TO:
Commissioners
RC into Mental Health System in Victoria
PO Box 12079
A' Beckett St
Melbourne 8006

[redacted]

June 24th, 2019

Dear Commissioners

Re: Submission to the Royal Commission into the Mental Health System in Victoria

Please find enclosed my written submission. I am the mother of [redacted] My submission is based on my more than 3 years of investigation into what happened in the last 12 days of my daughter's life. During this period she reached out most appropriately and responsibly first to her GP and then [redacted] Clinic [redacted] because she was suicidal. Tragically she took her life less than 8 hours after being discharged from [redacted] on 21 February 2016.

I have been given permission by the Coroner to place information from Coronial documents related to [redacted] death into the public arena. When I refer to and quote from documents provided to the Coroner I use quotation marks to indicate direct quotes. I can provide these documents if it is necessary. The Court Reference for the documents is COR 2016079**1**.

I had a meeting at [redacted] nearly two years after [redacted] death. This meeting brought out new information previously not known to the Coroner. As a result she set aside her previous Coronial Findings. The Coroner has now made a request to [redacted] Treating Psychiatrist and [redacted] Clinic for further explanation in relation to the concerns raised by this new information. I am still waiting for the Coroner's Amended Findings. I can forward them to accompany my submission once I have received them.

I have made this submission to the Royal Commission into the Mental Health System in Victoria in the hope it can help highlight the changes that need to be made in policies and procedures of psychiatric institutions dealing with suicidal patients. This may save others' lives and help others avoid being in the "waking nightmare" I am facing every day.

I would appreciate confirmation of you having received my submission to be sent to my email address shown above.

Yours sincerely

[redacted]

# Submission to Royal Commission into the Mental Health System in Victoria from Dr [redacted]

On March 4th 2016, and four days before what would have been her thirty sixth birthday, over 600 friends and family of my daughter, [redacted], gathered to celebrate her life. Tributes given at her funeral service spoke about her warmth, generosity, intelligence, ability to connect empathically with a huge range of people and of diverse cultures, her natural creativity, her love of nature, her infectious exuberance and her love of fun. They also extolled her abilities as a painter, a dancer, a storyteller, a sculptor, a teacher, a mentor, a poet, a songwriter, a singer, a linguist, (she could converse in half a dozen languages), a cook, a masseuse, a photographer, a caterer and a portraitist.

**[redacted] reaches out for help**

People who are suicidal are advised to consult health professionals to seek out appropriate support. My daughter did this. Twelve days before she took her life [redacted] made an appointment to see her GP. She even took with her a friend who is a nurse to ensure her doctor understood the strength of her suicidal impulses and her desire to find the right support. At this appointment [redacted] was given a referral to [redacted] Clinic [redacted]). That afternoon she attempted suicide for the first time in her life, however at the last minute pulled herself back.

Two days after consulting her GP [redacted] had an assessment interview at [redacted] with Dr [redacted]), the psychiatrist who later treated her when in the clinic. At this assessment interview [redacted] was once again open about her suicidal tendencies and her desire to be kept safe from them. In her response letter to [redacted] GP [redacted] noted she was informed by [redacted] "that she felt she reached the peak of her illness by being referred to the psychiatrist and hence **impulsively** wanted to end it all" and "she was glad she did not die." [redacted] was also informed by [redacted] GP that [redacted] "went to France when 15yo on exchange, where she was raped" and "that her relationship was maybe ending and *he* was potentially leaving her home soon." At this initial assessment interview [redacted] assessed [redacted] as "moderate to high long-term suicidal risk" of suiciding.

Once I learnt [redacted] was considering entering [redacted] I decided to visit to ask questions of the Intake Officer. This I did the afternoon before [redacted] was admitted - questions about her accommodation while in the clinic, her designated 'next of kin', and [redacted] discharge procedures. The information I was given by the Intake Officer turned out to be incorrect or in the case of 'next of kin' at best misleading.

