Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 1792

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: MELISSA GAULTIER

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	29 June 2022
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing Dates:	19 April 2021, 20 April 2021 & 23 April 2021
Appearances:	Mr Patrick Over of Counsel on behalf of family members (Maurice Blackburn Lawyers) Fiona Ellis of Counsel on behalf of Latrobe

	Regional Hospital (K&L Gates) Raph Ajzensztat of Counsel on behalf of Monash Health (Lander & Rogers)
Counsel Assisting:	Senior Sergeant Jenette Brumby, Police Coronial Support Unit

TABLE OF CONTENTS

I, AUDREY JAMIESON, Coroner having investigated the death of MELISSA GAULTIER

AND having held an Inquest in relation to this death on 19 April 2021, 20 April 2021 and 23 April 2021

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006

find that the identity of the deceased was MELISSA GAULTIER

born on 17 July 1982

died on 18 April 2017

at Morwell on the Princes Freeway.

from:

1 (a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (PEDESTRIAN).

In the following summary of circumstances:

On 18 April 2017, Melissa Gaultier stepped into the path of an oncoming truck on the Princes Freeway, Morwell. She died at the scene. Melissa Gaultier was a voluntary inpatient on the psychiatric ward, Flynn Unit, at Latrobe Regional Hospital, Village Avenue, Traralgon Victoria. On 17 April 2017, she had been granted leave but then absconded from the facility.[1]

[1] At the time of her death, Melissa Gaultier was a compulsory patient subject to an Assessment Order as it had been made after she failed to return from leave.

BACKGROUND CIRCUMSTANCES

1. Melissa Gaultier[2] was 34 years of age at the time of her death. She was married to Michael Gaultier[3] (Michael) and the couple lived in Traralgon, Victoria. Melissa was in her final trimester of her first pregnancy (approximately 28 weeks + 4 days gestation). She had a medical history of Type I insulin dependent diabetes mellitus and a mental health history of bipolar affective disorder and borderline personality disorder and had several hospital admissions related to mental ill health from the age of 20 years.
2. Initially ecstatic about her pregnancy, by the end of 2016 Michael noticed a deterioration in Melissa's mental wellbeing – she was not sleeping and had become obsessional about her blood glucose levels.

SURROUNDING CIRCUMSTANCES

3. On 21 March 2017, Melissa was admitted to Monash Medical Centre (**MMC**), Monash Health (**MH**) after clinicians became concerned that Melissa may have been misusing insulin to terminate her pregnancy after she had presented requesting a late termination of her pregnancy citing mental health issues. Melissa had been attending MMC for her obstetric and endocrinology care.
4. At her own request Melissa had remained at MMC as she was concerned about her risk of self-harm but eventually, with the purpose of receiving ongoing psychiatric support closer to her home, she was transferred to Latrobe Regional Hospital (**LRH**) Flynn Unit[4] on the evening of 12 April 2017. A tele-case-conference handover about Melissa's complex needs had occurred between MMC staff, Dr Tina Almukhtar (**Dr Almukhtar**) and Psychiatric Registrar, Dr Khushal Khan (**Dr Khan**) from LRH. After the case-conference Dr Almukhtar had also spoken to Consultant Psychiatrist Dr Vijay Prajapati (**Dr Prajapati**) at LRH on the telephone about Melissa and provided advice

[2] With the consent of Melissa Gaultier's family, she was referred to as "Melissa" during the course of the Inquest. For consistency, save where formality requires, I have also only referred to her as Melissa throughout the Finding.

[3] Michael Gaultier is now known as Michael Meall.

[4] Flynn Unit is the 31-bed inpatient psychiatric unit at LRH, 6 of which are high dependency

that Melissa should not be allowed any leave including leave with her husband due the risk around the same. At the time of her discharge from MMC Melissa was subject to an Inpatient Temporary Treatment Order (**ITTO**).

5. On the morning of 13 April 2017, Melissa was reviewed by Dr Prajapati. A Dr Ratjaltan was also present as well as a member of the nursing staff. Melissa's ITTO was revoked by Dr Prajapati. At approximately 4.15 pm she was discharged from the Flynn Unit to go home with her husband. Less than four hours later, Melissa had left her home necessitating Michael contacting the Police. Melissa was subsequently located and returned to the Flynn Unit by Police. Due to her risk of suicide, Melissa was made subject to an Assessment Order (**AO**).

6. On 14 April 2017[5] at 4.45 pm, the AO was revoked by Dr Indrapal Singh, consultant psychiatrist but Melissa remained in the Flynn Unit as a voluntary patient. Melissa was experiencing some fluctuation in her mental state but her overall risk assessment remained unchanged on a low to medium risk.

7. On 15 April 2017, Melissa's leave entitlement was cancelled following a disclosure that she intended to suicide. The nursing progress notes reflect that she should have a mental health assessment by a psychiatrist on the following day.

8. On 16 April 2017, Melissa's leave was reinstated to escorted leave despite the recommended psychiatrist assessment not occurring. Nevertheless, Melissa had several uneventful periods of escorted leave with her mother and husband.

IMMEDIATE SURROUNDING CIRCUMSTANCES

9. On 17 April 2017[6] Melissa's dressing gown cord was confiscated by a nurse after another patient disclosed that Melissa had said she was going to hang herself whilst on the ward.[7] Later that day Melissa requested to have 3 hours of unescorted leave off the

[5] 14 April 2017 was Good Friday, a public holiday.

[6] 17 April 2017 was Easter Monday, a public holiday.

