did not believe her psychiatric diagnosis of BPD was accurate. She attributed her symptoms to early life trauma which she did not discuss, and believed she had PTSD, which was a focus of her therapy with her Somatic Experiencing Therapist. She gave her consent for her psychiatrist and her Somatic Experiencing Therapist to be contacted by SVMHS. She explained that the Somatic Experiencing Therapist was going overseas and agreed to accept help with recommendations for a new private psychiatrist. It was agreed that Mr RNY would continue to stay with her for the present.

76. JVM was assessed as likely experiencing depression, despite her not fully engaging in the screening process, and the Psychiatric Registrar considered her reduction/cessation of her prescribed medications as contributing.

77. JVM's mental state examination included acute on chronic suicidal ideation, with partial judgement and insight. It was noted that *"Rapport was tenuous. The reliability of the information provided was poor and she appeared guarded"*[23].

78. Mr and Mrs RNY were invited to join towards the end of the hour-long session, after a plan of care had been developed. It appears that they were invited into the session with the focus of informing them of the outcome of the session and the agreed plan. This included exploring long term accommodation options, with a plan for the CATT to contact JVM on 12 April 2022 to establish her ongoing address and therefore ongoing care planning, and for the CATT to continue working on rapport building with JVM and to refine the basic safety plan.

79. Notes from the review indicate that:

> *JVM was asked for explicit permission to bring her parents into the interview, and the exact topics to be discussed were delineated:*
>
> i. *The assessment of her mood as depressed and the recommendations about increasing her medication.*
>
> ii. *That [the CATT] would help to link her back in with private supports, as per her preference, by speaking to her private psychiatrist … and her Somatic Experiencing therapist.*
>
> *JVM's parents were brought into the interview room and informed of the assessment results and plan. The exact immediate medication change, increasing desvenlafaxine to 100mg the following morning was explained*[24].

80. In addition, it was explained to Mr and Mrs RNY that their involvement was based on JVM's consent to discuss specific elements of her care as she was an adult and not living in the family home. It was noted there was tension between Mrs RNY and JVM about her Somatic Experiencing Therapist, following which JVM then became withdrawn.

[23] Coronial brief page 24.
[24] Coronial brief page 23.

81. The Psychiatric Registrar stated that Mr RNY expressed concern about not having a clear safety plan given the earlier text messages. The Psychiatric Registrar explained that the text messages containing suicidal thoughts were *"part of a complex and pathological ambivalence regarding care-seeking, which need to be addressed in an ongoing therapeutic relationship"*[25], and because of this a generic and partial safety plan had been discussed.

82. Mr RNY disputes this and stated that a generic safety plan was not offered to them. Mr RNY stated that he had to ask for a safety plan and was advised by the Psychiatric Registrar that the CATT needed to get to know JVM over the following days and weeks before they could develop a safety plan. Mr RNY also disputes that the risk mitigation strategies noted in the Psychiatric Registrar's notes were communicated to either himself or Mrs RNY.

83. The SVMHS notes indicate that JVM *"clearly stated that she would not tell her parents or anyone working in mental health if she was feeling unsafe"* and/or impulsive[26]. It was noted that JVM reported *"having a trusted friend who she would tell, who would be able to advocate appropriately on her behalf"*[27] but was unable to say *"if she could put barriers between herself and objects of threat to herself"*[28]. There is no evidence to suggest there was further exploration with JVM of her friend's availability or willingness to advocate for her.

84. The Psychiatric Registrar also noted that a voluntary psychiatric inpatient admission option was available, however Mr and Mrs RNY indicated that an admission was not for their daughter.[29] Mr RNY does not agree with this account. He stated that a voluntary admission was not discussed with, or offered to, them. Mr RNY suggested that if it had been, they would have accepted, as they had also been in support of a voluntary admission on Saturday 9 April and would not have declined an admission in the circumstances.

85. On Tuesday 12 April 2022, the Psychiatric Registrar left messages for JVM's treating psychiatrist and the Somatic Experiencing Therapist. The therapist called back and reported she had three sessions with JVM who had responded to touch therapy that *"was to improve issues related to early life neglect and lack of physical touch from primary carers during preverbal development"*[30]. The therapist reported she had found another psychologist who

[25] Coronial brief page 24.
[26] Coronial brief pages 24 and 25.
[27] Coronial brief pages 24.
[28] Coronial brief page 25.
[29] Coronial brief page 24.
[30] Coronial brief page 27.

was also a Somatic Experiencing therapist who may provide ongoing care to JVM once she left for overseas.

86. On the same day, a Senior Mental Health Clinician unsuccessfully phoned JVM twice and could not leave a voicemail either time. She sent a text message asking JVM to call the CATT with the number provided.

Events proximate to JVM's death

87. On Wednesday 13 April 2022, the CATT made additional calls to JVM, her father and her grandmother without success, and text messages were sent to each.

88. On this day, JVM travelled with Mr RNY to the family home in East Kew to visit her pets. During this visit, she appeared settled and calm and asked her father if she could go for a ride on her bike. Mr RNY agreed to this on the basis that there would be a strict time limit, and she would take her phone with her, which JVM agreed to.

89. At approximately 11.40am, JVM left the residence on her bike.

90. At around 12.30pm, the CATT spoke to Mr RNY who advised them that JVM would be relocating permanently to East Kew. He reportedly advised them that they were trying to link her in with a new psychiatrist and psychologist, but it was difficult to engage her consistently in therapy. The clinician advised Mr RNY of the Head to Help service and asked him to request JVM to call the CATT when she returned.

91. When JVM did not return at 12.30pm, as she had agreed to, Mr RNY attempted to contact her. He received a text message back, which stated *"I'm sorry, it's my time to die".* Mr RNY asked JVM where she was and she replied, *"Can't say".* Mr RNY contacted Victoria Police and registered JVM as a missing person, whilst continuing to attempt to ascertain her location.