I learnt from the Intake Officer that [redacted] had put down her partner as her next of kin. When I asked if I could also be put down as next of kin she said I would need to ask [redacted]. When I asked [redacted] she told me she had put both him and me down as her 'treatment contacts'. I assumed this meant that if there was to be a change in treatment I would be informed.

[redacted] was in [redacted] for 6 days. Tragically she took her life less than 8 hours after being released from the clinic. Despite all the knowledge supplied to [redacted] and [redacted] by [redacted] and her GP, rather than protecting her from her suicidal impulses, as [redacted] requested and her family and friends assumed, I believe the interventions of [redacted] and [redacted] increased [redacted] risk of impulsively suiciding.

In my submission I raise areas of concern to do with the interventions of [redacted] and [redacted] in relation to:

1. Misuse of medication
2. Unexpected placement in the Intensive Care Unit (ICU) on entering the clinic
3. Use of leave passes
4. Discharge procedures – no Assertive or Proactive Aftercare
5. Lack of duty of care by TMC in accepting individuals who are suicidal

**1 Misuse of medication**

When [redacted] entered the clinic she had been taking [redacted] for 6 days, 50mg once daily prescribed to her by her GP. The Medical Information Management System (MIMS) doctors refer to for Prescribing Information re [redacted] states:

*As improvement may not occur during the first few weeks or more of treatment, patients should be monitored appropriately and observed closely for clinical worsening and suicidality, especially at the beginning of a course of treatment or at the time of dose changes, either increases or decreases.*

The day [redacted] entered the clinic [redacted] doubled the dosage of her medication [redacted] to 100mg once daily. This is concerning as MIMS guidelines under Dosage and Administration/ Initial Treatment state:

*The recommended dose for [redacted] is 50mg once daily..In clinical trials..no additional benefit was demonstrated at doses greater than 50mg/day.*

Because of the side affects of the increased dosage, at [redacted] request, [redacted] halved it back to the original dosage two days later. MIMS guidelines do not allow for such dose changes. They state there needs to be at least 7 days between dose changes. They also state that changes in dosage can lead even more to [redacted] tendency to increase the risk of suicidality, impulsivity, anger and agitation in the first month of treatment.

Neither [redacted] nor her loved ones were informed of these potential side affects of her medication.

**2 Unexpected placement in ICU on entering the clinic**

Before [redacted] entered TMC I had been told by the Intake Officer and [redacted] and other family had been reassured she would be in a room in the general ward. When [redacted] entered the clinic she was unexpectedly placed in ICU. Both she and I were and told she could be there for up to a week because there was no room in the general ward available.

[redacted] had never been hospitalized before for any reason. That is, the last time [redacted] was a patient in a hospital was when I gave birth to her. Her texts to me and telephone conversations indicate she found this experience in the ICU highly traumatic. After I made several phone calls she was moved after 2 days to a room in the general ward. As she had been reassured by [redacted] she would not be put in ICU this initial and unexpected placement in ICU appeared to erode her trust in [redacted] and [redacted]

**3 Use of leave passes**

[redacted] was given leave passes from only her second full day in [redacted] and the day after she left ICU. It was also on the first day she was given Trans-cranial Magnetic Stimulation (TMS) a replacement for Electric Convulsive Therapy, and another treatment that would also affect her mind in unknown ways. Leave passes allowed her to wander the inner city by herself if she chose but mostly she used them when she had visitors.

Her medication had been doubled two days before she was given leave passes and then halved again on the first day she used them. MIMS guidelines clearly state patients need to be monitored for suicidality and impulsivity in the first month of taking Pristiq and also at times of dose changes. How could [redacted] be monitored by [redacted] when she was not in [redacted]? [redacted] told her brother [redacted] she could not understand why she was allowed leave passes when she had asked [redacted] that she be kept safe from her suicidal impulses.

Given what others said to me and what I experienced personally the fact that [redacted] had access to these leave passes from the day after she left ICU and only her second full day in [redacted] created in [redacted] and her loved ones anxiety and fear about her safety and confusion about her mental health status.