[7] Change to risk as identified with Melissa on 15 April 2017 and 17 April 2017 would now lead to an escalation of care.

grounds, which was denied but she was permitted to have escorted leave on the grounds for a period of 30 – 40 minutes.

10. Melissa contacted an old friend, Mescal Cox (**Ms Cox**) asking her to come to the hospital to visit her. Ms Cox arrived at the hospital at approximately 5.00pm and left the ward with Melissa soon after. According to Nurse Scott London he told Melissa in the presence of Ms Cox that her leave was limited to the hospital grounds and only for a period of 30 minutes.[8] According to Ms Cox, there was no conversation about the limitations of Melissa's leave that she was a party to.[9]

11. Ms Cox was not asked to provide her contact details nor was she provided with any emergency contact numbers or given any instructions in the event that she had any concerns during the leave period.

12. No mental health risk assessment was made of Melissa proximate to her going on leave with Ms Cox.

13. Melissa convinced Ms Cox to drive off the hospital grounds telling her that the only limitation to her leave was the time. Melissa also told Ms Cox that she had lost her baby and had separated from Michael.

14. At approximately 6.00 – 6.30 pm Ms Cox and Melissa attended at Ms Cox's home. Melissa initially stayed in the vehicle, but Ms Cox subsequently located Melissa in the rear shed of her property with a dressing gown belt and a knocked over chair. Concerned that Melissa had attempted to hang herself Ms Cox told Melissa that they needed to leave. Back in Ms Cox's vehicle, she told Melissa that she needed to return her to the hospital, but Melissa said she did not want to go back and convinced Ms Cox to drive her instead to a friend's house in Moe. At approximately 7.00 pm whilst *en route* to Moe on the Princes Freeway and just prior to the Yallourn turnoff, Melissa asked Ms Cox to stop the car. Melissa then got out of the car and ran off into nearby bushes.

[8] Statement of Scott London dated 19 March 2018, Coronial Brief at pp 308 – 309.

[9] Statement of Mescal Cox dated 14 July 2017, Coronial Brief at pp 47 – 55.

15. Ms Cox waited in her car for a short time hoping that Melissa would return. She subsequently drove to a friend's house to seek advice on what she should do.

16. At approximately 7.30 pm Ms Cox telephoned the hospital. When she was able to speak to a staff member, she was told that Melissa was only meant to be absent from the ward for 40 minutes so had now been missing from the ward for 2 hours and 20 minutes. Ms Cox provided her contact details and explained what had occurred.

17. Prior to Ms Cox contacting LRH, the Flynn Unit had attempted to call Melissa at approximately 6.45 pm and tried to contact Michael at approximately 7.00 pm. A search of the grounds was undertaken. Michael returned the Flynn Unit's call at approximately 7.30 pm, advising them that he had not heard from Melissa.

18. At approximately 7.43 pm an Assessment Order was prepared at the direction of the consultant psychiatrist and sent through to Police at 7.50 pm.

19. Throughout the night of 17 April 2017 into the morning of 18 April 2017 Police conducted several foot and vehicle searches in the local area and in the area where Melissa had absconded from Ms Cox's vehicle. Police also attempted to employ the use of the Airwing of Victoria Police, but this was deemed not possible due to weather conditions. Reports received about unknown persons walking on the Princes Freeway were also followed up.

20. On 18 April 2017 at approximately 6.20 am, Melissa stepped into the path of an oncoming truck on the Princes Freeway at Morwell in circumstances where the truck driver was unable to avoid colliding with Melissa.

21. Melissa and her unborn child died immediately from the injuries Melissa sustained.

JURISDICTION

22. Melissa's death was a reportable death under section 4 of the *Coroners Act 2008* ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. In addition, at the time of her death, Melissa was, immediately before death, a patient within the meaning of the Mental Health Act 2014. She was a voluntary patient at the time she went on leave and thus not strictly a "person placed in custody or care" as it is defined in section 3 of

the Act. She did however become such a person immediately before her death, without her knowledge, when she was made subject to an Assessment Order after she failed to return from leave.

PURPOSE OF THE CORONIAL INVESTIGATION

23. The Coroners Court of Victoria is an inquisitorial jurisdiction.[10] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[11] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [12]

24. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[13] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death,

[10] Section 89(4) Coroners Act 2008.

[11] Section 67(1) of the *Coroners Act 2008*.

[12] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[13] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

including public health or safety or the administration of justice.[14] These are effectively the vehicles by which the prevention role may be advanced.[15]

25. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

26. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. Melissa's voluntary status in a designated mental health service did not strictly equate to the definition of "in care" as defined in section 3 of the Act as paragraph (i) of the definition states that she be *a patient detained in a designated mental health service* to satisfy the "in custody or care" status and thus mandating the holding of an Inquest pursuant to section 52(2)(b) of the Act. As a voluntary patient up to the time she went on leave, Melissa was not strictly "detained". However, proximate to her death, Melissa had been a person/patient detained in a designated mental health service as she had been subject to compulsory treatment orders and/or assessment orders and/or Inpatient Temporary Treatment Orders during the period of her admission(s) from Monash Health and LRH, and finally, an Assessment Order was made after she absconded. I therefore determined that an Inquest into the death of Melissa was mandated.

27. This finding draws on the totality of the material; the product of the Coronial Investigation into the death of Melissa. That is, the court records maintained during the Coronial Investigation, the Coronial Brief and further material sought and obtained by the Court, the evidence adduced during the Inquest as well closing submissions from Counsel Assisting and Counsel representing the Interested Parties.