92. Victoria Police and JVM's family commenced searching for her.

93. Earlier the same day, JVM had also sent text messages to her ex-partner and his mother expressing suicidal ideation. At 12.50pm, JVM sent a message to her ex-partner's mother stating, *"I'm sorry but its my time to die".* They attempted to contact JVM, but JVM did not respond.

94. At 1.13pm, an X'Trapolis train TD2337, operated by Metro Trains Melbourne, was travelling towards Alamein between Willison and Hartwell Railway stations, when the driver observed

JVM quickly move onto the railway tracks. At the time, the train was moving at approximately 63km/h. The driver immediately engaged the emergency brake, but the train was unable to stop before it struck JVM. The train came to a stop shortly afterwards, and the driver immediately contacted emergency services.

95. Victoria Police attended the scene. They confirmed that JVM had sustained injuries incompatible with life.

96. The driver of the train undertook a preliminary breath test at the scene which returned a negative result.

Identity of the deceased

97. On 20 April 2022, JVM, born 2002, was identified via DNA comparison.

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

Medical cause of death

99. Forensic Pathology Registrar Dr Joanne Ho, under the supervision of Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 14 April 2022 and provided a written report of her findings dated 2 June 2022.

100. Dr Ho also reviewed the post-mortem computed tomography (**CT**) scan, the Victoria Police Report of Death (**Form 83**), medical notes from SVHM, medical records from Balwyn Central Medical, a note written by JVM, scene photographs, and the VIFM contact log.

101. The post-mortem examination revealed multiple injuries in keeping with the described circumstances.

102. Toxicological analysis of post-mortem samples identified the presence of diazepam (~0.06 mg/L), nordiazepam (~0.06 mg/L) and desmethylvenlafaxine (~0.8 mg/L). Alcohol was not detected.

103. Dr Ho provided an opinion that the medical cause of death was 1(a) multiple injuries sustained in a train incident.

104. I accept and adopt Dr Ho's opinion.

FAMILY CONCERNS

105. JVM's family submitted a significant number of concerns to the court regarding the mental health care and treatment provided to JVM prior to her death. JVM's family have also engaged directly with many of the services providers in this case to discuss their concerns and have undertaken significant advocacy around issues relating to youth mental health services. It is clear that their advocacy has raised the profile of, and focus on, young people's mental health services with organisations and members of parliament.

106. I acknowledge that JVM's family raised concerns regarding the services provided to JVM by Headspace. However, I am not satisfied that there was a sufficient causal link between this service contact and JVM's passing to warrant further investigation of those concerns. I note that significant advocacy by JVM's family with Headspace has resulted in changes to service delivery that should improve the experience of care for clients and their families within this service. These changes are testament to the benefits of lived experience in service improvement.

107. Whilst I have reviewed all the concerns and documents submitted to the court by JVM's family, not all of the concerns fell within the reasonable scope of a coronial investigation. The concerns discussed in this section, and in the remainder of this finding, are confined to those which relate to the services and issues that were most proximate to the fatal incident.

108. The concerns submitted by JVM's family included, in summary, that:

    a) JVM was not subjected to involuntary treatment pursuant to the MHA despite her presentation,

    b) treating clinicians dissuaded JVM from proceeding to a voluntary psychiatric admission on 9 April 2022,

    c) JVM was discharged from hospital whilst still actively suicidal,

    d) JVM's treating clinicians did not obtain collateral information from family/friends and JVM's other treating clinicians,

    e) the risk assessment and safety planning conducted in relation to JVM was inadequate,

    f) SVHM clinicians incorrectly diagnosed JVM as having BPD,

g) JVM's family members were not provided with adequate support and information to assist them to support her appropriately following her discharge,

h) contact with JVM and her family following her discharge from hospital was focused on determining where she would be residing, and therefore the appropriate service for her to access, instead of prioritising assessment and treatment of her mental health.

109. JVM's grandmother noted that JVM's family were *"distressed by the superficial assessment of JVM at St Vincent's, the readiness to discharge her despite her current suicidal (life threatening) status, the reluctant but eventual engagement with us to ascertain JVM's history and also the lack of post discharge guidelines and advice re management"*[31].

110. JVM's mother noted that JVM was repeatedly expected to find her own treating clinicians without referrals being provided, despite JVM experiencing significant mental distress at the time. Mrs RNY also noted that she and Mr RNY were not consulted by the HOPE team to provide collateral information about JVM's mental health, and similarly were not asked to provide collateral and background information about JVM's mental health during her last attendance at SVHM.

111. Mrs RNY also expressed concern that JVM was not admitted to SVHM as an involuntary patient. In addition, she stated that JVM's family members were *"given no verbal or written coaching, training, information nor any suggestions on how to manage JVM or signs to look out for"*[32].

112. Mrs RNY submitted that the SVMHS CATT did not appear to appreciate the severity of JVM's mental illness, did not obtain collateral information from her family, and did not develop a safety plan for her.

113. JVM's family submitted that the root cause of JVM's death was a failure by SVHM to *"ascertain an accurate diagnosis, in order to administer effective treatment"*, which occurred due to *"failure to collect all relevant information regarding JVM's history"*. They submitted that all psychiatrists who had treated JVM outside of SVHM had diagnosed her with major depressive illness and anxiety, and in July 2021 JVM's psychiatrist provided an additional diagnosis of psychosis.[33] They noted that JVM's psychiatrist had specifically assessed JVM

[31] Coronial brief page 45.
[32] Coronial brief page 68.
[33] I note that JVM's psychiatrist stated that he did not diagnose JVM with psychosis or a psychotic illness during the time that she was in his care.

for BPD and excluded this diagnosis, although he noted that she had *"features of borderline personality"*.