**4 Discharge procedures – no Assertive or Proactive Aftercare**

After experiencing all of these interventions over a 6 day stay in [redacted] [redacted] was allowed to self discharge against medical advice. [redacted] did not meet with [redacted] face to face nor did any other psychiatrist or doctor. Rather [redacted] gave the ok for her self discharge after a phone conversation with an attending nurse. In her Discharge Summary [redacted] assessed [redacted] as "moderate-high long term risk of repeated suicide attempts in view of incomplete treatment and impulsivity".

Despite this assessment of her suicide risk [redacted] was discharged with no Assertive or Proactive Aftercare put in place by [redacted] This is despite the fact that people are at risk of suiciding when they leave a psychiatric institution, and even more so for those who have had a previous suicide attempt. Her partner, as her designated 'next of kin' on the day of discharge, was rung by the nurse to tell him of her discharge. With no procedure for Assertive or Proactive Aftercare in place he was not informed about the importance of being there when she arrived home and of staying with her so he could monitor her. As a result [redacted] was dropped off by a friend at her empty home and later after he did come home he went out again and that is when she took her life.

There was also another reason why it was vital for Assertive and Proactive Aftercare to be put in place by [redacted] as [redacted] was discharged. Her caregivers should have been alerted about the need to monitor her because of her being on [redacted] MIMS Prescribing Information for patients and caregivers re [redacted]

*Patients and their caregivers should be alerted about the need to monitor for the emergence of anxiety, agitation, panic attacks, insomnia, hostility, impulsivity, akathisia, hypomania, mania, worsening of depression, and suicidal ideation, especially early during antidepressant treatment.*

And ideally I and other members of [redacted] family should have been informed by [redacted] and [redacted] about her discharge against medical advice, the need for her to be closely medically monitored and the potential side affects of her medication. With [redacted] and her loved ones well informed by [redacted] and [redacted] of the reasons for [redacted] to be closely monitored we could have all worked together to assist her in making wise choices about her management and care after she left [redacted]

**5. Lack of duty of care by [redacted] in accepting individuals who are suicidal**
In their response letter to my formal letter of complaint I sent soon after [redacted] death the General Manager of [redacted] offered me a meeting at the clinic. A Coronial Enquiry and Investigation was held and the Coroner deemed it was unnecessary to hold an Inquest.

After receiving the Coronial Findings in September 2017 I wrote to the General Manager finally taking up her offer of a meeting. I had noted inconsistencies and contradictions in information provided to the Coroner by [redacted] in relation to aspects of [redacted] care. In particular aspects in relation to assessment of her suicidal risk, her placement in ICU, dose changes in her medication, awareness of her sexual assault when she was 15 years old and her preferred next of kin.

The meeting was held on December 22nd 2017. My husband and my counselor from *Support After Suicide* accompanied me as observers. Statements made in the hour long meeting with the General manager of [redacted] Ms [redacted] Treating Psychiatrist, [redacted] the Director of Nursing, [redacted] and the Chairman of Accredited Psychiatrists at [redacted] Associate Professor [redacted] offered new information that indicated a lack of duty of care by [redacted] in accepting into their clinic those who present as suicidal. The first piece of new information concerns policies and procedures re Treatment at [redacted] and suicidality. The second concerns ignorance by the Treating Psychiatrist [redacted] of the potential impact of medication on suicidality. The third concerns policies and procedures at [redacted] related to communication with family and carers.

**i. Policies and Procedures re Treatment at [redacted] and suicidality**
Early in the meeting [redacted] explained the terms *long term* risk and *short term* risk in assessment of suicide risk at [redacted] This discussion led to the statement by [redacted] that [redacted] ***does not treat patients who are suicidal***. This discussion was in response to my questioning of how [redacted] could be discharged when she had been assessed by [redacted] in

her Initial Assessment Interview and then again in her Discharge Summary as medium to high *long term* risk of suiciding.