[14] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[15] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

STANDARD OF PROOF

28. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw.* [16] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

29. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

30. Melissa Gaultier was positively identified from a fingerprint comparison from the Victoria Police database. I completed a Form 8 Rule 32 *Determination by Coroner of Identity of Deceased* pursuant to section 24 *Coroners Act 2008*.

31. The identity of Melissa Gaultier was not in dispute and required no further investigation.

Medical Cause of Death

32. Dr Gregory Ross Young, Forensic Pathologist (**Dr Young**) at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on the body of Melissa

[16] (1938) 60 CLR 336.

Gaultier on 19 April 2017. In preparing his report dated 29 May 2017, Dr Young relied upon the following materials:

- Victorian Police Report of Death (Form 83);
- Medical records from Latrobe Reginal Hospital; and
- Post mortem CT scan.

Post mortem examination

33. In performing an external examination on the body of Melissa Gaultier, Dr Young reported that it showed multiple injuries to the head, torso, arms and legs. No unexpected signs of trauma were seen and that apart from the removal of stomach contents, an internal examination was not performed. A post mortem CT scan revealed extensive injuries including multiple pelvic fractures and the uterus showed a tear, with foetal extrusion. Dr Young commented that given the severity of the injuries it was likely that death occurred rapidly for both Melissa and the foetus.

Toxicology

34. Toxicological analysis of blood and vitreous humour showed markedly elevated acetone[17] (~ 235 mg/L and ~ 195 mg/L respectively). Vitreous humour glucose was also elevated[18] (~ 16mmol/L) which Dr Young opined was likely to have been higher at the time of death as glucose falls post mortem. Dr Young stated these findings are in keeping with diabetic ketoacidosis (**DKA**) which is a serious complication of diabetes mellitus where there is hyperglycaemia (high serum glucose) leading to dehydration, diuresis, retention of ketones and eventual metabolic derangements which may be fatal. Dr Young stated that the lack of insulin administration in an insulin-dependent individual may lead to DKA and that symptoms can include decreased alertness, confusion, vomiting, abdominal pain, thirst and frequent urination.

35. Toxicological analysis did not identify ethanol (alcohol) in either blood or vitreous humour or common drugs or poisons in blood or stomach contents.

[17] Acetone is an endogenous substance produced in humans, which may be elevated during fasting, for example, in diabetic ketoacidosis.

[18] Elevated glucose may be indicative of hyperglycaemia.

Forensic pathology opinion

36. In the absence of a full post mortem examination (autopsy) Dr Young ascribed the cause of Melissa Gaultier's death to: 1(a) Multiple injuries sustained in a motor vehicle incident (pedestrian).

Conduct of my Investigation

37. As the circumstances surrounding Melissa's death related to her engagement with mental health services, I requested the Coroners Prevention Unit (CPU)[19] to assist me with my investigation. The CPU requested statements from relevant persons and assisted in in identifying an appropriate independent expert psychiatrist to advise me on the appropriateness of Melissa's management including a review of the decision-making surrounding her leave.
38. An independent expert opinion was subsequently obtained from Professor Richard Harvey.
39. The investigation and the preparation of the Coronial Brief was undertaken by Detective Senior Constable (DSC) Mark Smith on my behalf.
40. Due to the COVID-19 pandemic and the consequential restrictions placed on the Victorian community, all proceedings were facilitated through the use of WebEx, enabling interested parties to participate remotely.

Direction Hearing/s

41. A Directions Hearing was held on 28 August 2020. Senior Sergeant Jenette Brumby, Police Coronial Support Unit appeared as Counsel Assisting the Coroner (SS Brumby). Other appearances for the Interested Parties included:
    - Ms F. Ellis of Counsel on behalf of Latrobe Regional Hospital;

[19] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of a coroner, the CPU assists coroners with research in matters related to public health and safety. The Unit also reviews the medical care and treatment administered to patients in matters referred to it by a coroner where concerns have been identified. The CPU is comprised of health professionals with training and skill in a range of areas including medicine, nursing, public health and mental health. Any review undertaken by the CPU on behalf of the Coroner is intended to provide clarity to matters that are in dispute and assist the Coroner to determine whether further investigation is warranted, including by way of expert report, or whether there is sufficient material on which to finalise the investigation.

- Mr R. Ajensztat of Counsel on behalf of Monash Health: and
- Ms E. Hart on behalf of the family.

42. Counsel for LRH indicated that certain concessions were evident in that LRH would not be saying that the granting of leave on 17 April 2017 was perfect nor was the search for Melissa done in a timely way.[20] Ms Hart spoke to an expert opinion that had been obtained on behalf of the family from Dr Michael Giuffrida but neither the Court nor the other Interested Parties had received this report from Maurice Blackburn Lawyers.

43. A further Directions Hearing was held on 13 November 2020. The appearances remained unchanged. The proposed witness list and the scope of the Inquest were discussed. The proposed witness list included:

- Mescal Cox;
- Michael Meall;
- Gibon Dube – Nurse Unit Manager, LRH;
- Cameron O'Brien – nurse, LRH;
- Scott London – nurse, LRH;
- Peta Moore – nurse, LRH;
- Dr Vijay Prajapati - LRH;
- Dr Khushal Khan -LRH;
- Dr Tina Almukhtar – MMC;
- Cathryn Hoppner – Clinical Director, LRH; and
- 3 experts including Professor Peter Doherty (provided on behalf of LRH), Professor Richard Harvey (Court appointed expert) and Dr Michael Giuffrida (on behalf of the family) – proposed to be heard concurrently.