114. JVM's father also noted that there was a significant history of serious mental illness on his side of the family, including schizophrenia, depression, bipolar disorder and completed suicides, which was known to treating clinicians at SVHM but not adequately taken into account during their assessment and diagnosis of JVM.

115. JVM's family submitted that the misdiagnosis of BPD led to a missed opportunity to reinstate JVM's antipsychotic medication.

116. They also provided a number of suggested recommendations for my consideration.

117. JVM's family also provided two expert reports to the court in support of their concerns, which I will summarise here.

Report of Professor Patrick McGorry

118. Professor Patrick McGorry AO is a doctor and consultant psychiatrist, a Professor of Youth Mental Health at the University of Melbourne and the Executive Director of Orygen, the National Centre for Excellence in Youth Mental Health.

119. Professor McGorry noted that JVM's diagnosis from all inpatient admissions, outpatient and private community care during the first two years of her illness was consistently one of severe depression and anxiety with chronic suicidal risk.

120. Professor McGorry noted that JVM's psychiatrist commenced her on antipsychotic medication, ziprasidone, although the psychiatrist's reports did not record a specific diagnosis of psychotic disorder.

121. Professor McGorry opined that the assessment of clinicians at SVHM in 2022 that JVM met the criteria for BPD was *"largely based on cross-sectional assessments with limited collateral history"* and were *"in sharp contrast to the previous diagnostic formulations of severe mood disorder and potentially psychosis"*.

122. Professor McGorry conceded that he had never assessed JVM himself directly, and on the objective material available JVM did have some of the criteria for BPD, including suicidal behaviour and self-harm, and identity confusion and change. However, he noted that *"many of these features are nonspecific and are also present in other mental disorders such as*

depression, bipolar disorder, PTSD and psychosis, particularly during the adolescent period when identity is evolving".

123. Professor McGorry noted that:

> *it is a common failing of acute and triage systems in mental health to prematurely close on a diagnosis of BPD without sufficient opportunity to assemble collateral information from community-based clinicians and family to characterise the longer term picture which is vital in substantiating this diagnosis.*

124. Professor McGorry conceded that it was difficult for him to state categorically that JVM was suffering from psychosis without having seen her. However, he stated that:

> *the account of JVM's level of functioning and behaviour indicates to me a significant level of cognitive impairment, disorganisation and severe fluctuating anxiety, emotional lability and suicidal risk during what is most likely to be a prodromal period. JVM's alienation from her loving parents, especially her mother, and her statements about being physically at risk at home, are readily interpretable as paranoid ideation or even as frank delusional belief. Adolescent "growing pains" and the not uncommon distancing of adolescents from their parents as part of normal individuation does not go anywhere near to explaining the level of fear and rejection that occurred. The parents' account indicates that belief was not only sustained but became more entrenched. In the context of the spectrum of comorbid and worsening symptoms described above, this pattern is more congruent with a primary psychotic illness than the more fleeting and poorly formed psychotic like symptoms that can be part of BPD alone.*

125. Professor McGorry's judgment was that:

> *BPD traits alone even if they were strongly validated (which they were not) are quite insufficient to account for the pattern, severity and course of [JVM's] illness. In retrospect such traits such as suicidality and identity issues are most likely to be a secondary consequence of her emerging psychotic illness. And, given her high functioning premorbid development and stable family prior to illness, I believe that a psychotic mood disorder or schizoaffective illness is the most likely specific diagnosis within the spectrum of early psychosis.*

126. He suggested that contributing factors as to why such a diagnosis was missed included *"the fragmentation of care and poor communication between providers concerning a young woman with a life threatening condition, and the role of potentially well-intentioned members of the community in potentially misunderstanding JVM's needs"*.

Report of Professor Jayashri Kulkarni AM

127. Professor Jayashri Kulkarni AM is a Consultant Psychiatrist and Professor of Psychiatry at the Alfred Hospital and Monash University.

128. Professor Kulkarni opined that there were several factors which contributed to JVM's death, including:

    1. *Inconsistent and varying diagnoses, with inconsistent treatment plans between healthcare professionals, over 3 years*

    2. *Borderline Personality Disorder being used as the main diagnosis for [JVM] by St Vincent's Hospital staff, to the exclusion of the more likely diagnosis of psychosis*

    3. *Some complacency in the management of suicidal ideas and actions expressed by JVM – probably because of her presumed Borderline Personality Disorder diagnosis*

    4. *Insufficient credence given to the RNY's family's observations and repeated expressed concerns*

    5. *Poor communication between healthcare professionals, services and family members involved with [JVM's] care.*

129. Professor Kulkarni noted that it was not clear how the diagnosis of BPD recorded in the SVHM notes was determined.

130. Professor Kulkarni disagreed with the BPD diagnosis and opined that JVM was experiencing first episode psychosis. She suggested that:

    if JVM had received a more accurate diagnosis of early psychosis, then the assessment of her insight plus judgment and her capacity for treatment adherence, would have perhaps had a different emphasis. Furthermore, she did not receive

sustained treatment with potent antipsychotic medications that may have treated her symptoms well.

131. Professor Kulkarni also noted that the information provided by JVM's family and friends to treating clinicians was not given sufficient weight, and that the risk assessments did not place a major emphasis on the communications JVM's family had received from her expressing suicidal ideation. Professor Kulkarni opined that if JVM's *"risk assessment had taken her escalating suicidal ideation into account, then she could have been convinced to be admitted to the Psychiatry ward, or even admitted involuntarily"*.