[redacted] explained that, ***although it was not written down in her Discharge Summary,*** [redacted] ***was assessed as low risk in the short term of suiciding on the day of discharge.*** She further explained that [redacted] was assessed by her as low *short term* risk of suiciding when given leave passes. [redacted] further explained this ***assessment of low short term risk of suiciding was necessary for*** [redacted] ***to have access to leave passes and also to be discharged.***

I expressed that I couldn't understand how [redacted] could be assessed as medium to high risk in the *long term* of suiciding but low risk of suiciding in the *short term* when [redacted] ***was informed by*** [redacted] ***and through her GP's referral of many factors that put*** [redacted] ***at risk of impulsively suiciding in the short term both while in the clinic and even more so when exiting it.***

These included the personal risk factors with which [redacted] entered the clinic of her:

- suicide attempt only 6 days before entering the clinic
- concerns about her suicidal impulses and her expression of desire to her GP and [redacted] to be kept safe from them
- rape when a student in France when 15 years old and thus potential for Post Traumatic Stress Disorder (PTSD) and especially given surrounding circumstances of the rape and present life circumstances known to [redacted]

And the risk factors created by the interventions of [redacted] and [redacted] of her:

- medication (and misuse of by [redacted] that increased its potential risk of impulsivity and suicidality in the first month of administration and at times of dose changes
- being further traumatised by unexpected placement in ICU
- being discharged with no Assertive or Proactive Aftercare in place despite the known suicidal risk for anyone when they exit a psychiatric institution and even more so when they have had a previous suicide attempt.

It was after this discussion that [redacted] said, [redacted] ***does not treat patients who are suicidal, we treat depression". She said she was treating*** [redacted] ***for depression, not for suicidality. She explained that if a patient was suicidal they would be sent elsewhere.***

**ii. Ignorance by the Treating Psychiatrist [redacted] of the potential impact of medication on suicidality**

When I raised my concerns that the way [redacted] had been administered by [redacted] while [redacted] was in the clinic could have increased [redacted] risk of impulsively suiciding [redacted] responded, ***"If a drug made you suicidal it would not be on the market."***

**iii. Policies and procedures re communication with family and carers**

a. Impotence of family in communicating with clinic re concerns

Another discussion that provided new information was initiated when I expressed my increasing anxiety about what I was observing while [redacted] was in [redacted] [redacted] ***asked me if I had considered speaking to somebody in the clinic about my concerns. I asked, "Who should I have contacted?"*** [redacted] ***said it would be*** [redacted] ***treating psychiatrist.*** I then explained how I had left several messages for [redacted] however she had not responded and nobody had explained to me why she didn't return my calls. ***It was only after her death I learnt that*** [redacted] ***had given instructions for*** [redacted] ***not to speak to me or her father.***

b. Assertive Aftercare not incorporated into [redacted] procedures

When I raised my concerns about a lack of Assertive Aftercare the discussion indicated such a strategy is not incorporated into [redacted] procedures. The Director of Nursing [redacted] did not even understand the concept as she responded that there was Aftercare in place as [redacted] had a plan for when she left the hospital. In response to this comment my counselor explained what the term 'Assertive Aftercare' meant. To this [redacted] stated, ***"If Aftercare was deemed necessary the patient would not be discharged."***

c. Lack of clarity of procedures re how next of kin is determined

Then I raised my concerns about inconsistencies around who was [redacted] next of kin. On [redacted] Discharge Summary for [redacted] she had noted "patient consented only to the brother [redacted] to be her next of kin" while in her Police Statement [redacted] wrote, "At the time of this first interview…it was conveyed by Ms [redacted] that they (*her partner and her brother* [redacted]) would be her preferred next of kin. " When I noted that her partner was the only one contacted on her discharge [redacted] said ***the next of kin is determined by who the patient chooses that to be at the time of discharge.***

d. Lack of policy guidelines at [redacted] re role of family meeting

Towards the end of the meeting [redacted] then asked me if I had considered bringing together the family in a **'family meeting'**. To this I replied that I hadn't seen this as my role. I was [redacted] mother not her mental health professional. It was then that [redacted] mentioned in some detail a paper he had written several years earlier when he was Chief Psychiatrist of the State of Victoria. This paper offered guidelines for psychiatrists on clinical practice standards and titled, "Working Together with Families and Carers." He spoke of its' key message that families and carers should be recognized, respected and supported as partners in providing care to patients and engaged as early as possible in treatment and care.