44. The proposed scope of the Inquest[21] included:

[20] Transcript (T) of proceedings at p 19 (Directions Hearing 28 August 2020).

[21] Also discussed at the first Directions Hearing on 28 August 2020.

- Decisions around granting Melissa leave – including that it had been cancelled on 15 April 2017 with a requirement for reassessment by a psychiatrist and why Melissa's leave was reinstated the following morning without a reassessment.
- Melissa's escorted leave granted on 17 April 2017 where it appears that hospital process was not followed by a staff member allowing Melissa to leave the ward.
- Risk assessment – proximate to Melissa being granted leave.
- Actions taken/procedures implemented when Melissa was noted to be absent without leave (AWOL).
- Examination of instructions given to staff in relation to recording and actioning alterations in leave status of patients.
- General compliance by staff at Flynn Unit with LRH policies and procedures.

Prior to the Inquest

45. On the afternoon of 13 April 2021, a statement from Catherine Hoppner, Executive Director of Mental Health Services and Chief Mental Health Nurse at LRH was provided to the Court and the other Interested Parties. The statement and the attachments amounted to approximately 85 pages. On the Friday before the commencement of the Inquest other material was received from LRH's legal representatives which provided a comparative precis of hospital protocols/policies in place at the time of Melissa's death to those now in existence.

INQUEST

46. The Inquest was conducted on 19 and 20 April 2021 with closing submissions heard on 23 April 2021. I continued to be assisted by SS Brumby, Mr Patrick Over of Counsel appeared on behalf of Melissa's mother and brother, Ms Maria Rogers and Mr Charlie Pizarro and Ms Fiona Ellis of Counsel appeared on behalf of LRH.

47. On 19 April 2021, after providing a summary of the circumstances surrounding Melissa's death, SS Brumby addressed me in relation to the additional material recently received from LRH and submitted *that despite multiple witnesses being summonsed*

and ready to proceed with their evidence, it is appropriate to reconsider the scope of issues to be explored at Inquest, as confirmed in November 2020.[22] Outlining the scope of the Inquest as detailed at the Directions Hearing on 13 November 2020, SS Brumby went onto submit that the majority of the issues defined in the scope had in most part been addressed in the very recently received material which depicted a myriad of changes that LRH have made to a number of their protocols.[23] A number of concessions had also been made about staff not complying with existing protocols in April 2017 or there being a lack of clarity in guidance to staff in 2017 and the hospital conceding some processes were not the subject of any protocol or formal policy at the time of Melissa's death. SS Brumby submitted that many of the new protocols now in place at LRH would likely prevent the recurrence of the set of circumstances that surrounded the death of Melissa. She further submitted that the new protocols and systems now in place at LRH specifically address the deficiencies or lack of clarity in hospital process that existed in 2017 and that the Court could have some confidence that these reflected a considerable change from how LRH conducts its business of providing mental health services which should avoid a similar tragedy in like circumstances.[24]

48. Consequentially the witness list proposed at the Directions Hearing on 13 November 2020 was able to be curtailed and the proposed conclave of expert witnesses to hear their concurrent evidence was rationalised and dispensed with due to the limited issues that remained requiring exploration.

49. The scope of the Inquest was also refined to:

- Decision making around the discharge of Melissa on 13 April 2017 from LRH into the care of her husband despite the advice of Monash Health that she should not be given leave until assessed by the treating team and that there was information available from her husband that he was not comfortable about confronting Melissa about his concerns and risk and taking her on leave.

[22] T at p 7.

[23] T at p 8.

[24] T at pp 8-9.

- The difference in content of the discharge documentation from Monash Health dated 12 April 2017 and of that from LRH on 13 April 2017 required further exploration to be fully understood.
- Issues around how collateral information should be considered and what role such information should play in assessing suicide risk and risk to an unborn child, as well as how conflicting collateral information from patient and other sources is reconciled.
- Consideration of risks in a complex patient with multiple needs, particularly around risks to an unborn child.

Viva Voce Evidence at the Inquest

50. Viva voce evidence was obtained from the following witnesses:
    - Michael Meall
    - Dr Tina Almukhtar
    - Dr Vijay Prajapati
    - Cathryn Hoppner[25]

ISSUES INVESTIGATED AT THE INQUEST

Concerns around risk to Melissa and her unborn child

51. Michael stated that he had made it clear to both hospitals that he could not care for Melissa as her husband – he said that at that time before the specific events, it was too difficult for him to keep Melissa and their unborn child safe.[26] He said that both hospitals were aware that Melissa was suicidal.

52. Michael confirmed some of the information depicted in the Discharge Summary[27] particularly under the heading "Discharge Plan" that at times he did not feel

[25] See: Statement of Ms Cathryn Hoppner plus attachments dated 23 April 2018 (Exhibit 5) and Statement with attachments, dated 13April 2021 (Exhibit 6).

[26] T at p 28. See also Discharge Summary dated 13 April 2017 from Monash Health, Coronial Brief at pp 242 – 243.

[27] *Ibid* at p 243.

comfortable discussing directly with Melissa about her care and his concerns.[28] He was however, supportive of the transfer from Monash Health to Flynn Unit – he said he thought *the change of scene* may have helped her because as far as he could see, there had not been any progress at Monash in terms of her mental health – *she would be stable one day and the next day extremely depressed and wanting to get the baby out or end her life.*[29]

53. In packing her bags for the move back to the LRH, Melissa told Michael several times that she did not want to go the Flynn Unit. Michael believed that it was no longer safe for him to transport Melissa there in his own vehicle as he could not see how he could drive the one-and-a-half-hour journey and at the same time care for Melissa – he feared that she would try to jump out of the car.[30] He communicated his concerns that Melissa's transfer should be handled by trained professionals. She was subsequently transferred by ambulance.