132. Professor Kulkarni opined that the misdiagnosis of BPD *"directly led to JVM's death"*.

INTERNAL REVIEWS

St Vincent's Hospital Root Cause Analysis Report

133. SVHM completed a Root Cause Analysis (**RCA**) following JVM's death. This review focused on the care provided to JVM and her family members, as her carers, in the week prior to her death. This included a review of JVM's medical records as well as interviews with clinicians and JVM's parents. The RCA was unable to identify a root cause of any systemic factors that directly contributed to JVM's death, but did identify several opportunities for service system improvement. St Vincent's used the London protocol analysis method for identifying care delivery problems, potential contributing factors, and improvement opportunities.

134. JVM's family raised a significant number of concerns during the SVHM review process. These included concerns regarding the gathering of collateral information from family and other treating clinicians, the mental health assessments and discharge planning completed in relation to JVM, the reluctance of clinicians to utilise the MHA for an involuntary admission, a lack of information and training for family/carers, issues relating to catchment areas, the conduct of mental health assessments via telephone, inadequate follow up by the CATT and poor communication between treating clinicians.

135. The SVHM review considered each of these concerns and found a number of contributing factors to the event which included:

    a) the Clinical Risk Assessment and Safety Plan form described in policy had not been implemented in the emergency department or by the CATT, and treating clinicians were therefore unaware of the requirement to complete this form;

b) due to a lack of express consent from JVM, the clinician did not seek collateral information from JVM's family without JVM being present, which may have impacted the clinical risk assessment and safety plan;

c) when there was a change in the safety plan from (acute inpatient to community treatment) there was no proactive initiation of an interview with JVM's family without JVM present, which led to clinicians assuming that they agreed with the assessment and plan;

d) the standard for clinical documentation at the time did not facilitate the process of providing a written copy of the safety plan to the client and their carers – noting that the provision of the plan to consumers and their carers is considered best practice and should be part of standard care;

e) that multidisciplinary clinical review only occurred weekly in the Emergency Department Mental Health (**EDMH**) and CATT services;

f) policy requirements for clinicians to present, discuss and document risk assessment and safety plans with the multidisciplinary team are difficult to enact in clinical practice leading to informal verbal sharing of information at Clinical Team Handover. Such discussions are not recorded in the medical record and may not include full multidisciplinary team review of risks and planning, potentially leading to incomplete assessments and loss of information.

136. The review also identified additional learnings which did not substantially contribute to the fatal event but were important learning and improvement opportunities, specifically:

a) a lack of requirement for clinical risk assessments and safety plans within the EDMH and CATT to be discussed with another senior mental health clinician or medical practitioner at the time of completion, and

b) a process for carers to escalate concerns is required, including details and phone numbers for the health service and for other support services which may be available to them.

137. Five recommendations were made as a result of the internal review, specifically for SVHM to:

a) Implement a standardised risk assessment and management template for use in the Emergency Department and CATT which is fit for purpose for every assessment.

b) Ensure that the best practice principle to engage carers separately to consumers, to ensure they can speak freely, is included in orientation as part of an interactive session led by the lived experience workforce.

c) Establish a process for the routine review of all risk assessment and management plans for EDMH and CATT discharges from the service within the prior 72 hours, and when possible incorporate lived experience.

d) Standardise formal documentation of clinical reviews in Medical Records Online (**MRO**).

e) Develop a standard contact details information sheet which can be included as part of the printed risk management plan and given to all consumers, which includes contact details and escalation pathways for the health service and external support services within the local area.

138. At my request the General Manager Mental Health & Addiction Medicine at SVHM provided a statement to the court dated 15 February 2023 which summarised the outcomes of the review and the steps taken by SVHM to implement the recommendations from the review. This statement indicated that SVHM had either implemented, or commenced implementing, measures to address all the above listed recommendations.

Review by the Office of the Chief Psychiatrist and Safer Care Victoria

139. JVM's family raised concerns regarding the SVHM review with both the Office of the Chief Psychiatrist (**OCP**) and Safer Care Victoria (**SCV**). As a result of this, the quality and rigour of the SVHM review was independently reviewed by both the OCP and SCV in collaboration.

140. SCV noted that overall, the quality of the SVHM review and the learnings and recommendations were appropriate. However, there were some missed opportunities that could have been further explored in the review including the clinical decision-making regarding JVM's admission, the collection of collateral information from JVM's family and psychiatrist, and post-discharge follow up, including who was best placed to support JVM and her family.

141. This feedback was provided to SVHM, who made an addendum to the RCA to address the feedback.

142. In the addendum, SVHM clarified that the Psychiatric Registrar in consultation with the Consultant Psychiatrist on-call assessed that an involuntary admission was inappropriate as there were less restrictive means reasonably available to enable JVM to receive treatment – specifically voluntary treatment in the community through engagement with the CATT.

143. The addendum identified additional actions to be undertaken by SVHM following JVM's death and added two further recommendations, specifically that SVHM:

    a) Review the Guidelines for Integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings, identify where there are opportunities to enhance practice, and implement change.

    b) Review opportunities to strengthen and support the process and documentation of risk assessments provided by the on-call Consultant Psychiatrists.

144. I was also provided with a copy of correspondence sent from the SVHM Chief Executive Officer to JVM's family, which acknowledged the issues in care that they had raised, provided an update about how the issues were being addressed by SVHM, and formally apologised.

Implementation progress

145. I requested a further statement from SVHM requesting an update on their implementation of the recommendations. A further statement was provided to the court, dated 4 March 2025, which indicated that SVHM have taken the following actions to implement the recommendations.