When I looked up the paper I was bewildered as to why he would have mentioned it in the context of the meeting as it expressed policy guidelines completely opposite to what was practiced by [redacted] and [redacted] As [redacted] is a consultant psychiatrist to [redacted] I now question who or what plays any role in monitoring the practices of consulting psychiatrists at [redacted] and what is the role of [redacted] in [redacted] While there were many aspects of this paper that were pertinent to what was missing in the care of [redacted] while she was in [redacted] the sentence that most stood out to me was:

*Prior to a consumer's discharge from either hospital or a community-based public mental health service, carers should be fully involved in disharge planning and implementing continuing care. The clinician's opinion should be based on an assessment of the family or carer's ability and willingness to provide care.*

**Who was taking responsibility for decisions about [redacted] treatment and care?**
I rang [redacted] on the Tuesday after [redacted] death. I left a message for [redacted] to ring me. I also explained to the receptionist that [redacted] had taken her life. Soon afterwards [redacted] rang me back. We spoke for about half an hour. [redacted] mostly talked about hospital policies and procedures.

In describing the discharge procedures and policies she explained that she had spoken to a nurse on the phone and it had been decided that [redacted]:

*"met the criteria for full capacity in making decisions on her treatment options and choices."*

[redacted] wrote this statement in her Police Statement and repeated it in other written material and in the meeting 2 years after [redacted] death. This phrase was expressed so often I am left wondering if [redacted] was the only one with responsibility for making decisions around her treatment options and choices while in [redacted] and while exiting it.

What use was the supposed expertise of the mental health professionals in the clinic if their knowledge was not utilized for [redacted] treatment and ongoing care? For example, when [redacted] decided to discharge herself against medical advice she did not have the knowledge that she was taking a drug that could make her more impulsive and suicidal for up to a month or that it had been administered against the guidelines and in a way by [redacted] while she was in the clinic that increased these tendencies. [redacted] also did not have the knowledge of the importance of Assertive and Proactive Aftercare because of the suicidal risk for individuals when they exit a psychiatric institution and even more so if they have had a previous suicide attempt. This knowledge about the medication [redacted] and the importance of Assertive and Proactive Aftercare for somebody who is exiting a psychiatric institution is assumed to be held by her treating psychiatrist. So what do they mean by [redacted] having "full capacity in making decisions" about discharging herself against medical advice when she did not have this knowledge? And if the Mental Health Act says they cannot keep her if she wishes to exit the clinic surely it is her treating psychiatrist's responsibility to alert [redacted] and her caregivers of this knowledge and the need, therefore, for her to be monitored carefully after she has left the clinic.

**In Conclusion**
Psychological literature highlights the role of unbearable psychological pain in suicide. Psychological pain pushes a person to contemplate how to take their life as a way to free them self from it. While experiencing this unbearable psychological pain one also hopes a person remains connected to that part of them self that wants to live and so they seek out appropriate support.

[redacted] openness with her GP and her treating psychiatrist at the clinic about her suicidal impulses and her expression of desire to be kept safe from them suggests that during the last 12 days of her life she was in contact with that part of herself that was in unbearable psychological pain and that part of herself that wanted to live. Her suicide note reinforces this understanding.

"My beautiful Family, my loving family - beautiful people who care for each other. I am so confused and in pain. I feel as though every day I awake to a gridlock of trauma, which comes in violent waves throughout my waking hours. I grieve for my life unlived and I grieve further, knowing that if only I could feel my heart beyond this rigidity of fear then I would have a good life to live at my fingertips. Life is peaceful. The world is good. The world is fucking overwhelming and I no longer feel I have a place in it. I don't have a place in it. I can't feel anything.