54. On the morning of 13 April 2017 Michael became disappointed about the level of care Melissa was getting in the Flynn Unit in relation to the management of her diabetes. He had understood from the meeting at Monash Health that Melissa would be provided with care at the Flynn Unit in relation to all her medical issues including her diabetes and pre-natal care in conjunction with her mental health issues but by her first morning in the Flynn Unit *there was a fairly decent mistake made in terms of her diabetes care.*[31] At the same time, Michael's concerns about self-harm from the day before seem to have dissipated as Melissa was presenting in a calm mood and was stating her intention to manage her diabetes herself, leading Michael to feel comfortable that day to care for her at home. Michael and Melissa met with her treating Team to discuss her discharge. Melissa was discharged into Michael's care less than 24 hours of her arriving at the Flynn Unit from Monash Health.

[28] T at p 31.

[29] T at p 32.

[30] T at p 32.

[31] T at p 33.

55. However, Michael agreed that only a few hours later Melissa's mood had significantly fluctuated and declined.[32] He said it was not unexpected as this pattern of change had occurred before but that he had earlier been extremely hopeful of something changing in her recovery by her return to her hometown.

56. Following her readmission to the Flynn Unit initially as a compulsory patient, and then as a voluntary patient, Melissa's moods continued to fluctuate. Episodes of escorted leave with both Michael and Melissa's mother over the next few days were event free and she attended her mother's home on Good Friday for dinner which Michael stated went very well- *it was peaceful, and it was a nice memory*.[33]

Decision making around Melissa's discharge

57. Dr Tina Almukhtar, (**Dr Almukhtar**) Psychiatric Registrar at MMC had been involved with Melissa's care between 21 March 2017 and 29 March 2017 and from 30 March and 12 April 2017. She confirmed that the catalyst for the making of the Assessment Order on 21 March 2017 was that Melissa had presented to the ED saying she was not coping with her pregnancy and that she wanted the foetus removed. Following a review by Consultant Psychiatrist, Associate Professor (A/Professor) Wong on 22 March 2017 it was determined that Melissa did not meet the criteria under the Mental Health Act to be detained as a compulsory patient, but she agreed to remain in hospital as a voluntary patient which also enabled her general health issues – Type I diabetes and her pregnancy to be reviewed by the appropriate specialities within the hospital. Throughout her admissions to MMC, Dr Almukhtar agreed that Melissa fluctuated in terms of her mood and in expressing thoughts of suicide or harm to her baby[34] while at other times, she appeared quite settled and her mental health, stable. For example, around the end of March 2017 planning for Melissa's discharge had begun because she was presenting as stable and stating she was happy to keep the baby. This particular discharge plan was however halted on 27 March 2017 following a review by

[32] T at p 37.

[33] T at p 37.

[34] T at p 47.

A/Professor Wong when Melissa again expressed her desire to have the foetus removed. Dr Almukhtar agreed that these fluctuations were to some degree to be expected as a feature of Melissa's diagnosis.[35]

58. Melissa's approved leave during her admission at MMC also varied as her risk to self and her foetus continued to fluctuate and Dr Almukhtar and Melissa's treating team often received information collaterally from Michael or other family members, including Melissa's sister-in-law, which cast doubt on the level of risk portrayed by Melissa herself. Throughout Melissa's admission at MMC Michael expressed his concerns about Melissa's risk and risk to the foetus and consequentially that he preferred that Melissa would remain an inpatient rather than being discharged into community care.

59. When it was decided that Melissa would be transferred from MMC to LRH, Dr Almukhtar was involved in the process by organising paperwork, organising a Discharge Summary[36] and contacting the relevant clinicians and persons at LRH. Discussions with Melissa and Michael also occurred, and Dr Almukhtar had a teleconference with LRH clinician, Dr Kushal Khan (**Dr Kahn**) to facilitate the handover of Melissa's care on 12 April 2017. At the time of that conference, Dr Almukhtar believed that Dr Kahn was a consultant psychiatrist who was to be involved in Melissa's care.

60. Dr Almukhtar also had a telephone discussion with Dr Vinjay Prajapati (**Dr Prajapati**) at LRH after her teleconference with Dr Kahn[37] at the request of A/Professor Wong as it was believed that Dr Prajapati would be Melissa's treating consultant psychiatrist at LRH. The Discharge Summary that accompanied Melissa to LRH and, specifically in the "Discharge Plan" section, stated:

---

[35] T at p 53.

[36] See Attachments A- J to Exhibit 2 – Statement of Dr Tina Almukhtar at pp 177 – 183 CB.

[37] T at p 51.

No leave at this stage until being reviewed by Flynn TT, taking into consideration that Husband did not feel comfortable to take her on leave when he was asked to and he found it difficult to confront Melissa of his concerns.[38]

61. Dr Prajapati recalled from his conversation with Dr Almukhtar that she had told him that Melissa should not have any leave until she is reviewed by the team, by the psychiatrist, that she had demonstrated inconsistent reporting in relation to her risks, demonstrated fluctuating moods and that there had been discussion about the ongoing management plan to support Melissa with her pregnancy.[39] Dr Prajapati acknowledged that he was aware that Melissa would be arriving at LRH the next day and that she would be admitted as a compulsory patient.[40]

62. After Melissa's admission to LRH on the evening of 12 April 2017, she was seen by Dr Prajapati along with Doctors Chin and Champika on the morning of 13 April 2017. At the time of this review Dr Prajapati said that he had the benefit of the telephone discussion with Dr Almahktar from MH where the issues/reference to Melissa walking in front of cars and the misuse of her insulin were discussed as suicidal risk factors.[41] Dr Prajapati also had the Discharge Summary from MH and LRH records of Melissa's previous admissions.