Recommendation 1

146. SVHM co-designed Safety Plan brochures with clinical staff and lived and living experience workers (**LLEWs**), for use in both the ED and the CATT outreach services, which were completed in July 2023. SVHM is also *"currently undertaking a pilot process of gathering feedback from clinicians, consumers and family/carers after using the forms in order to ensure they meet the needs of consumers and staff in documenting the agreed safety plan".*

147. SVHM also completed a literature review and co-design process with clinicians and carer and consumer consultants to inform the design of the Safety Plan brochures, in place of

redesigning the clinical risk assessment and management document. SVHM noted that the *"key focus was to design a patient-use Safety Plan that stayed with the person to support their crisis management. To ensure best practice regarding carer engagement when the consumer is in crisis, local written guidance was created for clinicians on how best to engage with carers when a consumer does not give consent to share information"*.

148. SVHM advised that no changes were made to the Risk Assessment and Management Template as it is considered to meet best practice standards.

Recommendation 2

149. SVHM moved away from developing a formal training program to co-creating local written guidance for clinicians on how best to engage with carers when a consumer does not give consent to share information. This resource has been introduced to clinical staff via team meetings and new staff receive an orientation to this information when they commence with the team.

Recommendation 3

150. SVHM have developed a process to ensure a Consultant Psychiatrist electronically reviews and signs off on all ED Mental Health and CATT discharges within 72 hours.

151. SVHM have been unable to incorporate LLEWs into the review team as they have been unable to introduce such staff into the ED Mental Health team or CATT. They plan to include LLEWs as part of the team reviewing discharges when funding resources allow for this in future.

Recommendation 4

152. In December 2022, SVHM updated handover documentation to an electronic template. Further updates were made in March 2023 to document a summary of the clinical discussion from the daily clinical review meeting directly into the medical records, which eliminated the need for the template created in December 2022.

Recommendation 5

153. SVHM included standard contact details for the CATT, guidance on escalation pathways for consumers in crisis, and contact details of local support services for carers in the Safety Plan brochures developed in response to Recommendation 1.

Recommendation 6

154. In May and June 2023, SVHM completed a gap analysis against SVHM processes and the recommendations in the Delphi Guidelines. The findings of this analysis were used to develop an action plan and SVHM has been working on actions to address the identified gaps, with the action plan finalised and updated in January 2025. Actions undertaken by SVHM to address the gaps included:

    a) creating visibility of the demand on the ED relating to presentations by consumers at risk of suicide to ensure appropriate staffing models and measures are in place to support periods of high demand

    b) improving the safety and wellbeing of consumers at risk of suicide whilst they are in the ED waiting room

    c) strengthening the training program for non-Mental Health staff who interact with consumers at risk of suicide

    d) creating joint education opportunities for Mental Health, Addiction Medicine and ED Mental Health & Alcohol and Other Drugs Hub staff with a focus on suicide prevention and engaging family/carers/supporters during crisis assessment and planning

    e) strengthening the provision of written information resources available to consumers and carers

    f) strengthening the provision of peer support from peer support workers in the ED

    g) reviewing and strengthening the Comprehensive Psychosocial Assessment process for a person at risk of suicide presenting to the ED

    h) increasing the involvement of carers, families and friends in the development and implementation of safety plans for consumers

    i) increasing the development and use of Advance Statements so that people who frequently attended the acute setting for suicide related risks are involved in the development of crisis management plans that set out a person's preferences for future treatment. These should be undertaken whilst the consumer is well

j) strengthening the discharge plan so that a copy is provided to the consumer before they are discharged, as well as the GP, and with the consumers consent, to the person's carers and family, and

k) improving the reliability of the provision of the discharge plan to the GP.

Recommendation 7

155. This recommendation was addressed by the actions taken in response to recommendation three, as detailed above.

FURTHER INVESTIGATIONS

Coroners Prevention Unit Review

156. I referred this matter to the Coroners Prevention Unit (**CPU**)[34] for their opinion regarding the mental health treatment provided to JVM, and the outcomes of the review completed by St Vincent's Hospital.

Involuntary treatment under the *Mental Health Act 2014* (Vic)

157. The relevant legislation in place at the time JVM received mental health treatment and care was the MHA. I note that this legislation has since been replaced by the *Mental Health and Wellbeing Act 2022* (Vic).

158. The MHA allowed for persons with mental illness to be treated compulsorily. However, treating a person against their wishes necessarily infringes their human rights. In recognition of the gravity of this infringement, the MHA necessarily and appropriately set a high threshold for compulsory treatment. In addition to experiencing mental illness, there must be an *immediate* need to receive treatment to prevent serious deterioration in the person's mental or physical health or serious harm to the person or to another person, and there must be no less restrictive means reasonably available to enable the person to receive that immediate treatment. Under the MHA, people are presumed to have the capacity to make their own decisions about treatment.

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

159. The CPU suggested that, based on the available information, JVM did not meet the criteria for compulsory treatment. They noted that experiencing suicidal thinking, suicidal gestures/acts or impulsivity did not by themselves meet the criteria for compulsory treatment under the MHA.

160. In addition, JVM was willing to engage in community-based care and had done so previously. She was an adult, and was not subject to any legislation (including administration, guardianship, or medical treatment) that would suggest she was unable to make her own informed decisions or that she did not have capacity.

161. Further, even if SVHM had subjected JVM to involuntary treatment under the MHA, she would not necessarily have remained in an inpatient unit, as the MHA has clear requirements for review and revocation of involuntary treatment orders as soon as the criteria are no longer met.

162. The CPU noted that compulsory mental health treatment can often shape the therapeutic relationship between consumers and providers[35]. There is no evidence to support that compulsory engagement in care creates a therapeutic alliance in which recovery can occur, and there is evidence that compulsory engagement can be traumatising and re-traumatising and undermine continued engagement with practitioners.

163. The National Mental Health Consumer and Carer Forum states that compulsory treatment *"precludes the development of trust and respect between consumers and families/carers and clinical staff, leading to fear and distress among consumers and a breakdown of therapeutic relationships"*[36]. Analysis of Your Experience of Service (**YES**) surveys across Victoria, New South Wales and Queensland in 2020-21 indicate that voluntary patients had more positive experiences with services than compulsory patients across all three states[37].