Please know that this was the kind of thing I could do to myself. I cannot fathom this right now as I sit on my verandah... the cruelty of it - the folly of it. The violence I inflict on myself and my loved ones leaves me feeling heartless and alien to even consider it - but I am too strung out - too traumatised. Too much is daily trauma of feeling so very far away from the Trishy deep inside. I don't know where I went wrong but - and I keep telling myself that this head space of suicide is just an avoidance of making decisions and acting on them - when did I become so weak and hopeless?

I am so deeply sorry. I love you all so much. I feel far away from this love though in my heart I know that it is real & deep & true and that I am causing much pain to those I wish most to cherish and celebrate with. This is madness. A madness which I would wish upon no-one.
I think so many times a day about how to end it - and then I consider the potential of life - but I feel chained. Straight jacketed. The smell of a gardenia amounts to nothing when one is so far gone."

In her suicide note [redacted] expressed the part of herself that was in unbearable psychological pain and the part of herself that recognized that if she didn't have this pain she had a good life to live when, for example, she wrote "every day I awake to a gridlock of trauma, which comes in violent waves throughout my waking hours" and then "if only I could feel my heart beyond this rigidity of fear then I would have a good life to live at my fingertips. Life is peaceful. The world is good."

When some of [redacted] family and friends encouraged her to enter [redacted] they did so with the understanding that [redacted] treated people who were suicidal. In her Initial Assessment Interview with [redacted] was completely open about her suicidality and her desire to be kept safe from her suicidal impulses while the correct treatment was found. Once [redacted] voluntarily admitted herself into the clinic her family was cut off from communicating with key people in the clinic responsible for her care and relinguished its capacity to look after [redacted] and keep her safe from her suicidal impulses.

It haunts me to know that rather than protecting her from her suicidal impulses, as she requested and her family and friends assumed, the actions of her treating psychiatrist and [redacted] in the six days [redacted] spent in the clinic potentially increased her risk of impulsively suiciding. These actions include dose changes made by [redacted] against the MIMS administration guidelines for Pristiq that increased its potential risk to impulsivity and suicidality in its first month of administration; [redacted] being further traumatised by unexpected placement in ICU and even more so given she

had never been hospitalized in her life; and her being discharged with no Assertive or Proactive Aftercare in place despite the known risk of suicide for anyone when they exit a psychiatric institution especially when they have had a previous suicide attempt and also given the MIMS Prescribing Information re [redacted] that patients and caregivers need to be informed about potential side affects of suicidality and impulsivity.

Information supplied to [redacted] and [redacted] by both [redacted] and her GP indicated [redacted] was at a high risk of impulsively suiciding in the short term. Yet [redacted] assessed her as low risk of suiciding in the short term, both when [redacted] was given leave passes on her second full day in [redacted] and then when she was allowed to self discharge against medical advice four days later. How can they make this assessment when the dose changes of her medication alone put her at a greater risk of impulsively suiciding in the short term?

Information gained through my meeting at [redacted] almost 2 years after [redacted] death, indicate [redacted] and [redacted] do not have knowledge and policies and procedures to support those who are suicidal. This suggests a lack of duty of care by [redacted] and [redacted] in accepting individuals, such as [redacted], who are suicidal

After the meeting I wrote to the Coroner and made a late request for an inquest into [redacted] death highlighting the new information I had learnt in the meeting about policies and procedures of [redacted] The Coroner replied that given this new information she would re-open the investigation into [redacted] death. I made this late request for an inquest in the hope that by doing so it would highlight changes that need to be made in policies and procedures of psychiatric institutions dealing with suicidal patients. Once I knew there was to be a Royal Commission into the Mental Health System in Victoria I withdrew my request for an inquest. I was informed, however, that the Coroner would still seek clarification from [redacted] and [redacted] in relation to the concerns raised by this new information. The Coroner also explained that her Amended Findings would be forwarded to me.

I have made this submission to the Royal Commission into the Mental Health System in Victoria in the hope it can help highlight the changes that need to be made in policies and procedures of psychiatric institutions dealing with suicidal patients. This may save others' lives and help others avoid being in the "waking nightmare" I am facing every day.