63. At the time of Dr Prajapati's review on 13 April 2017, Melissa was accepting of her pregnancy and denied thoughts to harm the baby. These inconsistent articulations regarding her pregnancy and thoughts of harming the baby and herself were part of Melissa's presentation and so it was taken into view, according to Dr Prajapati, but he also said that the important thing for him was that Melissa was not in a distressed state or in a crisis state where she might have less control over her behaviour or emotions.[42] Dr Prajapati stated that at the time he believed, that *she was not in a crisis state so there was no imminent risk at that stage. My opinion at that time was that she should be*

[38] See Attachments A- J (specifically **B**) to Exhibit 2 – Statement of Dr Tina Almukhtar at pp 177 – 183 CB.

[39] T at p 95.

[40] Under a Temporary Treatment Order

[41] T at p 145.

[42] T at p 97, 149.

stable for a few days, there will be crisis phases, and if we support around that then we can manage those risks. Those risks would then settle down. Again she would be back to her baseline level of risk which is always at the high risk, and she was going to continue with that for many, many years.[43]

64. In this same discussion with the doctors, Melissa also mentioned that she wanted to buy baby clothes which Dr Prajapati said showed that she had some forward or future planning – she was not presenting as hopeless or with hopelessness which is a risk factor according to Dr Prajapati's perspective.[44] When Melissa stated that her husband was now supportive of her being discharged home with him, Dr Prajapati said discharge then became a possibility[45] despite the conversation with Dr Almukhtar and the Discharge Plan content from MH. A later meeting with Melissa and Michael confirmed that Michael was now comfortable with Melissa being discharged home which, Dr Prajapati said influenced his decision to enable discharge to occur without the need for a longer period to observe Melissa as an in-patient. Melissa's mental health at the time, Michael's willingness to care for Melissa at home and that there were already community supports in place[46] were all matters Dr Prajapati took into consideration.[47] Dr Prajapati revoked Melissa's Temporary Treatment Order.

65. Melissa was discharge from LRH into her husband Michael's care at approximately 4.00 pm that day with a follow up plan with community mental health. Melissa's obstetric care and endocrine issues continued to be managed by Monash Health.

66. Dr Prajapati had no further involvement with Melissa and was unaware that she was readmitted that evening at approximately 11.00 pm. He stated that he *did not anticipate that she would get into a crisis state that soon*.[48] Dr Prajapati was aware that at the time

---

[43] T at p 149.

[44] T at p 97.

[45] T at p 121.

[46] Dr Prajapati stated in his *viva voce* evidence that *the community team were contacted, and they were happy to contact Melissa the next day and then work out with her what kind of input she needs*. (T at p 152)

[47] T at pp 100 – 101.

[48] T at p 125.

of participating in the handover meeting with MH and assessing her on her arrival at LRH that that would be the extent of his involvement with Melissa because he was not going to be working over the Easter period – 14, 15, 16 and 17 April 2017.

Professional staffing arrangements

67. Dr Prajapati explained that on "normal" weekdays there is an on-call psychiatrist each day at the hospital and a different one for "after-hours".[49] A total of three psychiatrists worked on the Flynn Unit during the day at that time.[50] On weekends and during a public holiday period, such as Easter, there is a roster, and one psychiatrist has to cover all the urgent matters, any admissions in the preceding 24 hours, any patients under the Mental Health Act, any advice required by the community teams and anything that the medical or surgical or other wards need.[51] Despite being the allocated treating psychiatrist for Melissa on 13 April 2017 and making the decision to discharge her on that day, there was no expectation that he should be notified of her readmission that same evening, and he was not.[52] He said that it was his assumption that the on call psychiatrist would deal with any issues arising related to Melissa and he did not expect to be contacted.[53]

Hospital review of the circumstances – outcomes of the Root Cause Analysis

68. Executive Director of Mental Health Services and Chief Mental Health Nurse Cathryn Hoppner (**Ms Hoppner**) gave evidence about the outcomes of the Root Cause Analysis conducted by the hospital after Melissa's death. Contained within her first statement to the Court[54] she confirmed that concessions had been made that:

    - There were no medical reviews during Melissa's second admission and no clear guidelines that existed as to how often a patient should be reviewed;

[49] T at p 108.

[50] T at p 111.

[51] T at p 103.

[52] T at p 123.

[53] T at p 155.

[54] Exhibit 5.

- There was no escalation to medical staff when Melissa's risk assessment of self harm and suicidality was assessed as having increased;
- Changes to Melissa's leave and the reasons for changes were not always clearly documented;
- Melissa's leave status was not always consistent with her risk;

69. Ms Hoppner confirmed that in her second statement to the Court[55] she had outlined significant changes that have occurred to hospital protocol and process and that she had taken the time to link these changes to the original scope of this Inquest.[56] Of note the expectation in 2017, and as the case remains, was that the allocated inpatient consultant psychiatrist would attend handover conferences however Ms Hopper said she believed that policy was unclear at the time. The rectification to the policy meant that the attendance of the medical officer, Dr Kahn, at the handover from MMC to LRH would not happen today.[57] In addition, changes to the admissions policy means that there is now an expectation that if the inpatient consultant psychiatrist *takes over a patient or has the handover with the treating team that they would become the treating consultant*[58] - effectively addressing the lack of continuity of care in Melissa's case.