[35] Saya A, Brugnoli C, Piazzi G, Liberato D, Di Ciaccia G, Niolu C and Siracusano A. 2019. Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry Around the World: A Narrative Review, Frontiers in psychiatry,10:271; Wyder M, Bland R, Blythe A, Matarasso B and Crompton D. 2015. Therapeutic relationships and involuntary treatment orders: Service users' interactions with health-care professionals on the ward, International Journal of Mental Health Nursing, 24(2):181–189.

[36] NMHCCF (National Mental Health Consumer & Carer Forum). 2020. Restrictive Practices in Australian Mental Health Services- external site opens in new window, NMHCCF website, Canberra, accessed 7 February 2023.

[37] Australian Institute of Health and Welfare. Involuntary treatment – Mental Health. www.aihw.gov.au/mental-health/topic-areas/involuntary-treatment.

Voluntary psychiatric admission to hospital

164. JVM's family stated that treating mental health clinicians at SVHM dissuaded JVM from continuing to agree to a voluntary admission to the acute inpatient unit on 9 April 2022. They raised concerns about the way the clinician spoke to JVM about the inpatient unit, and the way the clinician explained the impact of COVID-19 restrictions on the unit to her. They felt that this communication led to JVM electing not to undertake a voluntary admission.

165. The CPU opined that it was entirely reasonable for JVM to be informed that a voluntary admission would require her to remain in the unit for three days, despite her not being subject to involuntary treatment under the MHA, due to COVID-19 restrictions. JVM was entitled to know about this, and to make an informed decision about a voluntary admission.

Gathering of collateral information from family

166. It has been acknowledged by SVHM, and addressed in Recommendation 2 of their review, that their engagement with JVM's family, and particularly her father, was poor.

167. The Psychiatric Registrar explained to JVM's parents that the adult model for mental health services was different to the model for persons under 18 years old, which is generally more family inclusive. The CPU noted that it was reasonable for the Psychiatric Registrar to note this and to have asked JVM what aspects of her care she wanted to share with her parents.

168. The CPU noted, however, that it would also have been reasonable for JVM's parents to be engaged by treating clinicians earlier, without sharing any details that JVM did not want to share.

169. The CPU noted that JVM's parents did not have the power to make decisions on her behalf. However, the collateral information that they held could have informed the treatment planning and safety planning conducted in relation to JVM. It was also reasonable that any engagement with the family to obtain collateral information take place whilst JVM was not in the room. This has been acknowledged by SVHM.

170. The CPU noted that both the MHA and the *Mental Health and Wellbeing Act 2022* (Vic) have specified requirements for communication with family and carers, and the *Mental Health and Wellbeing Act 2022* (Vic) has increased the explicit duty to communicate with family and carers. However, both still require the consent of the client subject to the legislation.

Consultation with other treating practitioners

171. The available materials indicate that during JVM's last attendance at SVHM she was clear about her previous mental health history, her engagement with other practitioners, and her self-discharge from her private psychiatrist. The treating team were also informed by JVM that her medications had been reduced, and that she had experienced a subsequent deterioration in her mental state.

172. The CPU noted that it is not usual practice for private therapists to be contacted by ED clinicians unless there is an immediate reason such as, for example, a planned private admission.

173. At her appointment with the Psychiatric Registrar on 11 April 2022, JVM provided consent for the Psychiatric Registrar to contact her psychiatrist and the Somatic Experiencing Therapist, which he did. It could be argued that earlier contact with JVM's other treating clinicians may have provided more information upon which to develop a treatment plan. However, what the Somatic Experiencing Therapist subsequently reported from these conversations was already known to treating clinicians.

174. Although JVM's psychiatrist had not seen her for about six weeks, he may have been able to provide more context to her presentation, confirm that she had also been prescribed ziprasidone and indicate the reasons why this was prescribed. He could also have confirmed that he had never diagnosed JVM with psychosis or a psychotic illness.

175. The CPU noted that although it is contemporary practice to engage with other practitioners, contact by the CATT with the Somatic Experiencing Therapist and psychiatrist within 48 hours of JVM's discharge from the ED appeared to be reasonable.

176. It is not possible to state with any certainty whether earlier contact with JVM's psychiatrist and the Somatic Experiencing Therapist, or any contact with JVM's GP, would have changed the outcome, especially given that JVM had been non-adherent with her medications.

Discharge planning

177. The CPU noted that there was no evidence to suggest that alternative options such as a re-referral for HOPE or a sub-acute admission were considered. Instead, the focus of the treatment plan developed with JVM was to increase her antidepressant medication to a therapeutic level whilst engaging a new treatment team or service in the community.

Transfer of care to Alfred Health

178. The CPU noted that the transfer of JVM's care to Alfred Health, once she moved to Port Melbourne, was always an option and this was raised on at least two occasions with JVM. However, the SVMHS also recognised the impact of transferring clients unnecessarily and that care could be provided across catchments. The CPU stated that it was reasonable that SVMHS continued providing services to JVM until it was established where she was going to reside more permanently.

Private hospital admission

179. SVHM records indicate that the option of a private hospital admission was raised with JVM on both 8 April 2022 and 11 April 2022, however neither JVM nor her parents felt this was appropriate. As detailed earlier, JVM's parents dispute that this option was ever communicated to them, and they submitted that they would have been in support of a voluntary admission. It is possible that this option was only discussed with JVM and not her parents. Such admissions are usually arranged through a private psychiatrist and JVM would have needed to agree for any such admission to occur.