70. Ms Hoppner also gave evidence that the absence of a policy in 2017 to address the scenario of the reinstatement of leave being revoked is now the subject of a new protocol which includes specific details and instructions for staff to guide them through the process of leave being granted to an in-patient. The protocol comes with the proviso that leave can only be granted by a consultant Psychiatrist, must be documented in the medical records including any conditions attached to the leave and it must be communicated to the Nurse Unit Manager (NUM). The new protocol provides a clear process formula for staff to follow in respect of all iterations of leave including escorted, unescorted, on or off the hospital grounds and still enables staff to

[55] Exhibit 6.

[56] T at p 166.

[57] T at p 167.

[58] T at p 168.

reduce/cancel leave entitlements if an issue of risk arises. Any contemporaneous cancellation of leave requires nursing staff to make a clear and unambiguous strike through the leave description form and necessitates a review and completion of a new leave description form by a psychiatrist before leave can be reinstated.[59]

71. Addressing the specific scenario that enabled Ms Cox to take Melissa from the ward in 2017 without being requested to provide her name or contact details, has also been addressed with Ms Hoppner conceding that the process was not clear for staff in 2017. She also conceded that because the process surrounding leave and monitoring the same was unclear in 2017, there was an ad hoc approach to it.

72. Ms Hoppner candidly opined that in 2017 there was an issue with the culture within the Flynn Unit which was reflected in other shortcomings in clinical practice such as not complying with 30-minute observation requirements. She said:

So I think a mix of not enough education, limited, you know, clinical nursing leadership, not enough oversight that that practice was allowed to continue. So it wasn't being addressed I don't think well enough with that staff group around compliance.[60]

73. In her *viva voce* evidence Ms Hoppner addressed many other aspects of her two statements including that there is a change from "training" in 2017 to a greater emphasis and value on education[61] including but not limited to, more critical thinking around how does a policy apply to clinical practice. She said that this was also a culture shift with education now being more available, more valued and more attended. But she also said that save for a few compulsory education units like basic life support, education was not compulsory so they want to build a culture where people will go to education.[62] An educational program on the implementation on the range of new

[59] T at p 169.

[60] T at p 171.

[61] T at p 175.

[62] T at p 176.

policies referred to in Ms Hoppner's most recent statement[63] had recently commenced and although *prima facie* achieving 100 percent of staff before the end of June 2021, Ms Hoppner said it was really important and that was what they were planning to do[64] and a number of strategies were being implemented to that end. The new education/training strategies were predominately directed towards nursing staff but there was an expectation that medical and health staff would also attend as they are part of the treating team as explained by Ms Hoppner.[65] She agreed that some work needed to be done with the medical staff that they were also engaged and "on board" with the training program and objectives.[66]

74. Ms Hoppner also advised the Court that a peri-natal emotional health program involving two psychiatrists with expertise in dealing with pregnancy, childbirth and infants was in its early stages of development but reflected a significant change in practice in part to provide a health service within the in-patient unit for pregnant women which she said was *not completely uncommon*.[67]

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Melissa was a challenge to her mental health clinicians. She was complex and labile in her moods and hence in predictability but her complexity and thus risk was enhanced by her pregnancy and her insulin dependent diabetes, both of which were intertwined with what was to become her last interaction with mental health and medical services. As Ms Ellis stated, Melissa was consistent in her inconsistency *in her reporting of suicidal ideation and in her reporting of harm to her baby, whether by termination of*

[63] Exhibit 6.

[64] T at pp 196 – 200.

[65] T at p 207.

[66] T at p 208.

[67] T at p 182.

her pregnancy or otherwise.[68] Melissa used her diabetes to attempt the termination of her pregnancy and her desire to end her pregnancy in this way was influenced by her mental ill health. Her multi complex needs were multi complex vulnerabilities fraught with risk and she needed to be managed holistically.

2. To manage Melissa holistically required a commitment to that fundamental basic requirement for the implementation of good health care – communication or more specifically, the sharing of information about her. Monash Health demonstrated such a commitment. They provided a detailed handover to LRH with a discharge summary that was clear and unambiguous about the complex medical and mental health issues of Melissa. It also detailed issues of concern about Melissa's propensity to inconsistently report her levels of risk to staff and how she would then deny heightened issues of risk when confronted. The sharing of this information should have alerted LRH, as it was intended to forewarn them that Melissa could not necessarily be taken on "face value". These invaluable insights shared with LRH included details about the difficulties Michael experienced confronting Melissa about her conflicting accounts about risk, highlighting that the patient's self-reports alone in the absence of collateral information maybe fraught. Monash Health shared with LRH what it had learnt about Melissa during her admission and that information should have served as a foundation for LRH to spend time with Melissa to properly synthesize it. It was not just a few lines of information summarising an admission, it was comprehensive and depicted concerning patterns of inconsistent behaviours and fluctuating mental stability.

3. Little account of the information shared to LRH from Monash Health appears to have been heeded. The expediency at which Dr Prajapati at LRH reached a position so contrary to the assessment and advice from Monash Health facilitating Melissa's discharge within 24 hours of her admission to that facility is, as Counsel Assisting stated, perplexing.[69] And although I have no reason to dispute Dr Prajapati's evidence that he was influenced by Melissa's husband's support for her discharge, it remains a decision that was bereft of the benefit of time – time for LRH to observe Melissa for

[68] T at p 260.