Risk Assessment

180. The CPU noted that there are no reliable tools or methods for predicting suicide, including with adolescents and young adults and in the acute care area. While there are some factors known to increase suicide risk, the majority of people with these risk factors do not suicide. It is difficult to assess which people with identified suicide risk factors may suicide, and if they might suicide in the short term.

181. Predicting suicide is even more difficult in people who experience suicidal ideation in response to external stressors, as it can be difficult to predict when a stressor may occur and whether the person will experience suicidal ideation in response. Suicide attempts in such people tend to be impulsive and unpredictable.

182. A risk assessment is a clinical opinion formed by a trained clinician and is relevant only at the time of assessment and its completion. After discharge, clinicians have no control over the actions of a person that may change the severity or nature of that person's risks and of the ongoing validity of protective factors that have been used to inform the clinical opinion of current overall risk.

183. Regardless of the risk assessment tool used, a risk assessment is only as good as the available information, which is impacted by what the client chooses to share. JVM's documented poor rapport, guarding and withholding of risk information including an undisclosed plan would have impacted on any risk assessment.

Borderline Personality Disorder diagnosis

184. JVM's psychiatrist stated that he did not diagnose JVM with psychosis or a psychotic illness during the time she was in his care. He stated that first episode psychosis would be the differential diagnosis, however he also noted that if JVM was truly suffering from a psychotic illness, it was unlikely that the low dose of antipsychotic medication he prescribed her[38] would have resolved her issues.

185. Antipsychotic medications such as ziprasidone are commonly prescribed at lower doses to assist with anxiety. JVM's psychiatrist stated that ziprasidone is noted in medical literature to be beneficial for anxious depression and major depressive disorder.

186. The CPU noted that it is very difficult to definitively diagnose a mental health condition posthumously. They agreed upon review of the clinical records that there appeared to be symptoms and traits of a number of differential diagnoses including BPD traits, and it is possible that JVM was experiencing an episode of psychosis, however it is not possible to posthumously confirm diagnoses.

Safety planning

187. The CPU noted that safety planning is a tool used across many service types including mental health, child services and family violence. Safety planning in relation to suicide is generally considered to be effective in reducing suicidal behaviour though effectiveness is associated with the quality of the safety plan. It is challenging to study the effectiveness of safety planning in crisis situations such as ED, but what evidence exists is promising.

188. The available information does not support that JVM was engaged in a therapeutic alliance or that she had a reasonable rapport with treating clinicians. The Psychiatric Registrar who spoke to JVM on 11 April 2022 noted that JVM was guarded, and that the information she provided was unreliable. She had clearly stated she would not tell her parents or the mental health clinicians if she felt unsafe, but then said she would call a trusted friend.

[38] Initially 10mg at night, subsequently increased to 20mg at night.

189. At discharge from the ED on 8 April 2022 and at the appointment on 11 April 2022, safety was discussed with JVM and she agreed to stay with her father at her grandmother's residence. The available records suggest that clinicians thought this arrangement was appropriate and would contribute to her safety.

190. According to the ED Psychiatric Registrar, it was routine practice for her to discuss with families the following: monitoring of mental state; identifying trigger points; taking care of sharp objects, medication supervision and secure storage; warning signs such as disturbed sleep, not eating or drinking, presenting as withdrawn or depressed; not taking the prescribed medication; if there was any decline to contact the 24 hours triage access number, present to the ED, call an ambulance or police along with information about coping mechanisms or distraction techniques.

191. This practice is not reflected in the written records, nor was it the reported experience of JVM's parents, who submitted that this information was not conveyed to JVM or themselves. Further, no documented safety plan was provided by the ED Psychiatric Registrar.

192. In addition, the ED Psychiatric Registrar noted an assumption that JVM's family *"would have been aware of"* such mechanisms and techniques *"due to [JVM] having seen multiple psychiatrists"*. The CPU noted that it is unreasonable to assume that family/friends would be aware of such information simply because a client has had previous contact with a mental health clinician/service, particularly in circumstances where the assessing clinician is not privy to the details of the previous contact and engagement with the family/friends.

193. The CPU suggested that the safety planning on 11 April 2022 was basic and generic and there is little evidence to suggest that JVM's parents, and particularly her father, given he was the person who was going to stay with JVM, were asked about whether they believed they could contribute to JVM's safety, and what strategies they could employ.

<u>CPU Conclusion</u>

194. The CPU noted that JVM was not engaged, or did not have an established rapport, with a treating team; she was not effectively treated for her depression; she had increased suicidal thinking, a plan she refused to disclose, and impulsivity; and she was stressed by having to make choices about where she would reside and her future.

195. JVM believed she had either Complex PTSD or PTSD. However, having a PTSD diagnosis would not exclude other diagnoses including first episode psychosis, anxiety, BPD and Major Depressive Disorder, which require treatment.

196. The available evidence suggests that JVM's decision to self-cease and reduce her psychiatric medication contributed to a deterioration in her mental state.

197. Whilst there were issues identified in the care provided to JVM and her family regarding documentation, review of plans, clinical handover and the timely handing of a risk management/safety plan to the client and their family/carers, the CPU indicated that implementation of the SVHM RCA review recommendations should decrease the likelihood of similar issues arising in future.