[69] T at p 220. See also Mr Over's reference to *perplexing* events – T at p 236.

themselves, time to observe the characteristics of her behaviours that Monash Health had conveyed to them, time to make a reasonable and appropriate assessment of her risk. Instead, Melissa was put at significant risk by this discharge on 13 April 2017 with consequences for Michael and Police who had to become involved to secure her readmission only a few hours later.

4. Following Melissa's readmission to the Flynn ward on 13 April 2017 through to the 17 April 2017 there were several shortcomings in the implementation of leave entitlements including shortcomings in the documentation[70] related to leave entitlements, risk assessments and observations which I acknowledge, have now been addressed by LRH. The concessions provided by Ms Hoppner in her further statement with attached updated hospital policies and protocols confirmed that LRH failed to have formal processes in place to provide staff guidance and structure in relation to many of the processes that surrounded Melissa's cancellation of leave, reinstatement of leave and the process of executing a period of leave for a patient going off the ward. Significantly, concessions of non-compliance with hospital policy include the failure to conduct a risk assessment and mental state assessment prior to Melissa leaving the ward with Mescal Cox on 17 April 2017. Visual observation policy requirements were also conceded as not followed but have now been addressed by LRH.

5. I accept that the significant changes that have now been implemented by LRH are intended to be both restorative and preventative of like circumstances occurring as in Melissa's circumstances. The educational training regime and auditing processes albeit that they are in their infancy are based on ensuring that staff are both cognisant and compliant with the updated policies and protocols intended to provide a clear framework to manage patient care and safety.[71]

6. In reflecting upon and evaluating the surrounding circumstances to the actions of Melissa on 18 April 2017 I am cognisant of the comments of Forensic Pathologist, Dr

[70] See Closing Submissions from Mr Over – pp 239 – 249 addressing the documentation in the hospital file relevant to Melissa's leave entitlements.

[71] In her *viva voce* evidence, Ms Hoppner agreed with Counsel Assisting S/S Brumby that a definition of "**authorised psychiatrist**" referred to within the new protocols and policies would be helpful – T at pp 181 – 182.

Young about the evidence of the presence of diabetic ketoacidosis at the time of Melissa's death. The cognitive effects of ketoacidosis cannot be dismissed outright. The possibility remains that for example, if she was experiencing the cognitive effects of decreased alertness and confusion, that they played some part in her final decision to place herself into the path of a motor vehicle. However, it is a possibility only and cannot be substantiated and indeed, it is noteworthy that diabetic ketoacidosis has not been ascribed as a cause of her death or even as a contributing factor. Furthermore, the weight of the evidence, on the balance of probabilities is that Melissa's actions were intentional and consistent with her repeated articulations about suicidality and her planned method of the same.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that Latrobe Regional Health implement a patient continuity of care transfer admission policy for its inpatient mental health ward, which aims to rectify the circumstances associated with Melissa Gaultier's transfer admission from Monash Health, by ensuring that appropriately qualified clinician(s)/inpatient consulting psychiatrist receiving handover details from another hospital are rostered and available to continue with that patient's care on admission.

FINDINGS

1. I find that MELISSA GAULTIER born 17 July 1982, died on 18 April 2017 on the Princes Freeway at Morwell Victoria.
2. I find that the death of Melissa Gaultier occurred in circumstances related to her admission to Flynn Unit at Latrobe Regional Hospital on 12 April 2017 having been transferred from Monash Health.
3. I make no adverse finding against Monash Health in relation to its management of Melissa Gaultier whilst she was in their care and specifically in relation to how they managed and undertook a transfer of her care to Latrobe Regional Hospital. To the contrary, I find that the handover process by Monash Health to Latrobe Regional Hospital was comprehensive, covering all aspects of Melissa Gaultier's clinical course whilst in their care and identified all areas of ongoing concerns related to her health, her ongoing risks and risk to her unborn child.
4. I find that the management of Melissa Gaultier at Latrobe Regional Hospital between 12 April 2017 and 17 April 2017 was fraught with shortcomings and missed opportunities such that it did not reasonably or appropriately manage her risk to self and her unborn child. Had it done so, I find that the death of Melissa Gaultier and her unborn child could have been prevented while she was in their care.
5. I acknowledge the extensive restorative and preventative measures implemented by Latrobe Regional Hospital in response to the death of Melissa Gaultier. Those measures include a concerted effort to change the culture within the Flynn Unit exhibited by the significant improvements to staff and supports to all care providers.
6. I accept and adopt the medical cause of death as ascribed by Dr Gregory Ross Young and I find that Melissa Gaultier, a pedestrian, died from multiple injuries sustained in a motor vehicle incident in circumstances where I find that she intentionally placed herself into the path of a motor vehicle with the intention of taking her own life and that of her unborn child.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

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

Ms Emily Hart, Maurice Blackburn Lawyers on behalf of Ms Maria Rogers and Mr Charlie Pizaro

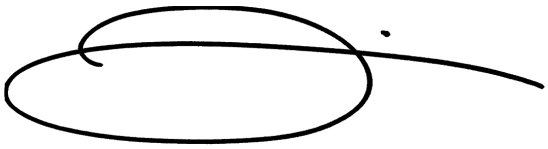
Michael Meall

Ms Jess Bayly, K & L Gates on behalf of Latrobe Regional Hospital

Ms Christine David, Lander & Rogers on behalf of Monash Health

Office of the Chief Psychiatrist

Signature:



AUDREY JAMIESON

CORONER

Date: 29 June 2022

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.