198. The CPU suggested that relevant guidelines[39] for safety planning in ED settings do not appear to have been followed to their fullest. In particular, the Department of Health and Human Services guideline, *Working with the suicidal person: clinical practice guidelines for emergency departments and mental health services*, notes that:

> *Where a decision has been made for the [Area Mental Health Service] to manage a person on an outpatient basis, either by CATT or through case management, there must be a written treatment plan derived from the assessment* ***to which the person has agreed****. This should include a written crisis plan developed by the treating clinician or treatment team with the person and their family when appropriate, which specifies what the person should do if they experience an acute suicidal episode, including methods of accessing emergency care and alternative ways of coping... Check if there is an existing treatment plan before proceeding to develop one. A copy of the crisis plan component of the treatment plan should be retained by Mental Health Triage, the CATT team and the person themselves.*[40]

[39] Department of Health and Human Services Victoria, *Working together with families and carers – Chief Psychiatrist's guideline* (August 2018); Black Dog Institute, *Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings* (November 2017); Department of Health and Human Services Victoria, *Working with the suicidal person* "Quick reference guide" (October 2010); Department of Health and Human Services Victoria*, Working with the suicidal person: clinical practice guidelines for emergency departments and mental health services* (March 2010);.

[40] Department of Health and Human Services Victoria, *Working together with families and carers – Chief Psychiatrist's guideline* (August 2018) 43.

199. Whilst the Psychiatric Registrar who reviewed JVM in the ED outlined what her usual routine practice involved, including a lengthy discussion with families in relation to safety planning, this was not reflected in the medical record, nor was it the experience of JVM's family.

200. The CPU noted that safety planning was used by SVMHS as a clinical and therapeutic engagement tool aimed at contributing to JVM's safety whilst the discharge plan, including the increase in antidepressant medication, was implemented.

201. The CPU were satisfied that the SVHM internal review addressed the identified deficiencies in relation to the engagement of JVM's family in safety planning.

The Royal Commission into Victoria's Mental Health system

202. The Royal Commission into Victoria's Mental Health System (**RCVMHS**) delivered its final report on 3 February 2021. Recommendations from the RCVMHS included a focus on suicide prevention, improving the mental health and wellbeing of young people, responding to crises in mental health, developing system-wide involvement of family members and carers and facilitating translational research and its dissemination.

203. I acknowledge the commitment of the Victorian Government to delivering on all the recommendations from the RCVMHS.

204. Recommendations 26[41] and 27[42] of the RCVMHS address suicide prevention and response initiatives. Phase one of reforms arising from these recommendations has been completed and the focus is currently on implementing the second phase. One of the priorities for this phase is focusing on prevention and promotion, and specifically preventing suicide and the onset of suicidal distress.

205. From 2024 – 2027, the Victorian Government will focus on the Mental Health Improvement Program (**MHIP**) and adopting the Zero Suicide Framework.

206. The MHIP was established in 2021 following the RCVMHS to support reform in mental health and wellbeing services. It aims to improve the safety and quality of care for people who access and work in Victoria's mental health and wellbeing services.

[41] Recommendation 26 – Governance arrangements for suicide prevention and response efforts. State of Victoria, *Royal Commission into Victoria's Mental Health System,* "Final report – Summary and Recommendations" (February 2021), 62.
[42] Recommendation 27 – Facilitating suicide prevention and response initiatives. Ibid, 63.

207. The Zero Suicide Framework is a framework providing opportunities for services to improve the care provided to persons with suicidal thoughts and behaviours.

208. The MHIP supports Victorian healthcare services to adopt the Zero Suicide Framework. In 2024, four mental health and wellbeing services were working with the MHIP to adopt the Zero Suicide Framework. The Victorian Government aims to support adoption of the framework across all Victorian healthcare services into the future.

FINDINGS AND CONCLUSION

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[43] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was JVM, born 2002;

    b) the death occurred on 13 April 2022 at the Railway Tracks Between Hartwell and Willison Railway Stations from multiple injuries sustained in a train incident; and

    c) I accept and adopt the medical cause of death as ascribed by Dr Ho and I find that JVM died from multiple injuries sustained in a train incident.

3. It is clear that JVM experienced deep lows and recurrent episodes of debilitating depression and anxiety, including ongoing suicidal ideation. Despite the professional assistance she sought, together with the love and support of her family, JVM suffered progressive worsening of her mental health in the months leading up to her death which appears to have been exacerbated by her decision to self-cease her psychiatric medication.

[43] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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…'.

4. I am satisfied that JVM intentionally took her own life in the context of her declining mental health.

5. Having considered all of the evidence, I am satisfied that the decision not to subject JVM to involuntary treatment under the MHA was appropriate given the circumstances of her presentation and the requirements of the MHA.

6. I accept that the information about the COVID-19 positive patient in the psychiatric inpatient unit, and the resultant requirement that JVM would have to remain on the unit for several days, may have impacted her ultimate decision not to accept an inpatient admission on 9 April 2022. However, I am satisfied that it was appropriate for JVM to be provided with this information prior to an admission to the inpatient unit.

7. I accept that the diagnoses of BPD may have been incorrect, and that JVM may have been suffering from first episode psychosis. However, I am unable to conclude that a diagnosis of first episode psychosis would have prevented JVM's death or would have resulted in a significantly different treatment outcome, such as an involuntary admission.

8. I am satisfied that there were deficiencies in the care provided to JVM and her family by SVHM. In particular, the communication with JVM's family, and the information and support provided to them, was insufficient. In addition, the safety planning undertaken for JVM did not meet applicable guidelines. However, I am unable to conclude that these deficiencies were directly contributory to JVM's death, and I am satisfied that SVHM have undertaken appropriate steps to address the identified issues.

COMMENTS

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

1. I support the ongoing work of the Victorian Government to implement the recommendations from the Royal Commission into Victoria's Mental Health System and encourage the Victorian Government to pursue opportunities to expedite the implementation of the Zero Suicide Framework across the mental health and wellbeing sector.

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

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

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

Mr and Mrs RNY, Senior Next of Kin

St Vincent's Hospital Melbourne

Headspace Hawthorn

Avant Law – on behalf of Dr SBR and Dr TKU

Constable Kobi Kruger, Coronial Investigator

Signature:

Coroner John Olle

Date: 3 July 2025

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